MONASH University

The Effects of Unresolved Trauma and Identity Feedback on Counsellor Misconduct and Malpractice

Paul David Kremer
BSocSc, BA (Psych), BSc (Hons) (Psych), PGradCert, MBA

A thesis submitted for the degree of *Doctor of Philosophy* at
Monash University in 2017

Copyright Notice

Abstract

A counsellor's unresolved trauma is a risk factor for breaching ethical standards and committing misconduct and malpractice. Around 20% of counsellors are impacted by unresolved trauma, however may ignore its presence and thus put themselves and their clients at risk. This thesis aimed to understand the mechanisms by which unresolved trauma leads to misconduct and malpractice. Data consisted of self-report responses from 419 professional counsellors with an average of 12 years' professional experience, court documents for 42 registered psychologists found guilty of professional misconduct, and annual reports of complaints made to professional counselling bodies. Notable findings indicate that complaints made against counselling professionals have increased over a five-year period (2011-2016), and that the breach reporting rate and attitudes and behaviours about ethics did not differ between regulated and unregulated counsellors. Self-reported explanations concerning *why* counsellor misconduct and malpractice behaviours occur coalesced into three themes: externalisation of responsibility for personal actions and behaviours, lack of objectivity, and an inability to understand how personal circumstance, including unresolved trauma and other mental health concerns, impact the delivery of therapeutic services. It appears that resolving trauma whilst practising increases the risk of breaching profession ethical standards. A mediation analysis indicated that the relationship between unresolved trauma and attitudes toward boundary crossings and violations were mediated indirectly via self-enhancement, with a medium effect. Counsellors with unresolved trauma may use self-enhancement to bolster their self-concept in order to support their own psychological health, which in turn impacts the therapeutic alliance. A multifactorial model is presented to explain the interaction between unresolved trauma, identity, social interaction and client factors as causes of unethical behaviours. This, in turn, may aid identification of 'at-risk' professionals. It is recommended that counsellors be taught to self-reflexively develop and continually test

"ethical intelligence" with peers and supervisors in order to make sound ethical decisions. Future intervention and prevention programs should focus on administering multifaceted campaigns targeting the 'counselling chain of responsibility' to improve counsellor wellbeing, better protect clients, and strengthen the counselling industry — both regulated and unregulated.

Keywords: unresolved trauma, self-enhancement, ethical behaviour, posttraumatic stress, wounded healer, ethical intelligence, counselling, ethics, transgressions, misconduct, malpractice, unregulated, regulated counselling

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signature: Paul Kremer
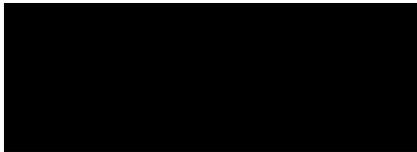
Date: 9th of September, 2017

Publications During Enrolment

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes *one* original paper submitted to a peer reviewed journal. The core theme of the thesis is to further our understanding of how factors associated with counsellors' unresolved trauma can assist in explaining misconduct and malpractice phenomenon. The ideas, development and writing up of all the studies/papers in the thesis were the principal responsibility of myself, the candidate, under the supervision of *Dr. Mark Symmons*. The inclusion of co-authors reflects the fact that the work came from an active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapter 3 my contribution to the work involved the following:

Thesis chapter	Publication title	Publication status	Nature and extent (%) of student's contribution	Co-author name(s) Nature and % of Co-author's contribution
3	Exploring the *why* of psychologist misconduct and malpractice: A thematic analysis of court decision documents	Under Review (2ndRound)	The candidate's contribution to this paper was estimated to be at least 75%. The candidate also devised the concept of the paper, obtained consent to access data, collected the data, entered and analysed the data. The candidate undertook the statistical and qualitative analyses, interpreted the results, prepared the paper for publication, all in consultation with Dr. Mark Symmons.	Dr. Mark Symmons, study conceptualisation, interpretation and editing - 20% Dr. Brett Furlonger, editing - 5%

I have a complete article of the submitted papers within the thesis.

List of Publications

The following additional activities occurred during my candidacy, with the following additional outputs, which include:

Journal Articles

Kremer, P. D., Symmons, M. A., & Furlonger, B. E. (*2nd Round Review*). Exploring the why of psychologist misconduct and malpractice: A thematic analysis of court decision documents. *Australian Psychologist.*

Industry Publications

Kremer, P. D. (2014). Practical ethics: Resolving ethical dilemmas. *Counselling Australia, 14*(5), 24-27. [Peer Reviewed]

Conference Presentations

Kremer, P. D., Symmons, M. A., & Furlonger, B. E. (2015). The psychology of professional misconduct: What an analysis of Civil and Administrative Tribunal decisions can tell us about malpractice causation. *Joint ANZAPPL/RANZCP FFP Conference, Canberra, 25-28 November*.

Kremer, P. D., Symmons, M. A., & Furlonger, B. E. (2014). The relationship between personal trauma and ethical counselling: The mediating influences of exploitation behaviours. *28th International Congress of Applied Psychology, Paris, France, 8-13 July, 2014*.

Kremer, P. D., Symmons, M. A., & Furlonger, B. E. (2014). The spectrum of impropriety: A thematic analysis of malpractice, and the relationship between mandatorily and voluntarily registered counselling professionals in Australia. *28th International Congress of Applied Psychology, Paris, France, 8-13 July, 2014.*

Kremer, P. D., & Symmons, M. A. (2013). Entering the counselling profession: Liminal

transitions and life apprenticeships. *Australian Counselling Association National*

Conference, 27th of September 2013, Gold Coast, Queensland.

Symmons, M. A., & Kremer, P. D. (2013). Technology: A brave new world of counselling.

Australian Counselling Association National Conference, 27th of September 2013,

*Gold Coast, Queensland.*
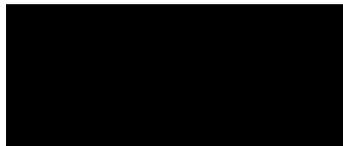
Paul Kremer   Date: 9th of September, 2017

The undersigned hereby certify that the above declaration correctly reflects the nature and

extent of the student and co-authors' contributions to this work.

Dr. Mark Symmons   Date: 9th of September, 2017

Table of Contents

Tables

Figures

Acknowledgements

Chapter 1: Introduction

Many believe that those in the helping professions, such as counsellors, psychologists, nurses and social workers, are better able to assist clients if they have had a similar or related experience. Indeed, that is the cornerstone of empathy, that walking a mile in the shoes of another provides the necessary understanding to truly understand the plight of another and then render assistance. The argument goes that without this experiential background the best the helper can offer is sympathy, which is a pale substitute for genuine empathy. It is well established that outcomes from the therapeutic working alliance are significantly improved when therapeutic empathy is high (Bordin, 1979, Horvath & Luborsky, 1993; Lustig, Strauser, Rice & Rucker, 2002). Therefore, it could be argued that it is better for clients to seek the services of counsellors who may have had similar life experience, including experiencing a similar trauma, to ensure optimal therapeutic empathy and working alliance.

Earlier traumatic events, or probably more correctly a perceived successful resolution of earlier traumatic events, are a common motivator for becoming a counselling professional (Frank & Paris, 1987; Elliot & Guy, 1993; Sussman, 2007). Counselling professionals include unregulated counsellors (who may be voluntarily associated with ACA or PACFA), regulated psychologists, social workers, and other professionals who identify as practising 'counsellors'. These counsellors believe they are ideally placed to help others who have experienced similar problems to their own (Richardson, Sheean & Bambling, 2009; Sussman, 2007). This is a fundamental tenet of mutual-aid groups such as Alcoholics Anonymous, in which members who have "been there" provide support to others in a shared struggle against alcohol dependence.

The idea that a counsellor is more effective if they have experienced previous trauma themselves is encapsulated in the concept of the 'wounded healer' identified by

Jung (1951). Jung held that those who have recovered from traumatic experience can develop increased therapeutic capabilities leading to superior working alliances with clients (Newcomb, Burton, Edwards, & Hazelwood, 2015; Prout & Wadkins, 2014). On the surface, this seems to be a very persuasive argument, with a logical extension that institutions should make prior trauma a selection criterion for entry into the counselling profession. However, the research does not support such an approach.

Indeed, evidence suggests that counsellors who have had past traumatic experiences may actually perform worse in professional practice (Ivey & Partington, 2014; Newcomb, Burton, Edwards, & Hazelwood, 2015; Zerubavel & Wright, 2012). The key likely lies in the successful resolution of the impact of the earlier trauma, and whether the individual has recovered completely. Counsellors with unresolved trauma – a failure to complete a process of consolidation following a traumatic incident (O'Donnell, et. al, 2012; Stovall-McClough & Cloitre, 2003; Walker, 2003) – are more likely to be dysfunctional or impaired (Guy, 1987). In turn, this may put them at greater risk of transgressing ethical boundaries than those who have resolved their traumatic experience. Consequently, the experience of trauma may lead to divergent outcomes whereby the trauma may serve as a resource or a liability. Ivey and Partington (2014) recognised the potential benefit of prior experience for building rapport. However, they also noted that for some counsellors unresolved trauma may compromise professional functioning and/or impair self-reflective capacity, leading to an increased risk of boundary crossings and violations.

To further investigate the concept of unresolved trauma and its impact, Newcomb, Burton, Edwards and Hazelwood (2015) examined the learning needs of those studying social work and human services who had histories of abuse, neglect or other significant negative childhood events. Their findings led them to conclude that students with

unresolved trauma may require additional support to avoid issues — such as countertransference —whilst in professional practice. Evidence from another study suggests that a history of sexual abuse trauma amongst males who went on to become counsellors significantly increased the likelihood they would commit misconduct in professional practice (Jackson & Nuttall, 2001).

Unresolved trauma may persist due to unconscious mechanisms or because of a deliberate process resulting in the counsellor ignoring, avoiding, and/or diminishing concerns relating to their issues. An unconscious or non-deliberate mechanism results in a lack of awareness of the personal problem, creating what Goleman (1998) calls a blind spot. A blind spot is a counsellor's inability to self-reflect and therefore expose personal problems, which may result in self-deceptive behaviours that are difficult for others, including supervisors, to detect. Alternatively, the counsellor may be aware of their unresolved trauma, however, may not seek help due to a fear of stigma (Skorina, 1982; Skorina, Bissell & de Soto, 1990; Smith, & Moss, 2009). Sherman and Thelen (1997) argued that counsellors have a tendency to equate personal problems with incompetence, which may dissuade the counsellor from taking steps to deal with personal concerns.

The avoidance of personal problems may lead to stress relating to a particular concern, and distress concerning unsuccessful attempts to resolve trauma that may result in impairment (Cushway & Tyler, 1994), potentially affecting client wellbeing and disrupting effective therapeutic outcomes (Smith & Moss, 2009). This is not only a concern for the welfare of the client within the client-counsellor dyad, but also in terms of the impact it has on the public awareness of counselling as a helping profession.

Professions such as medicine, dentistry, and nursing began addressing the relationship between impaired practitioners and ethical conduct in the late 1980s (Skorina, 1982; Skorina, Bissell & de Soto, 1990). At that time counselling professionals

appeared unable to discard what Skorina (1982) called an aura of invulnerability. Arguably, the mental health professionals' image of themselves as invulnerable to blind spots still exists decades later (Barnett & Cooper, 2009; Negesh & Sahin, 2011). An important question arises as to whether one can predict if impairment now or in the future will have a deleterious influence on working with clients. A second important question centres on how many counsellors who have experienced psychological difficulties might attempt to resolve those difficulties whilst currently working with clients (Elliott & Guy, 1993; Frank & Paris, 1987; Hardy & Calhoun, 1997; Sussman, 2007).

Ivey and Partington (2014) surveyed course entry panellists for clinical psychology programs to find concerns expressed about admitting students with unresolved trauma. Their rationale was that unresolved trauma may compromise the professional boundaries of students, impair self-reflective capacity, and lead to less than adequate client care. One explanation for this phenomenon might be that some counsellors equate, in part at least, a career in counselling with an opportunity to resolve personal trauma and heal themselves.

This strategy seems plausible as pursuing a counselling career offers access to a plethora of resources available to work towards healing oneself. Such resources include tertiary training and education in counselling/psychology, access to therapeutic supervision, and mentorship and peer support (Elliott & Guy, 1993; Frank & Paris, 1987; Sussman, 2007). It is possible that during training and counselling practice placements (for the completion of practical requirements in training), an opportunity may exist for counsellors-in-training to secure various forms of identity feedback, which may reduce or mitigate some of the effects of their trauma.

Identity feedback mechanisms (i.e. self-enhancement and self-verification) bolster personal identity, specifically supporting an individual's self-concept — a collection of

beliefs about oneself (Myers, 2009). Pyszczynski, Greenberg, Solomon and Schimel (2004) suggest that individuals are motivated to pursue positive self-evaluations because raising one's self-esteem protects the self-concept and reduces anxiety-related defensive behaviours protecting the self-concept. Taylor and Sherman (2008) suggest this occurs because self-enhancement (positive feedback) is useful in maintaining or improving psychological health when grappling with challenging life events, including unresolved trauma.

Counsellors with unresolved trauma may be more likely to seek out self-verifying and self-enhancing feedback in attempts to verify who they are (Swann, 1983) and be seen in a positive light by others, including clients, in order to maintain acceptable personal levels of self-esteem (Swann, Pelham, & Krull, 1989). In doing so, these individuals may have more relaxed attitudes to professional boundaries in order to increase opportunities to secure as much identity feedback as possible. This, ultimately, may increase the likelihood of ethical transgressions, misconduct behaviours, and negligence causing harm to their clients — otherwise known as malpractice. All of these concepts will be discussed in further detail across the thesis.

Research aims

The overarching objective of this project is to better understand how various factors associated with a counsellor's unresolved trauma impact their identity and subsequently their behaviours in therapeutic practice, and to understand how this might be associated with misconduct and malpractice behaviours. According much of the research in the field of counselling is classified as *outcome* and *process* research, failing to explore the more difficult questions regarding *why* (Orlinsky & Howard, 1986). Accordingly, this thesis examines the why of counsellor misconduct and malpractice.

The aims of this thesis/project are to:

1. Investigate the prevalence of serious misconduct in the regulated and unregulated counselling industry.

2. Identify explanatory themes that might assist in explaining why misconduct and malpractice behaviours might occur.

3. Develop a theory to explain the relationship between a counsellor's unresolved trauma and their increased risk of misconduct and malpractice.

4. Construct a model that explains the causal mechanisms of misconduct and malpractice.

5. Understand if differences exist between regulated and unregulated counselling professionals on measures of their ethical attitudes and behaviours.

6. Explore whether identity feedback mechanisms (self-enhancement and self-verification) mediate the relationship between unresolved trauma and counsellor's attitudes toward boundary crossings and violations.

Overview of thesis chapters

This thesis comprises ten chapters, including this introductory chapter. *Chapter 2* provides an overview of Australia's mental health industry. The chapter makes a case that regulation alone is not a sufficient deterrent in and of itself, and that prevention is better than reacting after a breach of conduct has occurred.

Chapter 3 contains a qualitative study that examines instances of misconduct and malpractice for Australian counsellors. This is an attempt to identify potential causal reasons for why such behaviours might occur. The study examines evidence that unresolved trauma is an antecedent of impairment associated with misconduct and malpractice.

Chapter 4 provides an overview of a number of factors associated with the propensity for counsellors to act against a client's best interests, potentially resulting in misconduct and malpractice. This chapter considers *types* or categories of counsellor-based factors that might increase the potential for a counsellor to transgress boundaries.

Chapter 5 presents an argument for a causal relationship between a counsellor's unresolved trauma and an increased risk of misconduct and malpractice. The chapter also explores the view that unresolved trauma appears to interfere with a counsellor's ability to provide effective interventions and support clients.

Chapter 6 contains a review of four models that explain malpractice and misconduct. A new model is then described depicting the interaction of the key variables of interest. The proposed model presents a mechanism explaining how a counsellor's unresolved trauma might lead to misconduct and malpractice behaviours and the identification of additional variables that assist in clarifying variable relationships.

Chapter 7 tests a specific element of the new model. It explores differences in attitudes and behaviours in relation to ethical and unethical conduct in counselling practice. Regulated professionals, such as psychiatrists and psychologists, are compared with unregulated professionals, such as general practice counsellors and psychotherapists. The analysis investigates counsellor attitudes toward three categories of behaviour: ethical, unprofessional and incompetent, and boundary crossings and violation behaviours. A secondary analysis explores prevalence rates for serious misconduct between regulated and unregulated practitioners.

Chapter 8 explores the mediators that might assist in clarifying the relationship between counsellors' unresolved trauma and attitudes toward boundary crossings and violations, thus empirically quantifying an important element of the proposed model. Counsellors completed three measures: a posttraumatic stress disorder screen, a self-

verification and self-enhancement survey, and attitudes toward boundary crossings or violations. Through a mediation analysis this study provides evidence for a relationship between unresolved trauma and attitudes toward boundary crossings and violations — which potentially lead to malpractice and misconduct— and the mediating effects of identity.

Chapter 9a is part of a larger general discussion. It has a research focus and so addresses the aims and associated hypotheses contained within the chapters and studies in the thesis. The chapter brings together all the components of the thesis culminating in the presentation of a potential causal pathway within the multifactor model developed in chapter 6. The model is then applied to an actual case study to confirm its utility beyond the theoretical.

Chapter 9b is a counterpart to 9a. It provides important practical implications and recommendations from the thesis that may be useful to counselling practitioners and the industry more broadly. Specifically, content in this chapter explores how counsellors might develop ethical intelligence, and resolve ethical dilemmas using a step-by-step methodology. This chapter also provides suggestions for the implementation of prevention and intervention strategies in a 'matrix fashion' covering the chain of responsibility for client care and assisting in efforts to reduce and mitigate misconduct and malpractice behaviours.

Chapter 10 is divided into three areas for convenience — conclusions, research recommendations and practical recommendations — it provides some concise points about the outcomes of the research.

Finally*,* an *additional research project* can be found in Appendix 1. This project was conducted as part of the overall thesis however is appended rather than incorporated because it is a related rather than central component to the thesis. It assesses the

psychometric properties of the 47-item Ethics of Practice Questionnaire - Revised (EPQ-R) using an Exploratory Factor Analysis (EFA). The original 83-item Ethics of Practice Questionnaire (EPQ), developed by Pope, Tabachnick, and Keith-Spiegel (1987), was designed to gauge the extent to which participants agreed that particular behaviours occurring during the provision of therapeutic services were ethical. The EPQ was originally designed and administered to a population of registered psychologists in the United States, therefore limiting its use to other populations outside of its intended scope without modification. This revised instrument can be administered to a more diverse population of counselling practitioners.

Chapter 2: An industry overview: Does regulation really matter?

It is generally accepted that around a quarter of any Western population will experience some form of mental health-related concern in their lifetime (World Health Organisation, 2017). Yet, the treatment rate does not match the prevalence rate. For instance, the Australian Institute of Health and Welfare (2013) estimated that 1.9 million Australians, approximately 9% of the population, received public or private mental health services in 2010-11. They also reported 15 million mental health-related General Practitioner (GP) visits in 2011-12, though it is not known how many unique clients this represents. In response to low treatment rates for mental disorders such as anxiety, depression and substance use disorders, Australia's national medical safety net – the Medicare Benefits Schedule – was introduced. The *Better Access* program was established in 2006 to provide publicly-funded rebates for six mental health visits per client per year, with additional rebated visits available in certain circumstances (Pirkins, Harris, Hall & Ftanou, 2011). While this spending was welcomed, it has not been without criticism. The rebates were limited to clients with significant mental health problems that could be addressed by evidence-based services— generally confined to behavioural approaches that could demonstrate the potential for impact within the six-visit window funded, primarily Cognitive Behavioural Therapy — provided by governmental — registered practitioners, such as psychologists. While this might be considered a good start, this group of clients and practitioners are a small subset of the potential need and the potential solution.

Diagnosable mental illness is not the only reason individuals seek help. People can present with a range of concerns that can significantly interfere with their cognitive, emotional, or social functioning (Department of Health and Aging, 2009), as well as dealing with emotional and physical abuse, anger management issues, family and

relationship issues, support in breaking addiction to various substances and activities, and so on. Likewise, clinical psychologists are not the only group who can help with these issues. If counselling is considered a function or activity rather than a job title, then there are other professionals who provide counselling services as a core element of their job. Beyond psychologists who are registered to practice but do not consider themselves clinical psychologists, there are therapists, counsellors, social workers, and others. These practitioners may not treat those with severe mental illness, but rather work to assist clients to improve their adaption to past, current and future situations, dealing with relationships, daily functioning, stress, less severe mental illness, and so on.

It is difficult to rigorously define counselling (Orlinsky & Ronnestad, 2005), though it can be argued that it is multi-faceted in terms of approaches, target clients, desired outcomes, and so on. Feitham and Dryden (1993) say that counselling is simply a process in which the application of psychological theories and communication skills are applied to resolving client concerns. It involves interactions between two or more people in which rapport building, communication skills, and solution-focused tactics are applied in support of positive outcomes for clients. The development of a relationship between client and counsellor creates a solid base upon which the application of therapeutic techniques can occur (Gelso & Carter, 1985; 1994). While the counselling function might be part of the approach of all mental health workers, they are not equivalent in the eyes of the law. For the purposes of this study, 'counselling' is defined as an interpersonal process performed by mental health professionals, either regulated or unregulated, as part of the delivery of therapeutic services to aid clients to develop self-understanding to make or enhance positive change. Using this definition, comparisons can be made between the various mechanisms available to regulatory bodies and industry associations aimed at preventing misconduct and malpractice.

For legal purposes, the somewhat amorphous counselling profession can be divided into two groups, regulated and unregulated. Regulated practitioners are typically psychologists, while unregulated counsellors often call themselves therapists or psychotherapists, or counsellors. To become qualified, and thus regulated, a psychologist must complete a set course of study and supervised practise through an Australian tertiary provider (or apply for equivalence if qualified outside Australia). The qualification consists of a three-year bachelor degree and honours year both majoring in psychology – vetted and licensed by the Australian Psychological Accreditation Council (APAC) – followed by either a two-year masters degree, a one year professional masters degree or a two-year internship (supervised practise). The term *psychologist* is protected in law and only those completing the requirements may use it. Once qualified they must register with the Australian Health Practitioners Regulation Agency (AHPRA) before they can begin to practise.

Unregulated professionals who are involved in counselling are a rather more nebulous group with respect to a clear definition. They are currently not required to complete a particular training program, or any training program at all, in order to call themselves a counsellor. They are also not required to belong to a legal or professional body, although some of them do. Higher education providers offer counselling degrees, though there is no national standard for content and assessment as there is for psychology programs. Graduates may apply for professional membership with organisations such as the Australian Counselling Association (ACA), the Psychotherapy and Counselling Federation of Australia (PACFA, which is a confederation of member associations, each with its own membership list of individual practitioners), or other body. In Australia there are an estimated 21,700 general counsellors (Department of Employment, 2015) and 26,000 social workers (Daly & Wilkinson, 2014). This contrasts with the 27,178 general

registered psychology practitioners and 4,192 provisional registrations (Psychology

Board of Australia, 2016).

Counselling has transitioned from a cottage industry into a profession and entered

an "age of accountability" (Ladney & Bradley, 2010, p. 9), to the extent that counsellors

should assume that at some point in their career they may well have to defend allegations

of misconduct and malpractice (Grenyer & Lewis, 2012; Tryon, 1986). In Australia, this

change has been driven by consumer demands and higher expectations for quality

services (Schofield, 2008), and as a consequence of a greater awareness about mental

health issues. An increase in the number of reported complaints (notifications) about

mental health professionals for misconduct and malpractice coupled with media exposure

of often tawdry details has also had an impact. There is evidence of significant change at

the counselling profession level for those in training, including greater scrutiny of formal

qualifications and tighter higher education requirements for membership to various

industry associations (Freckelton, 2011b; Richardson, Sheean & Bambling, 2009).

In Australia, both regulated and unregulated counselling professionals provide a

myriad of mental health services to a wide range of clients. Many of these professionals

are ostensibly guided by ethical principles enshrined within various codes of conduct and

standards taught to them during a range of courses. There are also laws and regulatory

frameworks to adhere to. The interplay between civil law, codes of conduct and ethics,

association/industry policy, government regulation, and mandatory reporting

requirements can be daunting to navigate, even for the seasoned professional. However,

at the core of it all is a basic inherent duty of care owed toward clients. This duty exists

above and beyond that which applies to ordinary people in everyday society. As such, it is

critical for counsellors to understand their obligations toward clients to avoid complaints

being made by, and damage done to, clients.

There are three separate potential opportunities for redress against a counsellor who has not properly discharged their duty of care – the civil system consisting of various regulatory tribunals and civil courts, professional standards committees operated by professional bodies, and the criminal justice system. Each has a part to play in the process and a counsellor may be taken to one, two or all three systems depending on the nature of the wrong committed. A counsellor might be taken to a civil court or small claims tribunal by a professional body or an individual client for financial compensation, and/or reported to a professional standards body to have their right to practice curtailed or cancelled or some other practice-related sanction imposed, and/or prosecuted through the criminal courts for criminal activity.

In an increasingly litigious society there is also a perceived threat of being taken to court and sued for breach of contract. Counselling professionals must therefore have sufficient understanding of the ramifications and risks associated with providing services and be sufficiently skilled and self-aware to mitigate against practitioner misconduct and malpractice pitfalls (Grenyer & Lewis, 2012), including understanding matters relating to boundary crossings and violations.

Counselling, professional misconduct and malpractice

Misconduct is defined as unacceptable or improper behaviour by a professional person in contravention of codes of ethics, potentially including illegal activities (Oxford, 2015). Severity of professional misconduct, hereafter known simply as misconduct, exists along a continuum between breaching codes of ethics, policies and regulations, through to criminal activity. A breach of a code of ethics, policy or regulation by a counsellor that is not considered illegal (not a crime against society) is often dealt with by an industry body or association in the first instance. For example, it is not illegal to enter business partnerships with others, yet such action is a breach of ethics under many codes of

conduct for counsellors in Australia if the other person is a current or former client.

Further, a counsellor who commits an act of fraud, such as invoicing a government body

for sessions that did not take place, is considered not only to have breached an ethics

code, but they are likely to be referred to the public prosecutor's office for criminal

charges. The primary difference between misconduct and malpractice is the absence of

demonstrable harm to a particular client or other individual as a result of the counsellor's

actions/behaviours.

Malpractice

At its core, malpractice involves negligence. Professional negligence simply

means a failure to exercise the level of care expected given the professional's training and

experience and the services they have undertaken to provide. It may involve the

commission or omission of an act that results in client damage, injury or loss. The area of

law concerned with negligence is held under the *Law of Torts.* A *tort*, a French word

meaning wrong, is a situation in which a civil wrong has been committed and wronged

party is able to claim for damages (Law Vision, 2008). In civil law the onus or standard

of proof is based on a balance of probabilities (Office of the Juries Commissioner and the

Victorian Law Foundation, 2010, para. 4), that one party failed to fulfil their civil

obligations (Library Council of New South Wales, 2011).

Malpractice is determined by satisfying four conditions: a) did the counsellor owe

the client a duty of care? b) did the counsellor breach that duty of care? c) did the client

suffer an injury or other damage? and d) was the injury or damage caused as a result of

the breach of the duty of care? If just one of these conditions is not satisfied, then

professional negligence has not been established and malpractice is avoided.

Estimates, based on the little data that is available, indicate a mean misconduct

and malpractice prevalence rate for therapists in the United States of 6% (range 0.9% -

12%). In Australia, it is predicted that over a 30-year career 2% of psychologists will be accused of serious misconduct potentially resulting in deregistration (Grenyer & Lewis, 2012). Evidence suggests that a higher proportion of men transgress compared to female therapists (ratio of 3:1), and that those who breach quite often do so on numerous occasions, as indicated by high recidivism rates (Procci, 2007). A similar finding by Grenyer and Lewis (2012) for Australia was that male psychologists are two and a half times more likely to have a misconduct complaint made against them than females.

Regulatory and administrate tribunals are also part of the civil law system. They consider a number of factors in each case before a charge of malpractice is made against a counsellor, including the role of accidents. Accidents fall into two categories: those that are reasonably foreseeable and thus avoidable, and the unforeseen or unavoidable (McDowell, 2000). For an accident to be classified as unavoidable the event must have occurred under circumstances that could not have been foreseen or prevented through reasonable precautions (McDowell, 2000). Any situation that occurs outside of an accidental ruling is considered a reasonably foreseeable event and will have ramifications for any practitioner deemed to have a duty of care for a client. An example of an accident that is reasonably foreseeable could be hastening or rushing the therapeutic process for reasons of personal convenience. This may create a condition in which the practitioner acts negligently due to a lack of consideration about the client's needs within the therapeutic process.

An unforeseeable accident may occur if a session is cut short because the counsellor is struck by an acute and severe case of physical or emotional impairment. The client's care might be impacted in a similar manner to rushing the session in order to leave early, but there is a lack of intention. The distinguishing feature between these two examples is the degree to which an event is reasonably foreseeable. In the second

situation, a counsellor who is self-aware of the acute condition and its deleterious impact should defer the session or refer the client to another practitioner in order to reduce the negative impact on the client.

The courts also consider the role of a mistake. A mistake is considered to have occurred if a counsellor proceeds on a particular course of action based on the ill-formed belief that certain facts exist, when it later turns out such information was materially different from reality (McDowell, 2000). For example, if actions or disclosures that ought to have been executed in practice have not been carried out, such as mixing up a pair of clients and providing the wrong treatment, then a mistake may have been made. Mistakes range from innocuous to harmful and can result in severe consequences for clients when counsellors fail to diligently and competently provide services.

The consequences of an unregulated industry

Regulated professionals such as psychologists and psychiatrists are required to adhere to the Health Practitioner Regulation National Law Act 2009. Unprofessional conduct includes behaviours that are considerably below the standard expected of a registered practitioner given their training and education. Unprofessional conduct also concerns misconduct, whether occurring in the therapeutic practice or not, that is inconsistent with a counsellor being a fit and proper person holding registration. While unregulated counsellors are not subject to the Health Practitioner Regulation National Act, charges for misconduct can be made against counsellors under the national Code of Conduct (Council of Australian Governments, 2015). In addition, both regulated and unregulated counsellors who voluntarily register with an industry association are required to commit to specific codes of conduct, against which violations may also be classified as misconduct.

The coronial inquest into the death of Rebekah Lawrence deemed that it was reasonably foreseeable that harmful consequences could arise when unqualified individuals attempt to deliver counselling programs without adequate training. Rebekah Lawrence was a participant in a personal development course run by persons without formal qualifications in therapeutic techniques, specifically those relating to regression therapy. At the coronial inquest Deputy Coroner MacPherson determined that Ms Lawrence's death after jumping naked out of a second storey window was not suicide (New South Wales Coroners Court, 2009). Rather, Deputy Coroner MacPherson stated "Ms Lawrence's mental health condition at the time of her death resulted in her death because of her participation in the self-development program" (MacPherson in Freckelton, 2011b, p. 477).

The Lawrence case illustrates that serious consequences can occur as a result of providers without formal training and without suitable understanding of the risks intervening in an attempt to resolve client problems (Freckelton, 2011b). In the Lawrence case the argument was made that the defendants, those individuals delivering the course, were grossly negligent. These so-called counsellors were practising beyond their capabilities and in the absence of adequate education and training. They also breached a contract with Ms. Lawrence, failing to provide her with desirable outcomes – including improved wellbeing – in exchange for a fee.

According to Freckelton (2011a), the Lawrence case incorporated two interrelated situations/conditions resulting in Rebekah's death. First, it should have been reasonably foreseeable that delivering a personal development course without adequate training and supervision would be negligent, a situation devoid of a duty of care toward potentially vulnerable clients. The second reasonably foreseeable act was that delivering such services negligently could result in client harm; in this particular case Ms Lawrence

jumping to her death from a window at her place of work shortly after attending the course.

The Lawrence case provides a poignant example for further exploration of a number of concepts presented thus far. In terms of potential actions, Rebekah's immediate family may wish to take civil action against the unqualified individuals who delivered the counselling program. Here, given the evidence of the case, the matter of negligence would most likely be proven. As such, damages due to the failure of the organisers to provide a duty of care to participants in the course would most likely be awarded for the loss and suffering caused to the family resulting from Rebekah's death.

As the organisers were unqualified, and thus unregistered, their actions in the Lawrence case are susceptible to action under the *Unregistered Health Practitioners Act*. In order to provide some form of safety net for the protection of clients using unregistered practitioners, New South Wales (Health Care Complaints Commission, 2012; HCCC), South Australian (Health and Community Services Complaints Commissioner, 2013; HCSCC) and Queensland state governments implemented a code of conduct for unregistered health professionals. In 2015 a national Code of Conduct was introduced (Council of Australian Governments, 2015; COAG) to be adopted by all states and territories (Australian Health Ministers Advisory Council, 2014). The code of conduct requires any person providing a health service, including counselling and psychological services, to do so in a safe and ethical manner. The organisers of the personal development program that Ms Lawrence attended, had such legislation been in place during that time, would have been susceptible to charges or claims under this Act.

Unfortunately, there is a paucity of published data, Australian or other, regarding prevalence rates for instances of misconduct and malpractice for regulated and unregulated counselling professionals. Of that which is available most data has, perhaps

not surprisingly, tended to focus on prevalence rates for regulated counsellors (e.g. Pope & Vetter, 1992; Procci, 2007; Grenyer & Lewis, 2012), presumably because such data is more readily available, more complete, and more standardised than that for their unregulated counterparts.

In order to cast a wider net, here 'counselling' is reframed more broadly — as an interpersonal process performed by mental health professionals, either regulated or unregulated, as part of the delivery of therapeutic services to aid clients to develop self-understanding to make or enhance positive change. Comparisons can then be made between the various mechanisms available to regulatory bodies and industry associations aimed at preventing misconduct and malpractice. This in turn provides a richer context for an examination of prevalence rates for notifications (complaints) and associated outcomes of reported instances of wrongdoing, and an assessment of the costs associated with administering and processing notifications for counselling professionals in Australia.

The ACA code of ethics provides a mechanism for dealing with complaints about members. It seeks to monitor, maintain, set and improve professional standards in counsellor education and practice (Australian Counselling Association, 2012). The second non-regulated counselling industry association, the Psychotherapists and Counsellors Federation of Australia (PACFA), also provides a framework for best practice code of conduct including seven main values/principles (Psychotherapists and Counsellors Federation of Australia, 2011). The PACFA code acknowledges the British Association of Counselling and Psychotherapy (BACP) and the American Psychological Association (APA) as foundational resources for the development of its 2009 and subsequent 2011 documents. The interdisciplinary complex of codes ensures ACFA has a solid base of tested ethics theory and demonstrates considerable alignment with the psychologists' code in Australia.

There is a considerable absence of mechanisms to capture data concerning notifications of alleged misconduct instances for unregulated counsellors compared with other professions such as psychologists. As such, the industry has only a vague picture of the actual extent to which professional misconduct exists. Daly and Wilkinson (2014) report that 50 complaints were made to the Australian Association of Social Workers (AASW) between July 2013 and June 2014. However, 27 of these complainants, or notifications, were informed that the individual about whom the complaint was made was not a member of the AASW, or due to the nature of the complaint AASW could not assist (no further explanation was given about the types of complaints that could not be processed, or why they could not be processed). Daly and Wilkinson (2014) suggested these cases of alleged misconduct or malpractice may go unaddressed.

Under-reporting due to various factors (stigma for example) likely applies to both regulated and unregulated counsellors, but under-reporting due to lack of knowledge about where and how to complain is more likely to apply to the unregulated cohort because there are a number of disparate industry bodies and report making is not always straightforward. Indeed, it is difficult sourcing and compiling complaints, or notifications, data about transgressing behaviour for unregulated counsellors due to a lack of consistency regarding how that data is be held, used, shared and accessed.

This exploratory study aimed to systematically gather data on the prevalence of serious misconduct in regulated and unregulated counselling industries. The main approach was to cast a wider-than-usual net for sets of data or information that could be integrated and consolidated, providing a snapshot in time for comparative purposes. It is hypothesised that the nationally standardised system of training, assessment, qualification and oversight will result in fewer instances of misconduct by regulated counselling practitioners than by unregulated counselling practitioners.

Method

Data sources

Data were obtained from various publicly accessible sources, including annual reports (2010-2014), submission documents from the Australian Health Practitioner Regulation Agency (2015), and the Psychotherapy and Counsellors Federation of Australia. In addition, a direct request (in accordance with the provisions of Monash Human Ethics Research Committee) was made to the Australian Counselling Association, which provided data relating to notifications and closures/outcomes from 2008 to 2013.

Procedure

Ethics approval for the project was provided by Monash University Human Research Ethics Committee (Approval Number CF13/2485 - 2013001319). Initially data were reviewed in order to achieve a level of familiarisation. Data about reported notifications (complaints) and associated closure stages (after assessment, investigation, panel review of tribunal hearing) for regulated and unregulated counsellors was collected and placed into Microsoft *Excel*. The data in the present study were analysed using the IBM Statistical Package for Social Sciences (SPSS), Version 23. All statistical analyses were conducted at a 95% confidence level.

Results

Regulated counsellors

During the 2015/16 reporting year AHPRA received 484 notifications (or complaints) regarding psychologists. AHPRA provide a detailed summary within annual reports concerning how notifications are processed. The majority of notifications ($n = 352$; 72%) were closed following an initial assessment. An additional 51 (11%) were closed following a health or performance assessment. The remaining 81 (17%) cases,

which constitute the most serious of all notifications, concluded after an internal panel or tribunal hearing.

Relative to other regulated professions such as nurses/midwives and occupational therapists, psychology ranks third highest in notifications concluding in a hearing or tribunal panel (see Table 1). This finding suggests that the seriousness of transgressing behaviour for psychologists is more severe than those committed by professionals in other regulated industries. In other words, when a psychologist does breach ethical bounds the act is more heinous, thus increasing the likelihood that the notification will result in a panel or tribunal hearing.

This finding provides an indication regarding the relative risks of harm associated with consuming mental health services from a psychologist versus the risk of harm when visiting a chiropractor, for example, for musculoskeletal concerns. Interestingly, chiropracty is a profession that is often the focus of media attention and reports in Australia concerning the provision, or lack of, non-beneficial or marginally beneficial therapeutic services (Singh & Ernst, 2008). Yet, a similar level of attention is not found with psychology.

Table 1. *Relative Ranking of Notifications Arising from Different Professions that Result in a Hearing or Tribunal 2015/16*

Profession	Registered Practitioners (*n*)	Notifications concluding in Hearing & Tribunal	Notifications by number of practitioners	Top 5 rank order
Osteopaths	2,094	10	0.48%	1st
Medical practitioners	107,179	383	0.36%	2nd
Psychologists	33,907	81	0.24%	3rd
Dentists	21,741	50	0.23%	4th
Pharmacists	29,717	60	0.20%	5th
Chiropractors	5,167	5	0.10%	
Chinese medicine	4,762	3	0.06%	
Nurses and midwives	380,208	191	0.05%	
Medical radiation practitioners	15,303	4	0.03%	
Occupational therapists	18,304	5	0.03%	
Physiotherapists	28,855	5	0.02%	
Optometrists	5,142	0	0.00%	

Source. AHPRA Annual Reports. Data relating to New South Wales and the Health Practitioners Commission is included.

The data found in Table 2 relates to the closure of complaints for regulated psychologists over time. Data from AHPRA annual reports indicates an increasing trend in the number of notifications resulting in a panel or tribunal hearing when accounting for changes in the population.

Table 2. *Closure of Panel and Tribunal Hearings for Regulated Psychologists 2011-2016*

Year of Closure	*N*	Panel	Tribunal	Total	Closures by *N*
2011-12	28,945	13	-	13	.0004
2012-13	29,645	18	9	27	.0009
2013-14	30,561	45	9	54	.0018
2014-15	31,717	24	22	46	.0016
2015-16	34,167	64	17	81	.0019
Total	-	164	57	221	-

Source. AHPRA Annual Reports. Data relating to New South Wales and the Health Practitioners Commission is included.

Unregulated counsellors

Table 3 provides the data for complaints made to the ACA and PACFA about members of these associations and the resultant charge, by category. Evaluating the table reveals that notifications typically fell into two categories. The first, and arguably the more serious, category concerns boundary crossings and violations that relate to sexual misconduct and inappropriate relationships. The second category relates to unprofessional behaviour and misconduct associated with breaches of confidence and poor service provision. Notifications received by both associations are heavily biased toward the second category (unprofessional misconduct) than the first (boundary crossings and violations).

Table 3. *ACA (2004-2013) and PACFA (2006-2001) Notifications Concluding in a Panel/Committee Decision*

Complaint Type	ACA	PACFA	Total
Breach of confidentiality	8	7	15
Inappropriate relationship	8	5	14
Dual and multiple roles	0	11	12
Discrimination	1	3	4
Unsatisfactory service or outcome	7	3	11
Other professional misconduct	6	24	31
Complain process	0	1	1
Fees/costs	0	2	2
Membership/functions/activities	7	5	12
Total	37	61	102

Note. ACA data collected over 9 years (2004-2013), PACFA over 5 years (2006-2011).

Prevalence rates for regulated and unregulated counsellors

Industry associations and the Australian government provide estimates concerning the number of regulated and unregulated professionals working within the industry at specific moments in time. Table 4 provides a summary of the notifications concluding in an ethics panel/committee or tribunal hearing for regulated and unregulated counsellors.

Table 4. *A Comparison of Snapshot Data and Sample Proportions for Regulated and Unregulated Counsellors*

Regulatory Status	Notifications Concluding in Panel or Tribunal	Years of Data in Analysis	Average Number of Notifications per year	Average Number of Professionals (5 years)	Notifications per 1000 professionals
Unregulated	107	7	15.3	20,250	0.76
Regulated	221	5	44.2	33,013	1.34

There are approximately half (57%) as many notifications for unregulated versus regulated counselling professionals, however a two tail *z*-score proportions analysis revealed that there was no significant difference ($z = 1.7$, $p = .0925$) between unregulated (95% CI [0.0004 - 0.0012]) and regulated counsellors (95% CI [0.0009 - 0.0017]) in terms of prevalence rates for serious misconduct resulting in an ethics panel/committee or tribunal hearing.

Discussion

The expectation that unregulated counsellors would be responsible for a relatively greater number of complaints was not supported by the data. For both groups the per capita rate of reported notifications that lead to tribunal or panel hearings was quite low, without a statistically significant difference between them. The fact that misconduct rates between the two groups were not statistically differentiated suggests that the presence of guiding regulations for professional behaviour are not a reliable way to predict rates of misconduct amongst counsellors. Importantly, for regulated psychologists this is a general increase over time for notifications, or complaints, resulting in panel review or tribunal hearing when accounting for changes in the population. This suggests that despite increased efforts to mitigate or reduce misconduct behaviours, such strategies may currently be ineffective.

It is important to note that the data used here for unregulated counsellors is drawn from the membership of ACA and PACFA. Both of these organisations have devoted significant attention to tightening their expectations and requirements for membership as part of a bid to gain acceptance by government and insurers for the purposes of being eligible for government rebates for client fees. Thus these counsellors might be better named "semi-regulated" or "quasi-regulated" rather than unregulated for the purposes of this analysis. There would seem to be support for this segregation. The unregulated counselling industry has been fighting since 2011 to gain acceptance as a complementary form of *natural therapy*. A core theme found within the numerous petitions submitted to government concern available mechanisms for the capture of ethical violations and processes and policies for addressing complaints made against counsellors, thus demonstrating an effective level of professional regulation (Australian Counselling Association, 2010). The ACA (2010) claims that statistics relating to risks associated with counselling services provided by its members are small, a point borne out by the current analyses.

A more useful evaluative comparison might be between statutory (legal by statute), voluntarily or self-regulated via industry association membership, and unregulated. However, as noted previously, there is currently no systematic collection of data at all for self-regulated counsellors, preventing such a comparison.

Another limitation on the collection of accurate data on misconduct malpractice may be associated with the reporting process. There are several reasons why a client may not report misconduct, some of which might differ between the groups of counsellors. The stigma of being a victim or fear of reprisals (direct threats against the client, or threats to cease treatment or break a dependent relationship), depending on the nature of the transgression, might make a client hesitate regardless of whether they had been

treated by a regulated, semi-regulated or self-regulated counsellor. However closer scrutiny, more oversight by supervisors and mandatory reporting might mean that a transgression by a regulated counsellor is more likely to come to light than for unregulated counsellors, which might have contributed to a lower frequency for the unregulated counsellors in the findings reported here.

In other cases, the transgression may have been inadvertent and perhaps not noticed by either party. Most boundary crossings are benign and not harmful to clients or counsellors (Glass, 2003). However, small repetitive behaviours that seem innocuous at first seem to gather momentum ending in a rather harmful situation. Simon (1989) posits that violations start out as subtle or seemingly harmless behaviours growing and developing in severity over time until an overt case of misconduct or malpractice occurs. It is commonplace that offenders later say they were on a slippery slope (Glass, 2003) toward transgression. Others may simply ignore, avoid, and/or diminish awareness of transgressing behaviours. This might result in a blind spot (Goleman, 1998), which is an inability to self-reflect, resulting in self-deceptive behaviours that are difficult for others, including supervisors and colleagues, to detect. This situation may occur for regulated or unregulated counsellors, though closer scrutiny by supervisors of regulated counsellors might arrest that slippery slide earlier for the former group.

The introduction of the *Unregistered Health Practitioners Act 2012* (New South Wales) is a step in the right direction, but getting a clear understanding about malpractice and misconduct on a national basis will take time as the codes are introduced state by state rather than nationally. A challenge will also lay in capturing all counsellors within the system, or steering clients away from those who refuse to register, or promoting those who do register and have thus agreed to be bound by a common set of principles of

practice. But these challenges are worth facing for the sake of even the small number of clients who are victims of unprofessional behaviours.

A central system that handles all complaints from inception to resolution, and through an appeals process, would also be to the community's benefit by providing confidence to clients and making it easier to track problems within the industry. Such a system might be ameliorated by improved training, credentialing and/or supervision.

The data used here relates to matters that have been closed at tribunal/panel stage. This does not necessarily mean it has been resolved to the satisfaction of the client who made the complaint. There is no way of knowing how many of these cases were continued elsewhere. For example, a case resulting in a panel review might then continue later in the civil system (a hearing by a civil and administrative tribunal, or pursuit of damages in court) completely independent of the governing body or association to which the client made the complaint.

The findings from this investigation have challenged the assumption that unregulated counsellors are more likely to engage in misconduct or malpractice than regulated practitioners. As this may not be the case, the matter warrants further investigation. One area worthy of additional attention is the opportunity for prevention rather than reaction to transgressions. This will require a better understanding of the antecedents leading to this behaviour so that they might be the focus of changes to training or supervision or oversight or client education. In order to better develop more appropriate interventions and prevention strategies, it is important to explore in more detail the nature of misconduct and malpractice where we might find indicators to provide direction.

Chapter 3: Exploring the *why* of psychologist misconduct and malpractice: A thematic analysis of court decision documents

This chapter is a paper that is currently under second-round review with The Australian Psychologist. It is reproduced here verbatim, thus the inclusion of elements such as its own abstract and reference list, and a degree of repetition with other parts of the thesis.

Objective: To identify causal reasons for misconduct and misconduct amongst Australian psychologists.

Method: During the five-year period from 2008-13, 42 psychologists were found guilty of misconduct and malpractice by civil and administrative courts across Australia. The court decision documents were analysed using Braun and Clarke's (2006) qualitative methodology to explore themes relating to the courts objective, the psychologists' subjective, and the authors' interpretive causal reasons transgressing psychologists engaged in misconduct and malpractice.

Results: Explanations given by psychologists for misconduct and malpractice behaviours included the use and abuse of legal and illicit substances, addiction behaviours, and impairment due to a mental disorder or unresolved trauma. Overall, male psychologists did not appear to be involved in misconduct and malpractice more often than female psychologists.

Conclusions: Psychologists' explanations concerning why misconduct and malpractice behaviours occurred coalesced into three themes: the externalisation of responsibility for personal actions and behaviours, a lack of objectivity concerning why such behaviours occurred, and an inability to understand how personal circumstance affected the provision of ethical services to clients.

Keywords: *Ethics, Malpractice, Misconduct, Psychologist, Court, Australia*

Psychology is a regulated profession in Australia. The *Health Practitioner Regulation Legislation Amendment Act 2014* aims to protect the health and safety of the public by providing mechanisms to ensure registered psychologists are fit to practice and do not act in a negligent manner. Psychologists registering to practice in Australia commit to a code of conduct outlining a specific standard of care they should provide to clients in therapy (Australian Psychological Society, 2007). A duty of care is imposed upon the psychologist, requiring the ethical delivery of services whilst prescribing a responsibility to do no harm or wrong to clients. It is important that appropriate levels of competence, inclusive of ethical practice, match the type of services offered, resulting in effective outcomes for clients (Jones & Armstrong, 2011). However, despite clear laws and regulations, misconduct and malpractice still occur.

Psychologists found guilty of gross acts of negligence and/or unprofessional conduct by a court are said to have engaged in misconduct and malpractice. Misconduct is defined as "unacceptable or improper behaviour, especially by a professional person, typically in contravention of codes of ethics and may include illegal activities" (Oxford, 2015); an example of misconduct would be a psychologist who engaged in defrauding an organisation, such as a worker's compensation authority. Malpractice is defined as "an act or omission leading to improper or negligent behaviour resulting in client harm" (Oxford, 2015); such as a psychologist who engages in a sexual relationship with a client that exacerbates the client's problems, resulting in harm.

Over a 30-year career approximately 20% of psychologists can expect to have a complaint, known as a notification in the Australian system, raised against them, and 2% of this same group will be accused of misconduct and malpractice, with male psychologists two and a half times more likely to have a misconduct complaint made against them than female psychologists (Grenyer & Lewis, 2012). Overall, an average of 441 notifications

relating to misconduct and malpractice against psychologists are made each year (Kremer, n.d.). During 2014 the Psychology Board of Australia (PsyBA, 2015) received approximately 480 notifications, or complaints, made against psychologists. The costs associated with administering and assessing notifications currently equates to approximately AUD$4.5 million (Australian Health Practitioners Registration Agency – APRHA, 2015) – around $10,000 per case. However, the real financial costs are substantially greater when taking into account the additional expenses associated with other civil suits and orders of compensation paid by professional indemnity insurers. In terms of the absolute number of complaints processed against professionals covered under the AHPRA umbrella, the psychology profession in 2013-14 was ranked third highest ($n = 54$; of 31,649 professional health services provider notifications), behind the medical ($n = 293$; of 99,209) and dental ($n = 67$; of 20,269) professions at panel reviews and court hearings (Kremer, n.d.).

The PsyBA employ various mechanisms to deal with the most serious notifications. Performance and Professional Standards Panel (PPSP) are the second highest form of disciplinary process available to PsyBA. A PPSP can hear matters relating to "unprofessional conduct" and are established should a regulatory board believe a psychologist has a health concern that leads to impairment, or their performance standard is unsatisfactory and warrants investigation (Australian Health Practitioners Registration Agency, 2015). The highest form of disciplinary process available to AHPRA is a court hearing, held for the most serious types of malpractice and professional misconduct. These cases often lead to suspension or cancellation of the psychologist's registration.

Data relating to consumer complaint reports, court hearings and PPSP's are collected and released in summary form in annual reports by associations such as

AHPRA. Grenyer and Lewis (2012) published a study of prevalence rates of notifications made against psychologists practising in New South Wales, Australia. They reviewed all complaints made by clients over a five-year period (2003-2007). In total, there were 248 notifications for misconduct concerning 224 registered psychologists from a total of 9,489 registered psychologists. According to Grenyer and Lewis (2012) 35.5% of all complaints related to 'poor communication standards'. This category included breaching confidentiality, acting in a rude or insensitive manner, and failure to secure informed consent. Poor communication was closely followed by 'professional incompetency' (16.5%), which included wrong or inappropriate diagnosis, and inadequate treatment. 'Poor reporting practises' (14.1%) includes issues such as poor record keeping and inadequate or a failure to file reports to bodies such as 'Workers Compensation', 'Family Court', and 'Victims of Crime'. 'Poor business practices' (12.5%) included overcharging, financial fraud and commercial disputes. 'Personal character', 'poor judgement', 'impairment', 'mental illness and addiction' and 'false use of title' combined accounted for 11.7% of the total. Finally, 'boundary violations' (9.7%) were next and included violations and exploitation of a sexual nature.

Notifications in and of themselves do not equate to ethical breaches, misconduct or malpractice. An analysis conducted by Kremer (n.d.) found that of the 480 notifications received by AHPRA in 2014, 72% were closed at an initial 'assessment' stage. These notifications may have been closed due to being vexatious, determined to be made to the wrong industry body, simply withdrawn by the claimant, or were without sufficient information and/or evidence to proceed to the next stage. Of the 28% of notifications that did proceed, 12% resulted in an 'investigation', 5% resulted in a 'health and performance assessment', 9% an internal 'panel review', and the remaining 2% a 'court hearing' (Australian Health Ministers Advisory Council, 2014).

In an effort to maintain the integrity of the profession, the PsyBA have produced a series of policy documents concerning supervision standards and continuing professional development. PsyBA adopted the Australian Psychology Society (2007) Code of Ethics and required all registered members to commit to it. The intent of the code was to maintain, improve and enhance the competence of members, and develop the qualities required for duties as a psychologist (Psychology Board of Australia, 2015). However, it appears that simply publishing such documents and pursuing a commitment from registered members to adhere to them is not sufficient to stop misconduct and malpractice, especially given that notification rates did not decline and the number of members appearing before a court did not fall. In order to pursue change a different approach to understanding and addressing misconduct and malpractice may be required.

There is, however, a paucity of research exploring the broad spectrum causes for misconduct and malpractice behaviours for psychologists. Much of the past research categorises ethics violations, examines frequency patterns, and/or calculates prevalence rates (e.g. Grenyer & Lewis, 2012; Pope, Tabachnick & Keith-Spiegel, 1987; Wilbert & Fulero, 1988). Few studies have attempted to examine why misconduct and malpractice behaviours occur. Of the few studies that do, researchers primarily confine their scope to therapists involved in sexual boundary crossings and violations (e.g. Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, 1983; Celenza & Gabbard, 2003; Gabbard & Lester, 1995; McAuliffe, Sauvage, & Morrissey, 2012; Shavit & Bucky, 2004).

The lack of research exploring the *why* of misconduct and malpractice is perhaps understandable given some of the hurdles researchers encounter when contemplating research in the field. First, depending on the type of study, receiving ethics approval for projects in which theories concerning misconduct and malpractice causality are to be tested can be an involved process. Second, gaining access to participants is often

challenging as many therapists and clients may be unwilling to participate due to embarrassment or shame, or their silence may be required during proceedings or afterwards as part of a settlement agreement. Moreover, direct access to victims is almost impossible, mainly because they are not identified in case decision data. Finally, when psychologists are willing to be interviewed they often sanitise their account of the incident, playing down their culpability, and exclude the victim's perspective entirely.

In order to gain a more objective insight, a thematic analysis exploring the nature of misconduct and malpractice through an examination of court decision document data sourced from the Australasian Legal Information Institute (AustLII) website was conducted.

Method

Sample/court decision document data

All data for this study were sourced with permission from the Australasian Legal Information Institute (AustLII) website, a research facility jointly operated by the Faculties of Law at Sydney's University of Technology and the University of New South Wales (UNSW) (Australasian Legal Information Institute, 2013). AustLII collates such data for publication, and other uses, with permission from various Australian courts. The sample was derived from published court decision documents covering a five-year period (2008-2013). All data were anonymized. Only cases in which the psychologist was found guilty of misconduct were analysed. The court hearings occurred in the following locations: 20 in Victoria, 16 in New South Wales, four in Queensland, and one hearing each in Western Australia and South Australia. The majority, representing approximately 86% of cases, were from Victoria and New South Wales (where the majority of Australia's psychologists operate).

The court's decision documents use the terms transgressor and psychologist interchangeably and 'victim' and client interchangeably. The same nomenclature is adopted for the present study, however when transgressor and victim are used here the authors do not imply any value judgments upon the individuals to which the labels refer. A total of 46 clients were identified within the court decision documents. Of these, five clients were underage, and four were in a correctional facility at the time the psychologist met them. There were several cases in which multiple victims were discussed. The total number of transgressing psychologists amounted to 42, though some had multiple charges levelled against them.

Design

The present study adopted Braun and Clarke's (2006) qualitative methodology; specifically, coding and extracting common elements, and identifying, analysing and reporting patterns (themes) within the data with the aim of producing both descriptive and explanatory analyses of the findings. Descriptive outputs related to similarities and differences between themes, whilst explanatory elements sought to provide new insights into participant's explanations of how or why misconduct and malpractice occurred.

A restriction was placed upon this study by AUSTLII relating to the research output. In order to avoid legal complications (such as disclosure of identifying information) with various judiciaries across Australia, this paper has been restricted to presenting general themes. Therefore, the present study adopted a 'little q' approach to qualitative research. Kidder and Fine (1987) distinguish between two types of qualitative research. 'Big Q' refers to traditional qualitative methods in which researchers actively explore the lived experience and participant-defined meanings with open-ended, inductive research methodologies. In contrast, 'little q' methods deal with very structured data often characterised by the imposition of other meanings associated with collection

and analysis processes. This is primarily due to predetermined factors impeding the methods of collecting, coding, and analysing data, including analysis of secondary data or data that were collected for a purpose other than the intended research project, such as court hearings.

Transgression themes are taken as given by the court. Causal themes, however, have been segregated into three categories by the authors: objective, as determined by the court; subjective, as offered by the transgressing psychologist and included in the decision document; and interpretive, which are offered by the authors after taking account of the content of the decision documents and informed by a larger research project involving the present authors that aims to develop an explanatory model of transgressions. Interpretive analysis is critical within the present study as the courts do not always provide a causal reason for the psychologist's transgressions.

Interpretive studies, according to Orlikowski and Baroudi (1991), attempt to understand phenomena through accessing the meanings found within the data — court decision documents. The goal of interpretive research is to identify and document through the interpretation of life events, situations, ceremonies and specific phenomena under investigation (Leininger, 1985) — including court hearings. Therefore, understanding a specified phenomenon requires the researchers to become immersed in data of the cases involving transgressing psychologists.

Procedure

Ethics approval for the project was provided by the Monash University Human Research Ethics Committee (Approval Number CF13/2485 - 2013001319). Approval was also provided by AustLII. Data were downloaded from the AustLII website. Any available demographic information was retained and examined. The naming convention — 'poor communication', 'professional incompetency' 'boundary violations', 'poor

business practices', 'poor reporting practises', 'personal character', 'poor judgement', 'impairment', 'mental illness and addiction' and 'false use of title'— employed by Grenyer and Lewis (2012) was adopted for categorising the data. As such, the data were reviewed, assessed and assigned to specific categories. A frequency count of instances can be found in Appendix 6.

Initially data were reviewed in order to achieve a level of familiarisation. The civil and administrative court decision documents were transposed into Microsoft Excel (Microsoft 2010) and categorised by location (state) and further by individual cases using a unique identifier. The data were condensed into thematic content, demographic information, evidence of potential causal factors, information concerning who made the notification, and the victim's data. The data were imported into Nvivo 10 (QSR International, 2012) for analysis.

The court records provide a very explicit association between the psychologist's actions and the specific section of the Australian Psychological Society's code of conduct in question. This alignment allows for comparisons between studies using a common platform. A data oscillation process — moving from individual words and phrases to broad themes and concepts and back again — assisted in identifying potential causal factors. The various combinations of content allowed for the formation of overarching and sub-themes. Using an inductive process, the authors immersed themselves in the details and specifics of the data to identify important dimensions and inter-relationships between objective and subjective accounts for transgression causes. The data were assessed for internal homogeneity and external heterogeneity (Patton, 1990). Internal homogeneity refers to the meaningful coherence and consistency of content within the theme, while external heterogeneity refers to the clearly identifiable distinction between the themes.

The transgression type relates to the offence itself – the reason the complaint was made in the first place. The transgression cause refers to the motives for the transgression. The transgression type (or types as there is often more than one for each case) is explicit in the detail of the court decision documents, while the cause must be inferred from the totality of the case detail. In some cases, the court may provide an explanation for the reasons it believes the transgression occurred, and for this study that is termed 'objective cause' – this has not happened for all cases, and tends to be more likely when alcohol or other substances are involved. Often a reason is offered by the offending psychologist for their behaviour, and for this analysis that is termed 'subjective cause'. As the court does not always provide a rationale for the cause, or identify the cause, in all cases, an interpretation of is also offered by the authors with reference to all available information in the decision documents, termed here 'interpretive cause'.

Results & Discussion

The outcomes of the analytical process taken for this paper are presented in four main sections. First, to provide context, the offences detailed in the court data are summarized according to the categories previously used by Grenyer and Lewis (2012). Second, the types of transgression as specified in the court decision documents are categorized (see Appendix 5). The third component, and primary focus of the paper, was a thematic exploration of the causes of the transgression on the basis of reasons offered by the offender, explanations specified by the court, and interpretations made by the authors. The fourth and final component explored the post hoc rationalisation, or reasons psychologists provided for their transgressing behaviour. The present study then considers the implications of these findings and offers directions for future research.

Transgression prevalence

Each notification dealt with by the courts focused on a core complaint. The AustLII data does not classify cases by complaint type, however the reason for the complaint can be ascertained from the court decision record. The categories used to summarise the complaints, based on those used by Grenyer and Lewis (2012), and the number of complaints, are contained in Table 5.

Table 5. *Frequency of Charges Made Against Registered Psychologists from Court Decision Document Data 2008 to June 2013*

Complaint Category	Frequency of Charge	Percent of Total
Boundary violation	28	37%
Professional—incompetency	16	21%
Professional—poor communication	13	17%
Personal Character	9	12%
Poor business practices	5	6%
False use of Dr/Professor or specialist title	3	4%
Professional—poor reports	1	1%
Misleading registration claim (e.g., practice while lapsed)	1	1%
Impairment (e.g., mental illness, addiction)	1	1%
Total	77	100%

Note. The total number of instances exceeds the number of cases because some cases involved more than one category of transgression.

Transgression types

The categories of offence used by Grenyer and Lewis (2012) provide a high-level means of summarising the cases contained within the court decision documents. While they allow comparisons and thus context, they are not necessarily the best way of grouping the current data. A more inductive, thematic approach has been taken here in order to develop a set of categories that better fit the decision documents in hand. These themes are considered in detail below.

Fraud. Fraud cases concern deception for financial gain, in this context that involves invoicing for psychological services that did not actually occur. Female psychologists were the subject of two of the three fraud cases contained in the data. The fraudulent claims occurred over multiple years (M = 2 years) and included approximately 922 sessions that did not occur, equating to an average of 230 sessions per psychologist (Mdn = 248 sessions). The accumulated total value of all three fraud cases was $117,839 (Mdn = $45,394). All fraudulent claims were made against governmental agencies such as the WorkCover Authority, Transport Accident Commission, and the Department of Justice – all in the state of Victoria. In a typical case an initial billing error led to a string of fraudulent claims netting the psychologist approximately $50,000 in dishonest income:

> "[The court] pointed out that the fraud, which initially arose due to billing errors, rapidly became deliberate and sustained. It was not a momentary error of judgment" (Court Case 1)

Offending psychologists in this category cited 'gambling addiction' as the primary reason for committing acts of fraud, which was consistent with an established association between problem gambling and financial crime (Blaszczynski, 1994; Sakurai & Smith, 2003). Smith (2003) explored motivations of individuals convicted of fraud more generally and found motivations associated with gambling were second only to a personal

desire for more money or simple greed, closely followed by financial mismanagement leading to 'financial pressures' of a personal or business nature.

Smith (2003) found, in the Australian Institute of Criminology and PriceWaterhouseCoopers report, that some individuals frequently rationalised the seriousness of the fraud by arguing that the money was used to conduct legitimate business activities and that there was an intent to repay clients' money. The report also detailed individual's requests to the court to consider a number of mitigating circumstances at the time of sentencing, including gambling addiction. Individuals requesting such consideration were, in essence, suggesting that some form of compulsion or dependence outside of their control was responsible for their actions.

Abuse of vulnerable clients. Almost by definition a client seeking help from a psychologist is vulnerable, made more so by divulging personal details. Entering a client-practitioner relationship and visiting the psychologist in their counselling suite also establishes a power imbalance between the learned and qualified professional and the client. In several cases in the data considered here ($n = 3$) the offending psychologist sent mobile/cell phone messages to clients that were not business related (e.g. setting or confirming appointments). In one case the messages expressed physical/emotional attraction toward the client; in some instances, the messages were sexually suggestive and/or explicit, whilst other messages were threatening. In two cases the offending psychologists sent messages expressing a clear threat of harm to a client. In one of those cases the offending psychologist was being charged with physical assault. This particular psychologist was placed into a diversion program.

Just over a quarter (28%) of all complainants ($n = 13$) had experienced significant trauma (rape, sexual abuse and transport accidents) and/or displayed some form of psychopathology (depression, anxiety and dissociative identity disorder). Some ($n = 3$)

expressed an intention to commit suicide and thus were considered extremely vulnerable by the court. All of these clients suffered further at the hands of transgressing psychologists:

> "[The client] had suffered major psychological traumas in [his/her] life, including rape and other sexual abuse… and was experiencing significant distress and psychological symptoms" (Court Case 6)

Victimised clients experiencing substantial vulnerabilities stated they felt incapable of stopping the offending psychologist's advances, leading one to conclude they were powerless to leave the relationship. For example, the power differential in favour of the psychologist was so great that the client dared not challenge the imbalance:

> "[The client] states that she felt powerless to stop the behaviour and powerless to leave" (Court Case 5)

Evidence from the present study indicated that some victimised clients ($n = 4$) believed they were manipulated by transgressing psychologists due to their personal vulnerabilities. These victims conveyed a level of helplessness in situations in which advances were made toward them. This may be analogous to the concept of 'predator and prey'. Clients may be considered as prey that has been wounded and far easier to dominate by the offending predatory psychologist. Offending psychologists within such cases demonstrated deceptive tactics and techniques which, according to Jones (2014), are key hallmarks of predatory behaviours.

Female psychologist's relationships with inmates. Female psychologists ($n = 3$) were exclusively represented in boundary crossings/violations with inmates in correctional institutions. In one case the psychologist had an inappropriate relationship with a juvenile offender:

"On the same date, a sexual relationship began between [her/him] and the
psychologist" (Court Case 3)

In several cases extensive communication occurred between psychologists and
inmates. In one particular case a psychologist used false identities to gain registration on
an 'approved contacts list' in order to participate in phone calls and exchange hardcopy
letters with the inmate:

"[The psychologist was added to the] telephone list and they [the psychologist and
inmate] spoke on over 400 occasions… discussions were often of an intimate nature"
(Court Case 4)

Giebel and Elbert (2014) explored the relationship between women in society and
prison inmates, finding that women in love with prisoners view their relationships as
something special, a deep, romantic and passionate *true love* (Giebel & Elbert, 2014, p. 3;
Isenberg, 1991). Women who fell in love with prisoners scored higher on ratings of
altruistic love styles indicating they focused on the needs of the inmate partner (Giebel &
Elbert, 2014). Anecdotal evidence suggests women are drawn to imprisoned men because
they believe they may be able to rehabilitate or rescue them from a troubled life. Isenberg
(1991) interviewed dozens of women romantically involved with prisoners – correctional
officers, psychiatrists, and psychologists – finding that many of the women had
experienced childhood trauma and that personal trauma potentially made them vulnerable
to manipulation from prison inmates (O'Keefe, 2000).

Drug use. The use of illegal substances by psychologists ($n = 4$) featured within
three of the cases reviewed. Such drug taking sometimes occurred in the presence of
clients:

"[The psychologist] admits to sharing a joint with [him/her] perhaps once a fortnight,
within a period of several months" (Court Case 7)

One offending psychologist injected him with drugs in the presence of a client and a social acquaintance:

> "[The psychologist] on one occasion injected an illegal substance into [his] stomach whilst at home [with a client]" (Court Case 8)

In other cases, the offending psychologist engaged in illicit drug use whilst meeting with clients in social environments such as at restaurants or cafes – meeting clients socially while in a practitioner-client relationship is a breach of the Australia Psychologist Society (APS; 2007) Code of Ethics.

In two of the cases within this category, offending psychologists referenced drug and alcohol consumption as affecting their judgment and influencing behaviour leading to [often multiple] transgressions. Nielson (1987) found that therapists working within alcohol and other drug services were often recovering substance abusers or were from families with a history of substance abuse. It is generally known within the literature that a significant association exists between stress and the motivation to use and abuse addictive substances (Sinha, 2008). Individual risk factors that specifically predict drug use as an adult (and may predict other conditions) include being male, certain personality traits, sensation seeking behaviours, and early childhood oppositional behaviour and conduct disorder (Degenhardt & Hall, 2012; Sinha, 2008). It is conceivable psychologists within the present study may have enduring, personal concerns associated with one or several of these risk factors.

For one of the offending psychologists within the present study, drug taking in the presence of clients appears to expose personal vulnerabilities related to addiction behaviours. That particular psychologist's behaviour may also be an attempt at increasing levels of personal power. The offending psychologist may have been asserting coercive

power over clients through threats or actual physical force, intimidation or extortion in an attempt to force the client to do something against his or her will (Zur, 2009). Drug use and encouraging clients to participate may be an extension of this control mechanism.

Causes of transgressions

The causal themes have been assessed in three ways - objective, subjective and interpretive. Objective reasons are those determined by the court. The court makes a decision based on the available evidence, including specialist testimony from professionals, and accounts provided by witnesses, the offender, and the victim. In some cases, psychologists appearing before court gave reasons (or excuses) for their behaviour. In an example from the current study, a financially foundering practise was cited as a reason for defrauding a government department client. Subjective causal reasons are those offered by the transgressing psychologist and contained within the court decision data. For example, a transgressing psychologist may claim that a certain incident/s is the result of external factors, such as the medication they were prescribed, or due to experiencing significant trauma. The authors also provide interpretive causal reasoning for why psychologists transgress. For instance, previous unresolved trauma in the psychologist's life might be implicated in different types of transgression.

These causes are discussed here, and again are the output of a thematic analysis of the court decision documents. In contrast to the previous section, presented here are themes regarding the reasons why psychologists might have engaged in misconduct and malpractice behaviours, rather than themes related to the nature of the transgression. Given the complexities of many of the cases, some transgression causal reasons presented here may overlap with another category. For example, a psychologist's explanations for transgressing behaviours may include 'drug taking' which may be related to 'mental health concerns'. Care has been taken to avoid, where possible, any overlap.

Psychologist mental health and impairment. Some psychologists explained to the court that they had engaged professional support for mental health disorders or conditions. They cited these disorders as causal reasons for transgressing behaviours. The disorders most commonly cited within the present analysis included major depressive disorder, posttraumatic stress disorder, and generalised anxiety disorder. Most offending psychologists claimed these disorders contributed to their transgressing behaviours. The majority mentioned the presence of only a single disorder, however in three cases more were cited (two cases mentioned comorbid depression and anxiety, and the third case discussed chronic adjustment and emotional disturbance).

In many cases the court commented on the psychologist's distress and connection to impairment. In the court's opinion, in several cases impairment contributed toward transgressing behaviours:

> "[The psychologist's] capacity to practise as a psychologist was impaired during the time [he] was treating the patient" (Court Case 10)

> "[The psychologist] was suffering from a mental illness at the time [she] had committed the offences" (Court Case 11)

> "[a mental disorder] and a specific set of circumstance of such unusual intensity that it impaired decision-making" (Court Case 14)

> "[The psychologist] poses a risk to children and young people substantially due to '[his] present level of insight and understanding into [his] personality and its vulnerabilities'" (Court Case 13)

> "[The psychologist] has some executive behavioural and functioning deficits and is affected by pathological grief over some significant losses" (Court Case 16)

A common message from the courts regarding this category relates to the psychologist's lack of objectivity and an inability to understand how their own personal distress affected the ethical provision of services. Two psychologists offered explanations attempting to excuse their behaviours due to impairment:

> "[the mental disorder is] impairing my social judgement leading to workplace boundary transgressions" (Court Case 4)

> "[The psychologist] appears to be excusing [her] behaviour on the basis that [she] was vulnerable because of previous traumatic experience and was to some extent the victim" (Court Case 15)

Indeed, the APS Code of Ethics (2007) states that psychologists continuously monitor their professional functioning if they become aware of problems that impair their capacity to provide competent psychological services. Specifically, the Code suggests that afflicted psychologists obtain professional advice regarding limiting, suspending or terminating the provision of psychological services.

Unresolved trauma. Unresolved trauma refers to re-experiencing traumatic and distressing events through invasive and disturbing thoughts and memories, attempts at avoidance, and issues with hyper-arousal, including difficulty sleeping, concentrating and hypervigilance (Australian Centre for Posttraumatic Mental Health, 2013). In the psychodynamic literature this is often referred to as unresolved conflict (Sussman, 2007). Several offending psychologists in the present study attributed their transgressing behaviours to a clinical diagnosis of a mental health disorder or some traumatic event. It is important to note that self-reported subjective trauma described in the present study relates more to personal life distress than to a clinically diagnosable Criterion A (DSM5; American Psychiatric Association, 2013) symptoms of trauma. In other words, the

individual/s suggested the continuing effects of such disorders somehow caused them to act, or not, in certain ways.

> "[The event] triggered memories of [her] own childhood sexual abuse" (Court Case 12)

The authors' interpretative view relating to this phenomenon is that a psychologist's unresolved trauma can interfere with their ability to provide objective and effective support to clients. Evidence presented here suggests this group are at greater risk of breaching ethical standards and engaging in misconduct and malpractice, a concept supported by others (Duncan & Miller, 2008; Geldard & Geldard, 2009; Sussman, 2007).

In other cases, the court acknowledged impairment due to traumatic events was a contributing factor. In such cases, it was said by the court, this condition lead to a reduction in the psychologist's capacity to remain objective during the provision of services, thus resulting in unethical behaviours. Some psychologists within the present study cited lapses in judgement due to trauma experienced because of relationship breakdowns and divorce. Evidence from the data suggests these psychologists, in their attempts to compensate for the lost relationship, may have engaged in inappropriate relationships – not necessarily intentionally – with clients to fill a void created by marital dissatisfaction or separation (Claman, 1987; Gabbard, 1996). Dissatisfaction in a relationship may result in a form of self-therapy whereby the psychologist engages with a client as a surrogate or substitute for the lost partner from a previous relationship. Epstein and Simon (1990) suggest that a psychologist's overt disclosure of personal problems results in client sympathy for the psychologist's situation that may result in an inappropriate level of relational connectedness.

Transgression rationale

Rationalisation is a post hoc process of explaining or excusing behaviour (Simon, 2009). A number of psychologists ($n = 7$) attempted to rationalise or shift responsibility for their transgressing behaviours, commenting that events within their particular case occurred as a consequence of some externalised phenomenon/force. Some psychologists ($n = 3$) also made an assertion that their actions were due to extenuating circumstances or personal difficulties beyond their control.

One psychologist tried to rationalise her transgressing behaviour as resulting from the effects of post-natal depression. However, the court determined that no evidence presented during the case suggested her post-natal depression caused or contributed to the transgression. This example may also fit within the previously mentioned mental health and impairment category. Whilst another attempted to explain that his inappropriate behaviours were somehow beneficial to the client. In that particular case the psychologist was of the opinion that those behaviours occurred as part of the therapeutic process and thus should not be considered transgressions at all. The psychologist, in defending his actions, stated the progression of the working alliance into an intimate relationship did not pose:

"an impediment to the therapy the client received" (Court Case 17)

In yet another case, the offending psychologist claimed:

"[He] had not exploited the patient, rather that [the client] had benefited from their relationship" (Court Case 18)

An explanation concerning what the court determined as overt disclosure and legitimising this as a form of therapy was quite prevalent. Two psychologists offered the following explanations:

> "at times to enhance the therapeutic relationship, I would also disclose elements of
> my personal life." (Court Case 17)

and,

> "I hope to make my clients feel as though I am a real person and to try to build a
> strong rapport." (Court Case 19)

suggesting that this tactic was a genuine attempt to:

> "demonstrate a human element" (Court Case 17)

An offending psychologist claimed a specific brand of anxiolytic (anti-depressant) was responsible for complications experienced whilst taking the prescribed dose. Such complications, he argued, resulted in his transgressing behaviours toward a client due to effects on his decision making processes. Another psychologist misused alcohol as a way of managing depression — self-medicating — and failed to seek support for underlying problems:

> "[The psychologist] misuse[d] alcohol as a way of managing low mood [and] showed
> limited insight into [his] behaviour" (Court Case 9)

The court determined the psychologist's misuse of alcohol was a contributing factor in his behaviour leading to misconduct. In another case, a psychologist cited the past use of cannabis as a contributing factor, however the court decided there was no causal association between his history of drug taking and misconduct behaviours.

Psychologists who displace responsibility potentially lack the required self-awareness that forms the foundation for professionals to act in ethical ways (Bazerman & Banaji, 2004; Schwebel & Coster, 1998). Moore and Loewenstein (2004) suggest that this lack of self-awareness might be due to differences in thought processing. Individuals

acting on self-interest tend to process thoughts more automatically and in a largely unconscious way. In order to rationalise and act out of self-interest whilst maintaining a façade of morality these individuals may engage in self-deceptive thinking and behaviour (Epstein & Simon, 1990; Tenbrunsel & Meesick, 2004).

Individuals who rationalise their behaviour seem to explain the circumstances of their transgressions as somehow being justified, until a tipping point is reached and the therapist begins down a slippery slope towards misconduct and malpractice (Glass, 2003; Koocher & Keith-Spiegel, 2008). Somer and Nachmani (2004) suggest therapists who sexually seduce clients sometimes rationalise their emotions as being genuinely romantic. Romantic or not, such behaviours are inappropriate in a client-therapist relationship. Within the present study, several offending psychologists expressed that improper relationships with clients would not hinder the therapeutic process, and in one case the offender expressed a belief that the client might benefit.

Implications for professionals

The present study provided some new insights into the causes of misconduct and malpractice behaviours of Australian psychologists, including evidence of potential causal factors explaining *why* such behaviours may occur. From a higher-level psychological standpoint, the transgression causes identified earlier coalesce around several core concepts.

The first explanatory concept concerns the externalisation of responsibility for personal behaviours. Trevino and Youngblood (1990) found an individual's internal locus of control — the ability to self-direct — significantly correlated with moral decision-making behaviours. Ensuring that psychologists have a good understanding of their personal qualities, including locus of control, is vital when discussing moral and ethical decision-making in the supervisory working alliance.

The second explanatory concept relates to a lack of objectivity. This lack of objectivity may be associated with self-deception (Epstein & Simon, 1990). In other words, while certain behaviours are occurring the psychologist is not consciously aware of the impact of their actions and may not regard such behaviours as a problem. Psychologists that fall under this category might be too close and too involved with the client, not able to think about and view the misconduct/malpractice situation they find themselves in dispassionately. Once the non-intentional action suddenly becomes apparent, the psychologists might rationalise their actions with hindsight, a concept often referred to as 'sense-making' (Weick, 1995).

A third explanatory concept concerns transgressing psychologist's inability to understand how personal circumstance — impairment, unresolved trauma — affects the provision of professional services. Despite the fact that the APS Code stipulates that psychologists monitor their professional functioning, this remains a serious concern. Psychologists should discuss with an associate, peer or supervisor any self-talk during which they might question their [in]ability to support clients' and not place their welfare in jeopardy. It is important to acknowledge that a logical safe-guarding measure is for others to point out a psychologist's incapacity to function at the expected level.

Within individual categories, for example fraud and sexual misconduct cases, gender is disproportionately involved as an explanatory factor. However, across all categories examined in the present study there was no gender bias for the totality of individuals found guilty of misconduct and malpractice. Literature relating to notifications (Grenyer & Lewis, 2012) or research focusing on a specific subset of misconduct and malpractice, for example sexual boundary violations (Jackson & Nuttall, 2001) indicate a bias toward male psychologists as the primary perpetrators. Yet, the present study found no gender differences within the court decision documents reviewed.

This finding challenges the current understanding of gender bias in psychology misconduct and malpractice. A plausible explanation for the difference in findings in the present study, compared to others, might reside within the very different approach this study employed. An approach which captures a diversity of transgressions due to the type of data explored — an examination of court decision documents.

Gaining access to participants who have transgressed is often difficult and such individuals may be unwilling to participate — potentially because of embarrassment or shame. Using court decision document data, as opposed to self-report data for example, provides two important ingredients in research. Firstly, the judicial system strives to remain objective when prosecuting cases against individuals who have committed professional misconduct and malpractice. Arguably, this level of objectivity is higher than participants' self-reported account of events. The courts employ, or call to testify, various professionals to provide evidence in cases to support an overall verdict regarding the individual's transgressions. Secondly, there is no bias in the types of cases prosecuted within the court system. This approach is effective for appraising a broad spectrum of transgressing behaviours with an increased level of objectivity, thus providing new insights.

It appears, given the inert nature of prevalence rates reported for misconduct and malpractice for Australian psychologists (Kremer, n.d.), that publishing statistics as a deterrent in isolation from other strategies may not be a sufficient deterrent. If prevention campaigns were augmented with more meaning this might make it easier for psychologists to internalise the content as directly relevant to them. For example, if they knew that unresolved trauma was a common implicating factor they might pause and wonder whether they should do something about their own history of trauma to avoid finding themselves in a similar situation to those described in the present study.

Likewise, illustrating individual cases that really demonstrate the *slippery slope*, for example in industry publications, might resonate with some psychologists. As such, they may avoid the slope altogether or get off it before it becomes too steep and/or too slippery — given that such slopes often don't have a constant gradient. An examination of psychologist misconduct and malpractice behaviour — and associated causal reasoning — is an important step in the development of more targeted prevention campaigns. Such prevention strategies may be connected to education programs, focused training at universities, within supervisory practice and in the development of policy and procedures (workplace and governmental).

Further considerations

Analysing court decision documents for themes and presenting them in isolation can create an illusion of simplicity. For instance, in a number of cases transgressions occurred across several categories. An example, in one case the psychologist engaged in a sexual relationship with a client and physically abused her whilst he was partaking in illegal substances with her. Psychologist's accounts of the reasons for their behaviours are given retrospectively, which offers the psychologist the opportunity to shape, sanitise and/or alter their version of events — never really uncovering the truth — for ulterior motives. Thus transgressing psychologists may reduce or mitigate culpability for behaviours in order to receive more lenient sentencing, and/or to reflect or deflect blame onto others in attempts to preserve personal reputations. Such behaviour could be understood as an attempt to stay gainfully employed as a psychologist at the conclusion of the court hearing and avoiding reporting by a supervisor. Despite these considerations, court decision document data provides an opportunity to examine potential casual factors for a broad-spectrum of misconduct and malpractice cases which otherwise would not be possible using alternate methodologies, such as surveys.

Future research. Future research might explore misconduct and malpractice behaviours and the role of unresolved trauma. Specifically, how these conditions might interfere with the provision of ethical services to clients. This concept was implicated in a number of the court cases analysed for this report, but is worthy of further investigation. To that end the current authors are undertaking research in this area. In addition, researchers — and/or supervisors — might like to explore how identified risk factors from the present study can inform supervisory and workplace policies and procedures. Research could focus on supervisory components for psychologists working within the prison system, providing governmental agency services, working with underage clients, and so on. Future research could explore psychologists' ignorance, misunderstanding or disagreement of their ethical obligations in practice when working with clients. The authors of the present study are currently undertaking research to investigating the attitudes of professionals toward various ethical behaviours in practice.

Recommendations

The following section provides a non-exhaustive list of feasible activities designed to reduce misconduct and malpractice:

1. Researchers could develop an 'early warning' screening instrument that provides an 'at risk' indication to psychologists and supervisors that might serve as a starting point for supervisory discussion for new and long-term psychologists.

2. Psychologists could complete an Adult Nowicki-Strickland Internal-External Control Scale (ANSIE; Nowicki & Strickland, 1973) in order to ascertain locus of control. Given that the present study found that externalisation of behaviours may be associated with the provision of ethical service, the results of the assessment might form part of supervisory conversations concerning ethical and professional

development. Such a discussion may result in initiatives and training to mitigate

externalisation beliefs exhibited by psychologists.

3. Policy makers could create workplace specific or industry-wide codes of conduct,

policies and/or procedures. Certain misconduct and malpractice phenomena, such

as the relationships between inmates and psychologists, and impairment due to

mental health concerns, warrant the development of additional guidance for

practising psychologists. These documents could serve as a talking point for the

supervisory relationship (management and clinical) in an attempt to draw out

boundary crossings and violations. Indeed, one might argue that such guidelines

already exist in current ethics of practice guidelines, therefore supervisors should

have more frequent discussions with supervisees to heighten awareness of the

risks associated with misconduct and malpractice.

4. Practising psychologists should engage in self-reflective practice with a supervisor

to develop self-reflective skills that may mitigate or reduce the likelihood of

slipping down the slope toward misconduct and malpractice. Psychologist self-

care is important. Self-reflective practices relate to adapting to constant change

and developing knowledge critical for responding to events in personal and work

settings. Ultimately, it is the individual's responsibility to ensure adequate self-

care through seeking guidance and support from various other professionals

(supervisors, general medical practitioners), friends, family and work colleagues.

5. As part of the court process, the court could mandate that as part of any sentence

the respondent must talk to an independent officer (who is an experienced

supervisor) about the circumstances around the case. As the interview would

occur after the hearing it cannot influence the outcome and it could stay

confidential and anonymous so that it cannot be usefully subpoenaed for future

trials or appeals. Such insights might provide an essential feedback mechanism to

PsyBA in the development of improved misconduct and malpractice prevention

strategies.

Chapter 4: Psychological antecedents of misconduct and malpractice:

A literature review

An examination of the literature has identified a number of factors associated with the propensity for a counselling professional to transgress against a client's best interests, potentially resulting in misconduct and malpractice. Some of those factors have already been mentioned in the previous chapters, this chapter brings them all together in an integrated, systematic, comprehensive manner. Without an integrative review it is difficult to truly understand and potentially properly address the problem of counsellors who harm their clients as the risk factors otherwise tend to be considered in isolation. A model for the occurrence of misconduct and malpractice breaches is the focus of a subsequent chapter. In preparation, this chapter takes an integrative approach to potential risk factors as antecedents, with thought to their nature, timing, and intentionality.

Of noteworthiness, although there was a concerted attempt to search for the latest literature to ensure theories and ideas were current, the author found that much of the published literature relating to the topic of interest seemed to decline and almost stop during late 1990s and early 2000's. For example, research relating to 'counsellor misconduct and malpractice', 'counsellors as trauma survivors', and 'exploitative counsellors' by influential authors in the field - including Simon and Epstein (1990, 1991), Pope, Tabachnick and Keith-Spiegel (1987), Pope (1990), and Gabbard (1991, 1995) - seemed to come to an end. Along with it the 'conversation' about misconduct and malpractice also seemed to end. Thus, this thesis includes research that is older than five years. This approach allows for an understanding of the history related to the phenomenon (Pautasso, 2013) and provided 'navigational guidance' for the overall direction of the thesis.

This chapter explores factors that might increase the propensity to transgress boundaries (crossings and violations), but as *types* or categories of counsellor-based factors; this allows for subsequent addition of further factors not detailed here. The psychological antecedents described here are divided into those that relate to the counsellor's prior experience of trauma, the current stressors they are experiencing, their own personality, their professional esteem, and their identity as a counsellor.

The experience of past trauma

Some individuals enter the counselling profession *because* of their previous experience of trauma. The aftermath and process of dealing with the impact of that seminal event (or events) may have fuelled a desire to leverage their own success to help others. Arguably, there is an attractive logic to the notion that a real and deep empathy can arise from experiencing a similar major event, and from personal experience of having travelled the difficult path the client must tread to progress from victim to survivor. In some cases that logic may be borne out. However, it is predicated on the assumption that the trauma *has* been successfully resolved by the counsellor and that there are no lingering elements that may have a subtle and possibly unrecognised impact triggering unexpectedly to cause problems. The counsellor is bound to believe the past trauma has been dealt with successfully given the fact it is in the (often distant) past and they are no longer receiving professional help for it.

The American Psychological Association (2015) defines trauma as a psychological response to an event such as an accident, rape, or natural disaster, immediately followed by shock and/or denial. Longer-term effects include strong unpredictable emotions, flashbacks, problems with relationships, and physical symptoms such as nausea and headaches. The trauma literature discusses the notion of 'big T' versus 'little t' trauma (Neborsky, 2003). 'Big T' trauma includes events such as death, injury

arising from a violent event, rape and so on; typically single events. In contrast. 'little t' trauma includes things like neglect, emotional abuse over time, or battling a life-threatening illness. The impacts of 'little t' trauma are cumulative, repetitive, and sustained (Neborsky, 2003). However, the "little" of little t trauma does not signify a reduced impact. Little t trauma is recognised as having a devastating impact on all aspects of the individual's development - including their physical growth, mental and physical health, self-esteem, attention, socialisation and capacity to learn (Duncan & Baker, 2003).

Age, it has been argued, may be a substantial factor in how traumatic events are experienced and processed. Van der Kolk, McFarlane and Weisaeth (1996) found traumatic experience has its most profound influence during the first decade of life, while Terr (1988) argued children under five at the time of the traumatic event maintain memories of their ordeal and continue reacting to reminders throughout their life. Regardless of age, trauma for any individual is going to have some impact on function. The question is, to what degree and how (if at all) might trauma be successfully resolved?

Unresolved trauma

It is common for people to experience a degree of psychological distress in the early aftermath of a traumatic incident (O'Donnell, Lau, Tipping, Holmes, Ellen, Varker, Elliot, Bryant, Creamer & Forbes, 2012). This might include emotional upset, anxiety, sleep and appetite disturbance. In most cases, these psychological symptoms will settle down in the days and weeks following the event (O'Donnell et al., 2012). However, for some, these symptoms do not dissipate so readily or completely.

The term *unresolved trauma* is somewhat amorphous. It originally emerged from the vast body of trauma literature arising from psychodynamic work (e.g. Garland, 2002). One appealing definition is impairment as an "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (Laliotis & Grayson,

1985, p. 85). This definition suggests that impairment can interfere with normal function in the delivery of psychological/counselling services. Stadler, Willing, Eberhage and Ward (1996) concur with Laliotia and Grayson's (1985) view that impairment is an 'inability to perform' not merely a potential of not performing. They define impairment as "the inability to deliver competent care resulting from alcoholism, chemical dependency or mental illness, including burnout or the sense of emotional depletion which comes from stress" (Stadler, Willing, Eberhage & Ward, 1996, p. 258).

More recently, the concept of unresolved trauma has been used quite extensively within the Attachment Theory literature. The construct is used as a framework for understanding the disruption in an individual's socio-emotional functioning (Crittenden & Landini, 2011; Fearon & Mansell, 2001). In the current context of counsellor misconduct and malpractice, unresolved trauma is defined as an individual's failure to complete a process of emotional and psychological consolidation following a traumatic incident (O'Donnell, et. Al, 2012; Stovall-McClough & Cloitre, 2003; Walker, 2003). According to Joubert, Webster and Hackett (2012), unresolved trauma reflects the degree to which trauma events have been resolved. Individuals considered 'resolved' are able to produce mental or behavioural strategies and integrate lessons from the event, protecting them from becoming overwhelmed, disorganised, dysregulated, or disoriented.

There are a number of problems associated with talking about trauma being "resolved" or not. Such a dichotomous arrangement may suit a medical framework in which the individual has a (psychological) injury that is cured by treatment – where that treatment might be a mix of psychological, pharmacological, and social interventions. In reality though the journey from victim to survivor to thriver (i.e. post-traumatic growth) is not always smooth and without detour or backtracking; and it is difficult for the individual or their counsellor to determine when or even if they *have* completed the

journey and are not at risk of some sort of relapse. Thus there is value in conceptualising the recovery process as a continuum.

Individuals who experience traumatic events during their life course can be placed on a continuum between two possible outcomes. At one end they accommodate new information within the context of the experience resulting in understanding and personal (post-traumatic) growth that positively shapes future behaviour (Lyengar, Kim, Martinez, Fonagy & Strathern, 2014). At the opposite end the individual does not accommodate new information from the event/s within the context of the experience, resulting in obstructive outcomes interfering with understanding and personal growth hindering future adaptive behaviour. The individual may move back and forth along the continuum as time passes, sometimes feeling good and empowered, and other times experiencing setbacks and negative affect triggered by reminders (e.g. anniversaries of the event or those lost, environmental cues, etc.).

This thesis explores unresolved trauma from a clinical psychology perspective, specifically relating to posttraumatic trauma. The term unresolved trauma relates more to the consequences, or latent impacts following a traumatic event, than to an individual's ability to resolve trauma per se. Instances of trauma can have a latent and explicit influence on individuals and its effects permeate networks of information processing, including emotional regulation, sensation and behaviour and action (Walker, 2007).

Posttraumatic stress disorder

Individuals scoring high on measures of PTSD are by definition diagnosed as experiencing the impact of unresolved trauma (Walker, 2003). It represents a relapse and potentially chronic dysfunction (Zerubavel & Wright, 2012). Mueser, Rosenberg, Goodman and Trumbetta (2002) found that 99% of people with severe mental illness reported experiencing at least one exposure to traumatic stressors, particularly events

such as physical abuse, neglect, combat exposure, witnessing a horrific event, or rape and

sexual molestation (Kesseler, Sonnega, Bromet, Hughes & Nelson, 1995).

The Diagnostic and Statistical Manual for Mental Disorders Fifth Edition (DSM

5; 2013) identifies the triggers for posttraumatic stress as exposure to actual or threatened

death, serious injury or sexual violation. This may occur as a result of direct exposure as

victim or as a witness, or indirectly by learning of a traumatic event through an associate

or family friend connected with the incident. If the event included actual or threatened

death this must have been violent or accidental in nature. Indirect exposure may be

through the course of professional duties, such as working as a counsellor. However, this

does not include indirect, non-professional exposure through electronic media - websites,

television etc.

Intrusion symptoms associated with PTSD are recurrent involuntary recollections

of the traumatic event. These may include traumatic nightmares, experiencing

'flashbacks', and either brief or extended episodes of loss of consciousness during those

moments. In addition, the intrusion may be intense and prolonged following exposure to

traumatic triggers or reminders including physiological responses to trauma-associated

stimuli coupled with persistent avoidance of stimuli associated with the trauma. This

includes trauma-related thoughts, feelings and reminders of trauma events, including

meeting people, visiting places, having conversations, and attending events associated

with the traumatic incident.

Other PTSD factors include negative alterations in thinking and mood associated

with the traumatic event/s, including an inability to recall key aspects of the traumatic

incident. This is connected to dissociative amnesia that is not associated with head injury

or the consumption of alcohol or drug use. This criterion is characterised by persistent

negative beliefs about the world or the self, i.e. "I am bad" or "the world is totally

dangerous". A hallmark of this component relates to persistent blame placed upon the self

or others for causing the traumatic event or the consequences connected to the event.

Persistent negative trauma-related emotions (fear, horror, anger, guilt), a significantly

diminished interest in personal activities, feelings of isolation and estrangement (feeling

alienated), and what is termed 'constrained affect' or an inability to experience positive

emotions. This, in turn, alters arousal and reactivity associated with the traumatic event.

Traumatised individuals may become irritable and/or aggressive with a tendency for self-

destructive or reckless behaviour.

Acute stress disorder

Acute Stress Disorder (ASD) describes acute stress reactions that may precede

posttraumatic stress disorder (Bryant, Friedman, Spiegel, Ursano, & Strain, 2011). ASD

was introduced into the DSM 5 to serve two important functions: First, to describe acute

stress reactions occurring within the initial month following trauma exposure that would

typically have gone unrecognised or be labelled adjustment disorders (Koopman, Classen,

Cardena & Spiegel, 1995); and second, to identify trauma survivors who might be at high

risk of developing PTSD at some later stage (Bryant, Friedman, Spiegel, Ursano, &

Strain, 2011).

ASD symptoms are identical to PTSD, but differ with respect to the duration of

the disturbance. The symptoms must be present for three days to one month following

trauma exposure. If symptoms present immediately they must last at least three days for

an ASD diagnosis. In addition, the traumatic event must have created clinically

significant distress or impairment within a social, occupational, or another significant

environment. Finally, the disorder cannot be attributed to physiologic effects of

substances, such as medication or alcohol, or another medical condition, such as a brain

injury. It must also not be better explained by another brief psychotic disorder (Diagnostic Statistical Manual for Mental Disorders, 2013).

Psychological woundedness

Woundedness is the residual effect of traumatic life events (Ivey & Partington, 2014), and can be a motivational force for the pursuit of clinical training (Ivey & Partington, 2014; Sussman, 2007; Wheeler, 2002). However, Ivey and Partington (2014) argue counsellors should ask themselves whether the psychological woundedness serves as a resource or a liability when working with clients.

Woundedness should not be viewed as a categorical variable of 'wounded vs. not wounded', but rather along a continuum ranging between facilitative and obstructive trajectories (Ivey & Partington, 2014: Zerubavel, & Wright, 2012). Facilitative recovery trajectories appear to be the most commonly discussed in the literature and represent the notion of the wounded healer (Jackson, 2001; Jung, 1946, O'Brien, 2011; Zerubavel, & Wright, 2012). At this end of the continuum the psychological trauma provides a constructive mechanism recurrently influencing and enhancing therapeutic benefits to clients (Jackson, 2001). In contrast, obstructive trauma interferes with a counsellor's ability to ensure client care (Gelso & Hayes, 2007; Ivey & Partington, 2014; Sherman, 1996; Smith & Moss, 2009).

The various trajectories along which a counsellor progresses in the aftermath of trauma over time are depicted in Figure 1. The model, devised by Zerubavel and Wright (2012), proposes several endpoints following successful or unsuccessful attempts to resolve trauma. The recovery trajectories are Posttraumatic Growth, Recovery, Relapse and Chronic Dysfunction. They argue that due to the dynamic nature of trauma recovery, inherent uncertainty surrounds a counsellor's future psychological functioning. Counsellors best placed to leverage their experience and help clients are those who have

experienced posttraumatic growth or recovery. Those who have descended into a pit of chronic dysfunction are not likely to have pursued careers as a counsellor due to their significant and ongoing impairment. The last group – relapse – are the main focus of this thesis. They experience periods of strength and confidence, and while they are on the upswing they may well function well and offer significant benefit to their clients. However, the unpredictable nature of the downswing – in terms of timing, depth and trigger – poses a risk to the client(s) with whom the counsellor is working when the relapse occurs.
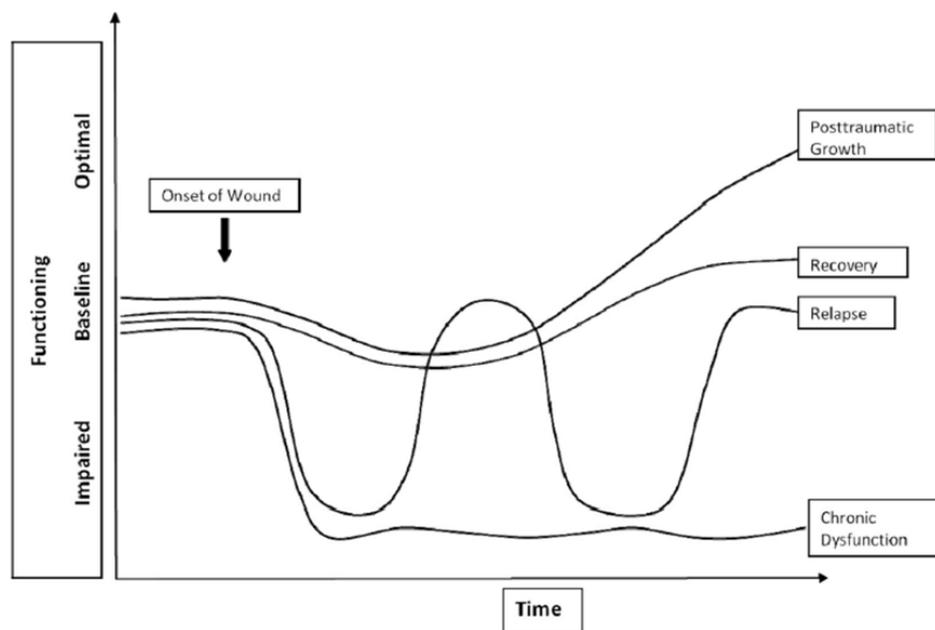
Figure 1. Trajectory of counsellor's woundedness over time (Zerubavel & Wright, 2012).

Zerubavel and Wright (2012) suggest recovery begins following the onset of the trauma or wound and follows one of their suggested pathways. A counsellor who recognises they are on the relapse trajectory (or has it pointed out to them, perhaps by a supervisor) may well take a "physician heal thyself" approach, which in itself can be damaging to client welfare. Instead they would be better served to seek psychological services (Frank & Paris, 1987), interactions (social or cathartic) with others outside their

own practice (friends, relatives, acquaintances) including social networks (Pyszczynski, Greenberg, Solomon & Schimel, 2004), and through the development of social-emotional capabilities - including emotional resilience and hardiness. Ignoring traumatic recovery until late in the counsellor's career appears problematic (Hinshaw, & Stier, 2008; Smith & Moss, 2009; Zerubavel & Wright, 2012). If successful, such strategies may assist the counsellor to transition through difficult life events. This might result in some form of personal growth, and potentially a transition from the relapse trajectory to either recovery or posttraumatic growth.

Unresolved trauma and unethical behaviours

Many professions, including lawyers, physicians and nurses, have well-established systems to identify and assist practitioners who may be distressed or impaired (Barnett & Hillard, 2001; Laliotis & Grayson, 1985). It was not until the early 1980s in the United States that a focus on impairment in the field of psychology began evolving, resulting in changes in policy and regulation to deal with impairment (Laliotis & Grayson, 1985; Sherman, 1996). During this time Laliotas and Grayson (1985) reported that no state-based psychological associations reported having programs available for, or to make a referral to, distressed and impaired psychologists.

Everall and Paulson (2004) suggest that counsellors suffering from re-experiencing traumatic events are at risk of violating ethical bounds and need to be aware of the intimacy of the therapeutic relationship and avoid behaviours that jeopardise client care. A counsellor failing to meet personal needs appropriately may become enmeshed with a client — over-involvement that blurs the boundaries between personal and professional interaction. Counsellors who neglect personal well-being, potentially due to mental health concerns, recognise the impacts on professional functioning and the effects on clients. In one study, Pope Tabachnick and Keith-Spiegel (1987) found that 85% of

APA psychotherapists surveyed indicated it was unethical to work when too distressed because of personal concerns; yet 60% revealed they had done so. Guy, Poelstra, and Stark (1989) found that 37% of distressed counsellors surveyed believed their distress decreased the quality of the care offered to clients, and 5% indicated that the quality of care was inadequate.

Jackson and Nuttall (2001) surveyed 323 mental health practitioners (138 men and 185 women). They categorised participants into histories of 'no abuse' and having experienced child sexual abuse. The authors then segregated the data based on two categories, those who had had sex with clients and those who had not (14 men and one woman). Of the 29 male practitioners reporting a history of child sexual abuse, six (29%) had engaged in sex with clients. This was compared with seven (6%) of the remaining 109 men who reported no sexual abuse history. A Z-test comparing the two proportions revealed a significant difference between the two groups. Clearly, not all counsellors with a history of childhood sexual abuse sexually exploit or abuse clients, and nor do all those who sexually violate clients have a history of childhood abuse, but it is a cautionary note.

Current stress

The stress a counsellor encounters on a daily basis might include the considerable pressure of working in or on a counselling business, and the general pressures of events that occur in the lives of ordinary people, such as marriage, divorce, raising a family, managing the financial pressure of the household and so on. These stressors may further be compounded by the impacts of earlier traumatic events. However, in contrast to the latent effects of trauma, it is likely counsellors are aware they are experiencing stress, and likely the impacts that stress may have on their professional and personal performance. Stress was identified as stemming from on the job factors for counsellors, including compassion fatigue and burnout (Cushway & Tyler, 1994), which can lead to

considerable personal and professional strain that in turn results in impairment (Faber, 1983).

The relationship between stress, distress, impairment and improper behaviour

The relationship between stress, distress, and impairment is well recognised (Barnett & Hillard, 2001; Gabbard, 1991; Pope, Tabachnick & Keith-Spiegel, 1987). Stress is a normal part of life and stressors range from minor (e.g. missing an appointment) to major (such as divorce). High levels of stress are associated with comorbid conditions such as low self-esteem in counsellors (Butler & Constantine, 2005), anxiety and depression in medical students (Ogden & Mtandabari, 1997), and substance abuse in psychologists (Thoreson, Nathan, Skorina & Kilburg, 1983). Distress as intense unresolved stress can make it difficult for an individual to manage (American Psychological Association, 2015). Examples may include the immense stress a counsellor might feel following a recent divorce, or the regular pressures of operating a viable counselling business. Pope, Tabachnick and Keith-Spiegel (1987) surveyed members of the American Psychological Association (APA) and found that 59% of psychologists reported working when too distressed to be effective.

Excessive distress can lead to impairment that may compromise the counsellor's professional functioning to the degree that it may harm the client and impact the delivery of effective services. Research examining distress amongst professional psychologists conducted by Prochaska and Norcross (1983) found that 82% of respondents identified they had some form of distress that was defined as "anxious or depressed moods, somatic complaints, lowered self-esteem, and feelings of confusion and helplessness about their problems" (p. 644). According to the American Psychological Association (2015), it is not the stress or even the distress that leads to impairment, rather inappropriate or

unsuccessful attempts to manage stress (American Psychological Association, 2015; Guy, Polestra & Stark, 1989).

Impairment infers that the counsellor's professional performance is compromised. The Australian Counselling Association code of ethics stipulates that members monitor themselves for signs of impairment and "refrain from providing professional services when such impairment is likely to harm a client or others" (Australian Counselling Association, 2014, p. 9). However, impairment can affect the counsellor's awareness such that the individual is unable to recognise, or denies (Ino, Tatsuki & Nishikwawa, 2001) the seriousness of their condition. Consequently, the probability of inappropriate, unethical, or possibly illegal behaviour is considerable (American Psychological Association, 2015), see Figure 2.

Figure 2. The stress-distress-impairment continuum

Counsellors who do not adequately deal with psychological conflict and unresolved trauma are more likely to experience disruptions in their empathic abilities (Everall & Paulson, 2004). This disruption often interferes with the therapeutic process, resulting in sub-optimal performance and potentially jeopardising client care. Counsellors falling into this category are also more likely to have difficulty maintaining a professional distance and engage in boundary violations (Neumann & Gamble, 1995).

Counsellor personality as a risk factor

Some personality traits are likely to be more conducive to effective counselling practice than others. For example, being open may make a counsellor less judgmental of a client's behaviour, being emotionally stable might make them less reactive and better able to be empathetic rather than sympathetic, and being more extraverted than introverted

might assist the counsellor to draw the client out. It stands to reason though that if there are traits of advantage, there are also bound to be traits that will make a counsellor less effective. This section explores a number of traits that may play a part in explaining transgressing behaviour. In particular, the focus is on traits that may interact with previous and potentially unresolved trauma to increase the likelihood of boundary crossings and violations.

Selfish gains

In ordinary relationships, indeed in ordinary conversations, there is a need to share approximately equally. That includes the time focused on each party to the relationship, the amount of talking versus listening, the amount of disclosure, and so on. That balance does not apply to a counselling relationship. The counsellor may well share some of themselves in order to build rapport and promote a sense of trust, but otherwise a significantly disproportionate focus must be afforded the client.

Counsellors who seek fulfilment of their own needs may blur objective reasoning when faced with decision-making processes related to duty of care (Geldard & Geldard, 2009). The term 'needs' in this sense equates to the counsellor leveraging the therapeutic process to work out his or her own vulnerabilities and problems (see Witmer & Young, 1996). For example, redirecting dialogue toward personal issues of interest to the counsellor for the resolution of the counsellor's concerns or problems — and thus not supporting the client on his or her journey— is clearly placing the counsellor's needs above those of the client.

The counsellor might also encourage the client to follow a specific course of action that is more to the benefit of the counsellor than the client (Geldard & Geldard, 2009), such as directing the client to engage in sexual activity that fulfils the counsellor's sexual fantasies. In one particular case a counsellor named Dawes was diagnosed as

having zooaphillia — an erotic fixation on animals — and was found by a Civil and

Administrative Tribunal to have actively encouraged his client to engage in sexual acts

with animals in the fulfilment of his personal sexual fantasies.

Selfish gains need not always be considered in terms of sexual deviancy.

Counsellors who need their clients too much may exploit them, tending to keep them

'needy' and dependent (Stierlin, 1972). Counsellors who require too little from their

clients, in terms of their own psychological needs, may lack the motivation to invest

sufficiently in the therapeutic process and, in turn, have insufficient empathic connection

with clients. Successfully recognising and then adjusting behaviours to ensure that the

median point between needing the client too much and too little ensures a level of balance

concerning personal motivations.

Narcissistic pathology

Pathological narcissism — a distorted sense of importance or ability — is often

associated with a compensatory need to feel special (Epstein & Simon, 1990). This

condition of *specialness* becomes a self-reinforcing, protective strategy to maintain self-

esteem and a technique for screening out external disappointment. Such a condition can

provide an individual with a sense of entitlement and enable self-justification for using

others as if they were objects rather than individuals (Epstein & Simon, 1990). As a

coping strategy, individuals displaying narcissistic behaviours tend to withdraw inwards

and seek internalised gratification. A fearful child escaping further rejection because of

abuse avoids interactions, preferring to create grandiose fantasies of acceptance and love

(Freud, 1914).

In this sense, unresolved trauma arising from childhood abuse may lead to

narcissistic pathology. As such, this pathological protection, the condition of *specialness*,

results in the individual ignoring the rules that govern interactions between "ordinary",

well-adjusted people (Epstein & Simon, 1990). Counsellors who ignore the rules —

counsellor client etiquette, societal rules, social norms etc. — may intentionally and

deliberately breach codes of conduct in the therapeutic setting, which can result in a

reduction in client welfare, which may be deemed to be misconduct and malpractice.

Twemlow and Gabbard (1989) studied and worked with numerous exploitative therapists

with narcissistic problems, noting that such individuals tend to rationalise their special

condition in such a way as to excuse their behaviour.

Dependency

Dependency typically relates to infant development and encapsulates the essential

needs of human attachment, including love, affection, shelter, protection, security, food,

and warmth (Ainsworth, 1969; Segen, 1992). Social Learning Theory regards dependency

as an interpersonal relationship beginning with an infant's symbiotic dependence and

attachment to the mother (Ainsworth, 1969). Dependency is resolved when a child

successfully journeys from complete reliance upon a primary caregiver to meet their own

physical and psychological needs through the development of a necessary self-concept

(Bowlby, 1958; Fairbairn, 1952). Bornstein (1994) suggests that children unable to

adequately develop personal security and successfully separate from mother experience

dependence issues in adulthood.

Unlike attachment theory, dependency is not constrained to specific stages of

development. Rather, its "nature and expression" alter throughout life (Harrison, 2011, p.

21). An individual's dependency alters over time in accordance with changing situational

and interpersonal factors (Harrison, 2011), influencing their capacity to balance

interdependency, intimacy, and autonomy (Steele, van der Hart & Nijenhuis, 2001). As

such, an individual who is unsuccessful in separating from an important person,

potentially because of trauma, may have unresolved, or continual traumas. For example,

relational separation, such as a loss of a partner or spouse due to divorce or marriage breakdown, may result in the ongoing effects of the trauma leading to residual dependency issues.

Epstein and Simon (1990) suggest a counsellor's residual dependency issues can manifest in therapy when the counsellor employs excessive disclosure of personal problems and concerns. Actually, disclosing thoughts and feelings is associated with improved wellbeing (Pennebaker, 1997; Pennebaker, Kiecolt-Glaser & Glaser, 1988), as long as it is the client who is the one providing the disclosure as part of the therapeutic process, and not the counsellor using excessive forms of disclosure — potentially disguised as part of the therapy — to derive some personal benefit. Here a client may express sympathy for the counsellor's situation and attempt to comfort and assist the counsellor. Thus, in this example, a switch occurs in the working alliance, the counsellor and their issues now become the subject of focus in the session. Such action may be seen as an attempt to secure emotional, or other, support from the client. In doing so the counsellor may attempt to optimise selfish gains, potentially stymieing client progress.

Maintaining professional esteem

For many people their vocation is more than a job and becomes part of who they are – this would apply to counselling to at least the same degree as other careers. However, for those who became counsellors after and *because* of some seminal life-altering event such as a trauma, their role as a counsellor may well seem more like a calling, even a destiny. Those individuals may go to significant effort, even if it is not deliberate and conscious, to protect that sense of answering the call and being an effective practitioner, to protect and enhance levels of professional esteem.

Identity feedback mechanisms and motivations for behaviour

Individuals are motivated to verify their self-concept by gathering feedback and evidence from social interactions (Higgins, 1987; Swann, 1983; Swann, Pelham, & Krull, 1989). Social interactions are also a way of communicating with others in an effort to obtain positive feedback thus enhancing a self-concept, that is, to gather positive feedback from others (Swann 1983). Social interactions are typically an external process of communication transference between the individual and social environment (Bandura, 1989). Two sources of identity feedback include self-verification and self-enhancement.

Self-verification is the process whereby individuals strive to ensure the stability of self-conceptions, be they positive or negative (Swann, 1983; Sedikides & Strube, 1995). Individuals engage in behaviours designed to signal to those around them that they would like to be seen as he or she sees themselves. Thus a counsellor could seek positive feedback from others that they are doing a good job at being a counsellor. Objective evidence of such success might be the amount of business they have, especially if it is via referrals from existing or past clients, or it might be the impact of their work in terms of helping clients deal with issues and who then no longer need support or help. A counsellor with more fragile or uncertain professional esteem might seek reassurance from existing clients, or even engineer situations that make their impact more obvious. Such manipulations would clearly be unethical, even if they were not deliberate.

Verification seeks to confirm perceptions. Self-enhancement seeks to increase the self-concept – akin to buffering the self for protective purposes. It is concerned with increasing positivity and decreasing negativity of the self-concept (Leary, 2007; Snyder, Stephan, & Rosenfield, 1976). The consumption of self-referent information gained through social interactions and evaluations provided by people in our lives, which may include clients, maximises the positivity of one's self-concept (Sedikides & Strube,

1995). A hallmark of self-enhancement is the use of social comparisons, especially comparisons with targets that place 'the self' in a favourable position (Brown, 1991). Both conditions act as a mechanism that verifies and confirms personal self-conceptions (Swan, 1983).

According to Gregg, Sedikides and Gebauer (2011), an individual's motivation to self-enhance and self-verify falls into three categories. First, individuals are often concerned with the accuracy of their identities, thus self-assessing and favouring true self-constructs over false constructs (Trope, 1980). Second, individuals are concerned with valence — attractiveness, positive and negative — of their identities, thus seeking out positive over negative feedback (Sedikides & Gregg, 2008). Third, individuals are concerned with the consistency of their identities, thus they are likely to favour familiar self-constructs over those that are novel (Swann, Rentfrow & Guinn, 2003).

The consequences of such motivations may be considered both good and bad, (Gregg, Sedikides & Gebauer, 2011). On a psychological level, motivations to pursue positive identity feedback (self-enhancement and self-verification) can be seen as a positive step for individuals attempting to improve their mental well-being and health. However, such motivations may result in negative consequences if the motivation is so strong that the acquisition of positive feedback comes at any cost — to the individual and those around her or him. In the professional working environment, Lonnqviust, Leikas, Verkaslo and Paunonem (2008) found that individuals who persistently and excessively hold positive views of themselves have poorer outcomes in terms of occupational performance, however the underlying mechanisms concerning why this occurs remain elusive.

Research supports an association between an individual's identity and their behaviour (Brown & Lohr, 1987; Hagger, Anderson, Kyriakaki & Darkings, 2006;

DeCelles, DeRue, Margolis & Ceranic, 2012; Stets & Carter, 2012). It is posited that self-identity perceptions may induce intentional behaviour by acting as a source of information when individuals make plans to act in certain ways. In a study examining the psychological processes underlying health related behaviours, Hagger, Anderson, Kyriakaki and Darkings, (2006) found that aspects of identity impact behaviour. Their participants ($N = 525$) completed several measures with results of a structural equation modelling process indicating that social identity influenced positive attitudes and subjective norms in perceived behaviour control. The results suggest that aspects of identity are influential in the decision-making process relating to health behaviours. The aforementioned research raises an important question, to what extent does the relationship between an individual's health concerns (mental or other) influence or induce behaviours — positive and negative — in order to improve well-being?

Self-deception

In some cases, misconduct and malpractice may be the result of a counsellor's self-deception (Epstein & Simon, 1990). In other words, while certain behaviours are occurring the counsellor is not aware of the impact of their actions and may not regard such behaviours as a problem. This lack of awareness is problematic as a counsellor's behaviours can significantly interfere with the provision of counselling services. An example might include the repression or denial of feelings that the counsellor is not coping due to stress and distress associated with trauma. In spite of contrary evidence, the individual ignores, avoids and diminishes awareness of personal problems blocking attention and creating what Goleman (1998) calls a blind spot. Such behaviour may be difficult for others, including supervisors, to uncover or identify. Due to the powerful nature of self-deception, Gabbard (1994) suggests that supervisors must assume that all counsellors are at risk of transgressing.

A number of plausible suggestions have been provided as to why unresolved trauma might increase the risk of misconduct and malpractice behaviours. Whilst each is detailed in isolation, the reality is that any combination of these factors may produce a complex condition affecting counsellor performance. For example, counsellors may derive advantage through selfish acts impacting the therapeutic relationship, and yet he or she may be oblivious to the problems those behaviours cause.

Personal identity

Personal identity relates to the ways individuals attempt to make sense of some facet or portion of their self-concept (Hogg, 2003). Oyserman, Elmore and Smith (2009) posit that individuals hold a collection of 'identities' that form the foundations of self-concept. Baumeister (1999) defines the self-concept as an individual's belief constructed from personal attributes regarding who and what 'the self' is. Self-concept theory proposes that individuals perceive and interpret their existence from externally located feedback (McAdam, 1986). An individual's perception of success, or failure, is associated with the ways in which individuals view themselves and their relationships with others (McAdam, 1986).

Counsellor identity

Identity is a collection of personal traits, characteristics, social roles and group memberships that define an individual (Oyserman, Elmore & Smith, 2009). Further, the individual typically consists of multiple identities to suit various situations and roles and demands. These identities provide an orientation through which individuals derive personal meaning given a specific situation or environment (Oyserman, 2009), typically in response to contextual and environmental cues that mediate and moderate who an individual thinks they are (Oyserman, 2009). The relationship between the self and identity is both a product of a particular situation and influencer of behaviour in situations

(Oyserman, Elmore, & Smith, 2009). However, social psychology and sociological literature typically views personal and social identities as separate concepts (Brewer & Roccas, 2001; Hogg, 2003).

Social identity

Social identities relate to the understanding that one is a member or affiliate of a group. This membership conveys meaning, rank and status compared others within the same groups and in difference groups (Oyserman, Elmore & Smith, 2009). For example, an individual may hold membership of a collective known as counsellors, and display behaviours based on what the individual believes members of this particular group do and how they act in society. Thus social identity is the distinctive characteristics shared by members of a particular social sector or group (Brown & Lohr, 1987).

Under the umbrella of social identity, Oyserman, Elmore and Smith (2009) posit that individuals engage in social roles. Social roles are aligned with membership of a particular group, requiring another person to play a complementary role. In order to be a professional counsellor one requires clients who recognise one's role. Personal identities may differ from social identity and social roles or may be linked to some or all identities (Owens, Robinson & Smith-Lovin, 2010).

Moral identity

Moral identity, generally speaking, is defined as the degree to which the idea of 'morality'- determining what is right or wrong, good or bad, acceptable and unacceptable in society - forms part of an individual's personal identity (Swanson, 2010). It concerns the psychological implications relating to moral associations that define the moral-self (Aquino & Reed, 2002). The most influential theory relating to moral development is Piaget's (1932) cognitive-developmental model, later expanded by Kohlberg (1971). The primary thesis of the cognitive-development model is that an individual's moral reasoning

predicts her or his moral behaviour. In contrast, socio-cognitive theories (Bandura, 1999; Bandura, Barbaranelli, Caprara, & Pastorelli, 1996) suggest moral standards and self-sanctions are essential components of moral behaviour. According to Aquino and Reed (2002), the essential difference between the two theories is that the cognitive–developmental model emphasises moral reasoning, and the socio-cognitive model highlights self-regulatory mechanisms. Both aspects are important because without self-regulatory mechanisms an individual's ability to engage in complex moral reasoning may have a significant effect on moral behaviour (Aquino & Reed, 2002).

Moral identity is one self-regulatory mechanism that prompts moral behaviours and actions (Erikson, 1964; Hart, Atkins & Ford, 1998). Not unlike other identities, an individual's moral identity is associated with certain beliefs, attitudes, and behaviours (Aquino & Reed, 2002). In the words of Damon and Hart (1992),

> "there are both theoretical and empirical reasons to believe that the centrality of morality to self may be the single most powerful determiner of concordance between moral judgment and conduct…People whose self-concept is organized around their moral beliefs are highly likely to translate those beliefs into action consistently throughout their lives" (p. 455)

The concept of moral identity being multifaceted and comprised of social and self-regulated components is not new. Nor is the notion that an individual's sense of who they are should relate to their actions and behaviour. Moral identity is comprised of other identity components (social identity and the self-concept) mediating the relationship between moral thought and action (Aquino & Reed, 2002).

Trauma and identity

The ways in which individuals compose life stories is related to personal identity (Berntsen & Rubin, 2007). According to Fitzgerald (1988), life stories are defined as a "set of stories that define who we are in narrative rather than declarative terms" (p. 269).

McAdams (2001) shares a similar notion of identity to that of Fitzgerald (1988), describing it as taking the form of a personal story. Given that major traumatic events are significant points in the lives of those who go through them, it stands to reason that the trauma and its aftermath will be a major chapter in that life story, and perhaps change the direction of the whole book from that point forward. Berntsen and Rubin (2007) argue that if the memory of trauma is viewed as a central turning point in an individual's life story, it could also be a primary component of personal identity.

Traumatic events can harm self-perception (Pennebaker, Kiecolt-Glaser & Glaser, 1988) and disrupt a coherent life narrative reflecting who an individual was, who they are now, and who they wish to be in the future (McAdams, 1996). According to Resick (1993), traumatic events create considerable upheaval in psychological functioning for a considerable time, even the rest of the individual's life. Resolving trauma through an understanding of the traumatic event is an important part of recovery (Pennebaker, Kiecolt-Glaser & Glaser, 1988).

Disclosing personal thoughts and feelings concerning traumatic life events is associated with improved wellbeing (Pennebaker, 1997; Pennebaker, Kiecolt-Glaser & Glaser, 1988). Trauma disclosure is associated with self-enhancement resulting in a more resilient self-concept (Pyszczynski, Greenberg, Solomon & Schimel, 2004; Taylor & Sherman, 2008). Conversely, inhibiting one's thoughts and feelings about trauma is associated with long-term stress and disease (Pennebaker, Kiecolt-Glaser & Glaser, 1988). Two pioneers of psychosomatic and health psychology, Alexander (1950) and Selye (1976), provide support for the relationship between psychological conflict, anxiety and stress, and increased disease. Therefore, it seems logical that a reduction in psychological conflict shall reduce illness (Pennebaker, Kiecolt-Glaser & Glaser, 1988).

Literature concerning how to resolve and deal with trauma most effectively usually centres around how individuals make sense of, understand and/or assimilate traumatic experience (Breuer & Freud, 1955; Hemenover, 2003; Pennebaker, Kiecolt-Glaser & Glaser, 1988). Breuer and Freud (1955) theorised that talking about thoughts and feelings associated with traumatic events is associated with a reduction in 'hysterical symptoms', or in more modern terms, somatic symptoms (Tasca, Rapetti, Carta & Fadda, 2012).

Pennebaker, Kiecolt-Glaser and Glaser (1988) suggest that confronting trauma may be beneficial for two important reasons. Firstly, individuals no longer need to inhibit or hold onto concerning thoughts and feelings from others within social networks, including family. Secondly, individuals confronting trauma may assimilate, resolve and make sense of the event, allowing the individual to move forward in life and become who they wish to be in the future (McAdams, 1996). Reframing trauma recovery from an isolated individual event into a social process provides another avenue of exploration. A social identity framework, according to Muldoon and Lowe (2012), allows identity to be viewed within a social context as individuals attempt to reintegrate the traumatic event.

Individuals who survive trauma often remark they are not the same person they were prior to the traumatic event (Brison, 2002; Crossley, 2000). Traumatic events can shape identity (Berntsen & Rubin, 2006). Traumatic memory forms a central component of personal identity, marking a turning point in an individual's life story. Perel and Saul (1989) found trauma for some has a cross-generational influence on the identity of family members of Holocaust survivors. Abramson and Seligman (1978) suggest resolving and integrating traumatic events into personal identity likely supports certain internal, stable global characteristics. That is, trauma is seen as being causally associated with [un]stable

characteristics of the self which are said to hold across different situations/events in one's
life.

Crossley (2000) argues the *lived experience* is disrupted by traumatic events
resulting in a deconstruction of the afflicted individual's world. Following the incident,
suffering is often lessened through the meaning individuals attach to their experiences
(Brody, 1987). This reconfiguration of personal meaning restores a degree of order and
connection to self-identity (Crossley, 2000). In this sense, the use of storytelling and other
forms of communication appears part of the healing process. For many, making sense of
'trauma' is part of 'reconstructing their world' however, it is often a very different place
once completed.

Chapter 5: Understanding how unresolved trauma might lead to
misconduct and malpractice

Ethical standards outline certain ways of acting and behaving that are aligned with what is expected of a professional working as a counsellor. However, counsellors, psychologists, psychiatrists and other mental health professionals do not always say and do things that are fully in accordance with ethical principles, or the law for that matter. Counsellors who breach ethics standards expose their clients to potential harm and can be judged guilty of malpractice. The harm extends to the wider profession through an erosion of trust when often salacious details are promulgated by media, and to others who might be put off seeking help for psychological issues. The need for the counsellor to be seen as trustworthy is not a corollary of counselling as a profession, but rather is part of the essence of the profession (Bond, 2010).

Misconduct, and sometimes malpractice, damages the therapeutic relationship, violates the treatment contract, and may exacerbate a client's underlying mental health problems (Epstein & Simon, 1990; Borys & Pope, 1989). For these reasons alone, understanding the causal factors of misconduct and malpractice is of paramount importance in protecting clients and maintaining counselling as a profession.

One avenue of investigation that may expand an understanding of the cause of misconduct and malpractice is an individuals' motivation for becoming a counsellor. For example, individuals who enter the helping profession, including counselling, in order to resolve their own psychological trauma (Elliott & Guy, 1993; Frank & Paris, 1987; Hardy & Calhoun, 1997; Sussman, 2007) may be at greater risk of breaching their profession's ethical standards and engaging in misconduct and malpractice behaviours due to the latent impacts of ongoing traumatic experience (Duncan & Miller, 2008; Geldard &

Geldard, 2009). This chapter ponders why an individual might attempt to resolve personal psychological trauma by training to work as a counsellor.

Resolving personal psychological trauma by training to work as a counsellor

Students entering counselling courses indicate that a primary motivator for entry is to assist people who, like them, have suffered (Ellis, 1972; Sussman, 2007). Indeed, many counselling students think that life experience qualifies them for entry into the counselling profession (Frank & Paris, 1987; Richardson, Sheean & Bambling, 2009). In 1972 Albert Ellis noted that many students undertaking clinical psychology training had previously suffered from anxiety and depression, had attended some form of psychotherapy, and then decided to undertake a career in counselling. Similarly, Hutchinson's (2011) interviews with students conducted as part of a graduate counselling program found that students often attempted to find better ways to focus interpersonal or social energy. In some cases students expressed they had overcome some major life challenges, including addiction and relationship breakdown (Hutchinson, 2011).

Dryden and Spurling (1989) found that many practising counsellors had experienced significant episodes of emotional distress in their childhood. Elliot and Guy's (1993) large-scale study comparing 340 female mental health workers with 2,623 women in other professions found that the former group had higher instances of childhood physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalisation and family dysfunction in their background compared to other professions.

Indeed, Jung's (1946) perspective on the relevance of life challenges to counselling was that a counsellor's experience with their own personal vulnerabilities made the individual more capable of helping others. Jung (1951) suggested the experience of personal trauma activated some form of increased empathic ability, allowing greater connection to clients. Jung further suggested that only a wounded healer

could effectively heal others. In line with Jung's postulation, Sussman (2007) also considered that those who have understood and mastered their own psychopathology have enhanced abilities to understand and help others. The key point was that the experience of trauma is a prerequisite to the development of empathy and compassion (Jung, 1951; Sussman, 2007), and that these were desirable characteristics in competent counsellors.

Training as a counsellor may provide a form of protection by masking suffering. Individuals who become helpers may protect the psychologically conflicted aspects of the self from future suffering, thus transforming them from a potential casualty into the strong, powerful and courageous survivor. The desire to become a counsellor may, in fact, be a consequence of what could be termed self-therapy. Similar to the concept of self-medication, in which individuals use a variety of drugs (legal and illegal) to provide a form of treatment for mental illnesses (Khantzian, 2003), self-therapy can be viewed as the pursuit of self-induced healing interventions for the resolution of unresolved trauma or other problems and concerns. Consequently, the aim of this study is to develop a theory for the relationship between a counsellor's unresolved trauma and the increased risk of misconduct and malpractice in practice.

Method

Participants

The participants were 419 Australians who provided counselling services. They included counsellors, psychologists, social workers, and psychotherapists. The sample consisted of 253 women and 52 men – 3 identified as "other" and 111 did not respond to the gender question. Respondents ranged in age from 25 to 76 years ($M = 52$ years, $SD = 11$) with an average of 12 years, and with a range between one and 42 years of practice experience ($SD = 9$). Of these participants, at the time of completing the survey 388 (93%) were practising, 23 (5%) were non-practicing, and 8 (2%) were students in

training. The students in training were asked to respond to the questions as if they were already in practice. The greater number of respondents were based in New South Wales (n = 145), followed by Victoria (n = 130), Queensland (n = 92), Western Australia (n = 46), Tasmania (n = 36), and South Australia (n = 30). Some respondents indicated that they provided services in multiple locations.

Measures

Unresolved Trauma. Unresolved trauma was explored using a self-report measure that asked about personal life distress rather than a clinically diagnosable Criterion A disorder such as PTSD (DSM5; American Psychiatric Association, 2013). All participants were asked to respond 'yes' or 'no' to the question "Have you suffered a significant traumatic event during your life?" A follow-up question asked "Are you still experiencing the effects of the trauma?" Participants responding in the affirmative to both questions were classified as having unresolved trauma.

Qualitative Responses. Participants were invited to provide a descriptor concerning their reasons for entry into the counselling profession, and also a taster of the type of trauma they experienced.

Impact Event Scale Revised (IES-R). An assessment of participant scores from the Impact Event Scale Revised screen (Weiss & Marmar, 1997) were used for subjective categorisations of unresolved trauma. Participants who indicated they were still experiencing the effects of past trauma were asked to provide information on the nature of the trauma.

The IES-R is a self-administered 22-item questionnaire. It covers the three clusters of symptoms for Posttraumatic Stress Disorder (PTSD) identified in the DSM-5 (American Psychiatric Association, 2013) - intrusion, avoidance, and hyperarousal. The IES-R is not a diagnostic tool; rather it is a screen for PTSD. Given the exploratory nature

of the present study, the IES-R measure is used to explore the effects of symptoms that could be associated with PTSD due to self-reported trauma, not clinically diagnosable trauma.

Responses are used to gauge the impact of a traumatic event and evaluate recovery. Respondents were asked to indicate on a five-point Likert scale their level of distress for each item, with 0 indicating a symptom does not occur at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; and 4 = extremely. Cronbach's reliability coefficients for the three subscales is high, with alpha for intrusion ranging from α = .87 to .92, for avoidance ranging from α = .84 to .86, and for hyperarousal ranging from α = .79 to .90 (Briere, 1997). Test-retest correlation coefficients for the subscales are: intrusion = .57, avoidance = .51, and hyperarousal = .59. However, in this particular study, only the total scores were used to assess the number of participants scoring above the cut-off indicators for the presence of PTSD symptoms relating to their recorded subjective trauma.

Rejection, Enhancement and Verification Scale Revised (REVS- R). The REVS is an adaptation of a scale developed by Bloch (2004) exploring self-enhancement, self-verification and rejection. Initially, the instrument was developed to measure participants' responses to relationship feedback, including self-enhancement, self-verification and rejection. For the current study, the instrument was modified by replacing the term 'friend' with 'client' to bolster face validity to the population of interest. Therefore, the 28-item instrument measured participant responses on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) to statements including: My clients know who I am deep inside, my clients value me as a person, and my clients don't understand me. Cronbach's reliability coefficients for the three factors (in the original, unadjusted instrument) are: Rejection α = .93, Enhancement α = .88 and Verification α = .88.

Ethics of Practice Questionnaire Revised (EPQ-R). The EPQ was developed by Pope, Tabachnick and Keith-Spiegel (1987) to measure the extent to which participants agreed that particular behaviours in the course of providing therapeutic services are ethical. The original 83-item instrument was reduced to 47 items for the present study. Items were selected based on relevance to a diverse population of interest — one that contains both regulated and unregulated counsellors in Australia. The items removed from the original EPQ-83 (see Appendix 7) were considered repetitive in nature and were deemed to be adequately covered by similar items elsewhere within the instrument — for example, the removal of 'having a client address you by your first name' and retaining 'addressing client by his or her first name' — and perceived relevance to a diverse population of counselling professionals (general counsellors, psychologists, social works etc.). An example of such an item includes 'utilising involuntary hospitalisation' which is not applicable to unregulated counsellors and generally registered psychologists in Australia.

Demographic Questionnaire. Questions were included to establish gender, age, area of practice, level of education, industry association status, and engagement with supervisory services.

Procedure

Ethics approval was received from Monash University Human Research Ethics Committee (Approval Number CF13/2485 - 2013001319). Approval was given to promote the study through industry associations and direct contact with organisations promoting mental health services online across Australia. Participants were emailed a link to access an online survey hosted by Qualtrics (www.qualtrics.com). Professionals willing to participate completed the set of questionnaires within 35-40 minutes. The present study administered several instruments — including the Impact Event Scale -

Revised, the Rejection, Enhancement and Verification Scale - Revised, and the Ethics in

Practice Question - Revised, which is not a focus of this study but is part of the larger

project — along with several questions regarding trauma history, motivations for working

as a professional counsellor, and several open text fields for qualitative responses.

Descriptive data were analysed using Microsoft Excel (Microsoft 2010).

Qualitative data were initially reviewed in order to achieve a level of familiarisation. The

open-end question response data were transposed into Microsoft Excel (Microsoft 2010)

and categorised by theme using a unique identifier. Responses were reviewed and

coordinated into various overarching themes. The data were condensed into thematic

content and overall theme names were assigned.

Results & Discussion

The first aim of this study was to examine why individuals enter the counselling

profession, and to identify the extent to which trauma plays a part in their counselling

career. The second aim was to develop a theory for the relationship between a

counsellor's unresolved trauma and the risk of misconduct and malpractice in practice.

Of all participants, 63% (n = 266 of 419) indicated that they had experienced

significant trauma at some point in their life. The average score on self-reported trauma

was 4.1 out of a possible 5 (M = 4.12, SD = .89), indicating that trauma was of a

considerable concern. These participants were then asked, *did the trauma experienced*

provide a catalyst, or a motivation, to begin a career in counselling? – 61% (n = 163) of

those who had experienced trauma indicated "yes, it did".

Investigating further, the 163 participants who had become therapists after

experiencing trauma were asked, *is the area in which you practice related in any way to*

the trauma experienced? a quarter of these participants (n =101, 62%) answered "yes".

Finally, these 101 participants were asked *are you still experiencing the effects of the*

trauma? 90% of participants (*n* = 91) indicated "yes" they were still experiencing

traumatic effects. This subgroup was then asked to complete the IES-R (Weiss &

Marmar, 1997) screening tool. Figure 3 provides a flow diagram of the progressive

subsets of participants self-selecting into the subgroup of interest – people who had

become counsellors due in large part to the experience of an earlier significant trauma

that may still have an impact upon them.
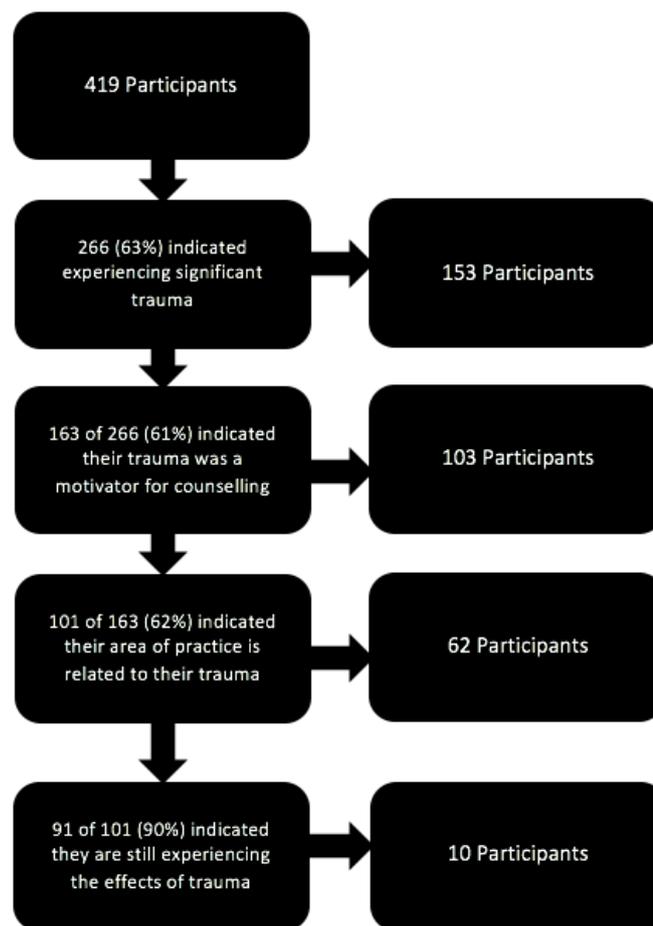
Figure 3. Participant inclusion flow diagram

      Based on the IES-R, 9 respondents had scores exceeding the threshold for

Posttraumatic Stress Disorder (PTSD) (though a more detailed session with the client

would be required to consider a formal diagnosis). Only one of the nine respondents

indicated they were not currently working as a counsellor, but they did not say why they

were not currently counselling. Thus 22% of counsellors participating in the present study

fit the description for what Jung (1951) termed *the wounded healer*.

Thematic analysis

The qualitative responses offered by study participants as to why they entered the

counselling profession centred around a number common themes, these included; 1. A

desire to assist others, 2. Valuing relationships with others, 3. Due to past experience, 4.

As a career change, 5. Having empathy for others, 6. For personal growth, and 7. To

resolve personal trauma. Below are some of the participant's responses as representatives

of the seven primary themes.

Theme 1. 'A desire to assist others'

"The thought of helping people appealed to me."

"To assist people to create the life they desire, to find happiness and to assist others
to heal."

"To help others improve and understand their issues."

"I like seeing people get better, grow and blossom and if I can be of some assistance,
that's good."

"I believe counselling can assist people experiencing emotional distress through
identifying their own already acquired skills in addition to learning new ones."

Theme 2. 'Valuing relationships with others'

"Relationships are one of my passions."

"I really enjoy working with people."

"To learn to interact with people."

"I believe that people can learn to form more satisfying relationships and that this will
contribute to a more peaceful world."

Theme 3. 'Due to past experience'

"After 22 years in therapy myself under one of Australia's finest, I believe I am well-
equipped to now assist clients on their journey."

"I had been in my own psychotherapy weekly for 4 years and felt that I could offer something back."

"I experienced some helpful personal development in my 20s and admired the skills of therapists."

Theme 4. 'As a career change'

"I was in charge of HR department of my own company in Europe and found I wanted to learn more about psychology - liked it so much that I changed career."

"It is an industry that I have felt drawn to for many years."

"This is a career change where increasing age is an asset and I hope to continue, productively, in this field for a long time."

"Necessary career change as I was made redundant at Department of Primary Industries."

Theme 5. 'Having empathy for others'

"I have empathy for persons going through tough times."

"I believed my empathetic nature would suit well for this role."

"I felt drawn to helping people in this way, and many people over the years would talk to me and share their emotional burdens."

"I like to connect with people who are struggling and delight in their relief and pleasure as they deal with what was so difficult."

Theme 6. 'For personal growth'

"I was hungry for personal growth and development."

"My own learning and development after overcoming anxiety and relationship issues."

"Personal life experiences e.g. my youth, ethnicity, abortion, marriage, divorce, four children with eldest severely & multiply disabled, grief & loss, church involvement, unemployment, financial limitations."

"I wanted to overcome fears and anxiety etc. it was challenging and wanted to know more about doing this for myself and others."

Theme 7. 'To resolve personal trauma'

"To help break the intergenerational cycle of trauma abuse and dysfunction."

"My father was an abusive alcoholic, I wanted to understand addiction, behaviours etc."

"To overcome grief and abandonment issues coupled with relationship issues - to help overcome obstacles and have better relations with others"

"A need to understand my own traumatic childhood."

"Marriage breakdown needed to be addressed."

The aforementioned responses, and overarching themes, indicate that for some the journey into counselling includes great emotional turmoil and instability. Noble and Walker (1997) argue that for some, *liminality* — a transitional period or phase akin to a rite of passage — may provide the catalyst to entering the counselling profession in order for the individual to find answers too strong, deeply personal inner drives that demand resolution (Ford, 1963). Liminality involves isolation, estrangement, social survival, threats to personal identity, and a departure from old pathways in the pursuit of new (Van Gennep, 1960). This separation produces emotional upheaval in which new coping mechanisms are formulated. In this way, becoming a counsellor and traversing a period of liminality could represent or function as post-traumatic growth and thus serve an individual well; not just in terms of healing but also longer-term personal development.

Keller and Schneider (1976) hypothesised that an important motivation for some entering the counselling profession was the need to resolve an identity crisis. The resolution of an identity crisis creates feelings of adequacy, worth and increases levels of self-esteem (Cast & Burke, 2002). Keller and Schneider (1976) interviewed students about their motivations for training. Their hypothesis that entering counselling to resolve an identity crisis as supported through results of psychological testing and observation. For others, entry into counselling may somehow support a desire for personal growth as a consequence of supporting others. In this context, helping others consists of leveraging

the therapeutic process at the expense of the client for selfish gains, which may be associated with increasing self-esteem through self-enhancement and self-verification of an idealised self-concept (see Rogers, 1959). Finally, unconscious motivations for becoming a counsellor may also play a part for many who believe, initially at least, that they had undertaken a career for professional reasons only to discover that personal reasons also dictated the decision (Henry, Sirns & Spray, 1971).

A taxonomy for entry into the counselling profession

It appears that some individuals enter the counselling profession attempting to resolve a traumatic event they have experienced in the past. It is proposed that there are three categories of individual entering training as a counsellor. The first category includes those individuals who enter in a deliberate, calculated bid to help themselves. This category of individuals seems to strive to improve their personal position, seeking out counselling, psychology and associated courses as a means to undertake a journey of self-discovery and healing or other intentions. Once qualified and given access to clients, the deliberate process of benefit-harvesting continues as interactions with clients serve as a mechanism or instrument for further gains. This is potentially the point at which client care may be compromised. This group can be classified as being 'pre-mediators' and are the group most likely to be of greatest concern for professional bodies. It is likely that this first group represents a very small portion of the overall number of individuals who enter the profession. Estimates of the proportion of those counsellors who will be accused of misconduct and malpractice in Australia is approximately 2% of registered counsellors (Grenyer & Lewis, 2012).

The second category includes those individuals who enter for the myriad of reasons outside of resolving personal trauma — indeed they may never have experienced trauma. Yet this group of individuals may still find benefit from participating in the

various courses and programs and working with clients. Whilst it is true that some of the counsellors within this group may well transgress professional boundaries, they will not do so due to pre-existing unresolved trauma. However, the resolution of other trauma conditions — vicarious traumatisation for example — is a possibility during their career.

The final category includes individuals who undertake training as a counsellor for personal benefit — self-improvement and/or the resolution of trauma — however they do not set out or intend to benefit from client interactions. Such individuals may enter training programs and once qualified think that they are mended or healed. The counsellors within this category may unintentionally slide down the slippery slope toward misconduct and malpractice typically due to blind spots or absence of effective self-reflective practice. Twemlow and Gabbard (1989) suggest that every counsellor struggles with the temptation to take personal gratification from the therapeutic situation.

A theory of why unresolved trauma might increase the risk of misconduct and malpractice

It is theorised that unresolved trauma impinges upon the counsellor's ability to provide safe, objective and effective therapeutic services to clients. Whilst there is a paucity of evidence to support this claim, Jackson and Nuttall (2001) provides some insight. They identified a direct relationship between trauma and misconduct/malpractice by surveying social workers, psychiatrists, and psychologists ($N = 323$). Their findings revealed three out of five (60%) male therapists who reported a high degree of psychological trauma were four times more likely to engage in boundary violations of a sexual nature than those without a history of trauma. Whilst a direct relationship appears to exist between psychological trauma and misconduct and malpractice, the various mechanisms explaining exactly how this might occur remain elusive. One particular

factor that might assist in providing an explanation for this phenomenon is a counsellor's attempt to protect or enhance their self-concept.

A counsellor's unresolved trauma may interfere with aspects of the self-concept, which may in turn affect clarity in judgment. Whilst not strictly isolated as a phenomenon associated exclusively with counsellors with unresolved trauma, self-verification — the tendency to seek only information or evidence that confirms an often initial and intuitive self-concept (Swann, 1983; Klayman & Ha, 1987; Wason & Johnson-Laird, 1972; Sedikides & Strube, 1995) — may play a part in explaining how a counsellor can continue to work with clients whilst possibly impaired. For example, a counsellor performing poorly in therapy due to unresolved trauma, and seemingly unable to assist clients, may wonder 'am I a competent counsellor?'. Based on previous behaviour the counsellor may conclude they are in fact a great counsellor. The counsellor then sets out to find, or only accept, data to confirm this hypothesis, thus ensuring the integrity of the self-concept that embodies the individual being 'a competent counsellor'. The counsellor looks for instances in which he or she performed well in sessions, rather than instances in which performance was poor (Kunda, 1990; Pyszczynski & Greenberg, 1987). The result is the creation of a blind spot concerning the truth about the counsellor's capacity to support others.

The creation of blind spots may be a defensive mechanism aimed at supporting an already fragile self-concept due to the unresolved trauma with which the counsellor is burdened. It is possible that the desire to hold onto a self-conceptualised identity is so strong it circumvents reality. As individuals strive to ensure the stability of self-conceptions, be it positive or negative (Sedikides & Strube, 1995) they engage in behaviours designed to demonstrate to those around them the way they see themselves. Other behaviours may include only attending social environments that are more

compatible with self-conceptions of who the counsellor thinks they are. This notion of selecting suitable environments may also translate into counselling practice. The counsellor may select clients with whom they wish to engage, rejecting or avoiding others in order to support personal conceptualisations of who they are. This may place the discarded client's welfare in jeopardy and breach professional etiquette or violate codes of conduct.

Whilst verifying only seeks to confirm perceptions, self-enhancement seeks to increase the self-concept – akin to buffering the self for protective purposes. It is concerned with increasing positivity and decreasing negativity of the self-concept (Leary, 2007; Snyder, Stephan, & Rosenfield, 1976). The consumption of self-referent information gained through social interactions and evaluations provided by people in our lives, which may include clients, maximises the positivity of one's self-concept (Sedikides & Strube, 1995). A hallmark of self-enhancement is the use of social comparison, especially comparisons to targets that place the self in a favourable position (Brown, 1991). The garnering, or harvesting, of clients — potentially those who have given favourable social feedback — may come at the client's expense. Client-centred, goal-oriented counselling practice may give way to a counsellor-lead social interaction for the benefit of the counsellor, and in the process violate multiple codes of conduct.

Implications for professionals

Life experience can assist counsellors in understanding the complexities of life. However, this appears to be useful only when the counsellor understands the distinction between personal and client motives in counselling (Richardson, Sheean & Bambling, 2009). Counsellors should not attempt to encourage clients to follow pathways that appeal to the counsellor, but rather provoke thought and action based on the client's own ideas and strategies, even if they fail. Counsellors should provide clients with, metaphorically

speaking, scaffolding to assist them in transitioning through difficult life events and empower personal growth. If a counsellor — afflicted with unresolved trauma — attempts to search for answers through assisting clients to find answers to similar personal problems, then the therapeutic process can become less about client welfare and potentially becomes more about the counsellor's welfare.

Counsellors may extract ideas and concepts from clients that benefit the counsellor's personal healing, potentially as a higher priority to supporting clients in their journey. Counsellors experiencing significant life events in which the causal factors cannot be determined, such as events deemed to be an act of god or those in which the perpetrator is never identified, or the victim cannot process the events due to post-traumatic stress, may result in the counsellor seeking alternative methods of closure. A counsellor's exploration of solutions to personal problems through the use and manipulation of a client is of considerable concern. Once the client's journey becomes a means to an end (Kant, 1996) – that end is the counsellors' selfish gains – and a considerable dilemma is apparent. Counsellors should strive to support clients with their own journey.

A counsellor's unresolved trauma experience might interfere with their ability to provide effective support to clients. Potentially, this group may be at greater risk of breaching professional ethical standards and engage in misconduct or malpractice. This chapter suggests a number of potential causal mechanisms – selfish gains, narcissistic pathology, dependency, self-concept biases, and self-deception (see Chapter 4) – in explaining the reasons why misconduct and malpractice might occur because of a counsellor's unresolved trauma. In isolation, or as a complex of factors, these mechanisms provide an important consideration, a warning signal, to counsellors that behaviours identified here may not be in the best interests of client welfare.

Two practical strategies in the prevention of malpractice, thus mitigating suggested causal mechanisms, are that counsellors should always keep the client's wellbeing ahead of personal gains, and undertaking self-reflective practice may eliminate self-deceptive behaviours ensuring professional services are provided objectively. Finally, future research could assess the validity of the suggested causal variables (self-verification, self-enhancement, exploitative behaviours) as mediators in the relationship between unresolved trauma and ethical behaviours in practice. In the next chapter the research examining what others have theorised in explaining malpractice and misconduct is explored, followed by the presentation of a holistic model that might explain why misconduct and malpractice occurs.

Chapter 6: Constructing a multi-factor causality model of

misconduct and malpractice

There are multiple factors involved in the likelihood that a counsellor will breach ethical boundaries. Some of those factors are situational, some are intrapsychic and others may be interpersonal. Like many human behaviours it is likely that no single factor drives the behaviour, but rather it is a complex interaction of factors across a period of time that may culminate in harm to the client. This chapter canvases the literature for attempts at explaining the causal mechanisms of misconduct and malpractice – three frameworks were found. The chapter concludes with the development of a new model to explain how counsellors come to commit misconduct and malpractice.

Simon's (1989) Neo-Freudian hypothesis

Simon (1989) advanced the idea that a counsellor's unconscious motivations drive unethical behaviours, ultimately resulting in negative behavioural consequences (transgressions) for the client. Simon's (1989) theory stems from Neo-Freudian psychology, expanding on Freud's work of Topographic and Structural theory (Freud, 1953; 1964). Freud's (1953) topographic theory views the mind as having three distinct facets: the conscious, pre-conscious and unconscious. Viewing the mind as a metaphoric 'iceberg', Freud (1953) argued that the smallest portion, the tip of the iceberg, contains conscious, readily accessible thoughts. Just below the surface, in the pre-conscious, memories are readily accessible and can be brought into consciousness. The remainder, the unconscious, Freud argued was not accessible to awareness and contains immoral urges, selfish needs, irrational wishes, unacceptable sexual desires and fears (Friedman & Schustack, 2010). Such feelings and thoughts are said to exert influence on our conscious awareness and behaviours from the unconscious. In Simon's (1989) approach these

unconscious motivators play a pivotal role in counsellor boundary crossing and violations.

Simon (1989) posits that counsellor boundary violations start out as subtle or seemingly harmless behaviours growing and developing in severity over time until an overt case of misconduct and malpractice occurs. For example, a counsellor hugging a client in sympathy within a therapeutic context constitutes innocuous behaviour. However, if the same counsellor's hugging behaviour becomes recurrent, gradually building in intimacy, then it is reasonably foreseeable that such behaviour constitutes a boundary violation. The intimation here is that unconscious desires, specifically pleasure-seeking impulses, manifest over time into behaviours that if left unchecked (due to the counsellor's lack of self-awareness or within the supervisory working alliance) can have a detrimental impact on the provision of ethical services. In order to assess if such exploitative behaviours occurred in practice, Epstein and Simon (1990) developed the Exploitation Index as an early warning indicator of boundary violations.

The Exploitation Index is a multi-factorial self-assessment questionnaire examining six causal subdomains – eroticism, exhibitionism, dependency, power seeking, greediness, and enabling. Epstein, Simon and Kay (1992) administered the Exploitation Index to 532 psychiatrists in the United States in an attempt to identify exploitative behaviours. The results of their study revealed that 43% of participants indicated at the conclusion of the survey that some of their behaviours may have been counterproductive to the therapeutic alliance.

Simon's (1989) concept for *why* counsellors might transgress rests on the premise that the 'bad factor' is some form of unconscious state of mind or personality, possibly an over-inflated ego or extreme narcissism that ultimately leads to wrongdoing. Simon's (1989) concept may seem highly plausible, though like much of the work contained

within the psychodynamic domain, this theory is not empirically testable. However, given the accumulation of cases over time and the development of the Exploitation Index, Simon's theory has gained some degree of acceptance for practitioners within the psychodynamic domain (Hoop, Di Pasquale, Hernandez & Roberts, 2008).

Jackson and Nuttall's (2001) victim-to-victimiser cycle

Jackson and Nuttall's (2001) concept focuses exclusively on sexual boundary violations. They suggest therapists who experienced childhood sexual abuse in the past are more likely to sexually exploit clients. The notion of a victim-to-victimiser cycle is not new. Empirical evidence suggests that the cycle is especially prevalent in males (Glasser, Kolvin, Campbell, Glasser, Leitch, & Farrelly, 2001; Hilton and Mezey, 1996; Knopp, 1984). Jackson and Nuttall (2001) surveyed 323 mental health practitioners, 138 (43%) men and 185 (57%) women, categorising participants into 'no abuse' and 'child sexual abuse' categories. They also categorised those who had had sex with clients and those who had not (14 males and 1 female). Of the 29 male therapists reporting a history of child sexual abuse six (29%) had engaged in sex with clients compared with seven (6%) of the remaining 109 men who reported no sexual abuse history.

In a related study, Hilton and Mezey (1996) found an association between child sexual abuse perpetrators and a history of sexual victimisation. They found that the more deviant the population of abusers the higher the instance of victimisation. They also found that a perpetrator's choice of victim was dependent upon the victim's characteristics, such as age, and that perpetrators tend to abuse victims in a similar way to that of their own abuse experience (Hilton & Mezey, 1996).

A causal explanation as to why counsellors with a history of childhood sexual abuse engage in sexual violations may be that the counsellor has not resolved personal victimisation issues and may seek recurring and inappropriate "sexual behaviour as a re-

enactment of personal trauma" (Jackson & Nuttall, 2001, p. 202).Counsellors may also

search for the "illusion of intimacy and connectedness" (Schwartz, 1992, p. 338),

engaging in sexual manipulation, exploitation, and hypersexual behaviour, pursuing

clients for gratification (Jackson & Nuttall, 2001). However, clearly, not all counsellors

with a history of childhood sexual abuse sexually exploit or abuse clients, and nor do all

counsellors who sexually violate clients have a history of childhood abuse. Indeed, not all

malpractice cases are of a sexual nature, and so at best this can only be part of a larger

picture.

Celenza and Gabbard's (2003) three-factor theory

Celenza and Gabbard's (2003) three-factor concept of malpractice shares

similarities with Bandura's (1989) model of triadic reciprocal causation. It proposes that

causal mechanisms of transgressions fall into one or more of the following categories:

situational, intrapsychic conflict, and interpersonal factors. In essence, this model

suggests that a counsellor's behaviour mutually influences and is influenced by personal

(intrapsychic), social (interpersonal), and environmental (situational) factors.

Situational factors are concerned with context and environment. They may impact

a counsellor's professional practice within a number of domains, including aspects of

their personal life or within the therapeutic context — the working alliance. Situational

factors may be so strong that in therapy a 'role reversal' occurs, where the counsellor

discloses personal concerns to the client in an overt and excessive way (Gabbard &

Celenza, 2003). For example, a counsellor may be in the midst of a life crisis, such as a

divorce, misconduct/malpractice litigation, or bankruptcy (Gabbard & Lester, 1995). The

counsellor's disclosure of personal information in this scenario is not for the benefit of

the client, but the counsellor. Hence, the roles are reversed. This might allow the

counsellor to obtain empathy or sympathy from the client – selfish gains — making therapy about them rather than the client. This constitutes a boundary violation.

Intrapsychic factors vary considerably but, typically, concern internalized conflicts between opposing drives, motives, or impulses. Typically, according to Gabbard and Celenza (2003), these conflicts fall into two domains: unconscious guilt for male counsellors "usually coinciding with a childhood history of having felt responsible for mother's unhappiness" (Gabbard & Celenza, 2003, p. 486), and the need for affirmation and recognition, typically because of neglect in early life.

Interpersonal factors primarily focus on transference and counter-transference. Transference is the process by which clients make personal assumptions about their counsellors by attributing to them qualities taken from past important relationships in their lives, including childhood relationships with parents (Freud, 1958). Freud indicated that transference was a universal concept and could equally apply to the counsellor (Freud, 1958). Countertransference relates to the counsellor's attribution of qualities towards clients, which disrupt the therapeutic alliance, such as a counsellor interacting with a client in a sexualised way due to strong sexualised feelings for the client (Gabbard & Celenza, 2003).

Considerations following a review of the models

Each of the concepts discussed is a piece of an interconnected puzzle. Simon's (1989) theory suggests the unconscious motivations of counsellors drive unethical behaviours, ultimately resulting in negative consequences for clients, and counsellors. Unethical behaviour begins as innocuous boundary crossings to head down the slippery slope (Glass, 2003) to violations and onward to misconduct/malpractice. Counsellors are likely to be unaware of gathering slipperiness, however the "id" is continually driving down that path, disguising intention. Perhaps a weaker "super ego" is unable to assert its

influence (e.g. via ethics and professional training), thus leading to a domination of one unconscious drive over the others. It is possible that the slipperiness is the increasing unconscious desire or temptation to, for example, engage in a physical sexual relationship with a client. Whilst the slope, or more precisely the gradient of the slope, might represent the succumbing to the temptation for the relationship.

Jackson and Nuttall's (2001) framework suggests therapists having experienced childhood sexual abuse in their past are more likely to sexually exploit clients. Whilst this theory relates exclusively to sexual boundary violations, it is important as it firmly anchors the explanation of misconduct/malpractice behaviour to a specific event in the counsellor's history. Jackson and Nuttall's (2001) theory suggests that childhood sexual abuse creates a mechanism for them to exhibit exploitative behaviours later in life. However, this theory fails to provide an understanding of how or why life course events, such as childhood abuse, actually create this mechanism.

The three-factor theory of Gabbard and Celenza (2003) proposes that mechanisms, or reasons for behaviours, fall into one or more of the following categories: situational, intrapsychic conflict and interpersonal factors. Here Gabbard and Celenza (2003) attempt to categorise behaviour through an exploration of the influences on them and the resultant behaviours across multiple levels - personal, social and environmental. Gabbard and Celenza's (2003) model provides an excellent framework for the development of a comprehensive model, however it does not provide inter-linkages between factors/variables. In other words, it fails to demonstrate potential causal pathways from behaviour activation/inception through to outcomes and consequences.

Constructing a multifactor model of causation

A more comprehensive and holistic model is required to better understand potential casual mechanisms for misconduct and malpractice, one that can be tested, and

can provide real opportunity for intervention. The focus of the model on offer is the influence of trauma on identity feedback of the professional counsellor and their propensity to engage in misconduct and malpractice. The model is depicted in Figure 4. In brief, the focus of the model is the counsellor's behaviour, and whether it is ethical or unethical (block 11). In an immediate sense that behaviour is determined by the counsellor's identity (or collection of identity components – block 4). That identity is the outcome of an interaction between the counsellor's social network, their membership of a professional body, their training, and their exposure to stressors and major life events and how they dealt with them.
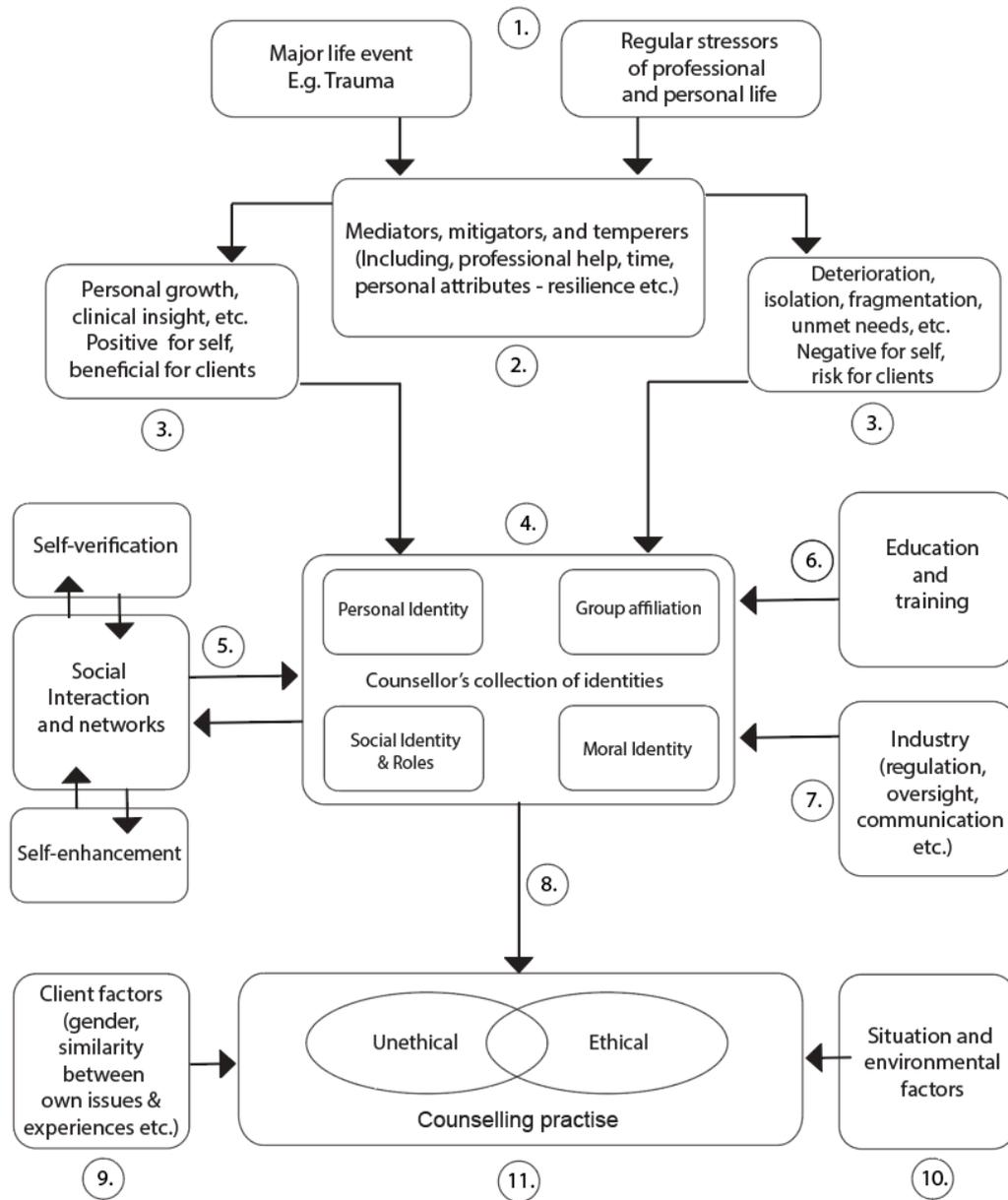
Figure 4. A multifactorial model for the pathway by which unresolved trauma leads to misconduct and malpractice (the numbers relate to the explanatory text).

Many counsellors enter the industry after some significant life event, often but not always a trauma of some sort (1). This influence is shown in the upper left corner of the figure and represents a historic, but no less powerful, impact. Beside it are the current stressors of everyday life, whether they are professional or personal. In either (or both)

case, the impact of those external events can have positive or negative impacts (3) for the individual as a person, and as a counsellor. The positive pathway results in a number of potential strengths, including personal growth (potentially post-traumatic growth - Zerubavel & Wright, 2012), experience of successful personal introspection and self-reflection, and clinical insight. The likelihood of travelling the positive path will likely be increased if they received professional assistance to deal with their problems, possess high levels of resilience, have a strong social network, have developed practises for dealing with stress (e.g. meditation or exercise), and so on.

In contrast, the negative pathway represents an individual who is (or was) overwhelmed by the trauma and stressors, did not have help, does not have significant others to call upon, is not resilient, and so on. Rather than being equipped with traits that will serve them well as individuals and counsellors, these individuals pose a risk to their clients (and themselves), even if they believe they are on top of things, that is, erroneously believe that they have successfully resolved the past trauma and are coping well with daily and life's stressors.

Rather than achieving post-traumatic growth, they are more likely to experience chronic dysfunction (Zerubavel & Wright, 2012). It is possible to switch from the negative to the positive pathway (or return to the positive pathway) by seeking help, building resilience and so on, but this requires a level of self-reflection; the earlier the switch, before significant pressure builds, the better. The pathway travelled – positive or negative – plays a part in shaping the counsellor, in determining their identity. This is an ongoing process because major life events may strike at any time, regular stressors occur on a daily basis, and the individual can change how they react, help may be sought at any time, the social circle alters as friends come and go and family changes, personal resources such as resilience can be deliberately enhanced (or can be dented), and so on.

Zerubavel and Wright (2012) argue that due to the dynamic nature of trauma recovery inherent uncertainty surrounds a counsellor's future psychological functioning. Counsellors best placed to leverage their experience and help clients are those who have experienced personal growth or recovery. Those who have descended into a pit of personal deterioration are not likely to be sufficiently supportive of clients due to their significant and ongoing impairment (Gabbard, 1995).

At the model's core (4) is the counsellor's identity, which is the ultimate arbiter and driver of their behaviour, and in this model is comprised of a collection of identity aspects: moral identity (Blasi, 1983; Hardy & Carlo, 2005), personal identity (Oyserman, 2009), group affiliation (Smith & Terry, 2003), and social identity and social roles (Oyserman, Elmore & Smith, 2009). Group affiliation involves identifying with a group, taking note of the similarities between the self and other group members, and/or effecting change in order to fit into the group. For example, part of a counsellor's identity will involve perceiving oneself as part of the counselling profession and thus sharing traits with others who belong to the group known as 'counsellors', or specific sub-groups such as psychologist or social worker or any of the other counselling roles included here under the heading of 'counsellor' (see Chapter 1 for further discussion).

Social identity relates to the distinctive characteristics shared by members of a particular social sector or group (Bradford Brown & Lohr, 1987). Social roles are aligned with membership of a particular group requiring another individual to play a complementary role in social or professional interactions, including being a client of a counsellor (Oyserman, Elmore & Smith, 2009).

Moral identity is the degree to which the idea of 'morality'- determining what is right or wrong, good or bad, acceptable and unacceptable in society - forms part of an individual's personal identity (Swanson, 2010). Personal identity relates to the ways that

individuals attempt to make sense of some facet or portion of the self-concept (Hogg, 2003).

Oyserman, Elmore and Smith (2009) posit that it is the collection of these 'identities' that form the foundations of self-concept. Baumeister (1999) defines the self-concept as an individual's belief constructed from personal attributes regarding who and what 'the self' is. Self-concept theory proposes that individuals perceive and interpret their existence from externally located feedback (McAdam, 1986). An individual's perception of success, or failure, is associated with the ways in which individuals view themselves and their relationships with others (McAdam, 1986).

Self-enhancement and self-verification are illustrated as identity feedback processes (5). The counsellor uses feedback loops to transmit and receive information across social networks, continually confirming and bolstering identity and the self-concept. According to Higgins (1987), Swann (1983), and Swann, Pelham, and Krull (1989), individuals are motivated to verify their self-concept by gathering feedback and evidence from social interactions. Social interactions are also a way of communicating with others in an effort to obtain positive feedback, thus enhancing a self-concept, that is, to gather positive feedback from others (see Chapter 4 for further discussion). Importantly this does not include communicating with clients to obtain feedback for verification or enhancement purposes.

There are likely to be factors that influence a counsellor's identity, specifically moral identity (6 & 7). They include the standard and duration of education and training an individual receives in becoming and maintaining professional counsellor status, and the industry environment (regulated or unregulated) in which they practice. In Australia, the term 'counsellor', unlike 'psychologist', is not a regulated one. As such, anyone can begin counselling without formal qualifications and training. Therefore, the extent to

which an individual receives training about ethical conduct when working with clients can range from non-existent to a professional doctorate. Likewise, along this continuum industry association standards and governmental regulation are also likely to influence moral identity (see Chapter 2 for further discussion).

An individual's identity is inextricably linked to their behaviour (Bradford Brown & Lohr, 1987; DeCelles, DeRue, Margolis & Ceranic, 2012; Stets & Carter, 2012). Thus the model provides a link between identity collection and counselling practise (see 8). However, interactions with clients are influenced by environmental and situational factors, as well as characteristics of the client. Client factors (9) might include the client's perceived strength or vulnerability, the relationship between their presenting concerns and the counsellor's own issues, and the level of vulnerability a client exhibits (Simon & Epstein, 1990). Environmental factors (10) might include the privacy of the consulting rooms or meeting a client in a social setting (Gabbard, 1995).

All of these factors ultimately influence whether the professional behaviours are ethical or unethical (11), or occupy the overlapping zone in which subjective evaluation determines the ethical nature of counsellors' actions. It is here that clinical boundaries are formed and maintained (Glass, 2003).

Boundaries are a primary component of the therapeutic relationship (Pope & Keith-Spiegel, 2008). Setting appropriate boundaries and working within their confines ensures appropriate behaviour is displayed in practice (Langs, 1979). Spruiell (1983) suggests that most counsellors operate responsibly within and across multiple boundaries. Examples of the types of boundaries experienced in counselling include: time, place, environment (office and the broader category of social interaction), money, gifts, scope and type of service, language (verbal and non-verbal), disclosure, proximity, and contact (Gutheil & Gabbard, 1993).

Boundary crossings are considered minor transgressions associated with constructive processes in therapy, which do not lead to harm (Gutheil & Gabbard, 1993; Glass, 2003). An example might be to innocently hug a client for reassurance or to celebrate a breakthrough, or allow a session to run over time. On the other hand, boundary violations are concerned with client harm associated with unethical behaviour and actions occurring from a misuse of power and/or exploitation (Zur, 2004). Examples of boundary violations include sexual assault, and emotional and physical abuse. The term boundary transgression is often used as an overarching concept to describe both crossings and violations (Gutheil & Gabbard, 1998).

Glass (2003) proposed a model (see Figure 6) to assist with understanding the relative position of boundary crossings and violations, and associated 'grey areas', in therapy. The model features two primary domains: ethical practice and malpractice. At the intersection and overlaid across the primary domains are two overlapping ovals representing boundary crossings and boundary violations. The model is explained using the numbering system below.
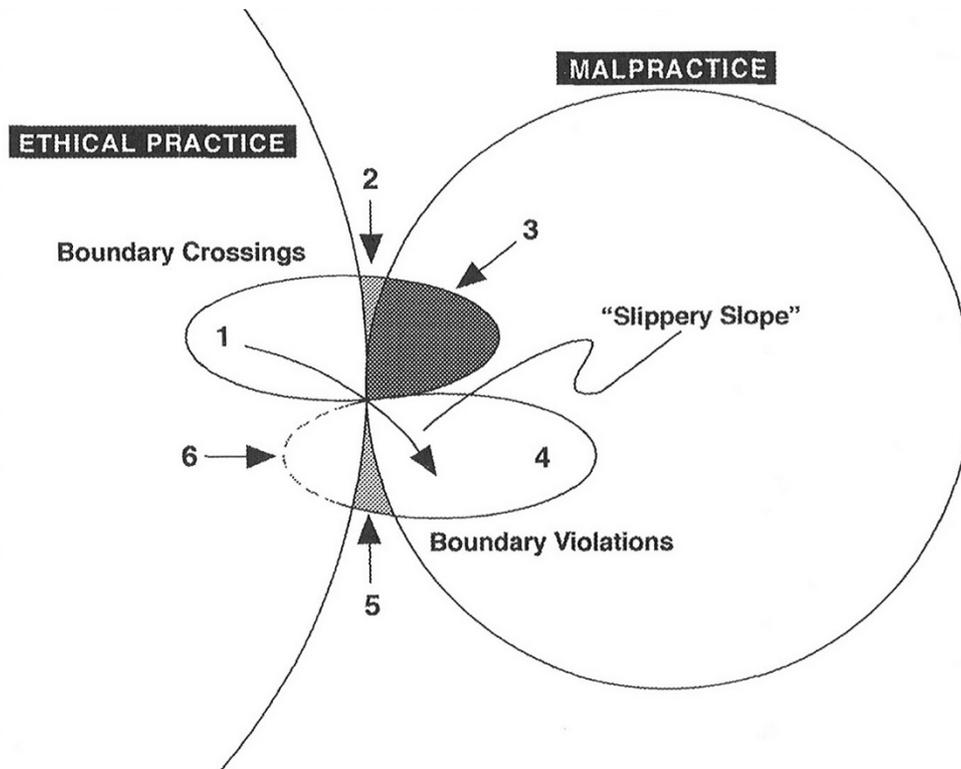
Figure 5. A model depicting the relationship between boundary crossings and boundary violations (Glass, 2003).

As previously discussed, most boundary crossings (1) are benign and not harmful to clients or counsellors. Boundary crossings are often viewed as single events, distinct moments in therapy that alter the character and limits of the therapeutic alliance (Glass, 2003). Boundary crossings are part of a pattern of behaviours used in conventional therapy (Glass, 2003). Moving to the left of the model provides a spectrum of boundary crossings. The grey area (2) is the small wedge of boundary crossings situated outside of ethical behaviours or those associated with malpractice. Boundary crossings representative of this location might include charging a higher fee for wealthier clients (Glass, 2003). Whilst such interventions aim to adapt or modify boundaries, the client may view them as intrusive. Yet, such behaviours are not steps down a slippery slope.

When boundary crossings become prolific, sustained, aggregated (3), unquestioned and unconnected to any obvious therapy they may be on the verge of misconduct or malpractice. Glass (2003) argues clients experiencing aggregated boundary crossings are denied effective treatment. They instead become so enmeshed — over-involvement with a client that blurs the boundaries leading to issues of personal and professional separation — with the counsellor that neither party can relinquish. An example of aggregated boundary crossing is a mutual friendship or companionship that displaces the therapeutic process. Initially the consultations concerned client-directed goals however the relationship transitioned into a friendship in which sessions would discuss movies or books. The sessions seemed to be stuck in a rut and both the counsellor and the client build a dependence upon the sessions for mutual benefit at the expense of the initial professional agreement.

Overt forms of boundary violations (4) include gross violations of confidentiality, financial and other forms of exploitation, dual relationships and so on. The most familiar form, according to Glass (2003), is sexual contact between counsellor and client. As previously mentioned, boundary violations result from the misuse of power or exploitative behaviours resulting in negligence of client care. Such behaviours have the potential to cause serious harm to not only the client – exacerbating existing conditions - but also the counsellor – if found guilty a loss of employment, livelihood, registration and membership.

Boundary violations that fall into this grey area (5) are considered to depart from established normal practice. Yet they are not so egregious that they cannot be worked through with a supervisor and with the client (Glass, 2003). For example, inappropriately discussing a client with the client's spouse's therapist without the proper consent, or unintentionally giving a bill to the wrong client thereby exposing another client's

personal details. Glass (2003) argues that non-sexual touching also rests in this category. For example, giving a client a hug or a pat on the shoulder. These acts may be uninvited, possibly welcomed, however could be threatening to the client.

Pseudoboundary violations (6) occur when clients subjectively interpret interventions as being boundary violations, when in reality they exist in the realm of ethical behaviour (Glass, 2003). For example, mandatory reporting of child sexual abuse. In such cases the client may feel aggrieved from a breach of confidentiality regarding some personal circumstance or situations. However, mental health practitioners may be required to discuss such disclosures in therapy to a third party for action. Glass (2003) argues such action is for the client's or a third parties' best interests, however, acknowledges that clients may feel it is unwarranted and a violation of his/her boundaries. In such instances the law of the land may transcend an extension of an ethical principle erroneously assumed by the client, for example that confidentiality it all-encompassing and inviolate.

Finally, the Slippery Slope. Glass (2003) does not explicitly describe this portion of the model. However, the inference drawn is that boundary violations that persist or have serious consequences result in a snowballing effect or action. Small repetitive behaviours that seem innocuous at first gather momentum ending in a harmful situation. The reaction from clients may be to notify an industry or governmental body and subsequent investigation, panel or court hearing. The outcomes from such a process may include a charge and conviction or record of misconduct and malpractice.

In order to test elements of the proposed model, the investigations in the following studies were undertaken. The first (Chapter 7) explores the attitudes of regulated and unregulated counsellors toward behaviours in practice to determine if a difference exists between counsellors in their responses to items exploring attitudes toward ethical and

unethical behaviours in practice. The second study (Chapter 8) seeks to understand how identity feedback acts as a mediator in the relationship between unresolved trauma and attitudes toward boundary crossings and violations.

Chapter 7: Does regulatory status influence counsellors' attitudes and actual ethical behaviour in practice?

In Australia counsellors can be regulated or unregulated, and the latter group can voluntarily belong to an association and be subject to their rules and guides, or entirely self-regulated. Regulated practitioners must have completed a course sanctioned by AHPRA and be registered. Clients of regulated practitioners have options for recourse for unsatisfactory services through AHPRA in the form of a panel or tribunal system (in addition to 'ordinary' civil processes). Unregulated practitioners may or may not be members of any number of professional associations in Australia, none of which have any real power to sanction members beyond cancelling their membership, which does not stop the counsellor continuing to practice. Clients of unregulated practitioners can seek redress through consumer law processes, which provide a framework for the protection of consumers from deceptive and unconscionable conduct (consumerlaw.gov.au, 2015). The intent protections are to provide consumers certain assurances from unsafe and defective goods and services (Australian Consumer Law, 2014). There is conjecture regarding the appropriateness of consumer law to protect the public from poorly delivered mental health services (Council of Australian Governments, 2015). Indeed, the Department of Health (2011) in Victoria and the Australian Health Ministers' Advisory Council (2011) raised concerns about a small, but significant, number of individuals consistently demonstrating a pattern of unethical behaviour. The first, and arguably most important, line of protection for clients — of both regulated and unregulated practitioners — is the counsellor's personal moral code and their experience and training. Tribunals and other legal processes come into play after something has gone wrong, and so can be classed as reactive protection.

In the counselling profession codes of ethics are intended to proactively protect clients — and practitioners and the profession and the community more generally — by

guiding professional behaviour. Further, all regulated practitioners and all unregulated practitioners that belong to professional associations have committed to abide by a suitable code of ethics. However, studies have shown found a discrepancy between knowledge of the way one ought to act and actual behaviour (Bernard & Jara, 1986; Smith, McGuire, Abbott & Blau, 1991; Wilkins, McGuire, Abbott & Blau, 1990). It appears that knowing and promising to follow a particular code of behaviour does not always guarantee adherence. In some instances, non-compliance may be intentional, premeditated or entirely deliberate to take advantage of the client. In other cases, malicious forethought may not have been present.

The process of counselling, it could be argued, is somewhat 'unnatural' for a social interdependent species. For example, when conversing with another person it is natural for each member of the dyad to share stories, experiences and views to an equal depth. Further, greater depth (and more personally meaningful and sensitive) of sharing fosters emotional intimacy and is a foundational element of romantic relationships and thus is evolutionarily adaptive. However, in counselling such open and matched two-way sharing is considered unethical, only the client should expose such sensitive detail while the practitioner must share no more than is necessary to build rapport. A problem arises in determining the level that is necessary. The minimum amount and depth that the practitioner 'needs' to disclose will vary between clients and stage of treatment and so cannot easily be defined as part of training. It is not difficult to imagine a practitioner unintentionally or inadvertently sharing a bit too much information and fostering intimacy that progressively develops into an inappropriate interaction between practitioner and client, an interaction that would be considered 'natural' in other circumstances.

Conversational inequality is but one example of behaviour expected of a counsellor that would not be adaptive in interactions outside the practitioner-client relationship. There is a constant tension between what might feel, and be, right in the outside world, and what *is*

right and expected in the client-counsellor relationship. It appears that when ethical guidelines are unclear, counsellors revert to their own judgements and value systems and use personal interpretations of what the code might actually mean rather than its actual intent (Jennings, Sovereign, Bottoroff, Mussell & Vye, 2005). That judgement will be impacted by a range of personal qualities such as locus of control, economic value orientation, political value orientation, Machiavellianism and moral cognitive development, all of which have been found to be significantly correlated with moral decisions-making behaviours (Hegarty & Sims, 1978; Trevino & Youngblood, 1990). Pope (2003) suggests in order to act ethically counsellors need to develop ethical behaviours through an educational process, integrating new and reinforcing existing knowledge into practice. Thus, it is not sufficient to simply be aware of appropriate codes of ethics, regulations or policy, counsellors need to create an approach that is actively and deliberately - with the support from a supervisor — aimed at fulfilling ethical responsibilities.

A pertinent question arises then, whether regulated practitioners more adept at resolving ethical dilemmas, or are they any more likely to breach ethical guidelines? Thus does the regulated/unregulated dichotomy provide proactive protection for clients by equipping them to be more ethical decision makers, or does it only provide better reactive protection through a better redress process? If Trevino and Youngblood (1990) are correct in their assertion that factors other than regulation are involved in ethical behaviours, then there should be no differences between regulated and unregulated counsellors and what they understand constitutes unethical and ethical behaviours in practice.

Method

This study is part of a larger project. As such, the content contained within this method section also pertains to other studies. However, the specific detail is provided in this chapter.

Participants

Participants were 419 Australian 'counsellors', including counsellors, psychologists, social workers, and psychotherapists, Table 6 provides a specific breakdown of the participant categories. The sample included 253 females and 52 males – 3 identified as "other" and 111 did not respond to the gender question. Respondents ranged in age from 25 to 76 years (M = 52 years, SD = 11) with an average of 12 years of practice experience ranging from one to 44 years' service (SD = 9).

Table 6. *Self-reported "type" of Counselling Professional, Split into Regulated vs Non-regulated Roles*

Category	Regulated	Non Unregulated	Category Total	Percentage of Overall Total
Counsellor	10	194	204	49.6%
Psychologist	71	0	71	17.3%
Psychotherapist	3	62	65	15.8%
Social Worker	0	24	24	5.8%
Hypnotherapist	0	9	9	2.2%
Lecturer/Instructor	1	7	8	1.9%
Therapist	0	7	7	1.7%
Life Coach	0	2	2	0.5%
Minister	0	1	1	0.2%
Mental Health Nurse	0	1	1	0.2%
Other	0	19	19	4.6%
Unknown	0	0	8	0.1%
Total	85	310	411	100%

Note. 8 of the 419 participants did not respond to this question

Participants were recruited through direct contact by email using publicly listed addresses. Those addresses were sourced using a Firefox browser add-on to scour the internet for providers of counselling services in Australia, harvesting email addresses that ended in .au. An email was sent to the owners of the email address inviting them to participate in the study. Advertisements were also placed with industry associations (on websites, in newsletters, etc.) such as the Australian Psychological Society and the Australian Counselling Association. The advertisements carried an internet address to access the survey directly.

A total of 1575 separate email addresses were acquired and placed into a customised participant panel in Qualtrics for distribution. 105 emails (6.7% of email addresses collected) bounced, that is they did not reach the intended person and the email exchange server sent back a "do not recognise email address" message. Sixty-two (4%) participants commenced surveys half of them (31) completed the survey. Promotion within industry associations including Australian Psychological Society, Australian Counselling Association and the Psychotherapist and Counselling Federation of Australia produced 422 survey completions.

A priori power analysis was conducted using G*Power 3.1.9.2 (Faul, Erdfelder, Buchner & Lang, 2009). It was estimated that to achieve a power of .95, for a medium effect size to be detected (Cohen's f^2 = .25, α = .05) a sample size of 90 participants is required. Therefore, the final sample size of 419 was deemed adequate.

Measures

Ethics of Practice Questionnaire Revised (EPQ-R). The EPQ was developed by Pope, Tabachnick, and Keith-Spiegel (1987) to measure the extent to which practitioners agreed that particular behaviours in the course of providing therapeutic services are ethical. The original 83-item instrument was reduced to 47 items for the present study to reduce impost on participants completing a number of instruments as part of a larger study and to increase completion rates. Some items removed from the original EPQ-83 (Appendix 7) were

considered repetitive and deemed to be adequately covered by similar items elsewhere within the instrument — for example, 'having a client address you by your first name' was removed and 'addressing client by his or her first name' was retained. Other items were removed to optimise relevance for a diverse population of counselling professionals (general counsellors, psychologists, social works etc.). For example, 'utilising involuntary hospitalisation' not applicable to unregulated counsellors and most registered psychologists in Australia and so was removed.

For the purposes of the present study the author divided items into three sub-categories based on an extensive review of various Australian codes of conduct (Australian Psychological Association, The Australian Counselling Association and The Psychotherapists and Counsellors Federation of Australia) and a review of the relevant literature concerning the ethical status of each item. The author and supervisors independently reviewed the selection (inter-rater reliability 97.2%) and a consensus was reached about the inclusion/exclusion of items in the EPQ-47. The author undertook an item analysis of the three categories revealing the following reliability outcomes (Cronbach's Alpha): behaviours considered ethical (α = .75), those associated with incompetence/unprofessionalism (α = .72), and those associated with boundary crossings or violations (α = .80). Participants were asked to rate ("Unquestionably no" to "Unquestionably yes") their agreement with a series of statements, such as "Being sexually attracted to a client," and "Advertising for services." Then rate ("Never" to "Frequently") the likely occurrence of these behaviours in their practice. They were also asked to indicate who had initiated such behaviour when it had occurred.

Demographic Questionnaire. Questions were included to establish gender, age, area of practice, level of education, industry association status and engagement with supervisory services

Procedure

Before commencing the study, ethics approval was received from Monash University Human Research Ethics Committee (Approval Number CF13/2485 - 2013001319). Approval was given to create awareness of the study through industry associations and direct contact with organisations promoting mental health services online across Australia. Counsellors received an email with a link to access an online survey hosted by Qualtrics (www.qualtrics.com). Professionals willing to participate provided implied consent and completed the questionnaire within a 35 to 40-minute period. Data were downloaded, collated, scored and analysed using Microsoft Excel and SPSS. All analyses were conducted at a 95% significance level.

An inductive process was used to analyse participant's responses to individual items in order to focus on the most poignant results. Consequently, only the most salient and novel themes are presented.

Results

Data were screened for missing values, outliers and normality. Ten outliers were located within the Boundary Crossings and Violations data and were 'winzorized' (Keselman, Algina, Lix, Wilcox, & Deering, 2008) to be within +/- two standard deviations from the mean to dampen their impact on the data.

Of the 419 counsellors, 388 (93%) were currently practising, 23 (5%) were not, and 8 (2%) were students in training. Student counsellors were asked to respond to the subsequent questions as though they were already in practice. The largest proportion of respondents offered therapeutic services within both metro and rural settings. The largest number of respondents were located in the state of New South Wales ($n = 145$), followed by Victoria ($n = 130$), Queensland ($n = 92$), Western Australia ($n = 46$), Tasmania ($n = 36$), and then the

state of South Australia ($n = 30$). Respondents indicated they provided services in multiple

states, hence the total sum of the states of location exceeded the total number of respondents.

Table 7 provides descriptive statistics for the overall means for the three component

measures for the EPQ-47, then parses the data further into the mean scores for regulated and

unregulated counsellors within each of the subdomains.

Table 7. *Descriptive Statistics for Ethical, Incompetent/Unprofessional and Boundary Crossings and Violations*

Behaviours	Industry Status	N	Mean	Standard Deviation
EPQ-47 Overall score	Regulated	54	63.34	10.57
	Unregulated	225	60.05	14.37
EPQ-47 subscales				
Ethical behaviours in practise[1]	Regulated	54	31.67	5.62
	Unregulated	225	29.34	6.82
Incompetent/Unprofessional[2]	Regulated	54	11.02	1.96
	Unregulated	225	10.49	2.77
Boundary Crossings &	Regulated	54	20.65	2.99
Violations[3]	Unregulated	225	20.22	4.78

Note: [1] Scores can range 19-95; [2] Scores can range 0-50; [3] Scores can range 15-75.

There was no statistical difference in the overall total mean scores for regulated and

unregulated counsellors. The mean scores for beliefs in whether specified behaviours were

ethical differed statistically between regulated and unregulated counsellors $F(1,277) = 4.98$, $p = .027$, with a medium effect size of $r^2 = .18$. However, the difference between regulated and

unregulated counsellors' mean scores for attitudes toward behaviours that were classified as Incompetent/Unprofessional did not differ statistically $F(1, 277) =,1.74$ $p = .189$.

The Boundary Crossings and Violations data violated homogeneity of variance and so Welch's F Ratio has been used (see Field, Miles & Field, 2012); again the difference between the two counsellor groups was non-significant $F_W(1, 277) = .393$, $p = .411$.

The EPQ asks participants how often the various behaviours had been experienced in professional practice, and who initiated the behaviours. Frequency responses in any category at, or fewer than, 10% were eliminated allowing for greater clarity, except where the result is of importance to the overall thesis of the paper. In what follows, the novel findings from the analysis presented in three categories: ethical behaviours in practice, behaviours considered incompetent or unprofessional, and boundary crossings or violation behaviours.

Ethical behaviours in practice

Frequency distribution data of participant responses to what they believe constitutes ethical behaviours in practice is in Table 8.

Table 8. *Frequency Distribution of Responses Toward Ethical Behaviours in Practice*

	Item	Ethical					Occurrence						Initiated			
		1	2	3	4	5	1	2	3	4	5	N/A	1	2	3	4
2	Charging a client no fee for therapy	13%	51%	.	11%	16%	26%	37%	15%	.	.	11%	42%	.	16%	.
4	Advertising your services	.	.	.	18%	68%	.	.	22%	19%	36%	.	78%	.	.	.
6	Filing an ethics complaint against a colleague	.	**37%**	.	13%	35%	59%	**29%**	.	.	.	.	18%	.	.	.
7	Telling a client you are angry at him or her	54%	35%	.	.	.	65%	25%	.	.	.	.	20%	.	.	.
9	Terminating therapy if client cannot pay	23%	33%	19%	16%	.	48%	**29%**	.	.	.	15%	12%	.	12%	.
12	Having clients take tests (e.g., MMPI, Neo PI-R) at home	46%	14%	34%	.	.	69%	7%	.	.	.	21%	.	.	.	.
16	Using a collection agency to collect late fees	29%	26%	25%	.	13%	73%	.	.	.	.	18%	.	.	.	.
19	Accepting a client's gift worth at least $50	62%	**28%**	.	.	.	73%	18%	.	.	.	.	.	**14%**	.	.
21	Accepting only male or female clients	35%	26%	15%	13%	12%	68%	.	.	.	.	14%	12%	.	.	.
23	Raising the fee during the course of therapy	44%	31%	.	.	.	56%	21%	12%	.	.	11%	24%	.	.	.
24	Breaking confidentiality if client is suicidal	.	.	.	17%	**68%**	18%	35%	28%	.	.	.	**46%**	.	**23%**	.
25	Allowing a client to run up a large unpaid bill	59%	26%	12%	.	.	65%	20%	.	.	.	12%	12%	.	.	.
26	Accepting goods (rather than money) as payment	55%	31%	.	.	.	79%	11%	.	.	.	.	.	.	.	.
28	Breaking confidentiality to report child abuse	.	.	**12%**	.	**76%**	26%	35%	25%	.	.	.	49%	.	.	.
30	Addressing client by his or her first name	.	.	.	15%	82%	.	.	.	.	90%	.	34%	.	61%	.
31	Crying in the presence of a client	17%	58%	.	12%	.	32%	51%	15%	.	.	.	37%	.	19%	.
36	Telling clients of your disappointment in them	63%	27%	.	.	.	70%	22%	.	.	.	.	20%	.	.	.
40	Using a lawsuit to collect fees from clients	**38%**	26%	29%	.	.	76%	.	.	.	.	18%	.	.	.	.
42	Avoiding certain clients for fear of being sued	26%	31%	30%	.	.	61%	21%	.	.	.	16%	16%	.	.	.
44	Being sexually attracted to a client	**61%**	**16%**	13%	.	.	69%	**21%**	.	.	.	.	13%	.	.	.
46	Engaging in sexual fantasy about a client	**79%**	.	.	.	.	79%	**12%**	.	.	.	.	11%	.	.	.

Notes: Black cells indicate the primary and grey cells indicate secondary salient items in analysis

Ethical: 1 = unquestionably not; 2 = under rare circumstances; 3 = don't know/not sure; 4 = under many circumstances; 5 =unquestionably yes.

Occurrence: 1 = never; 2 = rarely; 3 = sometimes; 4 = fairly often; 5 = very often; NA=not applicable.

Initiated: 1 = I did; 2 = the client; 3 = It was mutual; 4 = Not sure/Cannot recall; 5 = Never Occurred;

The results indicate that 37% of counsellors believed 'filing a complaint against a colleague' was a behaviour that should only occur under rare circumstances, and 18% of counsellors had actually filed a report against a colleague. Approximately a quarter of counsellors (28%) indicated under rare circumstances it was ethical to 'accept a gift worth at least $50', with 18% of counsellors revealing they had done so on rare occasions, and in 14% of cases it was initiated by the client. Counsellor's responses were more evenly divided on the issue of 'terminating therapy if a client could not pay for the service'. Whilst 56% of counsellors indicated it was either unquestionably not ethical or only ethical under rare circumstances, 35% of counsellors stated they did not know or yes, under many circumstances it was ethical to do so; 12% of counsellors actually had cancelled therapy due to non-payment, with 12% indicating it was through mutual agreement. A large portion (38%) of counsellors indicated 'engaging in legal action to collect fees' is unquestionably unethical or may only occur under rare circumstances. However, 29% of counsellors did not know or were not sure if such action was ethical and a small number of counsellors (2%) initiated taking action against a client. A majority of counsellors (85%) indicated 'they would break confidentiality if a client indicated they were suicidal'. In approximately a quarter of the cases (23%), breaking confidentiality was by mutual agreement between counsellor and client, while in 46% of cases the counsellor initiated the action. Seventy-six percent of counsellors indicated it was ethical to 'breach confidentiality if confronted with a case of child abuse' with 12% indicating they were not sure or did not know. Breaching confidentially for child abuse happened rarely (25%) and the counsellor reported the abuse (49%).

Behaviours Considered Incompetent/Unprofessional. Frequency distribution data of counsellor's responses to what they understand constitutes incompetent and/or unprofessional behaviours in practice is in Table 9.

Table 9. *Frequency Distribution of Responses Toward Unprofessional or Incompetent Behaviours in Practice*

	Item	Ethical					Occurrence						Initiated			
		1	2	3	4	5	1	2	3	4	5	N/A	1	2	3	4
5	Limiting treatment notes to name, date, and fee	60%	17%	**14%**	.	.	75%	11%	.	.	.	.	15%	.	.	.
11	Seeing a minor client without parental consent	53%	33%	.	.	.	70%	19%	.	.	.	.	9%	.	.	.
13	Altering a diagnosis to meet insurance criteria	81%	.	.	.	.	44%	.	.	.	.	54%	.	.	.	.
14	Telling a client: "I'm sexually attracted to you."	90%	.	.	.	.	92%	.	.	.	.	.	.	.	.	.
15	Refusing to let clients read their case notes	**49%**	25%	11%	.	.	66%	22%	.	.	.	.	10%	.	.	.
20	Working when too distressed to be effective	64%	**27%**	.	.	.	54%	**35%**	.	.	.	.	33%	.	.	.
22	Not allowing client access to testing reports	52%	25%	17%	.	.	65%	11%	.	.	.	20%	.	.	.	.
33	Accepting a client's decision to commit suicide	63%	**25%**	7%	2%	3%	73%	**14%**	5%			6%	9%	7%	**5%**	2%
34	Refusing to disclose a diagnosis to a client	47%	**30%**	16%	.	.	64%	16%	.	.	.	16%	15%	.	.	.
35	Leading nude group therapy	76%	6%	**14%**	.	.	88%	88%	.	.	.	12%	.	.	.	**49%**
45	Providing services outside areas of competence	74%	**20%**	.	.	.	66%	**24%**	.	.	.	.	11%	.	.	.

Notes: Black cells indicate the primary and grey cells indicate secondary salient items in analysis

Ethical: 1 = unquestionably not; 2 = under rare circumstances; 3 = don't know/not sure; 4 = under many circumstances; 5 = unquestionably yes.

Occurrence: 1 = never; 2 = rarely; 3 = sometimes; 4 = fairly often; 5 = very often; NA = not applicable.

Initiated: 1 = I did; 2 = the client; 3 = It was mutual; 4 = Not sure/Cannot recall; 5 = Never Occurred;

Counsellors generally agreed that 'limiting client's notes to a name, date and fee' did not constitute ethical behaviour (77%). However, a small subset (14%) did not know or were unsure of the ethical status of such behaviour and 15% of counsellors engaged in such behaviour. The majority of counsellors (74%) agreed it was unquestionably not or under rare circumstances ethical to 'refuse a client access to read case notes'. A small minority (11%) did not know or were not sure about the ethical status of this behaviour.

Approximately a quarter (27%) of counsellors indicated that under rare circumstances it was 'ethical to work with clients whilst too distressed to be effective'. Thirty-five percent of counsellors indicating such behaviours occurred only on the rare occasion, whilst 33% indicated they engaged in such behaviour. A quarter of counsellors (25%) felt that under rare circumstances it was ethical 'to accept a client's decision to commit suicide'. A further 7% did not know or were unsure about the ethical status and 5% indicated under many circumstances and unquestionably, yes, this was ethical. Approximately 10% of counsellors indicating this had occurred on the rare occasion in practice.

Five percent of counsellors indicated that such behaviours were mutually agreed between client and counsellor. A number of counsellors (30%) indicated under rare circumstances it was ethical to 'withhold a diagnosis from a client'. However, caution is advised when reviewing this result. The majority of counsellors in the present study are not permitted to make a diagnosis as this falls outside the scope of competence and training. This is reflected in the response rate the initiation section in which majority (82%) responding such behaviour was 'not applicable'.

The majority of counsellor's (76%) responses to the item 'leading nude group therapy' indicated it was unquestionability not ethical, with a smaller portion (14%) of counsellors indicating they had no idea of the ethical status of such behaviours. However, under the section for initiation of such behaviour, counsellors indicated a near 50/50 split

between not sure/cannot recall and never occurred. This result leads the author to the

conclusion the question may have been poorly worded resulting in confusion for respondents.

Finally, in this section, 20% of counsellors indicated that under rare circumstances it was

ethical to provide services 'outside of the counsellor's area of expertise'. Such behaviour,

according to counsellor's responses, occurred rarely and 11% indicated they had engaged in

this behaviour in practice.

   Behaviours Considered Boundary Crossings or Violations. Frequency distribution

data of participant responses to what they understand constitutes boundary crossing and

violation behaviours in practice are in Table 10.

Table 10. *Frequency Distribution of Responses Toward Boundary Crossings or Violations Behaviours in Practice*

	Item	Ethical					Occurrence						Initiated			
		1	2	3	4	5	1	2	3	4	5	N/A	1	2	3	4
1	Becoming social friends with a former client	41%	**49%**	.	.	.	64%	**26%**	.	.	.	.	.	.	**17%**	.
3	Providing therapy to one of your friends	67%	**28%**	.	.	.	66%	**25%**	.	.	.	.	.	.	**13%**	.
8	Hugging a client	11%	71%	.	**14%**	.	14%	55%	**26%**	.	.	.	.	**39%**	**39%**	.
10	Accepting services from a client in lieu of fee	65%	25%	.	.	.	78%	13%	.	.	.	.	5%	.	4%	.
14	Telling a client: "I'm sexually attracted to you."	90%	.	.	.	.	92%	.	.	.	.	.	.	.	.	.
18	Using self-disclosure or rapport as a therapy technique	.	47%	.	**26%**	18%	.	35%	40%	**13%**	.	.	79%	.	**11%**	.
27	Using sexual surrogates with clients	72%	.	**19%**	.	.	85%	.	.	.	.	11%	.	.	.	.
29	Inviting clients to a party or social event	85%	.	.	.	.	88%	.	.	.	.	.	.	.	.	.
32	Asking favours (e.g., a ride home) from clients	82%	15%	.	.	.	89%	.	.	.	.	.	.	.	.	.
37	Discussing clients (without names) with friends	58%	**33%**	.	.	.	45%	38%	**13%**	.	.	.	**22%**	.	.	24%
38	Providing therapy to your student or supervisee	52%	**32%**	.	.	.	64%	20%	.	.	.	.	.	.	**13%**	.
39	Giving gifts or commissions to those who refer clients to you	81%	.	.	.	.	85%	.	.	.	.	.	.	.	.	47%
41	Becoming sexually involved with a former client	79%	**15%**	.	.	.	91%	.	.	.	.	.	**2%**	.	.	.
43	Going into business with a client	90%	.	.	.	.	90%	.	.	.	.	.	.	.	.	.
47	Directly soliciting a person to be a client	72%	16%	.	.	.	80%	11%	.	.	.	.	.	.	.	.

Notes: Black cells indicate the primary and grey cells indicate secondary salient items in analysis
Ethical: 1 = unquestionably not; 2 = under rare circumstances; 3 = don't know/not sure; 4 = under many circumstances; 5 =unquestionably yes.
Occurrence: 1 = never; 2 = rarely; 3 = sometimes; 4 = fairly often; 5 = very often; NA=not applicable.
Initiated: 1 = I did; 2 = the client; 3 = It was mutual; 4 = Not sure/Cannot recall; 5 = Never Occurred;

Approximately half of all counsellors (49%) indicated under rare circumstances it was ethical to 'become social friends with former clients'. However, the majority indicated this had never happened, while 17% indicated a relationship had occurred by mutual agreement. Likewise, when exploring the question of 'engaging with an acquainted client' many counsellors (67%) viewed this as unquestionably not ethical, yet 13% indicated through mutual agreement between counsellor and client this actually occurred.

A minority of counsellors (14%) indicated that under many circumstances it was ethically acceptable to 'hug a client' in practise. Participants indicated an even split in the initiation of such behaviour between the counsellor (39%) and through mutual agreement with clients (39%). With regard to 'using self-disclosure as a therapeutic technique', counsellor responses ranged from under rare circumstances (47%), under many circumstances (26%) to unquestionably yes (18%). Fifty-three percent of counsellors indicated such behaviour occurred sometimes or fairly often, and 79% of counsellors initiated such behaviour. A small number (11%) responded such behaviour was through mutual agreement.

In response to the item 'use of sexual surrogates in therapy', approximately 20% of counsellors indicated that they did not know the ethical status of such behaviour, whilst the remainder (72%) indicated unequivocally not ethical. This result may reflect participant unfamiliarity of the term 'surrogate', thus raising doubts about the question's usefulness within the survey. The ambiguity of the item may have contributed to this unexpected result. Approximately one-third of counsellors (33%) indicated 'engaging in conversation with close friends about clients (withholding names)' was ethical under rare circumstances. Half of all counsellors who responded to this item (51%) indicated they

engaged in such activity rarely or sometimes. Twenty-two percent of counsellors indicated they initiated such behaviour.

Counsellors (32%) indicated under rare circumstances it was ethical to 'provide therapy to a supervisee or student' and 20% indicated this occurred on the rare occasion, and through mutual agreement (13%). This question must be considered in light of the fact not all counsellors in the present study are supervisors. The majority of counsellors (79%) indicated that 'engaging in a sexual relationship with a former client' was not ethical. Yet, a small minority (2%) indicated they initiated such behaviour.

Discussion

The present study aimed to explore differences between regulated and unregulated counsellors and their attitudes toward what constitutes unethical and ethical behaviours in practice. The hypothesis that there would be no significant differences between regulated and unregulated counsellors and what they understood constituted unethical and ethical behaviours in practice was partially supported. Findings from the analysis indicated no significant difference between regulated or unregulated professionals in terms of unprofessional/incompetent and boundary crossing/violation behaviours. This finding suggests, regardless of regulatory status, counsellors are able to discern equally behaviours that are considered unethical in practice. Yet, in terms of behaviours considered to be ethical in practice, regulated counsellors mean scores significantly differed from unregulated. This result may be interpreted as regulated professionals potentially having a greater consideration for what constitutes acting in an ethical manner, and may be reflective of regulated counsellors completing more years of tertiary education coupled with the very prescriptive requirements determined by AHPRA to become a regulated professional. The evidence presented here suggests that Trevino and

Youngblood (1990) are correct that other factors outside of regulation are responsible for ethical behaviours.

The results were then examined in terms of counsellor's responses to what they considered unethical and ethical behaviour, frequency of occurrence in practice, and who initiated the behaviour. In what follows, a discussion of counsellor responses for each of the three categories (Ethical, Incompetent/Unprofessional, and Boundary Crossings and Violations). For various reasons the following section should be read with caution. First, the study does not tell us why counsellors rated certain behaviours as common, rare, ethical or unethical, only that they did so on this occasion. Second, there may be discrepancies between behaviours reported by counsellors in the present study and actual patterns of behaviour. Third, there may also be a concern about the extent to which each item conveys the actual complexity of ethical/unethical situations in real life (Sullivan, 2002).

Reporting a colleague

In a United States psychologist survey only 58% of counsellors believe filing an ethics complaint about a colleague was an ethical act (Pope, Tabachnick, & Keith-Spiegel, 1987). Similarly, Tabachnick, Keith-Spiegel, and Pope (1991) found in their study 21% of psychologists' reported they had never ignored unethical behaviour of colleagues. Comparing these findings to the present study we find approximately half (48%) of counsellors felt that under many circumstances such behaviour was unquestionably ethical. Whilst approximately one third expressed only under rare circumstances is 'making a complaint about a colleague' ethical. A failure or decision not to act in making a complaint may be associated with the 'whistleblower' phenomenon. Whistle-blowers potentially face the risk of reprisal and other punishing consequences resulting from speaking out (Simon, 1978). Other potential explanations for this may

include, first, inaction may reflect the protective and compassionate nature of individuals comprising the counselling industry. Rather than report observed instances of breaches, counsellors may opt for direct communication with the individual concerned anticipating reparation of the situation following shortly after. Second, it may be very difficult to assess if suspected misconduct actually occurred because therapeutic sessions are not public forums. Thus, counsellors suspecting misconduct and malpractice cannot, with any certainty, evaluate the performance and conduct of a colleague with great ease to affirm suspicions.

Non-payment of fees

Many counsellors dismissed the notion of terminating therapeutic services because of non-payment of fees. Counsellors may feel that service provision should continue, even at a personal cost to them, in order to support and maintain a duty of care to clients. It would appear for some counsellors their duty extends beyond the contractual/transactional nature of a business relationship. In support of this notion, the American Counseling Association (2014) suggests counsellors establish fee structures given the financial status and location of the practice. The creation of undue hardship because of extravagant fees is seen as a contravention of the ethical code of conduct and places client wellbeing as the primary function of counsellors and counselling organisations.

In addition, some counsellors in the present study indicated it was unethical to engage in legal action to recover lost income from clients who did not pay for services. Such findings highlight an important issue when conducting business in this sector, the tension between a duty of care to a client and an ability to make a fair profit can affect business operations - specifically cash flow. A philosophical question counsellors might

ask themselves is 'to what extent is my business prepared to operate as a charity and as a wealth creating venture?'

Accepting gifts

Some counsellors in the present study indicated that clients have given gifts worth at least $50 in addition to fees already paid for services, (i.e. the gift was not in exchange for services). Zur (2015) highlights that many Australian codes of ethics or guidelines do not broach the subject of gift giving and acceptance, including the Australian Psychological Society, Australian Counselling Association and the Psychotherapists and Counsellors Federation of Australia and the Australian Association of Social Workers. However, the American Psychological Association (2015; APA) does cite a number of provisions including that psychologists should endeavour to value clients and do no harm. An important question a counsellor should answer when considering accepting or rejecting a gift is, will such action create harm? Second, counsellors should consider if such action is exploitative or likely to damage the therapeutic relationship (American Psychological Association, 2015).

The American Counseling Association (2014) states that counsellors should understand the challenges concerning the acceptance or rejection of gifts in an environmental context. For example, some cultures offer small tidings as a token of appreciation, respect and gratitude. the American Counseling Association (2014) advises counsellors to consider several factors before making a decision concerning gifts. Suggested considerations include: the nature of the therapeutic alliance, the actual or perceived value of the gift, the client's perceived motivation for giving the gift, and the counsellor's personal motivations for accepting or rejecting.

Confidentiality and reporting

The sanctity of the therapeutic relationship rests on several essential ingredients including trust between counsellor and client (Ardito & Rabellino, 2012). Clients are willing to share their innermost fears and private thoughts based on the understanding the counsellor will keep the client's confidence (Duncan, Williams, & Knowles, 2013). There are scenarios when a counsellor must breach client confidence such as when a client indicates that they are suicidal or the counsellor has suspicions for child sexual abuse. the present study indicated where such action occurred, it was by the counsellor's initiation that the breach of confidence occurred- which is to be expected given mandatory reporting regimes for all professionals. However approximately a quarter of counsellors responded it was by mutual agreement with clients for prevention of suicide. The latter was an unexpected finding.

Such a finding might reflect society's acceptance that discussing suicide is a plausible strategy for prevention compared to a lack of disclosure due to stigmatisation of mental health concerns. Advertising messages and communication from events such as 'R U Ok? Day'(https://ruok.org.au/) might influence client decisions to approach such stigmatised topics with counsellors, thereby leading to collaborative solutions, including working together to disclose suicide and seek appropriate interventions. A small percentage of counsellors indicated they don't know or are unsure about the ethical status of breaching client confidence to report child sexual abuse. Counsellors in this category may respond due to ignorance associated with mandatory reporting or the counsellors simply do not work with minors.

Case notes

Another important component of the therapeutic relationship is the collection of data and note taking. The majority of counsellors within the present study indicated it was

not ethical or they were unsure about the ethical status of allowing a client access to their records. This was a surprising finding. The Australian Psychological Society (2012; APS) stipulates it is permissible for clients to access their notes. However, the APS suggest counsellors facilitate access to client case notes and associated data with caution, as such documents may require professional interpretation or explanation to avoid potential client distress due to the nature of the content.

Keeping detailed and accurate notes is important for client welfare and development in therapy for a number of reasons. First, if the counsellor is no longer able to work with the client the notes should be of sufficient quality that a referred counsellor can continue therapy (Australian Psychological Society, 2012; Australian Association of Social Workers, 2015). Second, case notes, some would argue, are in part the client's confidential property.

It is possibly that conflicting or a lack of information accurate information concerning keeping, marinating and issuing case notes to clients is in part responsible for the findings in the present study. There may be a dynamic interplay that creates confusion for counsellors. On the one hand counselling educators — in universities, and colleges — may advise students that the client notes are the property of the client. Whilst, on the other hand business policy and legislation may stipulate client notes belong to the organisation, in which counsellors may be employed. The tension created by these conflicting guidelines, rules and policies may be the key driver of uncertainty in practice.

Incapacity to support clients

A minority of counsellors in the present study reported that on the rare occasion they worked with clients when too distressed to be effective. The relationship between stress, distress, and impairment is well recognised (Barnett & Hillard, 2001; Gabbard, 1991; Pope, Tabachnick & Keith-Spiegel, 1987). Stress is a normal part of life and

stressors range from minor (missing an appointment) to major (such as a death in the family). High levels of stress are associated with comorbid conditions. For example, low self-esteem in counsellors (Butler & Constantine, 2005), anxiety and depression in medical students (Ogden & Mtandabari, 1997) and substance abuse in psychologists (Thoreson, Nathan, Skorina & Kilburg, 1983). Distress is intense unresolved stress making it difficult for an individual to manage (American Psychological Association, 2015). Excessive distress can lead to impairment that may compromise the counsellor's professional functioning to the degree that it may harm the client and affect the delivery of effective services.

Several plausible reasons for this behaviour include, for commercial/business reasons and/or on the balance of probabilities the best course of action was to continue servicing the client. Counsellors operating their business activities as a 'sole trader' may experience a loss of income if they do not meet with clients. Economic factors may outweigh personal factors when evaluating such behaviours. It is conceivable that earning an income not only supports the counsellor personally but potentially the counsellor's dependent family. Therefore, when assessing the choice whether to see clients or not the decision may relate more to a comparison between the needs of the one versus the needs of the many. Likewise, on the balance of probabilities between working when too distressed to be effective and the benefit, or not, to the client, counsellors may decide it prudent to work when distressed. For example, a high care client may be suicidal. On the balance of probabilities, it may be beneficial for the counsellor to meet with the client as not attending may harm the client more.

Socialisation with clients

A large portion of counsellors in the present study viewed becoming social friends with a former client as unethical. Almost 50% of those counsellors accepted that under

rare circumstances this was a permissible practice. Likewise, a small minority indicated that they and their client mutually agreed to engage in social activities. Caution is advised when considering this particular result as what is not known is the time differential between the last therapeutic session and the beginning of the social relationship.

Many counselling codes of conduct stipulate that a counsellor and client wait at least two years following the final client consultation before a relationship can commence (Australian Counselling Association, 2012; Australian Psychological Society, 2012). The rationale for this policy is the prevention of a dual relationship situation. Counsellors and their clients who meet both professionally and socially may blur the boundaries between what is therapy and what is personal/social. Similarly, in the cases where counsellors provide services to existing acquaintances may alter the nature of the therapeutic alliance leading to a dual relationship situation.

Using self-disclosure and rapport as a therapeutic technique

Counsellor responses in the present study indicate the complex nature of disclosure and rapport as a therapeutic technique with an almost even split at either end of the ethics continuum - somewhat ethical to unquestionably so. Epstein (1994) suggests counsellors refrain from personal revelations in order to maintain focus on the client and their concerns. Overt disclosure may indicate the counsellor is unable/incapable of maintaining his or her professional role. Barnett (1998) concurs with Epstein (1994) adding that disclosure may jeopardise clearly defined boundaries required within a professional relationship.

Countering such views, Lazarus and Zur (2002) suggest clients are more intelligent than some would give credit. As such, relaxing boundaries can still ensure the integrity of the professional relationship and remain ethical as long as the counsellor ensures such action has a therapeutic intent (Lazarus & Zur, 2002). The mutuality of

disclosure may assist the therapist create an emotional bond and enhance the therapeutic relationship. However, disclosure should not only focus the relationship between counsellor and client rather support or scaffold the client in attaining their predetermined therapeutic goals. Counsellors employing disclosure or rapport as a therapeutic technique should consider boundary crossings and violations assessing the risk of harm against benefits to the client (Audet, 2011).

Engaging in sexual relationships with a former client

Responses in the present study indicated that a small minority of counsellors initiated a sexual relationship with a former client. However, it is not known if such behaviour was within the guidelines of the relevant codes of ethics for those individuals. Codes of conduct are very specific about engaging with past, present or future clients for the purposes of having a sexual relationship. the Australian Psychological Society (2007), the Psychotherapy and Counselling Federation of Australia (2011; 2015) and the Australian Counselling Association (2014) code of ethics also refer to two years' separation. The Australian Psychological Society (2007, p. 29) code C.4.3 states psychologists who wish to engage in sexual activity with former clients may do so following a two-year period from termination of service. However, this should be first explored with a senior psychologist. The reason, given in the code, is to assess any risks and vulnerabilities and to ensure the psychologist encourages the former client to seek independent counselling about the matter. Behnke (2004) suggests sexual relationships with former clients are more complicated in terms of ethics. The passing of time may decrease the intensity or the likelihood that such a relationship will result in harm. Completely forbidding such relationships may inhibit the clients right to exercise autonomy and choice in choosing personal relationships.

Limitations

Results here should be considered a reasonable starting point for the exploration of the ethical behaviours in practice phenomenon in Australia. Further, additional research could be conducted to attest to the reliability of the findings within the present study.

The authors acknowledge that the original EPQ (Pope, Tabachnick, & Keith-Spiegel, 1987) specifically measured ethical behaviours for regulated psychologists in the United States. As such, some of the situations may not directly apply to unregulated practitioners. For example, unregulated counsellors are forbidden to administer certain psychological instruments without appropriate training, therefore questions relating to diagnosis and the administration of test/s are not completely relevant. However, given the vast majority of counsellors have membership with an industry association requiring a minimum diploma level qualification, including an ethics component, answering such questions was deemed by the authors as appropriate and items were included.

Care must be taken when making inferences about results from the present study to the broader population/s of interest. The sample collected here looks specifically at a function, counselling. The amorphous nature of the population of interest provides a challenge when addressing generalizability - transferability from the sample to the parent population - and generality - application beyond a specific group - in participant selection (Orlinsky & Ronnestad, 2005). Of course the amorphous nature of the sample increases generalisability of the findings.

Conclusions

The present study investigated if differences in regulation affect ethical behaviours in practice. Evidence from regulated bodies and unregulated industry associations identifies a small minority of counsellors transgress ethical bounds resulting

in client harm (Australian Health Practitioners Regulation Agency, 2014; Australian

Counselling Association, 2012; Psychotherapists and Counsellors Federation of Australia,

2011). However, there is much debate given to regulated and unregulated counsellors that

focus on protecting the public in the prevention of harm.

      As Pope (2003) suggests, in order act ethically counsellors need to develop ethical

behaviours through an educational process integrating new and reinforcing exiting

knowledge and placing this into practice. It is not sufficient, Pope (1990) says, to simply

be aware of appropriate codes of ethics, regulation or policy. Therefore, other factors are

involved in explaining these findings. The present study found no difference in

prevalence rates for instances of serious misconduct between unregulated and unregulated

counselling professionals. This result indicates an almost identical likelihood ethical and

unethical conduct is associated with engaging the services of a regulated or an

unregulated counsellor in Australia. Yet, evidence from course programs demonstrates

that there are considerable differences in the level of training and education to associated

with securing status as a regulated versus unregulated counsellor.

      The *regulatory stream* (producing psychologist/psychiatrists etc.), with its

stringent training and supervision, does not appear to produce practitioners that are less

ethical than unregulated counsellors. However, regulated counsellors may have a greater

awareness of what constitutes ethical behaviour. The evidence presented here suggests

that Trevino and Youngblood (1990) may be correct that factors outside of regulations -

moral reasoning and decision-making – are based on personal qualities regardless of the

level of regulation and associated education and training. The present study provides

consumers with a certain degree of confidence that risks associated with visiting a

regulated or unregulated counsellor appear to be near identical. However, what this paper

does not explore is the counsellor's capacity to effectively support and resolve the client's

concerns. Consumers of counselling services are still required to make a selection based on their needs and desired outcomes. There are obvious differences in the support provided by regulated and unregulated counsellors and consumers would be wise to consult a General Practitioner in the first instance to ensure the best possible care.

Chapter 8: Unresolved trauma, identity feedback, and boundary crossings and

violations

An important determinant of an effective therapeutic relationship is the counsellor's ability to maintain and respect professional boundaries (Jackson & Nuttall, 2001; Pope, Tabachnick & Keith-Spiegel, 1987). Further, most counsellors commit to various codes of ethics that include provisions around boundaries. However, various industry associations report boundary crossings and violations by their members each year. The reasons *why* these crossings and breaches occur are often complex and their relationship with other factors remains empirically unclear. Two suggested factors that may assist in a greater understanding are the influence of a counsellor's past traumatic experience — more specifically their unresolved trauma — and the role of identity feedback — principally self-enhancement and self-verification — in protecting the counsellor from trauma-related effects. The present study seeks to examine the extent to which counsellors with unresolved trauma are influenced by the need to self-verify or self-enhance, and the impact this has on their attitudes toward boundary crossings and violations in their professional practice.

Many enter the helping professions, including counselling, in order to address their own unresolved trauma, also referred to as psychological conflict (Elliott & Guy, 1993; Hardy & Calhoun, 1997; Sussman, 2007) – consciously and deliberately or otherwise. As we have seen in Chapter 5, 91 participants (out of 419 – 22%) indicated unresolved trauma, with a further nine individuals exhibiting scores exceeding the screening threshold (scores over 30) indicating the likelihood of symptoms related to Posttraumatic Stress Disorder (PTSD). Only one of the nine individuals indicated they were not currently working as a counsellor, and only four of these nine counsellors were currently in therapy for their concerns. The projected prevalence rates for counsellors

within unresolved trauma currently practicing in Australia was determined to be approximately 1 in 5 counsellors, or about 20%.

Unresolved trauma is defined as an individual's failure to complete a process of consolidation following a traumatic incident (O'Donnell, et. al, 2012; Stovall-McClough & Cloitre, 2003; Walker, 2003). Unresolved trauma may be the result of an individual experiencing significant loss, relationship breakdown, abuse, neglect, or victimization. These events can be re-experienced through intrusive and distressing thoughts, flashbacks, sleep problems, hyper-vigilance, hyper-arousal and avoidance behaviours (Australian Centre for Posttraumatic Mental Health, 2013).

Everall and Paulson (2004) suggest that counsellors suffering from re-experiencing traumatic events, distress and hyper-arousal are at risk of violating ethical bounds. Serious breach/es of ethical guidelines may be the result of exploiting clients through various means, including repetitive boundary crossings and violations, creating dual role situations, or through role reversal in order to meet personal needs (Everall & Paulson, 2004). Smith and Moss (2009) propose that mental health concerns can affect the individual to a degree that it compromises the counsellor's effectiveness, resulting in substandard clinical care. Counsellors neglecting their mental health increase the possibility of impairment and hence affect the provision of effective services (Baker, 2003; Barnett, Baker, Elman, & Schoener, 2007).

Counsellors who disregard personal mental health concerns may not recognise the impact it has on their professional functioning and the effects on clients. Pope Tabachnick and Keith-Spiegel (1987) found that 85% of APA psychotherapists indicated it was unethical to work when too distressed because of personal concerns. Yet, 60% revealed they had done so. Similarly, Guy, Poelstra, and Stark (1989) found that 36.7% of

distressed counsellors believed their distress decreased the quality of the care provided to clients, and 4.6% indicated that the quality of care was inadequate.

In terms of evidence for a direct relationship between trauma and unethical practice, Jackson and Nuttall (2001) surveyed 323 mental health practitioners (138 men and 185 women). They categorised participants into 'no abuse' and 'child sexual abuse' groups. They segregated the data further into those who had had sex with clients (14 males and one female) and those who had not. Of the 29 male practitioners reporting a history of child sexual abuse six (29%) had engaged in sex with clients, significantly higher than the 6% of the remaining 109 men who reported no sexual abuse history. However not all counsellors with a history of childhood sexual abuse sexually exploit or abuse clients, and nor do all those who sexually violate clients have a history of childhood abuse.

Unresolved trauma may lead to situations in which individuals find themselves affected by two strong motives, desires or values that cannot be solved simultaneously, referred to as 'interpersonal conflicts' (Lewin, 1939); in other words, the tension created when an individual in the counselling profession is motivated to resolve personal trauma whilst simultaneously resolving the problems and concerns of others in need. In some instances, the individual is unable to identify the source of their tension or distress and as a result is unable to make rational judgements (Janis & Mann, 1977).

Behaviour, according to Lewin's (1939) seminal Field Theory of Conflict, is a function of the person, their environment, and intrapersonal conflict/s resulting from contradictory situations. Lewin (1939) argues there are three intrapersonal conflicts: 'Approach-Approach' conflict occurs when the individual is forced to make a choice between two positive outcomes, or goals, that are equally motivating; 'Avoidance-Avoidance' conflict occurs when the individual is forced to make a choice between two

negative courses of action; and 'Approach-Avoidance' conflicts occur when the

individual is faced with the choice of actions or outcomes that attract and repel at the

same time (Mangal, 1987).

Arguably, the most difficult conflict to contend with is 'Approach-Avoidance'

conflict. An individual conflicted within this category may be motivated towards

behaviours that are considered wrong, evil or degrading, yet at the same time the

attraction to the behaviour is so powerful the individual becomes restless without acting

upon it (Mangal, 1987). An example of 'Approach-Avoidance' conflict for a counsellor

may include a counsellor who places client welfare in jeopardy in order to garner

increased levels of identity feedback. Here the counsellor might be torn between working

with the client for the client's benefit and exploiting the client for personal benefit to

resolve personal trauma. In this scenario a counsellor might be motivated to use self-

enhancement and self-verification — two forms of identity feedback — to bolster or

support the self-concept (Sedikides & Strube, 1995), thus protecting the counsellor from

the effects of unresolved trauma.

Self-enhancement concerns an individual's attempts to gather only positive

feedback in support of a pre-existing self-concept (Sedikides & Strube, 1995), such as a

counsellor desperate to be seen in a highly positive light by others. Such a strategy has

been validated as a way of maintaining a healthy level of self-esteem (Leary, 2007). Self-

verification is a motivation to reinforce a pre-existing self-concept (Bloch, 2004), such as

a drive to have the client form the same positive view of them as a counsellor as they see

themselves. The interaction may create a condition in which the counsellor feels valued

and satisfied (Swann, 1986; 1987). However, within the therapeutic relationship there are

professional boundaries that need to be respected.

Crossing professional boundaries can range from harmless deviations from behaviours considered normal within the therapeutic alliance through to serious breaches resulting in considerable client harm (Norris, Gutheil, & Strasburger, 2003). Boundary crossings may include giving a client a hug whilst boundary violations may include physical or sexual abuse and other exploitative behaviours. Within therapy, a counsellor might begin an exploitative relationship attempting to attenuate unresolved trauma and/or personal conflicts.

Pyszczynski, Greenberg, Solomon and Schimel (2004) suggest that individuals are motivated to pursue positive feedback and self-evaluations because high levels of self-esteem reduce anxiety-related defensive behaviours protecting the self-concept. Taylor and Sherman (2008) propose that this occurs because individuals use self-enhancement in order to maintain or improve psychological health when grappling with unresolved trauma. Some support for Taylor and Sherman's argument from Butler and Constantine (2005), who found counsellors experiencing high levels of stress — specifically emotional exhaustion and depersonalization (i.e., developing negative and unfeeling attitudes toward others) — were found to have lower collective self-esteem. Collective self-esteem is a term used to describe how an individual's identity and personal characteristics relate to those of particular groups. Certainly, successfully resolving stress is paramount for a long career in counselling (Guy, Poelstra, & Stark, 1989).

The relationship between stress, distress, and impairment is well recognised (Barnett & Hillard, 2001; Gabbard, 1991; Pope, Tabachnick & Keith-Spiegel, 1987). Although stress is a normal part of life and stressors range from minor (e.g. missing an appointment) to major (such as a death in the family), high levels of stress are associated with comorbid conditions, for example low self-esteem in counsellors (Butler & Constantine, 2005), anxiety and depression in medical students (Ogden & Mtandabari,

1997) and substance abuse in psychologists (Thoreson, Nathan, Skorina & Kilburg, 1983). Intense unresolved stress in a counsellor may occur following a recent divorce, or those with some form of substance abuse. Pope, Tabachnick and Keith-Spiegel (1987) reported that 59% of psychologists worked when they were too distressed to be effective.

Arguably, excessive distress can lead to impairment that may compromise the counsellor's professional functioning to the degree that it may interfere with support for clients and influence the delivery of effective services (Everall & Paulson, 2004). Research examining distress amongst professional psychologists conducted by Prochaska and Norcross (1983) found that 82% of respondents identified they had some form of distress that was defined as "anxious or depressed moods, somatic complaints, lowered self-esteem, and feelings of confusion and helplessness about their problems" (p. 644). According to the American Psychological Association, it is not stress or even the distress that leads to impairment, rather inappropriate or unsuccessful attempts to manage stress (American Psychological Association, 2015; Guy, Polestra & Stark, 1989).

Impairment can affect a counsellor's awareness such that the individual is unable to recognise the seriousness of their condition (Ino, Tatsuki & Nishikwawa, 2001) or denies the seriousness of their condition (American Psychological Association, 2015). Consequently, the probability of inappropriate, unethical, or possibly illegal, behaviour is considerable (American Psychological Association, 2015). In a study examining conflicted therapists and ethical violations, Jackson and Nuttall (2001) concluded that the mere presence of a history of psychological conflict increased the likelihood of malpractice by a factor of four.

The present study aims to determine the extent to which counsellors reporting unresolved trauma are influenced by a need to self-verify or self-enhance, and what effect this has on their attitudes toward boundary crossings and violations. It was predicted,

therefore, that the relationship between unresolved trauma and client boundary crossings

and violations would be mediated by self-enhancement and self-verification.

Method

The current study is part of a larger project and the contents of the method section,

specifically information concerning participants and measures utilised, have been fully

explained in Chapter 7.

Design

A measurement-of-mediation design was used. Research in a new area typically

focuses on establishing evidence of a relationship between variables to understand if the

association is causal or because of a spurious phenomenon (Hayes, 2012). Mediation

analysis is beneficial when seeking to answer the question of 'how' variables interact

with each other (Hayes, 2007; MacKinnon, Fairchild & Fritz, 2007). The present study

employs a mediation analysis program called PROCESS (Preacher & Hayes, 2004). It

uses a bootstrapping technique to determine a mediation model. PROCESS uses a least

squares or logistic regression-based path analytic framework for estimating the direct and

indirect effects within simple and multiple mediator models (Hayes, 2014). The program

provided a regression analysis for the overall model and the inter-linkages between the

variables that calculated the upper and lower confidence intervals and provided a

probability that mediation, or moderation, was occurring in the constructed model.

Procedure

Ethics approval was received from Monash University Human Research Ethics

Committee (Approval Number CF13/2485 - 2013001319). Approval was given to

promote the study through industry associations and direct contact with organisations

promoting mental health services online across Australia. Participants were emailed a link

to access an online survey hosted by Qualtrics (www.qualtrics.com). Professionals

willing to participate completed the set of questionnaires within 35-40 minutes. The

present study utilised the total score for the IES- R subsets of the primary scale for the

REVS-R (self-verification and self-enhancement), and subsets of the EPQ-R (boundary

crossings and violations). Only participants indicating the presence of subjective

unresolved trauma completed the IES-R measure. Data were screened for missing values,

outliers and normality. Ten outliers were located within the Boundary Crossings data and

three within the Impact Event Scale-Revised participant data; these data points were

winzorized (Keselman, Algina, Lix, Wilcox, & Deering, 2008) and adjusted within +/-

two standard deviations from the mean to dampen their impact on the data.

A critical note on mediation analysis

Mediation analysis has become very popular in the field of psychology because

conducting such analysis/es seems to allow the researcher the opportunity to draw causal

conclusion from correlational data (Trafimow, 2015). However, this is illusory (Grice,

Cohn, Ramsey & Chaney, 2015; Kline, 2015; Trafimow, 2015) because correlation does

not equal causation (Trafimow, 2015). Mediation analysis is a useful technique when the

end goal is to understand how changes are transmitted from a casual variable via a

mediating, or intervening variable/s, leading to changes in an outcome variable (Little,

2013). An important, and often misguided, assumption in mediation analysis is that all

corresponding directional specifications for the variables of interest are correct (Kline,

2015). That is, an assumption is made that X is a cause of M and Y and Y is also caused

by M, see Figure 6.
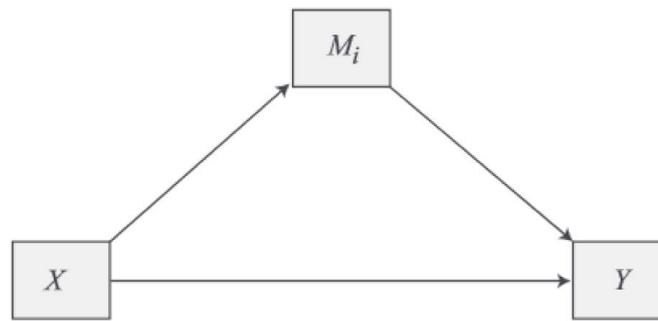
Figure 6. Model of a typical mediation analysis

Kline (2016) claims that many researchers believe, falsely, that directionality is tested in mediation analysis. The truth is that directionality is assumed to be accurate prior to conducting any analysis (Kline, 2015).

Consider a simple three-variable mediation model. Such a model provides six possible directions of causal flow (X→M→Y; X→Y→M; M→X→Y; M→Y→X; Y→X→M; Y→M→X). Hayes (2012) suggests that strong theory or logical impossibility precludes some of the more unlikely options. Within this thesis, mediation models and selected variable directionality is based on a comprehensive literature review. For example, some participants in this thesis self-reported experiencing some form of unresolved trauma. Participants are then asked about their attitudes toward ethical behaviours in practice. Such a relationship can only have one direction due to the sequence of events in time. First, the trauma is experienced and then attitudes toward ethical behaviours are provided. The mediation variable self-enhancement, is a continual process occurring as part of normal social interactions, and thus each variable within the model is part of a logical sequence of events occurring naturally for participants and providing the rationale for directionality.

Bootstrapping technique

The concept of 'bootstrapping' in statistics has gained considerable momentum in recent years. Bootstrapping is recommended for small samples ($n = <100$) analyses (see Preacher & Hayes, 2004; Preacher, Rucker, & Hayes, 2007) and provides an alternative statistical method to that of standard non-parametric testing. Bootstrapping is a resampling technique that assumes the sample derived from a population of interest is in fact the population. The statistic of interest, say a regression, is re-sampled repeatedly to provide a statistical inference (Mooney & Duval, 1993; Preacher & Hayes, 2004). The re-sampling process many include as little as 1000 and in excess of 10,000 subsamples.

A primary premise upon which bootstrapping operates is that the empirically derived sample is actually representative of, or mirrors, the population. However, an issue emerges over the treatment of sample data prior to running bootstrapping analysis. Should the data be left in its 'raw state', or should it be 'cleansed' reducing the impact of outliers?

Strictly speaking bootstrapping is considered a non-parametric analysis. As such a major assumption is that the sample must mirror the population of interest (Mooney & Duval, 1993; Preacher & Hayes, 2004; Preacher, Rucker, & Hayes, 2007). Non-parametric techniques are used in situations where the assumptions of normality are violated (Field, 2000). Samples that are quite small ($n = <100$) and overly skewed and samples with outliers that violate normality tests are prime candidates for non-parametric techniques. The aforementioned reasons provide a strong argument for why we should not 'cleanse' raw data and simply use the bootstrapping option in association with our selected statistical technique. However, there are a number of other factors to consider.

Data sets that violate normality assumptions should be screened for three fundamental reasons: errors, atypical values (Garner, Stapanian, & Fitzgerald, 1991), and

passive participant's scores. Errors can include incorrectly entered values or errors in transposition and values that are entirely improbably (e.g. an individual weight as a negative number or having a blood pressure of 1190 mmHg). Atypical values may indicate an actual case with actual values, which is very interesting in and of its self, requiring further exploration. Yet such responses skew the data considerably distorting representations about the population. It could be argued that 'atypical responses' are an important characteristic of analysis. However, a pertinent question remains 'who can ultimately adjudicate on such things'? Finally, passive participants may provide non-committal responses and those choosing a high or low point on a Likert Scale for all responses can skew the data. The author of the present study determined that ensuring the data is not highly skewed, even when using the non-parametric bootstrapping technique, is the preferred approach based on the argument that errors, passive participants, and atypical values may be present. Therefore, data has been cleansed. Where appropriate this has been reported within the methodology section.

Results

Missing data were replaced using mean replacement. All statistical analyses were conducted using a 95% confidence level. Individual predictor variables were assessed for outliers using Mahalanobis Distance, with a critical Chi Square value of 10.83 (χ^2 (1, $N =$ 111) = 10.83, $p = .001$). Further, the mediation and regression analysis predictor variables were assessed for outliers using Mahalanobis Distance and a critical value of 16.27 (χ^2 (3, $N = 112$) = 16.27, $p = .001$). No residual outliers were located. Casewise diagnostics were run on the data set, the analysis revealing no additional outliers (>|3 SD|).

The Impact Event Scale Revised screen was used to determine the nature of the trauma experienced by the participants – see Table 11. Whilst 'Anxiety and/or

Depression' ranked number 1 in the list, participants generally indicated its comorbidity
with a secondary condition.

Table 11. *Frequency and Percentage Breakdown of Type of Self-Reported Trauma*

Category of Trauma	Frequency	Percentage
Anxiety and/or Depression [Note: Comorbid Condition]	17	13%
Physical Abuse	12	9%
Child sexual abuse	12	9%
Family member with mental health concerns	12	9%
Family violence	11	8%
Loss and Grief	7	5%
Post-traumatic Stress Disorder	7	5%
Physical health concerns	7	5%
Bullying	6	5%
Attachment concerns	5	4%
Accident and injury	4	3%
Developmental trauma	4	3%
Breakdown (psychological)	3	2%
Divorce	3	2%
Alcoholism (within the family)	3	2%
Cancer	3	2%
Assault	2	2%
Rape	2	2%
Suicidal ideation	2	2%
Dysfunctional family	2	2%
Eating disorder	2	2%
Miscarriage	1	1%
Workplace related stress	1	1%
Drug addiction	1	1%
Torture	1	1%
Financial stress	1	1%
Sleep Disorder	1	1%
Total	132	100%

Note: Participants were able to indicate multiple traumas

Descriptive data for the variables are found in Table 12.

Table 12. *Descriptive Statistics for Impact Event Scale, Self-enhancement, Self-verification, and Boundary Crossings and Violations*

Variable	Mean	Std. Deviation	Range	Skewness	Kurtosis
Impact Event Scale	11.76	9.51	0-88	.66	-.50
Self-enhancement	26.67	3.70	8-40	-.028	.90
Self-verification	29.09	2.72	9-45	-.27	.43
Boundary Crossings & Violations	28.29	5.77	0-75	.67	.70

Intercorrelation Analyses. As recommended for small samples ($n < 101$),

bootstrapping (see Preacher & Hayes, 2004) was used to calculate a Pearson's Correlation

Coefficient. Based on 10000 bootstrapped samples using bias-correction and accelerated

95% confidence intervals the analysis revealed a significant correlation between all

variables except for self-verification, which was removed from further analysis. 71

participants completed all three measures required to conduct mediation analysis.

Participant's scores on the Impact Event Scale-Revised were significantly correlated with

scores on the self-enhancement sub-scale, and scores on the self-enhancement sub-scale

were significantly correlated with attitudes toward boundary crossings and violations in

practice, see Table 13.

Table 13. *Intercorrelational Analyses for Mediation Variables*

Variables	Comparison	N	Confidence Intervals (lower/upper)	r	Sig.	r²
Impact Event Scale	Self-enhancement	71	.047 / .525	.29	.015	.08
Impact Event Scale	Self-verification	71	-.066 / .306	.12	.318	.01
Self-enhancement	Boundary Crossings & Violations	71	.164 / .578	.40	.001	.16
Self-verification	Boundary Crossings & Violations	71	-.110 / .391	.16	.198	.03
Impact Event Scale	Boundary Crossings & Violations	71	-074 / .459	.27	.022	.07

Note. 95% confidence interval, participants that did not complete all measures were excluded from analysis.

Mediation Analyses: A meditation analysis was conducted to determine whether self-enhancement and self-verification were mediators of the relationship between unresolved trauma and attitudes toward boundary crossings and violations in practice (see Figure 7). It was based on 10000 bootstrapped samples using bias-corrected and accelerated 95% confidence intervals (as per Preacher & Hayes, 2004) showed that unresolved trauma had a significant total effect on attitudes toward boundary crossings and violations in practice (*TE* = .19, *se* = .08, *p* = .022), a non-significant residual direct effect (*DE* = .12, *se* = .08, *p* = .14), and a significant indirect effect for self-enhancement (*IE* = .08, *se* = .04, *LLCI* = .014, *ULCI* = .19).
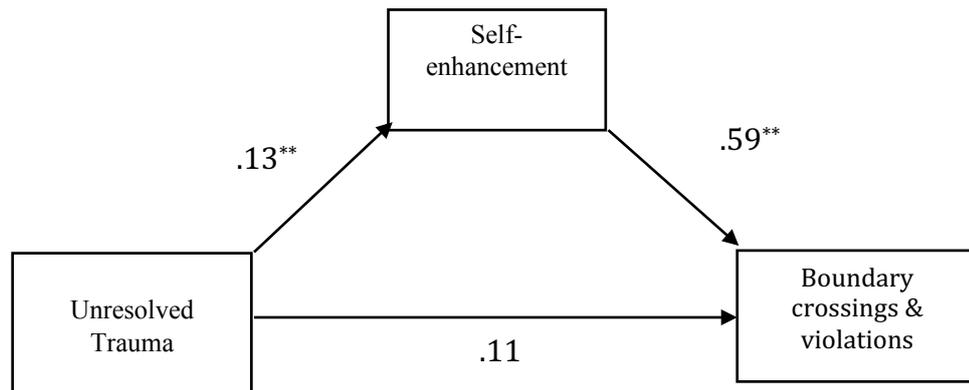
Figure 7. Diagram of the mediation analysis coefficients between the variables, ** p < .01.

As zero is not in the 95% confidence interval, and so the indirect effect for self-enhancement is significantly different from zero at $p < .05$ (two tailed). Therefore, self-enhancement indirectly mediated the relationship between unresolved trauma and attitudes toward boundary crossings and violations in practice with a medium effect size of 10% ($k^2 = .10$; Preacher & Kelley, 2011).

Discussion

The present study aimed to determine the extent to which counsellors indicating unresolved trauma were influenced by the need to self-verify or self-enhance, and what effect this has on their attitudes toward boundary crossings and violations. There was partial support for the prediction that the relationship between unresolved trauma and client boundary crossings and violations is mediated by self-enhancement and self-verification. Results indicated self-enhancement indirectly mediated the relationship between unresolved trauma and boundary crossings and violations, however self-verification did not.

In line with those of Leary (2007), findings from the present study indicated participants with higher scores on the IES-R may be more likely to seek out self-enhancing, or positive identity feedback, potentially wanting to be seen in a positive light by others. Counsellors with unresolved trauma in the present study may have been motivated to seek out increased levels or to sustain levels of self-esteem (Bandura, 1997). Pyszczynski, Greenberg, Solomon and Schimel (2004) suggest that individuals may be motivated to pursue positive self-evaluations as a strategy for increasing levels of self-esteem. This acts as a buffer and reduces anxiety-related defensive behaviours that, in turn, protect the self-concept. Importantly, self-enhancement may be useful in preserving or cultivating psychological health. This is especially useful when individuals are grappling with challenging life events, including experiencing significant trauma (Taylor & Sherman, 2008).

In order to garner sufficient positive feedback, counsellors with unresolved trauma may be likely to indicate more relaxed attitudes toward boundary crossings and violations with clients in the therapeutic relationship. For example, counsellors establishing an extra-ordinary social relationship with a client in parallel with the therapeutic relationship may create a dual relationship — that is often cited as leading to malpractice (Caudill, 2015). Whilst still in the context of therapy, it may be that counsellors with unresolved trauma have different goals, or objectives, compared to a counsellor without unresolved trauma. The goal may be to seek out self-enhancing feedback from the therapeutic alliance that would not otherwise be sought had the condition not existed. This may result in a split in the therapeutic alliance with the counsellor potentially focused on the needs of the self and not those of the client.

This split in the therapeutic alliance situation might create what Lewin (1939) terms an 'Approach-Approach' conflict. The counsellor may be forced into making a

choice between two positive outcomes, or goals, that are equally motivating, such as a choice between working toward client oriented goals (resulting in fees for therapeutic services) or the opportunity to extract some form of social feedback. Whilst is not unethical to garner social feedback — and therefore enjoyment — from the therapeutic relationship, excessive crossing or violations of professional boundaries can result in client harm (Glass, 2003).

Findings from the present study suggest that engaging in positive relationships with clients may provide confirmatory feedback following which the counsellor may feel better about him or herself. This finding is consistent with that reported by Katz and Beach (2000) who found that individuals seek relationships with others who provide positive reinforcement, viewing these relationships favourably. Whilst codes of ethics contain instructions against engaging in dual relationships, Gottlieb (1993) suggests that this is aspirational in nature and difficult to avoid in practice. However, because of the potential for serious harm some dual relationships have been specifically forbidden, especially sexual relationships (American Counseling Association, 2014).

A possible explanation for the finding that self-verification was not a significant mediator might be because counsellors in the present study already *know* who they are. This notion of *knowing* might stem from their professional identity, which is reinforced by other feedback within the counselling environment and not associated with clients, such as the application of labels or titles. For example, individuals completing from a three-year undergraduate university (or other training institution) degree might feel a title or label is bestowed upon them. Events such as graduation ceremonies may provide further validation or confirmation of the status the individual holds within the counselling profession. This, it is argued, might provide these counsellors' adequate verification of the self.

The impacts of trauma

It is clear from the diversity of self-report data in the present study that events leading to a counsellor's trauma, or source/s of distress, are complex. Presumably the resolution of some of the more serious concerns require considerable intervention/s and support and raises the question about competency and capacity (Ivey & Partington, 2014). For example, to what degree are counsellors with a history of trauma potentially compromised such that they should not engage in a therapeutic alliance with clients with similar trauma related concerns to those of the counsellor? Counsellors interacting with clients presenting with similar concerns may trigger or activate intrusive thoughts associated with the past or ongoing trauma.

In the present study anxiety and/or depression were comorbid with many of the concerns reported by counsellors. Of some concern, nine participants in the present study indicated scores above the cut-off threshold on the IES-R and eight of the nine were still practicing. This finding raises another question about the adequacy of supervision as traumatised counsellors may not be honest with supervisors about the challenges they face or may be unaware of the extent of the impact it has on clients.

Practical implications

Engaging in self-enhancing behaviour may also be a catalyst for transgressing boundaries, potentially placing client welfare at risk. Innocuous attempts to self-enhance might assist traumatised counsellors by providing them with an opportunity to continue to work as a professional without harming the client. However, at the intersection between a counsellor's personal and professional life is the requirement for counsellors to be aware of the degree to which such behaviours overlap. Counsellors in such a predicament should take precautions to prevent client harm. At all times the primary focus for all counsellors

should be the client (Hill, 2005; Horvath & Bedi, 2002). Without an effective client-counsellor working alliance the success of therapy is considerably undermined.

Limitations and future research

One limitation of the present study is that mediation analysis examines the relationships between the predictor and criterion variables at but a single point in time. As such, there is still a question as if this phenomenon persists over the longer term. Secondly, it is unlikely all therapists who have suffered trauma exploit their clients, and not all therapists who violate their duty of care toward clients have a history of trauma. A third limitation relates to the adjudication of behaviours considered unethical is a highly complex and subjective process requiring considerable investigation and debate to achieve consensus about what constitutes ethical and unethical behaviours given the facts of specific scenarios. Finally, caution is advised when discussing the results of the mediation analysis as the present study only provides evidence for a small effect.

Future research might also develop a diagnostic instrument or screen for administered to counselling supervisees in the presence of supervisors as a means to assess their potential for exploitative behaviours in practice. Such a tool or screen may also be of use when identifying *at risk* counsellors and directing them toward support services — in the form of personal counselling and/or additional training and education. It is important to recognize, however, that such an instrument could only suggest the potential to engage in behaviours that might lead to misconduct and/or malpractice (Perry & Sheldon, 1995, in Jackson & Nuttal, 2001). A follow-up study may compare and contrast the findings from participants who deliberately transgressed ethical bounds, investigating the relationship between attitudes toward items on the EPQ-R and actual transgressing behaviours.

Conclusions

Previous research suggests that a counsellors' traumatic experience provides a catalyst or motivation to begin a career in counselling. However, such motivations need to be carefully considered in light of the impacts from any negative effects of trauma including influencing a counsellors' capacity to deliver effective counselling services. Counsellors with unresolved trauma working with clients suffering from similar trauma related concerns may need to consider the effect of trauma related triggers. For example, issues relating to transference — emotional transmission from client to the counsellor — and/or countertransference — the emotional transmission from counsellor to client (Racker, 2012).

The present study suggests that attitudes toward boundary crossings and violations is indirectly mediated by the counsellor's need to self-enhance. In other words, our understanding of the relationship between a counsellor's unresolved trauma and their potential for increased boundary crossings and violations is better explained when examining the concept of self-enhancement. Therefore, in order to reduce or mitigate the impacts of personal trauma counsellors expressed a desire for self-enhancing feedback from clients potentially to bolster personal identity (Pyszczynski, Greenberg, Solomon & Schimel, 2004). In doing so, these counsellors may have more relaxed attitudes to professional boundaries in order to increase opportunities to secure as much identity feedback as possible. If counsellor attitudes translate into actual behaviours in practice, then such behaviours may result in negligence — breaching a duty of care owed to a client. Such behaviours may potentially result in misconduct and malpractice.

Chapter 9a: General discussion

An important determinant of an effective working alliance is the counsellor's capacity for empathic attunement (Bordin, 1979, Horvath & Luborsky, 1993; Lustig, Strauser, Rice & Rucker, 2002). Empathy arises from understanding a person's situation and their associated emotions. Jung (1951) argued that to truly understand, and then properly assist, someone in psychological distress, it helps if the counsellor has had a similar experience. This is perhaps intuitively understood since many individuals enter helping professions such as counselling after going through their own traumatic event (see Chapter 5). In many cases, they have made a conscious decision that their own experiences of dealing with a trauma will be of assistance to others, and that their success in surviving the ordeal will offer salutary lessons to others. The veracity of this expectation is predicated on the assumption that the counsellor has successfully resolved their previous trauma. If it remains unresolved when the counsellor begins seeing clients it may have a deleterious impact on the client. This might occur through the counsellor using interaction with the client to deal with their own inner conflict, and it may be intentional or unintentional, or it may arise suddenly and expectedly.

One potential effect of an unresolved trauma may be a level of self-doubt or reduced self-efficacy as a counsellor, which in turn would detract from a positive self-identity as an effective helper. To mitigate this negative-state the counsellor might be motivated to pursue positive self-evaluation, because raising one's self-esteem reduces anxiety-related defensive behaviours, protecting the self-concept (Pyszczynski, Greenberg, Solomon & Schimel, 2004). Self-concept perceptions, the way we view ourselves, may induce certain behaviours and can influence the way we act and how we plan to act in the future (Hagger, Anderson, Kyriakaki & Darkings, 2006; Ramirez, Dennhardt, Baldwin, Murphy & Lindgre, 2016). Consequently, aspects of identity are

influential in the decision-making process, specifically when considering health-oriented behaviours (Hagger, Anderson, Kyriakaki & Darkings, 2006). This raises an important question: to what extent does an individual's mental health concerns influence their behaviours — positive and negative — in order to improve well-being? One theory offered by Taylor and Sherman (2008) suggests that self-enhancement (positive social feedback) is useful in maintaining or improving psychological health when grappling with challenging life events, including trauma.

Counsellors with unresolved trauma, and therefore who may be dysfunctional or impaired (Guy, 1987), appear to be at greater risk of transgressing ethical boundaries than those who have dealt with or resolved their trauma. This, in turn, may lead to client neglect or harm and result in a charge of misconduct or malpractice. Notwithstanding efforts by various industry bodies and associations to eliminate misconduct and malpractice behaviours, the literature reveals that relatively little is known about the reasons why misconduct and malpractice behaviours occur. This thesis sought to bridge this gap by exploring the relationship between the effects of counsellors' unresolved trauma on their identity and the impacts this might have on their attitudes toward behaviours (ethical and unethical) in practice.

Answering the thesis aims and hypotheses

This thesis set-out to address six aims and three hypotheses, with an overall objective of examining the reasons why counsellor misconduct and malpractice occurs. The six aims and their associated hypotheses are revisited here and each is addressed in turn.

Aim 1: *Investigate the prevalence of serious misconduct in the regulated and unregulated counselling industry.*

With no nationally coordinated reporting structure it is difficult assembling data for general counsellors as they exist in an unregulated industry. The prevalence rates presented in Chapter 2 are likely an underestimate of the reality of the misconduct and malpractice problem. Plus, there still remains the illusion that all counselling activities are indeed regulated to some extent. The public, it appears, shares a common misconception that unregulated general counsellors are in fact fully or partially governmentally regulated, and that unregulated counsellors have sufficient qualifications to practice (Hodges, 2011).

A survey about the views of Australians ($N = 18,485$) regarding their views on qualifications and regulatory requirements for practicing as general counsellors was conducted (Hodges, 2011). A majority, 63% of respondents, indicated that they believed a degree (bachelor or postgraduate) was required to practice general counselling and when asked 'who would you make a serious complaint about a general counsellor to', 37% responded to a governmental body or authority, 29% would go to the police, 41% would complain to the counsellor's employer and 41% would contact the counsellor's professional association (participants were able to provide multiple responses to items). Responding to an item about a counsellor being found guilty of a serious issue, 91% of respondents indicated they believed the counsellor would be struck-off or banned from practicing. Such misconceptions amongst the public can create confusion regarding where to go to report abuse at the hands of a counsellor, resulting in a report not being made at all, or not being recorded. This would compound the problem of under-reporting instances of misconduct and malpractice in Australia. The *Unregistered Health Practitioners Act 2012* (New South Wales) provides some form of safety net for the public against those not within the regulated industry.

The number of complaints resulting in panel reviews and tribunal hearings for counselling professionals (regulated and unregulated) have generally increased over the last five years — even when accounting for increases in the population over time (see Chapter 2). For regulated counsellors (psychologists) the costs for handling complaints has increased over the last few years. However, relative to other professions, psychology ranks as the third highest on a per capita basis with notifications concluding in a hearing or tribunal. This finding suggests that for the population of psychologists transgressing behaviours are occurring more frequently than by professionals in other regulated industries — such as osteopathy and chiropracty.

There may be several reasons for the increase in complaints and relatively high ranking. First, a lack of change in the ways government regulators and industry bodies and associations have addressed the problem of misconduct and malpractice behaviours. Secondly, an increased awareness of mental health in communities across Australia may equate to increased demand for mental health services, and potentially the demand is outstripping supply, impacting upon the quality of services provided and hence more complaints. Indeed, a decline in jobs growth in the sector has been recorded in recent years (2013-2015; Australian Bureau of Statistics, 2015). As such, counsellors are under more pressure to take on more clients, possibly at the expense of personal welfare. Finally, the abundance of information and the connectedness of social media may have created an increased awareness amongst clients regarding unacceptable behaviour by counsellors, leading to more complaints of poor conduct.

Hypothesis 1: *That the nationally standardised system of training, assessment, qualification and oversight will result in fewer instances of misconduct by regulated counselling practitioners than by unregulated counselling practitioners.*

In Australia, both regulated and unregulated counselling professionals provide a diverse array of mental health services. Public perception about differentials in the standard of care provided by regulated and unregulated counselling professionals suggest an imbalance of potential risks, thus clients may preference counselling services based on training, education and regulation. The hypothesis that regulated counsellors provide a more risk-free service relative to unregulated counsellors is an attractive one, but has not been tested empirically. This is primarily due to the problems associated with collecting appropriate and complete data on the incidence of misconduct and malpractice from various industry associations.

The hypothesis that the nationally standardised system of training, assessment, qualification and oversight will result in fewer instances of misconduct by regulated counselling practitioners than by unregulated counselling practitioners was not supported. Following an analysis, there was no statistical difference between the two populations for instances of recorded misconduct. This finding provides evidence that somewhat refutes the common [mis]perception that regulated counsellors (psychology and psychiatry) are safer. However, additional research is required to verify the reliability of this finding. In order to do this, a practical solution regarding the lack of a national dataset (regulated and unregulated) is required.

Besides those few counsellors – regulated and unregulated – who transgress each year, the findings from the study in Chapter 2 are encouraging, as it appears — albeit on the basis of a very crude analysis — that the risks associated with attending 'counsellors' are not significantly higher when seeking support from unregulated versus regulated counsellors. Jones and Armstrong (2011) suggest a duty of care is imposed upon all counsellors, ensuring the ethical delivery of services and preserving a level of responsibility to do no harm or wrong to a client/s, a claim supported by the results

reported here. It is important that appropriate levels of competence, inclusive of ethical

practice, match the type of services provided, resulting in effective outcomes for clients

(Jones & Armstrong, 2011). As such, evidence from studies within this thesis and from a

review of the literature suggests that the implementation of additional regulation and

control may not improve sufficiently improve the issues of misconduct and malpractice

alone. It is clear that an investigation regarding the underlying mechanisms for why

misconduct and malpractice occur was warranted.

Aim 2: *Identify explanatory themes that might assist in explaining why misconduct and*
malpractice behaviours might occur.

Previous research has examined the types of interactions, or risk factors, related to

misconduct and malpractice (see Novotney, 2016). The study in Chapter 3 explores

counsellors' explanations concerning *why* misconduct and malpractice behaviours occur.

Much of the past research into misconduct and malpractice transgressions have sought to

categorise ethical violations and calculate prevalence rates (Grenyer & Lewis, 2012;

Pope, Tabachnick & Keith-Spiegel, 1987; Wilbert & Fulero, 1988). Such approaches are

important, however, they operate at a rather superficial level not really getting to the core

of the issues that underlie the statistics. In order to gain additional insights into the

misconduct and malpractice phenomenon, an examination of court decision document

data for transgressing regulated counsellors was undertaken.

A thematic analysis of tribunal decision documents for a five-year period from

2008-13 (see Chapter 3) revealed several potential reasons for misconduct and

malpractice amongst registered psychologists. Explanations (or excuses or justifications)

offered by counsellors found guilty of charges included use and abuse of legal and illicit

substances and impairment due to mental disorders or unresolved trauma. The study also

found that men were not involved in misconduct or malpractice more often than women. This evidence contests a perceived risk factor that being male increases the likelihood of committing misconduct and malpractice (Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, 1983). In isolation these explanations are insufficient to create a condition for transgressing. In a related field of study, Finkhelor (1984) developed a four-factor model to explain the sexualised abuse of children. Finkhelor's model is of particular relevance here as the activities mimic, or can partially mimic, some of the suggested process involved in transgressing behaviours identified within the study in Chapter 3. Finkhelor's model suggests that in order for individuals to transgress he or she must meet four conditions: (a) be motivated to do so, (b) overcome internal inhibitions, (c) overcome any external constraints, and (d) overcome any resistance from the client.

Finkhelor's (1984) model may not be entirely appropriate in explaining all of counsellor transgression behaviours, because not all counsellors intend to transgress (Simon, 1989; Glass, 2003). Yet, for predators who do have intentions to breach boundaries, Finkhelor's model fits extremely well, as we seen next.

The evidence from the study in Chapter 3 suggests that some counsellors who transgressed [ab]used illicit and legal substances. These may have been as a form of 'encouragement' in overcoming internal inhibitions — the second stage in Finkhelor's model – an idea supported by Hetherington (2000). Explanations for transgressing behaviours provided to the courts may have been bilateral, first, potentially the removal of internal inhibitions, and second, the use of drugs and alcohol may provide a plausible excuse or reason for transgressing behaviours — 'the drugs made me do it' so to speak. As such, those who want to commit intentional misconduct and harm badly enough will simply go ahead and do it. They are not likely to turn to alcohol and drugs to help them

do it. However, being on alcohol or drugs may make them more likely to do it because their inhibitions down.

External constraints to transgressing, the third factor in Finkhelor's model, may be removed through the coordination and arrangement of isolation and privacy situations with clients. In several cases in Chapter 3, the use of drugs and alcohol with clients occurred in locations such as the homes of transgressing counsellors, or within the confines and privacy of the counselling rooms, or in social settings — cafes, bars and restaurants. This finding supports the previous work of Simon (1989) that exploitation of clients frequently occurs away from the counselling rooms. As such, these interactions within social or personal environments may somehow legitimise transgressing behaviours within the context of 'a relationship' (Hetherington, 2000). Inviting clients to social events might also be seen as a way of overcoming client resistance to counsellor advances. Overcoming client resistance is minimised by the counsellor through a 'selection process'. Counsellors can select clients (victims or prey) who are considered vulnerable. Indeed, the study in Chapter 3 found that the level of vulnerability of clients was a commonly occurring theme within the analysis. Jehu (1989) suggests that psychological pressure may be applied by counsellors in a physical or intimidatory way. Again the study in Chapter 3 supports this notion of threats of/and actual violence toward clients (and their families) as a mechanism to secure client compliance.

the thematic analysis in Chapter 3 also uncovered several underlying constructs for transgressing counsellors that coalesced into three themes: the externalisation of responsibility for personal actions and behaviours, a lack of objectivity concerning why such behaviours occurred, and an inability to understand how personal circumstance — including mental health — affected the provision of ethical services to clients. Each shall be discussed in turn next.

The first theme, the externalisation of responsibility for transgressing behaviour, is a common theme in the literature, often relating to the shame and guilt offenders experience following apprehension (Proeve & Howells, 2002), which in turn can result in a decrease in self-efficacy. As such, those counsellors who transgress may externalise, or blame, other people or factors for their actions in an attempt to protect their self-concept. As shown in Chapters 4 and 5, self-enhancement (the acquisition of positive feedback) is useful in maintaining or improving psychological health when grappling with challenging life events (Taylor & Sherman, 2008).

The second theme arising from the analysis in Chapter 3, that a 'lack of objectivity' is commonly associated with misconduct and malpractice behaviours, is not a new finding (Everall & Paulson, 2004). Counsellors who lack objectivity are at increased risk of breaching ethical boundaries (Everall & Paulson, 2004). Within the therapeutic alliance, the counsellor needs to be aware of matters relating to intimacy, and avoid behaviour that degrades or vilifies a client. Counsellors should not use their positional power to manipulate or control the lives of clients (Meiselman, 1990). Further, it is important for counsellors to ensure awareness of the warning signs that signal the possibility of a breakdown in the provision of ethical service (Meiselman, 1990). This breakdown may be associated with the third theme, an inability to understand how personal circumstance affects performance. Evidence suggests that counsellors may ignore, avoid, and/or diminish awareness of personal problems, creating a blind spot (Goleman, 1998) — an inability to recognise (objectively) an individual's current state of wellbeing. Thus a counsellor may be unable to self-reflect or ignore codes of conduct and continue to practice. An inability to understand that personal circumstances impact upon the provision of services is detrimental to the counsellor, the client and the wider industry.

In order to support a minority of those who transgress, further research is required into 'counsellor's objective assessment'. Such research could seek to understand how counsellors view their own needs — including seeking the support of others in order to more critically evaluate what is moral and ethically right — and the needs of their clients. The study presented in Chapter 3 has two significant limitations, first it is retrospective in nature and second, it relies on information provided for purposes not related to research. Thus is not an ideal source of data, however, given that defendant counsellors are under oath and the evidence is collected they are presumably more honest and fully disclosing than if the author were to interview or survey them. A better method, for future research, would be to examine the court decisions documents and then interview the counsellors directly after proceedings are concluded. This is likely the time that they will feel they have nothing left to lose in talking with a researcher. Such a method could be court mandated as part of the restitution – aiding both the professional and the wider community that make up the profession. Such additional steps might improve an understanding of the warning signs and aid in deterring counsellors contemplating transgressing behaviour.

Aim 3: *Develop a theory to explain the relationship between a counsellor's unresolved trauma and their increased risk of misconduct and malpractice.*

Following an extensive review of the literature, in Chapter 5 it was argued that a counsellor's unresolved trauma can interfere with their ability to provide objective and effective support to clients. Unresolved trauma was one of the factors noted as a potential causal mechanism in court decision documents of counsellors found guilty of transgressing against client/s (see Chapter 3). This finding is consistent with previous research (Gabbard & Celenza, 2003; Duncan & Miller, 2008; Geldard & Geldard, 2009;

Simon, 1989). Therefore, given the available research in the literature and supporting

evidence for the studies within this thesis, it is a plausible theory that a counsellor's

unresolved trauma is associated with misconduct and malpractice.

A suggested avenue through which an increased risk of transgressing behaviours

might occur includes interactions with clients which may trigger thoughts and emotions

related to unresolved trauma issues within the counsellor (Williams, Judge, Hill &

Hoffman, 1997). It is argued that this activation may result in a form of trauma-

reactivation and result in a divergence between the counsellor's personal motivations for

practising counselling — which might include attending to personal concerns — and

support for clients with their presenting concerns. Counsellors failing to meet personal

needs appropriately may become enmeshed with a client. That is, they may become

overly involved and cross boundaries (Everall & Paulson, 2004).

A counsellors' unresolved trauma may interfere with aspects of the self-concept in

turn affecting clarity in judgment. The self-concept is bolstered and reinforced by identity

feedback, specifically self-enhancement, which increases positivity and decreases

negativity of the self-concept (Leary, 2007; Snyder, Stephan, & Rosenfield, 1976). In

other words, the consumption of self-referent information gained through social

interactions enhances the counsellor's identity, protecting them against their trauma

(Sedikides & Strube, 1995).

A hallmark of social identity feedback is the use of social comparison, especially

comparisons with other individuals that allow an individual to place 'the self' in a

favourable position (Brown, 1991). Gaining a client's 'favour' may result in crossing

boundaries, or potentially violating them, in pursuit of self-reinforcing feedback that

bolsters the self-concept. Bolstering the self-concept is often seen as a defensive strategy

that can mitigate or reduce posttraumatic symptoms, including unresolved trauma

(Pyszczynski, Greenberg, Solomon & Schimel, 2004; Taylor & Sherman, 2008). An important conclusion from Chapters 4 and 5 was the further refinement of the concept of identity feedback as a mediator variable, which may provide greater clarity in explaining the direct relationship between unresolved trauma and behaviours in practice that may result in misconduct and malpractice.

The next three aims are all related, therefore they have been grouped together. Aim 4 was to construct a model explaining potential mechanisms for misconduct and malpractice behaviours. Aims 5 and 6 relate to studies that test various components of the developed model in order to provide evidence in support of the theory underlying for the model. They are discussed next.

Aim 4: *Construct a model to explain the mechanisms of misconduct and malpractice.*

A multifactor model (see Chapter 6) may assist in explaining the interaction of several identified variables (e.g. unresolved trauma and identity) in counsellor misconduct and malpractice. The model did not attempt to explain all possible variants of misconduct and malpractice behaviour, rather explored the nature of the behaviour from a very specific perspective, related to posttraumatic stressors and how they are likely to be processed. The model is revisited later in this Chapter providing a refresher before proceeding with a demonstration of how the multifactor model works.

Aim five: *Understand if differences exist between regulated and unregulated counselling professionals on measures of their ethical attitudes and behaviours.*

The study in Chapter 7 explored differences in attitudes and behaviour toward ethical and unethical conduct between members of a regulated profession, such as

psychiatrists and psychologists, and members of unregulated professional bodies, including general practice counsellors and psychotherapists. Participants comprised 419 Australian counsellors responding to an online questionnaire. A considerable focus on the argument for regulation is that regulation protects the public. In order to provide a validation to the assertion that other factors are involved, the following hypothesis was tested.

Hypothesis 2: *That factors other than regulation are involved in ethical behaviours, then there should be no differences between regulated and unregulated counsellors and what they understand constitutes unethical and ethical behaviours in practice.*

Evidence from the study in Chapter 7 supported the hypothesis that factors other than regulation and codes of conduct appear to be involved in counsellors acting in ethical and unethical ways. It is more likely that other factors, which may include moral reasoning and decision-making, and others associated with personal qualities within the individual such as locus of control, economic value orientation, political value orientation, Machiavellianism and moral cognitive development (Hegarty & Sims, 1978; Trevino & Youngblood, 1990), are likely to be in part responsible for ethical attitudes and behaviours.

Whilst these factors are likely responsible for such behaviours in any individual, the question remains; are regulated counsellors less likely to be motivated by these factors — due to training, education and governmental regulation — compared to those in an unregulated environment. The evidence suggests that education and training, industry governance, association rules and compliance strategies and the over-arching governmental regulation — where applicable — appears to have little or no impact on the

counsellor's attitudes with respect to what they consider to be unethical behaviours in practice. It appears that knowing and promising to follow a particular code of behaviour does not always guarantee adherence. It is conceivable that non-compliance to codes of conduct may be intentional, premeditated and entirely deliberate to take advantage of the client. In other cases, malicious forethought may not have been present.

Aim six: *Explore whether identity feedback mechanisms (self-enhancement and self-verification) mediate the relationship between unresolved trauma and counsellor's attitudes toward boundary crossings and violations.*

Chapter 8 explored whether identity feedback mechanisms (self-enhancement and self-verification) mediate the relationship between unresolved trauma and counsellor attitudes toward boundary crossings and violations. Participants in the study were 419 Australian counsellors, 91 of whom indicated unresolved trauma, of which 71 then completed three measures exploring posttraumatic stress disorder, identity feedback, and ethical behaviours in practice.

Hypothesis 3: that the relationship between unresolved trauma and client boundary crossings and violations would be mediated by self-enhancement and self-verification.

A mediation analysis provided partial support for the hypothesis. The direct relationship between unresolved trauma and attitudes toward boundary crossings and violations was mediated by self-enhancement but not self-verification. The results from that study indicated the relationship between unresolved trauma and attitudes toward boundary crossings and violations is mediated indirectly via a need to self-enhance, or seek out positive feedback with a medium effect. Participants with higher scores on the posttraumatic stress screen were likely to seek out self-enhancing positive feedback. This,

potentially, is due to them wanting to be seen in a positive light by others. As such, this behaviour might form part of a strategy to maintain a healthy level of self-esteem (Sedikides & Strube, 1995).

These counsellors may have more relaxed attitudes toward crossing boundaries to secure 'favour' from the client. For example, a counsellor may establish a social relationship with a client in parallel to the therapeutic relationship to garner self-enhancing feedback, creating a dual relationship situation — which has been identified as one of the more common factors associated with misconduct and malpractice cases (see Chapters 2 & 3).

The crucial finding from this study was the suggestion that counsellors with unresolved trauma appear to need increased amounts of positive feedback, perhaps as a protective mechanism to reduce trauma-related stress. However, this need may come at a considerable cost, because during the process of harvesting sufficient self-enhancing feedback counsellors may also transgress boundaries, potentially placing client welfare at risk. This, in turn, may lead to misconduct and malpractice behaviours.

A major limitation associated with the study in Chapter 8 is that it tests a mediation model at a single point in time, which is a cross-sectional research design. As such, the findings are not representative of what might occur over a longer period. Therefore, future research could look at longitudinal research designs to confirm the findings in this thesis.

Following the empirical testing of components within the developed multifactor model, it is now possible to understand the possible relationships and interplay of variables given the impacts of unresolved trauma. However, before we examine potential pathways we revisit the initial model next as a refresher.

Revisiting the model of a functional counselling practitioner

Experiencing a trauma plays a role in many individuals training to become a counsellor. An estimated 60% of counselling professionals in Australia experienced significant trauma at some point before becoming a counselling practitioner (see Chapter 5). Counsellors cited the following reasons for entry: to assist others, because they value relationships with clients, and having empathy for those undertaking a personal growth journey.

A portion of counsellors expressed a desire to resolve personal trauma. It is estimated 20%, of counsellors may currently be experiencing the continuing effects of trauma (see Chapter 5). This unresolved trauma may impact on their capacity to provide ethical counselling services to clients. In order to better understand how this might occur we need to explore the mechanisms or pathways within the proposed multifactor model (see Chapter 6). As a matter of convenience, the multifactor model presented earlier in Chapter 6 is duplicated here (for comparative purposes) – see Figure 8 for a representation of a functional counselling practitioner.
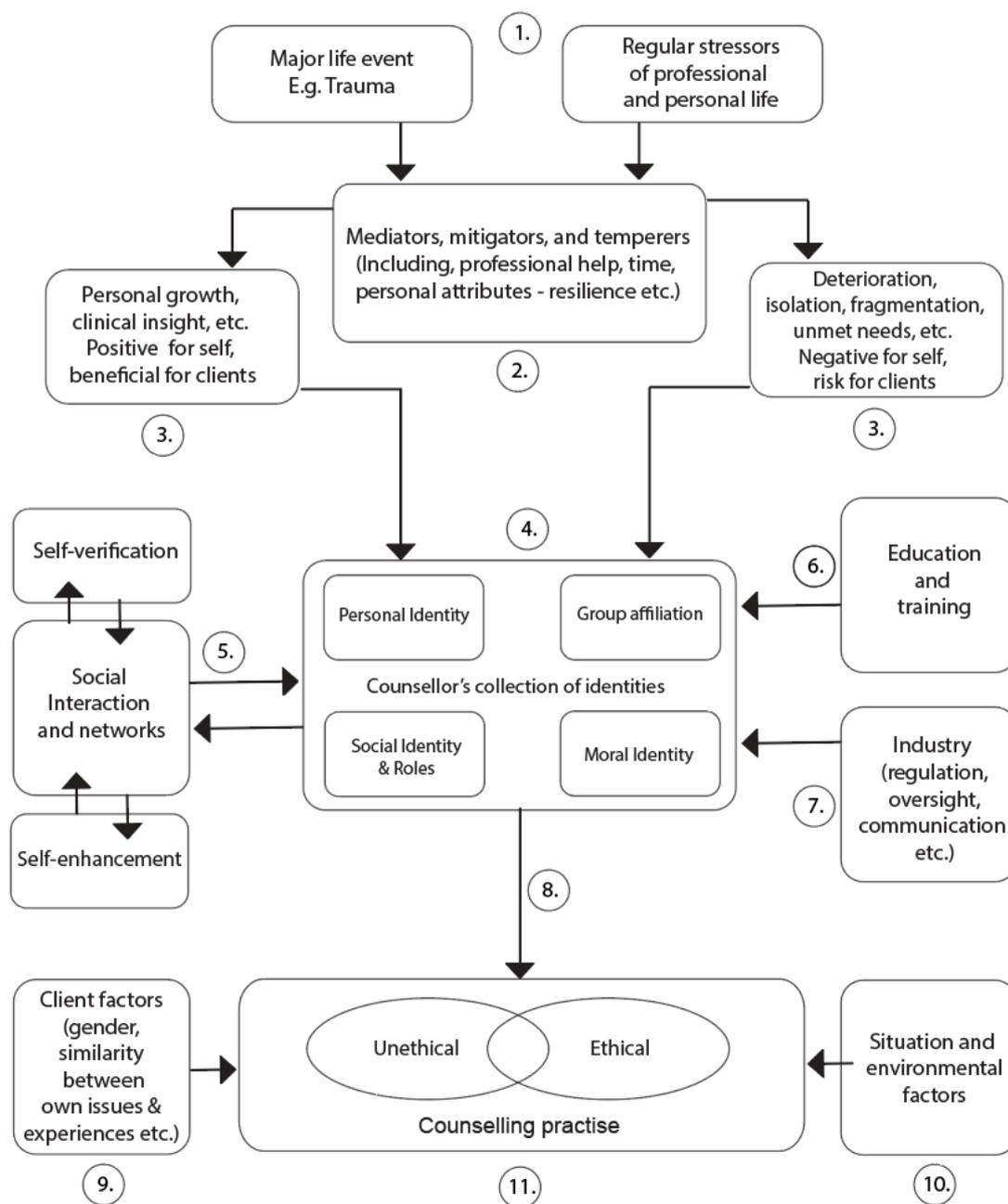
Figure 8. Model of a functional counselling practitioner

In brief, the model depicts how events, including experiencing trauma, have an impact on identity. It is suggested that counsellors use a range of mitigating and tempering processes to resolve significant life events (1 & 2). Serious life events and their effects can be useful, or deleterious, to counselling practice depending on their influence

(3). The resolution, or not, of traumatic events influence the counsellor's collective

identities including those specifically relating to practicing as a counsellor – personal,

social and moral identities along with group affiliation are included (4). Social processes,

self-enhancement and self-verification are employed to garner feedback from the social

world, continually confirming and bolstering identity and self-concept (5). Interactions

with clients are influenced by client factors (9), but also environmental and situational

factors (10). These might include the client's perceived strength, or vulnerability, and the

relationship between their presenting concerns and the counsellor's own issues — biases

and other concerns they bring into the working alliance. Behaviours in practice may be

ethical or unethical, or occupy a grey overlapping zone in which subjective evaluation

determines the ethical nature of the counsellor's actions (11).

Interaction of variables within the multifactor model

The proceeding version of the model (Figure 9) highlights — in red — the

impacted components that potentially influence the delivery of effective therapeutic

services to clients.
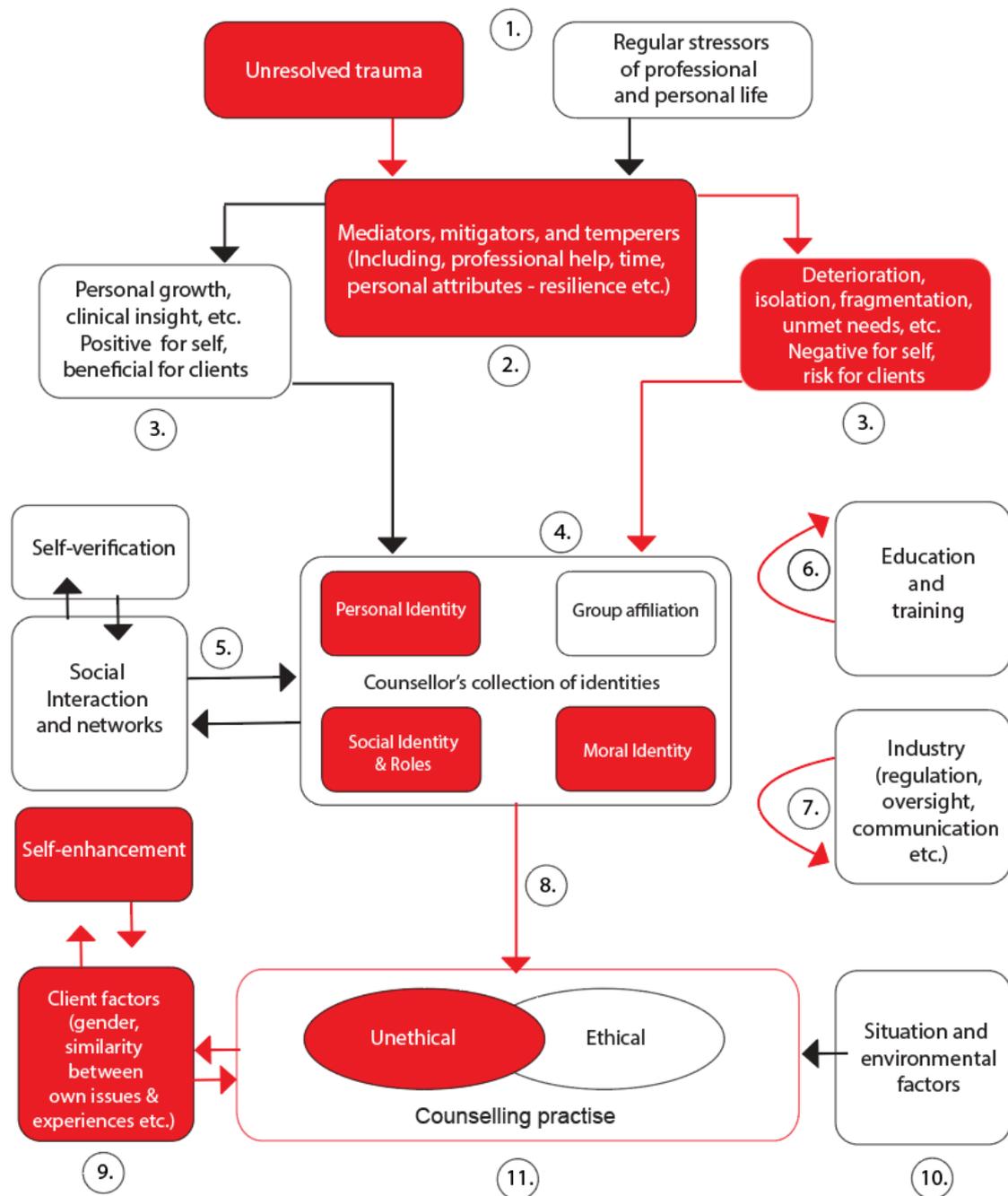
Figure 9. Suggested pathway in the multifactor model for counsellors with unresolved trauma

In this version of the multifactor model, attempts to resolve traumatic experience are dysfunctional. unresolved trauma compounded by everyday stressors both a personal and work related leads to unmet needs, isolation and estrangement from others, including family members (Kotler, 1993; Racusin, Abramowitz & Winter, 1981). Such separation

from social and family networks affects identity. mediators and mitigators are ineffective (2). The mechanism for the successful mitigation of negative personal events is absent, as a result the counsellor's well-being is under threat. This has specific implications for clients, as the methods employed by the counsellor to deal with personal unmet needs may impact upon the delivery of effective counselling services (3.) and upon the counsellor's collection of identity, specifically social roles and moral identity.

Within the identities component (4), personal and social identity factors may be affected by the ongoing tension between the individual continuing to operate as a counsellor AND attempting to resolve the effects of unresolved trauma. The social roles clients might then play — validating the counsellor's social identity — becomes confused, creating a split in the objectives for therapy. This split represents differences in goals between those of the client and those of the counsellor. The turmoil created as the counsellor struggles for improved wellbeing creates a moral tension which may influence moral identity. This influences behaviours concerning what is considered right or wrong, good or bad, helpful and unhelpful. Personal and social identity is constantly reinforced, verified, and enhanced through feedback and communication from interacting with others (Swann, 1986; 1987). Trauma-effected counsellors may substitute social interactions and networks that typically occur outside of their role as a counsellor (acting as a healing mechanism) and use the therapeutic relationship to fulfil personal needs (see Witmer & Young, 1996), thus creating a split — a divergence in the intended purpose of a *client-led-goal-oriented* working alliance.

A tension, or intrapersonal conflict (Lewin, 1939), exists within the counsellor between the provision of therapeutic services for the client's benefit and the need to resolve the persistent effects of trauma (for the counsellor's benefit). The social roles that clients traditionally play (being the client) under this new model alter significantly,

transforming into something other than for the benefit of the client. Counsellors failing to meet personal needs appropriately may become enmeshed with clients (Everall & Paulson, 2004). That is, they become entangled or intertwined with the client, which obscures boundaries leading to issues with personal and professional separation. If left unchecked, violating professional boundaries may create a dual relationship situation. For afflicted counsellors, this tension is likely to exacerbate pre-existing problems due to the stress created by holding two conflicting roles at the same time (Everall & Paulson, 2004), creating a cognitive dissonance (Festinger, 1957) making ethical decision making more complex and more difficult.

The model suggests that traumatised counsellors might be motivated to secure identity feedback which is garnered from client interactions in therapy (5). Identity feedback is related to behaviours that motivate individuals to reinforce or bolster a pre-existing self-concept (Bloch, 2004). Counsellors may desire others see him or her as they see themselves, and in doing so they can create a condition in which they feel valued and satisfied (Swann, 1986; 1987). Self-enhancement concerns the counsellor's attempts to gather positive feedback, thus being seen in a positive light in order to maintain a healthy level of self-esteem (Leary, 2007). For example, a counsellor may focus on engaging with the client so that the client views the counsellor in the best way possible. This may be at the expense of the counsellor focusing on the best interests of the client.

The model allows for how industry regulation and codes of conduct (regulated and unregulated) have little or no influence on the counsellor (6). Likewise, the counsellor's level of education and training is not likely to be a sufficient deterrent of unethical behaviours (7). Interactions with clients might now shift in focus, thus seeking to fulfil the counsellor's needs for self-verification and self-enhancement, potentially at the client's expense. Clients become a convenient substitute for the counsellor's social

interaction and networks that may have been abandoned (or might never have existed) due to isolation and estrangement as they grapple with personal trauma.

Client factors (9) may now serve as a trigger for unethical behaviour. For example, the client might have a similar problem to the counsellor, conjuring strong emotions in the counsellor that require considerable effort and time to process and resolve. In therapy, the focus turns from the client oriented goals toward the counsellor objectives. This split in the purpose of the working alliance may result in afflicted counsellors neglecting the wellbeing of the client in pursuit of personal remedies for the emotional/mental health situation in which they find themselves. The model also suggests that some counsellors, potentially using clients as a personal consult, attempt to resolve personal issues through a process of self-enhancement. Evidence from the study in Chapter 8 and from a review of the literature support this notion of self-enhancement as a factor that assists in clarifying the relationship between counsellors' unresolved trauma and the potential for a greater risk of boundary crossings and violations.

An important component in this model is how counsellors resolve personal problems. First, the types of concerns that clients present with in therapy may exacerbate the counsellor's problems. it is known that counsellors working with clients with deep psychological and demanding problems are susceptible to Secondary Traumatic Stress (STS; Iliffe & Steed, 2000) and/or emotional duress from hearing firsthand the client's trauma experiences. Second, clients recounting events relating a trauma, similar to the counsellor's trauma may trigger strong emotions (transference and counter-transference), exacerbating underlining concerns. Third, depending on the severity of the clients' problems, counsellors might evaluate the level of client strength, or weakness, seizing on an opportunity to exploit the client for personal gain.

In order to acquire sufficient identity feedback, counsellors may be motivated to relax professional and personal boundaries with clients in therapy, leading to unethical practise (11). Such relaxations might include over-sharing, or excessive disclosure, of personal information and/or engaging in social activities with clients. Taking advantage of the captive audience, it is argued, allows counsellors with unresolved trauma the potential to derive selfish gains in the fulfilment of personal needs. The concept of 'needs' in this sense equates to leveraging the therapeutic process to resolve personal vulnerabilities and problems. If left unchecked, such a strategy may see the counsellor gradually slide down a slippery slope into misconduct and malpractice behaviours (Gabbard, 1996; Glass, 2003). In order to understand the reliability of the model and its relevance to an actual case, the model is applied to the case of Allan Keith Huggins next.

Application of the model: The case study of Allan Keith Huggins

Allan Keith Huggins was a 68-year-old former counsellor found guilty of 16 child sexual abuse charges committed while he ran a program at a school in Western Australia (Menagh, 2015). Six victims, all boys aged 13 to 17, attended the school whilst a seventh boy was a private counselling client. Huggins falsified a qualification on his Curriculum Vitae, an Advanced Diploma in Adolescent Development and Counselling from the University of London (Offer, 2015), and a number of other qualifications still require verification - a Master's Degree in Adolescent Psychopathology from Manchester University and a Certificate in Teaching from the University of New England. The acts of abuse perpetrated against the young boys occurred over 25 years ago (circa 1990).

In early 2008 Huggins ran a national campaign to encourage people to report sexual abuse. One of Huggins' victims discovered he was still working as a counsellor and lodged a complaint with the Australian Counselling Association (ACA; Offer, 2015). Huggins wrote an apology to the victim, via the ACA, in June 2008, in part admitting to

and acknowledging that "it is entirely possible that these allegations have substance"

however he could not recollect the incident (Offer, 2015). The ACA advised that "Allan

Huggins was a registered ACA member up until February 2, 2009, and he was

deregistered due to a series of complaints made against him" (Armstrong 2015, in Offer,

2015).

During the trial for the sexual abuse charges, evidence was presented including

that the victims, all troubled boys, were groomed by Huggins. Boys were massaged as

Huggins attempted to masturbate and penetrate them. One boy was told that in return for

oral sex all his problems would go away (Menagh, 2015). Huggins pleaded not guilty to

the charges, admitting only to the abuse relating to the notification made against him in

2008. In that particular case Huggins cited a number of mitigating factors, including that

he was coming to terms with his own abuse at the hands of teenage boys when he was

aged between seven and 12 years (Offer, 2015). Judge Sweeney said that psychological

reports found that Huggins displayed narcissistic and grandiose personality traits. Judge

Sweeney accepted that one of the factors underlying his offending was a repression of his

sexuality coupled with depression (Menagh, 2015). Given the facts of the case, the author

has applied the components to the model and highlighted the elements that have been

activated. Figure 10 provides the Huggins version of the multifactor model.
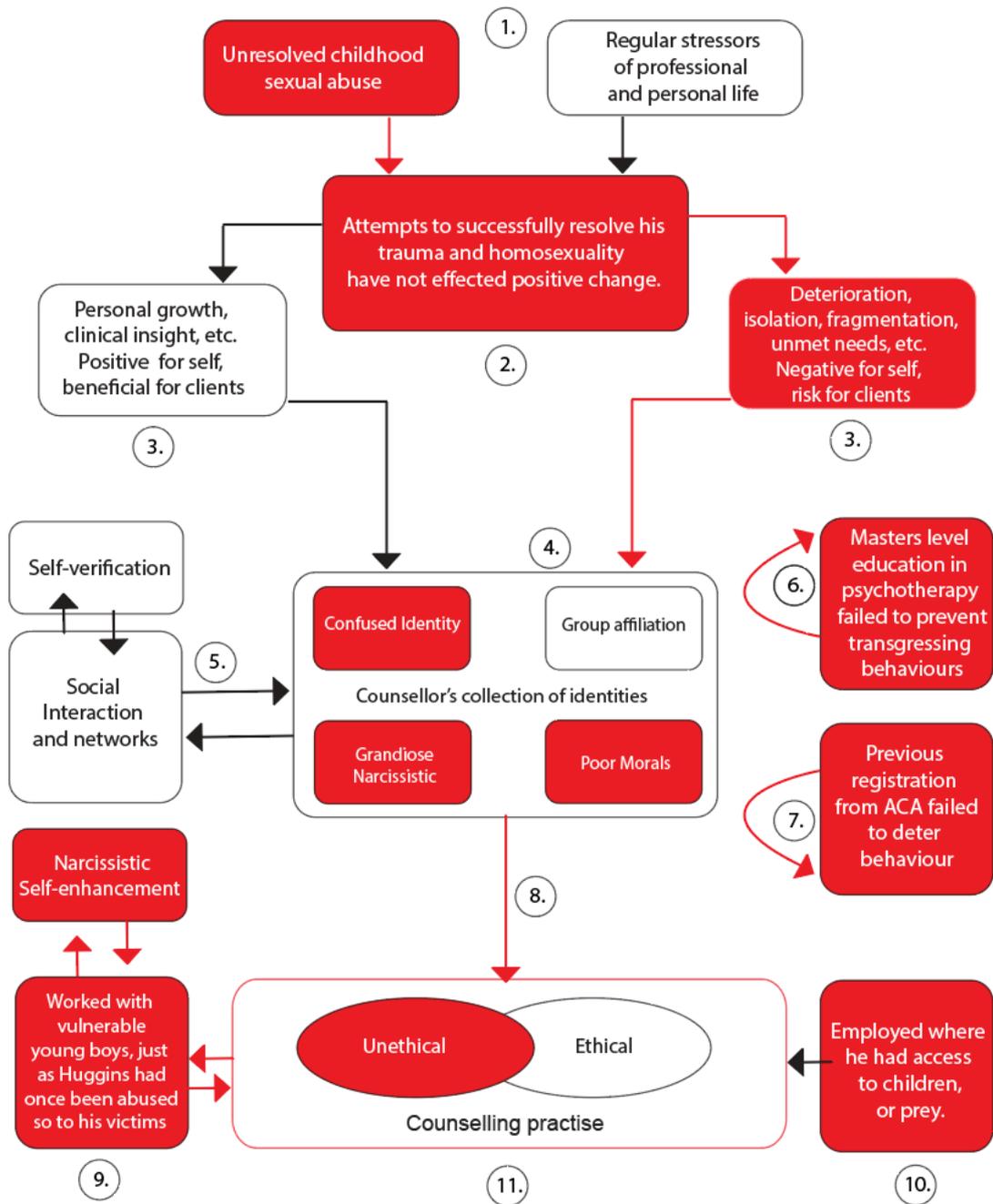
Figure 10. Huggins case and the multifactor model

Whilst a single case study does not confirm or substantiate a theory, this case does illustrate a number of important ideas highlighted within the multifactor model presented in this thesis. First, not only does Huggins describe a traumatic life event (childhood sexual abuse) occurring in his past (1) but he also recounts his considerable struggles to

deal with his (unresolved) trauma and consequential sexual orientation (homosexuality) as a result of the event (2). Huggins spoke of his desire to repress his sexuality and trying to come to terms with his suffering of abuse (3). In order to resolve some portion of his trauma it is likely his identity that was impacted by its continuing unresolved trauma (4). It is equally likely that he acted in such a manner as to satisfy his identified narcissistic and grandiose tendencies.

The case does not specifically address the matter of social identity feedback, namely self-enhancement, narcissistic and grandiose personality traits are often associated with the requirement for a heightened of admiration from others. Indeed, individuals with elevated narcissistic tendencies use self-enhancement strategies (5) to increase self-enhancing feedback relative to nonnarcissists (Raskin, Novacek, & Hogan, 1991; Campbell, Reeder, Sedikides & Elliot, 2000; Wallace, 2011). Huggins transgressed ethical bounds (11).

The area in which Huggins practiced counselling was within the same field in which Huggins' trauma was experienced, working with troubled children (9). Whilst Huggins' intention might have initially been to assist children in need of support, like he required so many years ago, some of his clientele eventually became his victims. Huggins had entered into a 'victim-to-victimiser' cycle (Hilton & Mezey, 1996) that Knopp (1984) suggests is particularly common in paedophiles who prefer boys as targets. Judge Sweeney stated, "You actively sought out positions that put you in positions of trust over young boys, and you took no steps to remove yourself from temptation" (Sweeney 2015, in Menagh, 2015, para. 7). It was possible that Huggins' inability to deal with his personal problems significantly impacted his ability to be an effective counsellor.

The full details of the case have been suppressed to protect the victims. However, it was known that towards the end of his career Huggins was a member of the Australian

Counselling Association. As such, he committed to a code of conduct specified by that association. However, this did not dissuade Huggins from doing wrong (7). Members of the association are required to have a certain level of training and education and undertake regular supervision and professional development each year. This too had little effect on his actions (6).

It is not known if at the time the offences occurred Huggins was a member of an industry association or even if he was qualified for any education degree or training that he proclaimed on his Curriculum Vitae. Regardless, Huggins worked within the Pallister Young People's Program at Greenwich Hospital on Sydney's North Shore where he practiced counselling. Working within a hospital environment presumably Huggins would have made a commitment to do no harm, to support clients rather than (as was the case with Mr Nolan, a victim) abuse clients, especially children. It appears that Huggins' motivations and unethical behaviours transcend any education completed –imagined or actual - and any codes of conduct (Australian Counselling Association, 2014) that he may have undertaken an oath to uphold.

An important component of this thesis is to provide counselling practitioners with some prudent guidance concerning how to best address the potential negative consequences of working with clients whilst attempting to resolve personal trauma. In the following chapter, the author discusses the practical implications and specific recommendations from the findings of the various studies and a review of relevant literature within the thesis.

Chapter 9b: Practical applications

Many counsellors enter the profession as part of a healing process after experiencing a traumatic episode in their own lives. While that experience, it is argued, may provide them with insight and a heightened sense of empathy (Jung, 1951), if the counsellor has not reached a state of psychological resolution they may be at increased risk of violating ethical boundaries. Counsellors' awareness of risk factors associated with unresolved trauma is vital for their own and client wellbeing. Ultimately, it is the counsellor's responsibility to ensure adequate self-care by seeking guidance and support once problems arise.

This chapter explores the practical implications of the research findings and is intended to assist in reducing incidences of transgression behaviour. This chapter builds on Chapters 2 to 8, like Chapter 9a did, however while Chapter 9a focused on drawing together the PhD program as a research project, Chapter 9b pulls together the applied project with direct and immediate implications for practice. Thus the remainder of this chapter introduces and explores a concept called Ethical Intelligence, first put forward by Pope and Vasquez (2016), but extended here with a particular focus on unresolved trauma – a focal point of this thesis. It then considers the 'counselling enterprise' of providing counselling services to clients, however in a systematic manner that allows for more thoughtful targeting of interventions. Again, unresolved trauma will be used as an example.

Ethical intelligence

Regulated and unregulated counsellors aligned with industry association promise to uphold ethical standards. Further, to gain entry as a member of any counselling association, these counsellors are required to undertake studies in counselling which include codes of conduct in practice. Yet, despite this training transgressions still occur. It

is likely that more education is not going to improve the situation. A new way forward is required.

A concept that may be of value is called Ethical Intelligence. Ethical Intelligence is "an active process of continuous awareness that involves constant questioning and personal responsibility" (Pope & Vasquez, 2016, p. 2). The application of ethical intelligence includes developing an ability to recognise when emotional states (e.g. anxiety, distress, impairment) might impact upon professional practice. An awareness of such concerns might be the result of communication received from a colleague, family member or supervisor that a counsellor requires psychological support. It is important for the counsellor to then act upon such information. Take, for example, a counsellor disclosing to another counsellor or supervisor that they have experienced an activation of feelings associated with their trauma history when working with a client. The colleague or supervisor might suggest that seeking help could be beneficial. This would go some way to ensuring adequate self-care would result in improved wellbeing for the counsellor. Also, this would allow the counsellor to care for others. Such critical awareness of the counsellor's personal circumstance might result from self-reflective practice, which is discussed next.

Self-reflective practice

Counsellors ought to be aware of the intersection between their personal and professional life and the degree to which they overlap. This is an important component within the Pope and Vasquez (2016) model for developing ethical intelligence. Also in support of such an approach, the American Psychological Association's (2008) code of ethics is very specific that it is the therapist's responsibility to ensure that personal problems (including unresolved trauma) or conflicts do not interfere with an ability to provide effective and ethical services. Counsellors require a strong degree of self-

awareness and self-reflection. It is important to ensure that client welfare is maintained as the primary objective of counselling. Engaging in self-reflectivity is a good way to ensure objectivity in professional decision making and assessment in practice.

Self-reflective practice is mainly concerned with 'self-development' and often confused with 'reflection'. It is neither an individual activity nor a relaxation or meditative process (Osterman & Kottkamp, 1993). Self-reflective practice is an active process involving a number of individuals. Typically, a supervisor works with a supervisee developing an improved level of self-awareness about their performance as a counsellor. This creates opportunities for ongoing personal and professional development (Osterman & Kottkamp, 1993). Professionals who engage in 'reflection', and not reflective practice, may engage in self-deceptive thinking by missing critical elements of their practise. This may include an inability to detect unethical behaviours or to recognise issues that may impact upon performance, such as unresolved trauma. Counsellors who engage in self-reflective practice find it a critical component in evaluating personal performance and how this influences client welfare (Osterman & Kottkamp, 1993). Such evaluations should extend to an awareness and ability to resolve ethical dilemmas.

Ethical decision-making model

A suggested process for counsellors to develop the necessary skill for ethical decision-making, according to De las Fuentes, Willmuth and Yarrow (2005), is to appraise and adopt one's own ethical decision-making model. The idea is that a counsellor will apply this 'personal model' (with integrity) covering all aspects of their personal and professional activities. Counsellors engaging with and building-up personal models will improve or increase ethical intelligence (Pope & Vasquez, 2016). Thus, recognising and being critically aware of ethical and legal dilemmas, including the identification of dilemmas through research and in consultation with colleagues and

supervisors. The counsellor should be able to reconcile conflicts between various codes and laws related to their specific counselling profession.

Seven-step process for resolving ethical dilemmas

There are a number of specific recommendations for counsellors to resolve ethical dilemmas. Forster-Miller and Davis (1996) incorporated the work of Van Hoose and Paradise (1979), Kitchener (1984), Stadler (1986), Haas and Malouf (1989), Forester-Miller and Rubenstein (1992), and Sileo and Kopala (1993) and constructed a seven step ethical decision-making model.

The model includes seven stages, or steps, allowing counsellors to deconstruct the ethical dilemma and provide a scaffold to work through situations logically and carefully. The seven steps are; 1) for counsellors to identify the problem, 2) apply a code of ethics, 3) make a determination about the nature and complexities of the dilemma, 4) generate a potential a set of potential courses of action, 5) consider the potential consequences of all options and choose a course of action, 6) evaluate the selected course of action, and finally 7) implement that course of action. Each of these stages/steps shall be discussed in greater detail next.

1. **Identify the problem**

In identifying the problem counsellors attempt to gather as much specific information about the circumstances of the situation as possible. It is important to remain objective and professional throughout this information gathering process. It may assist counsellors to write down ideas about the situation in order to gain clarity. Outline only the facts in the case and separate out any innuendo, assumptions, hypotheses, or suspicions. Determine if the nature of the problem is ethical, legal professional or clinical, or maybe it is a combination of multiple conditions. If the problem is legal in nature, counsellors should seek suitable legal advice.

Counsellors should take a few moments to think about the role they play within the situation. How does the situation relate to the client/s and other significant parties? Does the organisation you work for have operating procedures or policies that require action within a specified period? Does company policy require you to make a report concerning the situation? Viewing an ethical problem through several viewing lenses, or frames of reference, may also assist in highly complex situations. The usefulness of well-kept and well maintained client records and case notes will serve counsellors well in times in which problems arise.

2. **Apply a relevant code of ethics.**

With the problem now clearly defined and all available information at your fingertips, counsellors are encouraged to read the most relevant code of ethics and try to find if the issue is addressed there. If the matter/s are addressed within the code of ethics there may be a set of specific actions to follow, and typically, this will lead to a resolution of the matter. In order to apply the ethical standards, it is essential that a thorough understanding of the implications for all parties concerned be achieved. Should the problem be more complex and a resolution is not clear, counsellors may be faced with a true ethical dilemma and need to continue with the following steps.

3. **Determine the nature and dimensions of the dilemma**

Several avenues may be followed ensuring maximal understanding of the various dimensions in the matter. Consider the moral principles of autonomy, non-maleficence, beneficence, justice, and fidelity. Decide which principles apply to the specific situation, and determine which principle takes priority in this case. In theory, each principle is of equal value, which means a challenge to determine the priorities when two or more of them are in conflict. Review the relevant professional literature to ensure use of the most current professional thinking in reaching a decision. Consult with experienced

professional colleagues and/or supervisors, as they will review the information gathered

and may see other issues that are relevant or provide a perspective not yet considered.

They may also be able to identify aspects of the dilemma not being viewing objectively.

Consult state or national professional associations to see if they can provide help with the

dilemma.

4. **Generate potential courses of action**

The creation of 'mind maps', or brainstorming ideas, to determine possible

courses of action may assist in this process. Remember to be creative and enlist the

support of others in generating options.

5. **Consider the potential consequences the course of action**

Considering all the information you have gathered and the actions and priorities

you have set, make a list of the possible consequences arising from each course of action.

Consider all parties, including you, in this process. Remove any options that you believe

will not provide the desired result and may in fact exacerbate the problem further.

6. **Evaluate the selected course of action**

Review the selected course of action. Stadler (1986) suggests applying three

simple tests to ensure the appropriateness of the selected course. Apply the test of justice,

assessing the fairness by determining how you would treat others in the same situation.

Apply the test of publicity, ask yourself whether you would want your behaviour reported

in the press, and finally the test of universality, ask yourself whether you could

recommend that same course of action to another professional in a similar situation. If,

when assessing the course of action, more ethical concerns are raised, then starting the

entire process over carefully re-evaluating each step may be required. If you believe that

you have arrived at a solution that ticks all the boxes, then you are ready to move to

implementation.

7. Implement the chosen course of action

This last step is often difficult and sometimes requires great courage and strength. After the implementation process, it is often a good idea to follow-up on the situation to assess if your actions had the anticipated effect and consequences. Van Hoose and Paradise (1979, p. 58) suggest that a counsellor "is probably acting in an ethically responsible way concerning a client if (1) he or she has maintained personal and professional honesty, coupled with (2) the best interests of the client, (3) without malice or personal gain, and (4) can justify his or her actions as the best judgment of what should be done based upon the current state of the profession".

An example

In the first instance, the counsellor is required to identify the problem. This might be that the continuing effects of unresolved trauma are impacting upon the counsellor's ability to support clients because they are too distressed to do so. In applying the ACA (2012, p. 13) code of ethics, "Counsellors will monitor their functioning and will not counsel when their functioning is impaired…by personal or emotional difficulty, or illness, counsellors will monitor the point at which they are no longer competent to practice and take action accordingly". As such, the counsellor must make a determination about the nature of the dilemma, which in this example is impairment due to unresolved trauma, and set about generating a set of potential courses of action. Such actions are likely to include cessation of work, a thorough handover of clients, seek professional support, as well as consulting with their supervisor. Upon evaluating the potential consequences of all options they choose a course of action and implement that course of action.

Given the multitude of factors involved in and related to an individual's development and the creation/development of moral behaviour, it is naïve to assume that

training and education programs alone are completely responsible for the moral character

of students and graduated practitioners (De Las Fuentes, Willmuth & Yarrow, 2005;

Narvaez, & Lapsley, 2014). Like most developmental processes, moral character

develops over time and usually within a framework, which can be set by training and

education organisations. This will allow counsellors to make choices concerning

character development through professional/training experience and enculturation. Thus,

newly graduated counsellors will have the best opportunity to develop and understand the

norms and values of ethical counselling culture (Narvaez, & Lapsley, 2014). However,

there is a wider industry context to be considered in terms of prevention and intervention

to arrest and stop misconduct and malpractice. This shall be considered next.

Implementation of prevention and intervention strategies

The core topic of this thesis is interactions between counsellors with unresolved

trauma and their clients. As such, the following is a list of interactions to be considered

when considering prevention. These interactions have been categorised according to their

distance from the client. Figure 11 provides a diagram of the associated relationship

between these interactions relative to the client in the centre.
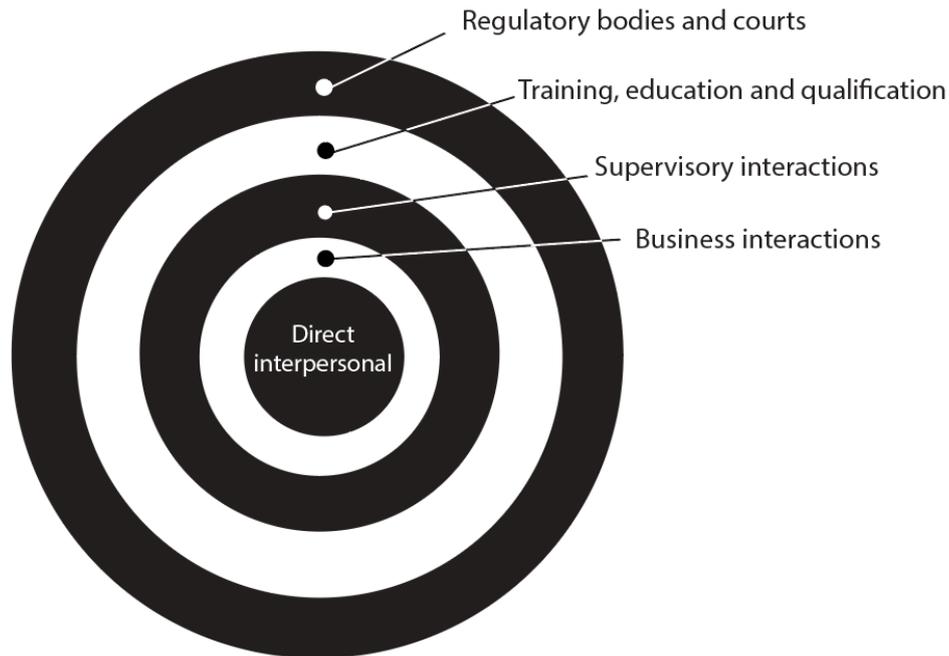
Figure 11. Chain of responsibility

Direct interpersonal interactions

Direct interpersonal interactions between client and counsellor within the context

of therapy form part of the therapeutic alliance (Bordin, 1979). As such, each interaction

must be conducted on an ethical basis. A key component of the working alliance is trust.

Trust binds the counsellor with the client so that client can participate fully in the

therapeutic process, of which the quality of client participation is the most important

determinant of outcomes from counselling (Orlinsky, Grawe & Parks, 1994). If

boundaries are crossed or violated, this destroys trust and impacts the outcomes of the

counselling process, not to mention may result in the client making a complaint which

may conclude in misconduct or malpractice.

Business interactions

Business interactions with client are considered non-therapeutic, however they are

a necessary stage in the process of receiving therapeutic support. Even here there is an

opportunity for transgression (e.g. over-charging). Counselling businesses are unlike other businesses who are relatively free to do what they like (within limits) in terms of marketing and promoting their business activities. The APS, for example, provides very specific guidance on the types and content of communication businesses can use to attract and maintain clients. These guidelines are provided to ensure counsellors do not treat clients as a 'means to a business end'. Thus, clients in this business context should never be abused or mistreated, as they shouldn't within the therapeutic alliance. In addition to the duty of care counsellors owe to their clients, businesses are places within which people are employed and as such are required to provide a safe and healthy environment for all that work within or visit them.

Supervisory interactions

Interactions with the supervisor do not directly involve the client, however supervisors are vicariously responsible for what happens to counselling supervisee's clients. The supervisory relationship is all about the client from the counsellor's perspective and the supervisor has a responsibility to ensure that the supervisee is not mistreating the client, and that adequate care is provided to all clients (Armstrong & Jones, 2011). Supervisors also have responsibility for the welfare of the supervisees, and as such are obligated to have 'tough conversations' with counsellors when it comes to taking time away to undertake some self-care.

Training, education and qualification

Counsellors are required to meet the minimum training and qualification standards for the specific service they provide and the memberships they hold. This is to ensure counsellors meet the level of competence in their field. Counsellors have an obligation to meet the Ongoing Professional Development (OPD) regime stipulated by the various member and regulatory bodies in order to keep registration or maintain membership. In

addition, training, education and qualification is about course administrators and facilitators plus the professional bodies whose job it is to accredit courses. Accreditation is a vital step in the process as it instils the concept of ethical practice into courses offered to ensure ongoing learning about ethics. In Australia, for example, the Australian Psychology Accreditation Council (APAC) is the overseeing body for all psychology courses in Australia. Similarly, the ACA also accredits university and vocational programs to meet their standards. It is argued that counsellors who successfully graduate such courses are supposedly educated in the ways of ethical practice. However, if this was true for all counsellors, then misconduct and malpractice — for a minority — would not be evident, nor increasing today (see Chapter 2).

Regulatory bodies and courts

Regulatory bodies and courts hold counsellors to the ethical principles outlined in various codes of conduct and in terms of government regulations and Acts, or laws. Such entities use punishment, deterrence, and restitution to enforce the various codes and laws relating to the type of counselling performed. Because regulatory bodies and courts operate at a 'society level' they are also tasked with ensuring that clients have confidence in the system. This includes providing mechanisms to the public so that clients can make a report against a counsellor. Also, where none exist, such as in an unregulated industry, the development of laws — such as the *Unregistered Health Practitioners Act 2012* (New South Wales) — are established to provide a safety-net for clients who use the services of unregulated counsellors. As such, clients must be given certain assurances and feel comfortable in seeking out mental health support if one needs it.

A holistic approach to prevention and intervention strategies

It is proposed that prevention and intervention strategies could be designed to influence at several levels or tiers across the industry. Table 14 provides an overview of a

matrix of factors associated with the implementation of prevention/intervention strategies

for the counselling profession in Australia.

Table 14. Relative Position and Function of Counselling Industry Stakeholders

Interactions	Direct Personal	Business	Supervisory	Training & Education	Regulatory Bodies & Courts
Factors					
Policy & Procedure	Commitment to Codes of Conduct	Occupational Health and Safety	Requirements and Expected Standards	Accreditation and Standards of Courses	Codes of Conduct/Laws
Learning	Skilled in Craft	Knowledge Culture	On-the-job Training	Training & Education	Certification & Endorsement
Cultural	Professional and Moral Development	Acceptable Standards of Work	Agreed Pathways Forward for Clients	Inclusive Environment	Ideals for Practising Counselling
Environmental	Situational Awareness	Specific to Industry Sector	Collaboratively Created	Specific to counselling sector	Regulated and Unregulated
Disclosure	Based on Context, Not Personal	Workplace Policy Relevant to Client Groups	Collaborative Support for Action	No requirements	Mandatory Requirements
Functional	Self-reflective and Competent Practice	Employee and Client Protection	Vicarious Protection and Support for Client/s	Teacher and Student Dyad	Consumer and Member Protection
Relational	Client, Peers, Supervisor	Employee and Employer, and Customer, Vendors	Supervisee and Supervisors, Client	Customer and Provider	Government, Members, Courts, Consumer Groups

This matrix is a good way of setting out who has responsibility for what and recognising that there are multiple stakeholders that contribute to preventing client harm. The matrix also allows a visual tool for a multifaceted and coordinated response to prevention and intervention.

The suggestion being put forward here is that if a client is harmed it is not only the responsibility of the counsellor concerned (although they are the one most likely to face the biggest sanctions and penalties). However, the action, or inaction, of others (supervisors, peers etc.) related to the counsellor and their professional performance (i.e. supervisory working alliance, or through workplace competencies assessments etc.) who may have contributed to the client harm are also held to account. The degree to which they are accountable is determined by a panel review or court. The chain of responsibility, the role each party plays in ensuring client protection, ensures each level contributes to the welfare of the client and commits to reduction measures for misconduct and malpractice.

Take for example a strategy that might address the problem that unresolved trauma could have on counsellors' professional and personal functioning. Currently codes of conduct require counsellors not to work when too distressed to be effective. However, evidence suggests that often counsellors may ignore, avoid, and/or diminish awareness of personal problems creating a blindspot (Goleman, 1998) — an inability to recognise (objectively) an individual's current state of wellbeing. Thus a counsellor may be unable to self-reflect, or they ignore such codes and continue to practice. Therefore, the following example provides a new way of looking at prevention and intervention in addressing unresolved trauma in counsellors.

At the first tier, the Personal level, counsellors are expected to commit to codes of conduct. However, whilst the codes suggest that counsellors must be aware of issues

related to impairment, the codes do not advise how such awareness can be acquired nor maintained. As such, counsellors could engage in self-reflective practice. Such behaviour would include interacting with supervisors and peers to discuss how issues of unresolved trauma (assuming their awareness of such concerns) might impact upon their performance and how they might deal with such concerns. Self-reflective practice is akin to professional development and such an approach will support counsellors in upholding the duty of care owed to clients. Indeed, self-reflective practice might be mandated by supervisors forming part of the ongoing professional development strategies.

Reinforcing interventions and prevention strategies at the next level up, the Business Level, we see that those operating a business have a duty of care — under the auspices of Occupational Health and Safety (OH&S) — to employees and clients of the business. As such, employers have an obligation to ensure employees carry-out their duties in an ethical manner. Thus enforcing 'acceptable standards of practice', such as ensuring counsellors have dealt with, or are dealing with, unresolved trauma. Additionally, workplace wellness programs could be configured to ensure a varied focus on workplace health concerns (Huang, Mattke, Batorsky, Miles, Liu, & Taylor, 2016). Programs that provide incentives — not inducements — for employees tend to have higher participation rates (Huang, Mattke, Batorsky, Miles, Liu, & Taylor, 2016). So implementing an appropriate program could be an effective mechanism to supporting counsellors with unresolved trauma.

Supervisors, the next level up, may wish to monitor behaviour over time, potentially administering early warning screens to supervisees. Thereby, providing the supervisor with a few key details or indicators for discussions within the supervisory working alliance. The outputs may also provide the required evidence to make a recommendation for a referral/s for the supervisee to seek personal counselling. Given the

creation of blind spots (Goleman, 1985) this might be required to ensure supervisees are made aware of the concerns, likewise should the supervisee engaging in transgressing behaviours evidence can be presented at panel or tribunal hearings. Results of various instruments/screens could be monitored over time with changes in responses providing an early warning indicator for appropriate intervention/s.

At the Training and Education level, providers might identify at 'risk students' directing them toward support services and allowing them to seek support whilst in training. Such an approach could provide graduated counsellors an opportunity to resolve trauma and then practice. Indeed, it is known that some medical schools will endeavour to remove or transfer students from medical courses who seem unsuitable for graduation (Yates & James, 2010). Whilst such an approach seems quite harsh, the reality is that when it comes to client wellbeing in a hospital situation avoiding the potential for risk seems paramount.

Finally, at the highest level, Regulatory Bodies & Courts, could identify unresolved trauma as a condition and ask that those who front panel reviews or appear before courts to undergo assessment which includes exploring for concerns related to unresolved trauma. Recognising unresolved trauma in this way would provide a legitimate reason for the condition to be specifically mentioned in codes of conduct for supervisors. It would also mean that unresolved trauma could form part of the screening process for course accreditation, forming part of the ethics process. Recall that we are talking about 'unresolved' trauma, not the mere presence of trauma. To discriminate on the basis of the presence of trauma would likely see the removal of a significant number of students and practitioners. The presence of resolved trauma does not seem to provide a concern; however unresolved trauma in counsellors, who are also likely impaired, is likely to be a cause for concern (see Chapter 8).

Chapter 10: Conclusions and recommendations

This last chapter provides some important outcomes from this thesis. The chapter is divided into three areas — conclusions, research recommendations and practical recommendations — for convenience. Each of these categories is addressed in turn next.

Conclusions

- Relative to other regulated professions, such as nurses/midwives and dentistry, regulated counsellors (psychologists) rank third highest (after controlling for differences in population size) in terms of complaints concluding at panel review or tribunal hearing stages.

- Even after accounting for increases in the population, evidence suggests there is a general increase in the frequency of instances of complaints/notifications concluding in a panel review or tribunal hearing over a five-year period (2011-2016).

- Costs associated with handling complaints/notifications — processing the more serious complaints through panel reviews and tribunal hearings — are increasing. There is likely a knock-on effect through increased member and registration fees. Also, there are likely costs to the reputation of the profession as issues of misconduct and malpractice escalate.

- A review of tribunal decision documents revealed common themes for explanations for transgressing behaviour given by counsellors found guilty of charges included: due to issues concerning use and abuse of legal and illicit substances and consequential behaviours, and because of impairment due to mental disorder or unresolved trauma.

- Explanations for *why* counsellors might transgress coalesced into three themes: the externalisation of responsibility for personal actions and behaviours, a lack of

objectivity concerning why such behaviours occurred, and an inability to understand how personal circumstance — including unresolved trauma — affected the provision of ethical services to clients.

- Sixty-three percent of respondent counsellors indicated some form of trauma in their lives and many indicated their trauma was a motivating force for becoming a counsellor.

- Twenty-five percent of counsellors surveyed indicated the presence of self-reported unresolved trauma. Unresolved trauma could interfere with a counsellor's ability to provide effective interventions and support to client outcomes. Potentially those in this group may be at greater risk of breaching profession ethical standards.

- The relationship between unresolved trauma and attitudes toward boundary crossings and violations is mediated indirectly via self-enhancement. Counsellors with unresolved trauma may use self-enhancement to reinforce the self-concept maintaining or improving psychological health.

Research recommendations

- The development of an early warning screen identifying 'at risk' counsellors might be useful within the supervisory working alliance. Such an instrument might serve as a starting point for supervisory discussion, especially for new and long-term counsellors, those counsellors who have experienced considerable personal change (such as a traumatic event), and those who might have transitioned into a new work environment (for example working in a prison).

- Several other potential variables (see Chapters 4 & 5) that might offer greater clarity in explaining the relationship between unresolved trauma and/or misconduct and malpractice behaviours in counsellors. The suggested mediator or moderator variables include, narcissism, issues of dependency and selfishness. The multifactor

model could be augmented to accommodate new variables. For example,

narcissistic pathology is often related to an individuals deflated or threatened sense

of self potentially due to traumatic experience or injury (Epstein & Simon, 1990).

As such, narcissism might replace self-enhancement — a social feedback

mechanism — as a mediator due to its relationship with trauma an identity.

- Researchers — and/or supervisors — might like to explore how identified risk

  factors from the present study might inform supervisory and workplace policies and

  procedures. Research could focus on supervisory components, for example

  psychologists working within the prison system, providing governmental agency

  services and working with underage clients might be warranted.

- Another area of research to consider is the role of unresolved trauma and the effects

  on empathic attunement within the working alliance. As such answering the

  question, does a counsellor's unresolved trauma increase or diminish his or her

  capacity for a therapeutic alliance?

Practice recommendations

- The development of a central system that handles 'all complaints' from inception to

  resolution, and through an appeals process. Such a mechanism would be to the

  community's benefit by providing confidence to clients and making it easier to

  track problems within the industry. The outputs and analysis from such a system

  might improve training, credentialing and/or supervision practices.

- The development of workplace (and other environments) policy and procedures

  regarding the risks associated with working with specific client groups. Such policy

  might provide an understanding of the critical factors involved in misconduct and

  malpractice, potentially a 'workplace hazard' notification that may be included in a

  risk register. For example, policies regarding female counsellors working with male

prison inmates. It has been identified that this category of misconduct is relatively

frequent, as such a warning that relationships can form between inmates and

counsellors which have the potential to the counsellor's objective judgement.

Whilst having such guidance in and of itself maybe insufficient to deter misconduct

and malpractice (indeed one might argue that such guidelines already exist in

current ethics of practice guidelines), these documents serve as a talking point for

the supervisory relationship (management and clinical) and as they form part of

workplace health and safety systems there is likely a focus on them and potentially

some form of measurement and review. Thus, bringing the conversation about the

risks to counsellors into the open for debate and discussion.

- Counsellors should understand what self-reflective practice is and actively engage

  in it. Self-reflective practices relate to adapting to constant change and developing

  knowledge critical for responding to events in personal and work settings.

  Ultimately, it is the individual's responsibility to ensure adequate self-care through

  seeking guidance and support from various other professionals (supervisors, general

  medical practitioners), friends, family and work colleagues. Engaging in a reflective

  practice with a supervisor is an excellent forum to develop self-reflective skills.

  Supervisors can assist supervisees with developing a critical awareness about their

  personal situation and advise that they seek support for presenting concerns.

- Education and training programs should look at frameworks for counsellors to

  develop personal ethics models (Pope & Vesquez, 2016). Assisting those in training

  to develop the required skills for ethical decision-making seems to be a vital

  component for counsellors. The development of personal models for ethical

  decision-making should be explicitly listed as an outcome within relevant programs.

- Future intervention and prevention programs should focus on administering multi-

  faceted strategies at varying levels (see Chapter 9b) in order to achieve the required

  influence and resultant positive change for the entire profession.

References

ABC News. (2013, 8 May). *Australian schools 'facing psychological health crisis'*.

Retrieved from http://www.abc.net.au/news/2013-03-26/australian-schools-facing-

psychology-crisis/4594234

Abramson, L. Y., & Seligman, M. E. P. (1978). Learned helplessness in humans: Critique

and reformulation. *Journal of Abnormal Psychology, 87*(1), 49–74. doi:

10.1037/0021-843X.87.1.49

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among

therapist trainees. *Training and Education in Professional Psychology, 2*(1), 26. doi:

10.1037/1931-3918.2.1.26

Akinade, E. A. (2005). *Dictionary of guidance and counselling*. Ibadan: Olu-akin

Publishers.

Alexander, F. (1965). *Psychosomatic medicine: Its principles and applications*. New

York: W. W. Norton & Company.

Anand, P. (1993). *Foundations of rational choice under risk*. Oxford: Oxford University

Press.

American Counseling Association. (2014, 28 February). *Code of ethics*. Retrieved from

http://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychological Association. (2008, 19 September). *The intersection of

psychologist's personal and professional lives*. Retrieved from

http://www.apap.org.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental

disorders (5th ed.)*. Arlington, VA: American Psychiatric Publishing. doi:

10.1176/appi.books.9780890425596

American Psychological Association. (2010). *Ethical principles of psychologist and code of conduct: Including 2010 amendments*. Retrieved from http://www.apa.org/ethics/code/

American Psychological Association. (2015, 28 February). *Advancing colleague assistance in professional psychology*. Retrieved from http://www.apapracticecentral.org/ce/self-care/colleague-assist.aspx.

American Psychological Association. (2015, 23 August). *Trauma*. Retrieved, from http://www.apa.org/topics/trauma/

Aquino, K. F., & Reed, A. (2002). The self-importance of moral identity. *Journal of Personality and Social Psychology, 83(6)*, 1423–1440. doi: 10.1037//0022-3514.83.6.1423

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in psychology*, *2*, 270-281. doi: 10.3389/fpsyg.2011.00270

Armstrong, P., & Jones, C. (2011, 25 August 2014). ACA Submission to the Inquiry by The Senate Community Affairs Committee into Commonwealth funding and administration of mental health services. Retrieved from http://www.aph.gov.au/DocumentStore.ashx?id=7cf2be66-5939-4844-8a95-ef24df33d79d

Aron, L. (1996). *A meeting of minds*. Hillsdale: Analytic Press.

Atkinson, J. W. (1957). Motivational determinants of risk taking behaviour. *Psychological Review, 64*, 359–372. doi: 10.1037/h0043445

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly, 24*(2), 85-100. doi: 10.1080/09515070.2011.589602

Australasian Legal Information Institute. (2013, 2 June). AustLII. Retrieved from

   www.austlii.edu.au

Australian Bureau of Statistics. (2015, 21 May). Jobs outlook. Retrieved from

   http://joboutlook.gov.au/default.aspx

Australian Centre for Posttraumatic Mental Health. (2013, 17 October). *Australian*

   guidelines for the treatment of acute stress disorder & posttraumatic stress

   disorder: Guidelines summary. Retrieved from http://www.acpmh.unimelb.edu.au

Australian Consumer Law. (2014, 26 May). *Australian consumer law Act*. Retrieved from

   http://www.consumerlaw.gov.au/content/Content.aspx?doc=the_acl.htm

Australian Counselling Association. (2010, 1 June 2014). *Australian Counselling*

   Association in response to consultation of unregistered health practitioners.

   Retrieved from http://www.ahmac.gov.au/cms_documents/pdf/No%2095%20-

   %20Australian%20Counselling%20Association%20Inc.pdf

Australian Counselling Association. (2012, 1 June 2013). *Code of ethics and practice.*

   Retrieved from

   http://www.theaca.net.au/documents/ACA%20Code%20of%20Ethics%20v8.pdf

Australian Counselling Association. (2013). Malpractice and misconduct statistics.

   [Unpublished raw data].

Australian Health Ministers' Advisory Council. (2011, 16 February 2014). *National*

   registration and accreditation scheme. Retrieved from

   http://www.health.gov.au/internet/main/publishing.nsf/Content/work-nras.

Australian Health Ministers' Advisory Council. (2014, 2 October). *Independent Review of*

   the National Registration and Accreditation Scheme for health professions.

   Retrieved from

http://www.coaghealthcouncil.gov.au/DesktopModules/EasyDNNNews/Document

Download.ashx?portalid=0&moduleid=514&articleid=68&documentid=74

Australian Health Practitioner Regulation Agency. (2013, 20 October). *Conduct.*

Retrieved from http://www.ahpra.gov.au/Notifications-and-Outcomes/Conduct-

Health-and-Performance/Conduct.aspx.

Australian Health Practitioners Registration Agency. (2015, 2 November). *National*

Board guidelines for registered health practitioners: Guidelines for mandatory

notifications. Retrieved from

http://www.psychologyboard.gov.au/documents/default.aspx?record=WD14%2f133

26&dbid=AP&chksum=6PgV3lDTI0fwe%2bSb0D342g%3d%3d

Australian Institute of Health and Welfare. (2013, 20 October). *Mental health services in*

brief 2013. Retrieved from

http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544723

Australian Psychology Accreditation Council. (2016, 11 May). *About the Australian*

Psychology Accreditation Council. Retrieved from

https://www.psychologycouncil.org.au/about/

Australian Psychological Society. (2007, 14 September 2013). *Code of ethics*. Retrieved

from http://www.psychology.org.au/Assets/Files/NewCode160807WEB.pdf

Australian Psychological Society. (2013, 26 December). *Counselling psychology*.

Retrieved from http://www.psychology.org.au/community/specialist/counselling/

Australian Psychological Society. (2015a, 4 October). *Annual report, 2015*. Retrieved

from https://www.psychology.org.au/Assets/Files/2015-APS-Annual-Report.pdf

Australian Psychological Society. (2015b, 31 May). *Ethics.* Retrieved from

https://www.psychology.org.au/about/ethics/

Australian Psychological Society. (2015c, 20 December). *Psychologist's records: Management, ownership and access*. Retrieved from https://www.psychology.org.au/Assets/Files/Management-ownership-access-psychologist-records.pdf

Australian Register of Counsellors and Psychotherapists. (2011, 26 December 2014). *About ARCAP*. Retrieved from http://www.arcapregister.com.au/About_ARCAP.htm

Australian Association of Social Workers. (2015, 20 December). *Ethical guidelines: Case notes*. Retrieved from https://www.aasw.asn.au/document/item/2356

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional wellbeing*. Washington, DC: American Psychological Association.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Bandura, A. (1989). Social cognitive theory. In R. Vasta (Ed.), *Annals of child development: Six theories of child development* (pp. 1-60). Greenwich: JAI Press.

Bandura, A. (1999). Moral disengagement in the perpetration of inhumanities. *Personality and Social Psychology Review, 3*, 193–209. Retrieved from https://www.uky.edu/~eushe2/Bandura/Bandura1999PSPR.pdf

Bandura, A., Barbaranelli, C., Caprara, G. V., & Pastorelli, C. (1996). Mechanisms of moral disengagement in the exercise of moral agency. *Journal of Personality and Social Psychology, 71*(2), 364–374. doi: 10.1037/0022-3514.71.2.364

Barnett, J. E. (1998). Should psychotherapists self-disclose? Clinical and ethical considerations. In L. Vandecreek, S. Knapp, & T.L. Jackson (Eds.), *Innovations in clinical practice: A source book* (pp. 419-428). Sarasota, FL: Professional Resource Exchange.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of

wellness: The self-care imperative. *Professional Psychology, Research and

Practice, 38*, 603–612. doi: 10.1037/0735-7028.38.6.603

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology:

Service and Practice, 16*(1), 16–20.

Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The

availability, nature, and use of the colleague assistance programs for psychologists.

Professional Psychologist: Research and Practice, 32(2), 205-210. doi:

10.1037/0735-7028.32.2.205

Barrett, R. J. (1998). The schizophrenic and the liminal persona in modern society.

Culture, Medicine and Psychiatry, 22, 465-494. Retrieved from

http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.515.3106&rep=rep1&typ

e=pdf

Baumeister, R. F. (1999). *The self in social psychology.* Philadelphia: Psychology Press.

Bazerman, M. H., & Banaji, M. R. (2004). The social psychology of ordinary ethical

failures. *Social Justice Research, 17*(2), 111-115. doi:

10.1023/B:SORE.0000027544.56030.04

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists

seeking mental health care. *Professional Psychology: Research & Practice, 44*(3),

150–157. doi:10.1037/a0031182

Beauchamp, T. L. & Childress, J. F. (2001). *Principles of biomedical ethics*. New York:

Oxford University Press.

Behnke, S. (2004, 24 January 2013). *Sexual involvements with former clients: A delicate

balance of core values*. Retrieved from

http://www.apa.org/monitor/dec04/ethics.aspx

Ben-Daya, M., & Hariga, M. (1988). A maintenance inspection model: Optimal and

heuristic solutions. *International Journal of Quality & Reliability Management,

15*(5), 481-488. doi: 10.1108/02656719810220597

Bennett-Woods, D. (2005, 10 June 2014). *Ethics at a glance*. Retrieved from

http://rhchp.regis.edu/hce/ethicsataglance/ethicsataglance.pdf

Bentler, P. M., & Bonett, D. G. (1980). Significance tests and goodness of fit in the

analysis of covariance structures. *Psychological Bulletin, 88*(3), 588-606. doi:

10.1037/0033-2909.88.3.588

Bernard, J., & Jara, C. (1986). The failure of clinical psychology graduate students to

apply understood ethical principles. *Professional Psychology: research and

Practice, 17*(4), 313-315. doi: 10.1037/0735-7028.17.4.313

Berntsen, D., & Rubin, D. C. (2006). The centrality of event scale: A measure of

integrating a trauma into one's identity and its relation to post-traumatic stress

disorder symptoms. *Behaviour Research and Therapy, 44*(2), 219-231. doi:

10.1016/j.brat.2005.01.009

Berntsen, D., & Rubin, D. C. (2007). When a trauma becomes a key to identity: Enhanced

integration of trauma memories predicts posttraumatic stress disorder symptoms.

Applied Cognitive Psychology, 21(4), 417-431. doi:10.1002/acp.1290

Black's Law Dictionary. (2013, 10 April). *The law dictionary*. Retrieved from

http://thelawdictionary.org/civil-law/.

Blasi, A. (1983). Moral cognition and moral action: A theoretical perspective.

Developmental Review, 3, 178-210. doi: 10.1016/0273-2297(83)90029-1

Blaszczynski, A. (1994). Criminal offenders in pathological gamblers. *Psychiatry,

Psychology and Law,1*(2), 129-138. doi: 10.1080/13218719409524836

Bloch, A. S. (2004). Connecting self-enhancement and self-verification messages in

friendships. (Masters thesis). University of Central Florida.

Bond, T. (2010). *Standards and ethics for counselling in action.* London: Sage

Publishing.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working

alliance. *Psychotherapy: Theory, Research and Practice*, *16*(3), 252-260.

doi:10.1037/h0085885

Bornstein, R. F. (1994). Adaptive and maladaptive aspects of dependency. *American

Journal of Orthopsychiatry, 64*(4) 622-635. doi: 10.1037/h0079563

Borys, D. S, & Pope, K. S. (1989). Dual relationships between therapist and client: A

national study of psychologists, psychiatrists, and social workers. *Professional

Psychology: Research and Practice, 20*, 283-293. doi:10.1037/0735-7028.20.5.283

Bosede, A. F. (2010). Ethical principles of guidance and counselling. *International

Journal of Tropical Medicine, 5*(2), 50-53. doi:10.3923/ijtmed.2010.50.53

Bouhoutsos, J., Holroyd, J., Lerman, H., Forer, B., & Greenberg, M. (1983). Sexual

intimacy between psychotherapists and patients. *Professional Psychology, 14*, 185-

196. doi:10.1037/0735-7028.14.2.185

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of

Psycho-Analysis, XXXIX*, 1-23. Retrieved from

http://www.psychology.sunysb.edu/attachment/online/nature%20of%20the%20chil

ds%20tie%20bowlby.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative

Research in Psychology, 3*(2), 77-101. doi: 10.1037/13620-004

Breuer, J., & Freud, S. (1955). *Studies in hysteria.* London: The Hogarth Press.

Brewer, M. B., & Roccas, S. (2001). Individual values, social identity, and optimal

distinctiveness. In C. Sedikides, and M. Brewer, *Individual self, reflective self and*

collective self, (pp. 219-237). Philadelphia: Psychology Press.

Briere, J. (1997). *Psychological assessment of adult posttraumatic states.* Washington:

American Psychological Association.

Brison, S. J. (2002). Outliving oneself: Trauma, memory, and personal identity. In C. L.

Mui and J. S. Murphy, *Gender struggles: Practical approaches to contemporary*

feminism, (pp. 137-165). New York: Rowman & Littlefield Publishers INC.

Brody, H. (1987). *Stories of sickness*. New Haven: Yale University Press.

Brown, B. B., & Lohr, M. J. (1987). Peer-group affiliation and adolescent self-esteem: An

interaction of ego-identity and symbolic-interaction theories. *Journal of Personality*

and Social Psychology, 52(1), 47-55. doi: 10.1037/0022-3514.52.1.47

Brown, J. D. (1991). Accuracy and bias in self-knowledge. In C. R. Snyder & D. F.

Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective*

(pp. 158-178). New York: Pergamon.

Bryant, R. A., Friedman, M. J., Spiegel, D., Ursano, R., & Strain, J. (2011). A review of

acute stress disorder in DSM‑5. *Depression and Anxiety, 28*(9), 802-817. doi:

10.1002/da.20737

Burke, E. (1991). *Reflections on the revolution in France, and on the proceedings in*

certain societies in London. London: J. Dodsley.

Burke, P. (1991). Identity process and social stress. *American Sociological Review, 56*,

836-849. Retrieved from http://www.jstor.org/stable/2096259

Burke, W. F. (1992). Countertransference disclosure and the asymmetry/mutuality

dilemma. *Psychoanalytic Dialogues, 2*, 241-271. doi:

10.1080/10481889209538931

Burns, J. H. (2005). Happiness and utility: Jeremy Bentham's equation. *Utilitas, 17*(1), 46-61. doi:10.1017/S0953820804001396

Butler, S. K., & Constantine, M. G. (2005). Collective self-esteem and burnout in professional school counselors. *Professional School Counseling, 9*, 55–62. doi: 10.5330/prsc.9.1.17n4415l163720u5

Campbell, K. W., Reeder, G. D., Sedikides, C., & Elliot, A. J. (2000). Narcissism and comparative self-enhancement strategies. *Journal of Research in Personality 34*, 329–347. doi:10.1006/jrpe.2000.228

Cast, A. D., & Burke, P. J. (2002). A theory of self-esteem. *Social Forces, 80*(3), 1041-1068. doi: 10.1353/sof.2002.0003

Caudill, B. (2015, 2 November) *Malpractice and licensing pitfalls for therapists: A defense attorney's list*. Retrieved from http://kspope.com/ethics/malpractice.php.

Celenza, A., & Gabbard, G. O. (2003). Analysts who commit sexual boundary violations: A lost cause? *Journal of the American Psychoanalytic Association, 51*(2), 617-636. doi:10.1176/foc.5.4.foc483

Cissna, K. N. L., & Sieburg, E. (1981). Patterns of interactional confirmation and disconfirmation. In C. Wilder-Mott & J. H. Weakland, *Rigor and imagination: Essays from the legacy of Gregory Bateson* (pp. 253-282). New York: Praeger.

Claman, J. M. (1987). Mirror hunger in the psychodynamics of sexually abusing therapists. *American Journal of Psychoanalysis, 47*, 35-40. doi:10.1007/BF01252330

Cohen, R. L. (1986). *Justice: Views from the social sciences*. New York: Plenum Press.

Coleman, J. C. (1970). Abnormal psychology and modern life. Bombay: Taraporewala & Sons.

Coleman, E., & Schaefer, S. (1986). Boundary inadequacy in drug dependent families. *Journal of Counseling and Development, 64*, 345-349. doi: 10.1080/02791072.1986.10524476

Consumerlaw.gov.au. (2015, 20 September). *The Australian consumer law: Resources for consumers.* Retrieved, from http://www.consumerlaw.gov.au/content/Content.aspx?doc=acl_resources/resources _consumer.htm

Commonwealth of Australia. (2012, 24 December). *Mental health statement of rights and responsibilities.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/E39137B3C170F93 ECA257CBC007CFC8C/$File/rights2.pdf

Costello, A. B., & Osborne, J. (2005, 21 February 2015). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment Research & Evaluation, 10*(7), 1-9. Retrieved from http://pareonline.net/getvn.asp?v=10&n=7

Council of Australian Governments. (2015, 2 October). *COAG health council.* Retrieved from http://www.coaghealthcouncil.gov.au/

Crittenden, P., & Landini, A. (2011). *Assessing adult attachment: A dynamic-maturational approach to discourse analysis.* New York: W. W. Norton.

Crofts, P. (2003). Researching the link between gambling and crime. Evaluation in Crime and Justice: Trends and Methods. [Conference] Australian Institute of Criminology in conjunction with the Australian Bureau of Statistics, Canberra (pp. 24-25).

Crossley, M. L. (2000). Narrative psychology, trauma and the study of self/identity. *Theory & Psychology, 10*(4), 527-546. doi: 10.1177/0959354300104005

Cushway, D., & Tyler, P.A. (1994). Stress and coping in clinical psychologist. *Stress Medicine, 10*, 35-42. doi:10.1002/smi.2460100107

Dalkey, N. C., & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. *Management Science, 9*(3), 458-467. doi: 10.1287/mnsc.9.3.458

Damon, W., & Hart, D. (1992). Self-understanding and its role in social and moral development. In M. Bornstein & M. E. Lamb, *Developmental psychology: An advanced textbook* (pp. 421–464). New Jersey: Erlbaum.

Degenhardt, L., & Hall, W. (2012). Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *The Lancet, 379*(9810), 55-70. doi: 10.1016/S0140-6736(11)61138-0

de las Fuentes, C., Willmuth, M. E., & Yarrow, C. (2005). Competency Training in Ethics Education and Practice. Professional Psychology: *Research and Practice, 36*(4), 362. doi: 10.1037/0735-7028.36.4.362

Department of Employment. (2012, 12 May 2014). *Job outlook counselling.* Retrieved from http://joboutlook.gov.au/keyword.aspx?keyword=counselling.

Department of Health and Aging. (2009). *The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing.* Canberra: Department of Health and Aging.

Disch, E., & Avery, N. (2001). Sex in the consulting room, the examining room, and the sacristy: survivors of sexual abuse by professionals. *American Journal of Orthopsychiatry, 71*(2), 204. doi:10.1037/0002-9432.71.2.204

Drell, M. J., Siegel, C.H., & Gaensbauer, T. J. (1993). Posttraumatic stress disorder. In C.H. Zeanah. *Handbook of infant mental health.* (pp. 291-304). New York: The Guilford Press.

Dryden, W., & Spurling, L. (1989). *On becoming a psychotherapist*. London: Tavistock.

Duncan, S., & Baker, T. (2003). What are the significant dimensions of harm to a child?

In P. Reder, S. Duncan & C. Lucy, *Studies in the assessment of parenting*. Brunner:

Routledge.

Duncan, B. L. & Miller, S. D. (2008). When I'm good, I'm very good, but when I'm bad

I'm better: A new mantra for psychotherapists. *Psychotherapy in Australia, 15*(1),

60–69.

Duncan, R. E., Williams, B. J., & Knowles, A. (2013). Adolescents, Risk Behaviour and

Confidentiality: When Would Australian Psychologists Breach Confidentiality to

Disclose Information to Parents? *Australian Psychologist, 48*(6), 408-419. doi:

10.1111/ap.12002

Eccles J. S., Adler, T. F., Futterman, R., Goff, S. B., Kaczala, C. M., Meece, J. L., &

Midgley, C. (1983). Expectancies, values, and academic behaviors. In J. T. Spence

(Ed.), *Achievement and achievement motivation* (pp. 75–146). San Francisco: W. H.

Freeman.

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health

professionals: Childhood trauma and adult functioning. *Professional Psychology:

Research and Practice, 24*(1), 83-90. doi: 10.1037/0735-7028.24.1.83

Ellis, A. (1972). Psychotherapy without tears. In A. Burton, *Twelve therapists*: *How they

live and actualize themselves*. San Francisco: Jossey-Bass.

Einhorn, H. J., & Hogarth, R. M. (1981). Behavioral decision theory: Processes of

judgment and choice. *Annual review of Psychology, 32*, 53-88.

doi:10.1146/annurev.ps.32.020181.000413

Epstein, R. S., & Simon, R. I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 54*, 450-465.

Epstein, R.S., Simon, R. I., & Kay, G. G. (1992). Assessing boundary violations in psychotherapy: Survey results with the exploitation index. *Bulletin of the Menninger Clinic, 56*, 150-166.

Erikson, E. H. (1964). *Insight and responsibility*. New York: Norton.

Eriksson, B. G., & Hummelvoll, J. K. (2008). People with mental disabilities negotiating life in the risk society: a theoretical approach. *Journal of Psychiatric and Mental Health Nursing, 15*(8), 615-621. doi:10.1111/j.1365-2850.2008.01276.x

Everall, R. D., & Paulson, B. L. (2004). Burnout and secondary traumatic stress: Impact on ethical behaviour. *Canadian Journal of Counselling, 38*(1), 25-35.

Faber, B. A. (1983). Psychotherapists' perceptions of stressful patient behaviour. *Professional Psychology, 14*, 697-705. doi:10.1037/0735-7028.14.5.697

Fairburn, W. R. D. (1952). *An object-relations theory of personality*. New York: Basic Books.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analysis using G*Power 3.1: tests for correlation and regression analysis. *Behaviour Research Methods, 41*(4), 1149-1160. doi:10.3758/BRM.41.4.1149

Fearon, R. M., & Mansell, W. (2001). Cognitive perspectives on unresolved loss: Insights from the study of PTSD. *Bulletin of the Menninger Clinic, 65(3)*, 380–396. doi:10.1521/bumc.65.3.380.19845

Feitham, C., & Dryden, W. (1993). *Dictionary of counselling*. London: Whurr.

Festinger, L. (1957). *A Theory of cognitive dissonance*. Stanford, CA: Stanford University Press.

Field, A. P. (2000). *Discovering statistics using SPSS for Windows: Advanced techniques*

   for the beginner. London: Sage.

Field, A. P., Miles, J., & Field, Z. (2012, 20 August). *Discovering statistics using R*.

   London: Sage.

Fieser, J. (2015, 15 April). Ethics. Retrieved from http://www.iep.utm.edu/ethics/

Finkhelor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free

   Press.

Fitzgerald, J. M. (1988). Vivid memories and the reminiscence phenomenon: The role of

   a self-narrative. *Human Development, 31*, 261–273. doi:10.1159/000275814

Ford, E. S. C. (1963). Being and becoming a psychotherapist: The search for identity.

   American Journal of Psychotherapy, 17, 472-482.

Ford, G. (2006) *Ethical reasoning for mental health professionals.* Thousand Oaks: Sage.

Forester-Miller, H., & Davis, T. (1996). *A practitioner's guide to ethical decision-

   making*. Chicago:American Counseling Association.

Forester-Miller, H. & Rubenstein, R. L. (1992). Group Counseling: Ethics and

   Professional Issues. In D. Capuzzi & D. R. Gross (Eds.) *Introduction to group

   counseling* (307-323). Denver, CO: Love Publishing Co.

Frank, H., & Paris, J. (1987). Psychological factors in the choice of psychiatry as a career.

   Canadian Journal of Psychiatry, 32, 118-122.

Freckelton, I. (2011a). Unscientific health practice and disciplinary and consumer

   protection litigation. *Journal of Law and Medicine, 18*, 645-668.

Freckelton, I. (2011b). Psychotherapy, suicide and foreseeable risk of decompensation by

   the vulnerable. *Journal of Law and Medicine, 18*(3), 467-477.

Fretz, B. R., & Mills, D. H. (1980). *Licensing and certification of psychologists and counselors: A guide to current policies, procedures, and legislation*. San Francisco: Jossey-Bass.

Freud, S. (1914). *On narcissism: An introduction. The standard edition of the complete works of Sigmund Freud (Vol. 14)*. London: Hogarth Press.

Freud, S. (1953). *The interpretation of dreams, the standard edition of the complete psychological works of Sigmund Freud* (Vol. IV). London: The Hogarth Press and the Institute of Psychoanalysis.

Freud, S. (1958). *Observations on transference-love: Further recommendations on the technique of psycho-analysis III*. London: Hogarth Press.

Freud, S. (1964). *An outline of psychoanalysis, the standard edition of the complete psychological works of Sigmund Freud* (Vol. XXIII). London: The Hogarth Press and the Institute of Psychoanalysis.

Friedman, H. S., & Schustack, M. W. (2010). Personality: Classic theories and modern research (5th ed.). Canada: Pearson.

Gabbard, G. O. (1991) Psychodynamics of sexual boundary violations. *Psychiatric Annals, 21*(11), 651-655. doi: 10.3928/0048-5713-19911101-06

Gabbard, G. O. (1994). Sexual misconduct. In J. M. Oldham, & M. B. Riba, *Review of psychiatry.* Washington, DC: American Psychiatric Press.

Gabbard, G. O. (1995). Transference and counter-transference in the psychotherapy of therapists charged with sexual misconduct. *Psychiatric Annals, 25(*2),100–105. doi:10.3928/0048-5713-19950201-09

Gabbard, G. O. (1996). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy, 50*, 311–322.

Gabbard, G. O., & Lester, E. P. (1995). *Boundaries and boundary violations*. New York, NY: Basic Books.

Garland, C. (2002). *Understanding trauma: A psychoanalytical approach*. Chicago: Karnac.

Garner, F. C., Stapanian, M. A., & Fitzgerald, K. E. (1991). Finding causes of outliers in multivariate environmental data. *Journal of Chemometrics*, *5*(3), 241-248. doi: 10.1002/cem.1180050311

Garrett, T. (1998). Sexual contact between patients and psychologists. *The Psychologist,11*, 227-230.

Gazzola, N., Horvath, A., Page, L., Synard, P., & Toukmanian, S. (2009, 1 May). *The psychotherapeutic professions in Canada*. Retrieved from http://c.ymcdn.com/sites/www.psychotherapyresearch.org/resource/resmgr/importe d/events/barcelona/reports/report_canada.pdf

Geldard, D. & Geldard, K. (2009). *Basic personal counselling: A training manual for counsellors* (6th ed.). Frenchs Forest: Pearson Education Australia.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy. *Counseling Psychologist, 13*, 155–243. doi:10.1177/0011000085132001

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296–306. doi:10.1037/0022-0167.41.3.296

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities.* Mahwah: Erlbaum.

Giebel, G., & Elbert, T. (2014). The perception of a woman's love in a relationship with a prisoner is erotic and altruistic. *Journal of Forensic Science & Criminology, 1*(4), 1-4. doi:10.15744/2348-9804.1.402

Gil, S., & Weinberg, M. (2015). Secondary trauma among social workers treating trauma clients: The role of coping strategies and internal resources. *International Social Work, 58(*4), 551-561. doi:10.1177/0020872814564705

Goldberg, C. (1986). *On being a psychotherapist: The journey of the healer.* New York: Gardner.

Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of clinical psychology*, *59*(5), 555-568. doi:10.1002/jclp.10159

Goleman, D. (1985). *Vital lies, simple truths*: *The psychology of self-deception.* New York: Simon & Schuster, Inc.

Glass, L. L. (2003). The grey areas of boundary crossings and violations. *American Journal of Psychotherapy, 57*, 429-444.

Glasser, M., Kolvin, D., Campbell, D., Glasser, A., Leithch, I., & Farrelly, S. (2001). Cycle of child sexual abuse: links between being a victim and becoming a perpetrator. *British Journal of Psychiatry, 179*, 482-494. doi:10.1192/bjp.179.6.482

Glover, E. (1955). *The technique of psycho-analysis*. New York: International Universities Press.

González-Prendes, A., & Resko, S. (2012). Cognitive-behavioral theory. In S. Ringel, & J. Brandell (Eds.), *Trauma: Contemporary directions in theory, practice, and research.* (pp. 14-41). Thousand Oaks, CA: Sage Publications.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy, 30*(1), 41-48. doi: 10.1037/0033-3204.30.1.41

Gregg, A. P., Sedikides, C., & Gebauer, J. E. (2011). Dynamics of identity: Between self-enhancement and self-assessment, S. J. Schwartz, K., Luyckx, & V. L. Vignoles,

(Eds.). (2011). *Handbook of identity theory and research* (pp. 933-938). New York: Springer. doi:10.1007/978-1-4419-7988-9

Grenyer, B. F. S., & Lewis, K. L. (2012). Prevalence, prediction, and preventions of psychologist misconduct. *Australian Psychologist, 47*, 68-76. doi:10.1111/j.1742-9544.2010.00019.x

Grice, J. W., Cohn, A., Ramsey, R. R., & Chaney, J. M. (2015). On muddled reasoning and mediation modeling. *Basic and Applied Social Psychology, 37*(4), 214-225. doi:10.1080/01973533.2015.1049350

Gutheil, T.G., & Gabbard, G.O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*(3), 409-414. doi:10.1176/ajp.155.3.409

Guy, J. D. (1987). *The personal life of the psychotherapist*. New York: Wiley.

Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice*, *20*(1), 48. doi:10.1037/0735-7028.20.1.48

Haas, L. J. & Malouf, J.L. (1989). *Keeping up the good work: A practitioner's guide to mental health ethics.* Sarasota, FL: Professional Resource Exchange, Inc.

Hagger, M. S., Anderson, M., Kyriakaki, M., & Darkings, S. (2007). Aspects of identity and their influence on intentional behavior: Comparing effects for three health behaviors. *Personality and Individual Differences, 42*(2), 355-367. doi:10.1016/j.paid.2006.07.017

Hair, J., Anderson, R. E., Tatham, R. L., & Black, W. C. (1995). *Multivariate data analysis*. New Jersey: Prentice-Hall Inc.

Handelsman, M. M., & Uhlemann, M. R. (1998). Be careful what you wish for: Issues in

the statutory regulation of counsellors. *Canadian Journal of Counselling, 32*, 315-

331.

Hardy, M. S., & Calhoun, L. G. (1997). Psychological distress and the medical student

syndrome in abnormal psychology students. *Teaching of Psychology, 24*(3), 192-

193. doi:10.1207/s15328023top2403_10

Hardy, S. A., & Carlo, G. (2005). Identity as a source of moral motivation. *Human

Development, 48*(4), 232-256. doi:10.1159/000086859

Harrison, M. (2011). *Counselling Psychologists' perception, understanding and

experience of client dependency within the overall therapeutic relationship and its

impact on the therapeutic process.* (Doctoral dissertation, Roehampton University).

Hart, D., Atkins, R., & Ford, D. (1998). Urban America as a context for the development

of moral identity in adolescence. *Journal of Social Issues, 54*(3), 513–530.

doi:10.1111/j.1540-4560.1998.tb01233.x

Hayes, A. F. (2009). Beyond Baron and Kenny: Statistical mediation analysis in the new

millennium. *Communication Monographs*, *76*(4), 408-420.

doi:10.1080/03637750903310360

Hayes, A. F. (2013). *Introduction to mediation, moderation, and conditional process

analysis: A regression-based approach.* New York: Guilford Press.

Hayes, A. F. (2014, 28 March). PROCESS: An SPSS add-on for mediation and

moderation analysis. Retrieved from http://www.processmacro.org/.

Health Care Complaints Commission. (2012, 11 June). *Public health regulation:

Schedule 3 code of conduct.* Retrieved from

http://www.legislation.nsw.gov.au/fragview/inforce/subordleg+311+2012+sch.3+0+

N?tocnav=y

Health Care Complaints Commission. (2015, 27 September). *Mr Gareth Michael Dawes: Unsatisfactory professional conduct, professional misconduct, impairment and lack of competency*. Retrieved from https://www.hccc.nsw.gov.au/Publications/Media-releases/2015/Mr-Gareth-Michael-Dawes---unsatisfactory-professional-conduct--professional-misconduct--impairment-and-lack-of-competency

Health and Community Services Complaints Commissioner. (2013, 11 June). *Code for unregistered health practitioners*. Retrieved from http://www.hcscc.sa.gov.au/wp-content/uploads/2013/12/h_Plain-English-Version-Code-of-Conduct.pdf

Health Practitioner National Law Act. (2009). *Health practitioner regulation national law Act.* Retrieved 11 June 2013 from http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC045.pdf

Hetherington, A. (2000). Exploitation in therapy and counselling: a breach of professional standards. *British Journal of Guidance and Counselling, 28*(1), 11-22. doi: 10.1080/030698800109583

Hegarty, W. H., & Sims, H. P. (1979). Organisational philosophy, policies and objectives related to unethical decision behaviour: A laboratory experiment. *Journal of Applied Psychology, 64*, 331-338. doi:10.1037/0021-9010.64.3.331

Henry, W. E., Sirns, J. H. & Spray, S. L. (1971). *The fifth profession: Becoming a psychotherapist*. San Francisco: Jossey-Bass.

Henson, R. K., & Roberts, J. K. (2006). Use of exploratory factor analysis in published research: Common errors and some comment on improved Practice. *Educational and Psychological Measurement, 66*(3), 393-416. doi:10.1177/0013164405282485

Hemenover, S. H. (2003). The good, the bad, and the healthy: Impacts of emotional disclosure of trauma on resilient self-concept and psychological distress.

Personality and Social Psychology Bulletin, 29(10), 1236-1244.

doi:10.1177/0146167203255228

Herlihy, B., Healy, M., Cook, E. P., & Hudson, P. (1987). Ethical practices of licensed

professional counselors: A survey of state licensing boards. *Counselor Education*

and Supervision, 27, 69-76. doi:10.1002/j.1556-6978.1987.tb00742.x

Hickie, I. B., & McGorry, P. D. (2007). Increased access to evidence-based primary

mental health care: Will the implementation match the rhetoric? *Medical Journal of*

Australia, 187(2), 100-103.

Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological*

Review, 94(3), 319-340. doi:10.1037/0033-295X.94.3.319

Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic

relationship: Inextricably intertwined in the therapy process. *Psychotherapy:*

Theory, Research, Practice Training, 42(4), 431-442. doi:10.1037/0033-

3204.42.4.431

Hilton, M. R. & Mezey, G. C. (1996). Victims and perpetrators of child sexual abuse.

British Journal of Psychiatry, 169, 408 -415. doi:10.1192/bjp.169.4.408

Hinshaw, S. P., & Stier, A. (2008). Stigma as related to mental disorders. *Annual Review*

of Clinical Psychology, 4, 367–393. doi:10.1146/annurev.clinpsy.4.022007.141245

Hodges, C. (2011, 20 August, 2017). The view of Australians regarding regulatory

requirements of counsellors and qualified therapists. Retrieved from

https://www.aasw.asn.au/document/item/1819

Hogg, M. A. (2003). Social identity. In M. R. Leary, & J. P. Tangney, *Handbook of self*

and identity (pp. 462-479). New York: Gilford Press.

Hogg, M. A., & Terry, D. J. (2014). *Social identity processes in organizational contexts.*

Philadelphia, PA: Psychology Press.

Holland, J. L. (1966). *The psychology of vocational choice: A theory of personality types and model environments.* Waltham, MA: Blaisdale.

Holland, J. L. (1997). *Making vocational choices* (3rd ed.). Odessa:Psychological Assessment Resources.

Hook, T. L. (2007). *The role of self-concept and narcissism in aggression.* (Doctoral dissertation, University of Saskatchewan Saskatoon).

Hoop, J. G., Di Pasquale, T., Hernandez, J. M., & Roberts, L. W. (2008). Ethics and culture in mental health care. *Ethics & Behavior*, *18*(4), 353-372. doi:10.1080/10508420701713048

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69) New York: Oxford University Press.

Howard, J. (2006). Expecting and accepting: The temporal ambiguity of recovery identities. *Social Psychology Quarterly*, *69*(4), 307–324.

Horvath A. O., & Luborsky L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consult Clinical Psychology, 61*(4), 561–573. doi:10.1037/0022-006X.61.4.561

Hovland, C. I., & Sherif, M. (1980). *Social judgment: Assimilation and contrast effects in communication and attitude change*. Westport:Greenwood.

Huang, H., Mattke, S., Batorsky, B., Miles, J., Liu, H., & Taylor, E. (2016). Incentives, program configuration, and employee uptake of workplace wellness programs. *Journal of Occupational and Environmental Medicine, 58*(1), 30-34. doi:10.1097/JOM.0000000000000613

Hutchinson, D. (2011). *The essential counselor: Process, skills and technique*. Vermont: Sage Publications.

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators of domestic violence. *Journal of Interpersonal Violence, 15*, 393–412. doi:10.1177/088626000015004004

Ino, A., Tatsuki, S., & Nishikawa, K. (2001). The Denial and Awareness Scale (DAS). *Japanese Journal of Alcohol Studies and Drug Dependence, 36*(3), 216–34.

Isenberg, S. (1991). *Women who love men who kill.* New York: Simon & Schuster.

Ivey, G., & Partington, T. (2014). Psychological woundedness and its evaluation in applications for clinical psychology training. *Clinical Psychology & Psychotherapy, 21*(2), 166-177. doi:10.1002/cpp.1816

Jackson, S. W. (2001). Presidential address: The wounded healer. *Bulletin of the History of Medicine, 75,* 1–36.

Jackson, H., & Nuttall, R. L. (2001). A relationship between childhood sexual abuse and professional misconduct. *Professional Psychology: Research and Practice, 32, 200–204*. doi:10.1037/0735-7028.32.2.200

Janis, I. L., & Mann, L. (1977*). Decision making: A psychological analysis of conflict, choice and commitment*. New York: Free Press.

Jennings, L., Sovereign, A., Bottorff, N., Mussell, M. P., & Vye, C. (2005). Nine ethical values of master therapists. *Journal of Mental Health Counseling*, *27*(1), 32-47. doi: 10.17744/mehc.27.1.lmm8vmdujgev2qhp

Jehu, D. (1994). *Patients as victims: Sexual abuse in psychotherapy and counselling*. Chichester:Wiley.

Jones, D. N. (2014). Predatory personalities as behavioural mimics and parasites: Mimicry-deception theory. *Perspectives on Psychological Science, 9*(40), 445-451. doi:10.1177/1745691614535936

Jones, C., & Armstrong, P. (2011, 10 May 2013). *Establishing a national register of mental health practitioners: A submission to the inquiry by the senate community affairs committee into Commonwealth funding and administration of mental health services*. Retrieved from

https://www.theaca.net.au/documents/Jones%20&%20Armstrong%20-%20Submision%20to%20Senate%20Enquiry%2026072011.pdf

Joubert, D., Webster, L., & Hackett, R. K. (2012). Unresolved attachment status and trauma-related symptomatology in maltreated adolescents: An examination of cognitive mediators. *Child Psychiatry & Human Development, 43*(3), 471-483. doi:10.1007/s10578-011-0276-8

Jung, C. G. (1946). *The psychology of the transference, Coll. Works, XVI.* London: Routledge and Kegan Paul.

Jung, C. G. (1951). *Fundamental questions of psychotherapy*. Princeton, NJ: Princeton University Press.

Kant, I. (1996). The metaphysics of morals. Cambridge: Cambridge University Press.

Karch, M. (2015, 15 April). *Boolean: How to find some or all of your search terms in Google.* Retrieved from

http://google.about.com/od/searchingtheweb/qt/booleantip.htm

Katz, J., & Beach, S. R. (2000). Looking for love? Self-verification and self-enhancement effects on initial romantic attraction. *Personality and Social Psychology 26*(12), 1526-1539. doi:10.1177/01461672002612007

Keats, P. A., Laitsch, D., & Fraser, S. (2010). Contemplating regulation for counsellors in Canadian schools: Current issues and concerns. *Canadian Journal of Educational Administration and Policy, 108*, 1-33.

Keller, U., & Schneider, R. (1976). Specific problems in the initial phase of

psychoanalytic training. *Dynamische Psychiatrie, 9*(1), 12-39.

Kemerling, G. (2011, 14 February). *Aristotle: Ethics and virtues.* Retrieved from

http://www.philosophypages.com/hy/2s.htm.

Keppel, G. (1993). *Introduction to design and analysis: A student's handbook*. New York:

W.H. Freeman and Company.

Keselman, H. J., Algina, J., Lix, L. M., Wilcox, R. R., & Deering, K. N. (2008). A

generally robust approach for testing hypotheses and setting confidence intervals

for effect sizes. *Psychological Methods, 13*, 110-129. doi:10.1037/1082-

989X.13.2.110

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). *Posttraumatic

stress disorder in the national comorbidity study*. *Archives of General Psychiatry,

52*(12), 1048-1060. doi:10.1001/archpsyc.1995.03950240066012

Khantzian, E. J. (2003). The self-medication hypothesis revisited: The dually diagnosed

patient. *Primary Psychiatry,10,* 47-48, 53-54. doi:10.3109/10673229709030550

Khele, S., Symons, C., & Wheeler, S. (2008). An analysis of complaints to the British

Association for Counselling and Psychotherapy, 1996-2006. *Counselling &

Psychotherapy Research, 8*(2), 124-132. doi:10.1080/14733140802051408

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The

foundation for ethical decisions in counseling psychology. *Counseling

Psychologist, 12*(3), 43-55. doi:10.1177/0011000084123005

Kidder, L. H., & Fine, M. (1987). Qualitative and quantitative methods: When stories

converge. In M. M., Mark, & R. L., Shotland (Eds.), *Multiple methods in program

evaluation: New Directions for Program Evaluation* (pp. 57-75). San Francisco:

Jossey-Bass.

Klayman, J., & Ha, Y. W. (1987). Confirmation, disconfirmation, and information in

> hypothesis testing. *Psychological Review, 94*, 211-228. doi:10.1037/0033-
>
> 295X.94.2.211

Kline, R. B. (2015). The mediation myth. *Basic and Applied Social Psychology, 37*(4),

> 202-213. doi:10.1080/01973533.2015.1049349

Kline, R. B. (2016). *Principles and practice of structural equation modelling* (4th ed.).

> New York, NY: Guilford Press.

Knopp, F. H. (1984). *Retraining adult sexual offenders: Methods and muddles*. Syracuse:

> Safer Society Press.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of

> client perceptions of the effects of helpful therapist self-disclosure in long-term
>
> therapy. *Journal of Counseling Psychology, 44(*3), 274-283. doi:10.1037/0022-
>
> 0167.44.3.274

Kohlberg, L. (1971). From is to ought: How to commit the naturalistic fallacy and get

> away with it in the study of moral development. In T. Mischel, *Cognitive*
>
> *development and epistemology* (pp. 164–165). New York: Academic Press.

Koocher, G. P. & Keith-Spiegel, P. C. (2008). *Ethics in psychology and the mental health*

> *professions: Standards and cases*. New York: Oxford University Press.

Koopman, C., Classen, C., Cardena, E., & Spiegel, D. (1995). When disaster strikes,

> acute stress disorder may follow. *Journal of Trauma Stress 8*(1), 29–46.
>
> doi:10.1007/BF02105405

Kottler, J. (1993). *On being a therapist*. San Francisco: Jossey-Bass.

Kremer, P. D. (n.d.) PhD [Unpublished raw data.]

Kunda, Z. (1987). Motivated inference: Self-serving generation and evaluation of causal

theories. *Journal of Personality and Social Psychology, 53*, 636-647.

doi:10.1037/0022-3514.53.4.636

Kunda, Z. (1990). The case for motivated reasoning. *Psychological Bulletin, 108*, 480–

498. doi:10.1037/0033-2909.108.3.480

Kunda, Z. (1999). *Social cognition: Making sense of people*. Massachusetts:

Massachusetts Institute of Technology.

Kutz, S. L. (1986). Defining "impaired psychologist". *American Psychologist*, *41*,(2),

220. doi:10.1037/0003-066X.41.2.220.a

Ladany, N., & Bradley, L. J. (2010). *Counselor supervision.* New York: Taylor &

Francis.

Langs, R. (1979). *The therapeutic environment*. Northvale, NJ: Jason Aronson.

Laliotis, D., & Grayson, J. (1985). Psychologist heal thyself: What is available to the

impaired psychologist? *American Psychologist, 40*, 84–96. doi:10.1037/0003-

066X.40.1.84

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *The Journal

of Humanistic Counseling, 46*(1), 20. doi:10.1002/j.2161-1939.2007.tb00023.x

Law Vision. (2008, 15 September 2013). *The law of torts*. Retrieved from

http://www.lawvision.com.au/uploads/PDFs/Tort%20Law%20.pdf

Lazarus, A. A., & Zur, O. (2002). *Dual relationships and psychotherapy.* New York:

Springer.

Leary, M. (2007). Motivational and emotional aspects of the self. *Annual Review of

Psychology, 58*(1), 317-344. doi:10.1146/annurev.psych.58.110405.085658

Leggett, A. (1994). A survey of Australian psychiatrist's attitudes and practices regarding physical contact with patients. *Australian and New Zealand Journal of Psychiatry, 28*(3), 488-497.

Lewin, K. (1939). Field theory and experiment in social psychology: Concepts and methods. *American Journal of Sociology, 44*(6), 868-896. doi:10.1086/218177

Lewin, K. (1997). *Resolving social conflicts and field theory in social science*. Washington, DC: American Psychological Association.

Library Council of New South Wales. (2011, 19 May 2014). *Civil law*. Retrieved from http://www.legalanswers.sl.nsw.gov.au/guides/australian_legal_system/what_the_law_deals_with.html.

Little, T. D. (2013). *Longitudinal structural equation modeling*. New York, NY: Guilford Press.

Lönnqvist, J. E., Leikas, S., Verkasalo, M., & Paunonen, S. V. (2008). Does self-enhancement have implications for adjustment? *Basic and Applied Social Psychology, 30*(4), 377-386. doi:10.1080/01973530802502374

Lustig, D. C., Strauser, D. R., Rice, N. D., & Rucker, T. F. (2002). The relationship between working alliance and rehabilitation outcomes. *Rehabilitation Counselling Bulletin, 46(*1), 24-32.

Lyengar, U., Kim, S. Martinez, S., Fonagy, P., & Strathern, L. (2014). Unresolved trauma in mothers: Intergenerational effects and the role of reorganization. *Frontiers in Psychology, 5*, 1-9. doi:10.3389/fpsyg.2014.00966

MacKinnon, D. P., Fairchild, A. J., & Fritz, M. S. (2007). Mediation analysis. *Annual Review of Psychology, 58*, 593-614. doi:10.1146/annurev.psych.58.110405.085542

McAdam, E. K. (1986). Cognitive behaviour therapy and its application with adolescents. *Journal of adolescence, 9*(1), 1-15. doi:10.1016/S0140-1971(86)80024-0

McAdams, D. P. (1996). Personality, modernity, and the storied self: A contemporary framework for studying persons. *Psychological Inquiry, 7,* 295-321. doi:10.1207/s15327965pli0704_1

McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology, 5*, 100–122. doi:10.1037/1089-2680.5.2.100

McCune, A. (2005, 2 June 2013). *Rights based ethics*. Retrieved from http://rhchp.regis.edu/hce/ethicsataglance/RightsBasedEthics/RightsBasedEthics.pdf

McDowell, B. (2000). *Ethics and excuses: The crisis in professional responsibility*. Westport, CT: Quorum Books.

McKeddie, J. (2013). Profiling a profession: A Victorian survey assessing lay attitudes toward and knowledge of counselling psychologists. *Australian Psychologist, 48*(2), 128-138. doi:10.1111/j.1742-9544.2011.00046.x

McMinn, M. R., & Meek, K. R. (1996). Ethics among Christian counselors: A survey of beliefs and behaviors. *Journal of Psychology and Theology*, 24, 26-37.

McMinn, M. R., Meek, K. R., & Mc Ray, B. W. (1997). Beliefs and behaviours among CAPS members regarding ethical issues. Faculty Publications - Graduate School of Clinical Psychology. Paper 145.

McRay, B. W., McMinn, M. R., & Meek, K. R. (1998). Questioning the "slippery slope": Ethical beliefs and behaviors of private office-based and church-based therapists. *Counseling and Values, 42*(2), 142. doi:10.1002/j.2161-007X.1998.tb00419.x

Mangal, S. K. (1987). *Abnormal psychology*. New Delhi: Sterling Publishers Private Limited.

Mathews, L. L., & Gerrity, D. A. (2002). Therapists' use of boundaries in sexual abuse

    groups: An exploratory study. *Journal for Specialists in Group Work, 27*(1), 78-

    91. doi:10.1177/0193392202027001007

Martin, P. D. (2006). *An investigation into the effects of vicarious trauma experienced by*

    health care workers (Doctoral dissertation, University of South Africa).

Meiselman, K. C. (1990). *Resolving the trauma of incest*. San Francisco, CA: Jossey-

    Bass.

Meir, E. I., Tziner, A. & Glazner, Y. (1997). Environmental congruence, group

    importance and job satisfaction. *Journal of Career Assessment, 5*, 343-353.

    doi:10.1177/106907279700500307

Menagh, J. (2015, 23 September). *Former counsellor sentenced for abusing boys at Perth*

    school. Retrieved from http://www.abc.net.au/news/2015-09-11/perth-paedophile-

    keith-huggins-sentenced/6768270

Mental Health Counselors and Marriage and Family Therapists: Occupational Outlook

    Handbook: U.S. Bureau of Labor Statistics. (2016, 5 May). *Bls.gov*. Retrieved from

    http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-

    and-marriage-and-family-therapists.htm#tab-6

Microsoft. (2010). *Excel* [Computer software]. Available from http://www.microsoft.com

Miller, D. T., & Turnbull, W. (1990). The counterfactual fallacy: Confusing what might

    have been with what ought to have been. *Social Justice Research, 4*, 1-19.

    doi:10.1007/BF01048532

Mind. (2010, 15 October). *The protection we deserve: Findings from a service user*

    survey on the regulation of counsellors and psychotherapists. Retrieved from

    http://www.cpcab.co.uk/downloads/The_Protection_We_Deserve__survey_report.p

    df

Mooney, C. Z., & Duval, R. D. (1993). *Bootstrapping: A non-parametric approach to statistical inference*. CA: Sage Publications.

Moore, D. A., & Loewenstein, G. (2004). Self-interest, automaticity, and the psychology of conflict of interest. *Social Justice Research, 17*(2), 189-202. doi:10.1023/B:SORE.0000027409.88372.b4

Mount, M. K., & Muchinsky, P. M. (1978). Person-environment congruence and employee job satisfaction: A test of Holland's theory. *Journal of Vocational Behaviour, 13*(1), 84-100. doi:10.1016/0001-8791(78)90074-X

Muldoon, O. T., & Lowe, R. D. (2012). Social identity, groups, and posttraumatic stress disorder. *Political Psychology, 33*(2), 259-273. doi:10.1111/j.1467-9221.2012.00874.x

Munro, G. D., & Ditto, P. H. (1997). Biased assimilation, attitude polarization, and affect in reactions to stereotyped-relevant scientific information. *Personality and Social Psychology Bulletin, 23*, 636-653. doi:10.1177/0146167297236007

Mueser, K.T., Rosenberg, S., Goodman, L.A., & Trumbetta, S. (2002). Trauma, PTSD and the course of severe mental illness: An interactive model. *Schizophrenia Research, 53*(1), 123-143. doi:10.1016/S0920-9964(01)00173-6

Mullen, P. E. (2001). Dangerousness, risk and the prediction of probability. In M.G. Geldner, J.J. Lopez-Ibor, & N. Andreason (Eds.), *New Oxford Textbook of Psychiatry London*. London:Oxford University Press.

Myers, D. G. (2009). *Social psychology*. New York: McGraw-Hill Higher Education.

Narvaez, D., & Lapsley, D. (2014). Becoming a moral person–moral development and moral character education as a result of social interactions. In M. Christen, C. van Schaik, J. Fischer, M. Huppenbauer & C. Tanner, *Empirically informed ethics:*

Morality between facts and norms (pp. 227-238). Switzerland: Springer

International Publishing.

Neborsky, R. J. (2003). A clinical model for the comprehensive treatment of trauma using

an affect experiencing-attachment theory approach. *Healing trauma: Attachment,*

mind, body, and brain, 282-321.

Negash, S., & Sahin, S. (2011). Compassion fatigue in marriage and family therapy:

Implications for therapists and clients. *Journal of Marital and Family Therapy,*

37(1), 1-13.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical complaints made against

credentialed counsellors: An updated survey of state licensing boards. *Counselor*

Education and Supervision,41, 57-70. doi:10.1111/j.1752-0606.2009.00147.x

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of

psychotherapists: Countertransference and vicarious traumatization in the new

trauma therapist. *Psychotherapy, 32*, 341-347. doi:10.1037/0033-3204.32.2.341

Newcomb, M., Burton, J., Edwards, N., & Hazelwood, Z. (2015). How Jung's concept of

the wounded healer can guide learning and teaching in social work and human

services. *Advances in Social Work and Welfare Education, 17*(2), 55-69.

New South Wales Coroners Court. (2009, 22 August 2013). *Coronial inquest Rebekah*

Anne Lawrence. Retrieved from

http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m40160116/

69_inquest_into_the_death_of_rebekah_lawrence.pdf

New South Wales Psychologists Act of 2001, (2001, 21 January 2014) *New South Wales*

psychologists Act. Retrieved from

http://www5.austlii.edu.au/au/legis/nsw/num_act/pa2001n69222.pdf

Nielsen, L. A. (1987). Substance abuse, shame and professional boundaries and ethics:

Disentangling the issues. *Alcoholism Treatment Quarterly, 4*, 109-137.

doi:10.1300/J020v04n02_08

Nienhuis, J. B., Owen, J., Valentine, J. C., Winkeljohn Black, S., Halford, T. C., Parazak,

S. E., Budge, S., & Hilsenroth, M. (2016). Therapeutic alliance, empathy, and

genuineness in individual adult psychotherapy: A meta-analytic review.

Psychotherapy Research, 1-13. doi:10.1080/10503307.2016.1204023

Niolon, R. (1999, 2 July). *The therapeutic relationship: Research and theory*. Retrieved

from http://www.psychpage.com/learning/library/counseling/thxrel2.htm.

Noble, C. H., & Walker, B. A. (1998). Exploring the relationships among liminal

transitions, symbolic consumption, and the extended self. *Psychology and

Marketing, 14*, 29-47. doi:10.1002/(SICI)1520-6793(199701)14:1<29::AID-

MAR3>3.0.CO;2-Q

Norris, D. M., Gutheil, T. G., & Strasburger, L. H. (2003). This couldn't happen to me:

boundary problems and sexual misconduct in the psychotherapy relationship.

Psychiatric Services, 54(4), 517-522. doi:10.1176/foc.5.4.foc476

North, D. C. (1993). What do we mean by rationality? *Public Choice, 77*(1), 159-162.

doi:10.1007/BF01049229

Novotney, A. (2016, 20 August). 5 ways to avoid malpractice. Retrieved

http://www.apa.org/monitor/2016/03/malpractice.aspx

O'Brien, J. M. (2011). Wounded healer: Psychotherapist grief over a client's death.

Professional Psychology: Research and Practice, 42(3), 236-243.

doi:10.1037/a0023788

O' Donnell, M. L., Lau, W., Tipping, S., Holmes, A. C., Ellen, S., Judson, R., Varker, T.,

Elliot, P., Bryant R. A., Creamer, M. C., & Forbes, D. (2012). Stepped early

psychological intervention for posttraumatic stress disorder, other anxiety

disorders, and depression following serious injury. *Journal of Traumatic Stress,*

25(2), 125-133. doi:10.1002/jts.21677

O'Keefe, L. (2000). The partners of prisoners: Their reality, how they contribute to the

criminal justice system and prisoner rehabilitation and how we can assist. Women

in corrections: Staff and clients conference convened by the Australian Institute of

Criminology, Adelaide, South Australia.

Offer, K. (2015, 15 September). *Evil acts of a perennial predator*. Retrieved from

http://www.perthnow.com.au/news/western-australia/allan-keith-huggins-had-a-

dodgy-cv-and-child-sex-conviction-but-how-did-he-get-away-with-it-for-so-

long/story-fnhocxo3-1227219865761

Office of the Juries Commissioner and the Victorian Law Foundation. (2010, 28

November 2013). *What a jury has to decide*. Retrieved from

http://www.courts.vic.gov.au/jury-service/what-jury-has-decide.

Ogden, J., & Mtandabari, T. (1997). Examination stress and changes in mood and health

related behaviours. *Psychology and Health, 12*, 289–299.

doi:10.1080/08870449708407406

Oordt, M. S. (1990). Ethics of practice among Christian psychologists: a pilot study.

Journal of Psychology and Theology, *18*(3), 255-260.

Orlinsky, D. E., Grawe, K., Parks, B. K. (1994). Process and outcome in psychotherapy.

In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior*

change (4th ed., pp. 270–378). New York, NY:Wiley.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L.

Garfield and A. E. Bergin, *Handbook of psychotherapy and behaviour change: An*

empirical analysis. (pp. 311–385) New York: Wiley.

Orlinsky, D. E., & Ronnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC: American Psychological Association.

Orlinsky, D. E., Ronnestad, M. H., Willutzki, U., Wiseman, H., & Botermans, J. F. (2005). The prevalence and parameters of personal therapy in Europe and elsewhere. In J. Geller, J. C. Norcross, & D. E. Orlinsky (Eds.), *The psychotherapist's own psychotherapy: Patient and clinician perspectives*. Oxford: Oxford University Press.

Orr, P. (1997). Psychology impaired? *Professional Psychology: Research and Practice, 28*, 293–296. doi:10.1037/0735-7028.28.3.293

Osterman, K. F., & Kootkamps, R. B. (1993). *Reflective practice for educators: Improving schooling through professional development.* California: Corwin Press Inc.

Owens, T. J., Robinson, D. T., & Smith-Lovin, L. (2010). Three faces of identity. *Annual Review of Sociology, 36*, 477-499. doi:10.1146/annurev.soc.34.040507.134725

Oxford Dictionaries. (2013, 1 June). *Malpractice.* Retrieved from http://oxforddictionaries.com/definition/english/malpractice.

Oxford Dictionaries. (2015, 26 April). *Misconduct.* Retrieved from http://oxforddictionaries.com/definition/english/misconduct.

Oyserman, D. (2009). Identity-based motivation: Implications for action-readiness, procedural-readiness, and consumer behaviour. *Journal of Consumer Psychology, 19,* 250-260. doi:10.1016/j.jcps.2009.06.001

Oyserman, D., Elmore, K., & Smith, G. (2009). Self, self-concept, and identity. In, M. R. Leary, & J. P. Tangney, *Handbook of self and identity*. New York: Guilford Press.

Packman, W. L., Cabot, M. G., & Bongar, B. (1994). Malpractice arising from negligent

psychotherapy: Ethical, legal and clinical implications of Osheroff v. Chestnut

Lodge. *Ethics & Behaviour, 4(*3), 175-197. doi:10.1207/s15327019eb0403_1

Parry, R. (2009, 10 July 2014). *Ancient ethical theory*. Retrieved from

http://plato.stanford.edu/archives/fall2009/entries/ethics-ancient.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury

Park, CA:Sage.

Pautasso, M. (2013). Ten simple rules for writing a literature review. *PLoS

Computational Biology,* 9(7), 1-4. doi:10.1371/journal.pcbi.1003149

Pease, K. (2001). Rational choice theory. In E. McLaughlin & J. Muncie, *The Sage

dictionary of criminology*. London: Sage Publications.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process.

Psychological Science, 8, 162-166.

Pennebaker, J. W., & Beall, S. (1986). Confronting a traumatic event: Toward an

understanding of inhibition and disease. *Journal of Abnormal Psychology, 95*(3),

274-281. doi:10.1037/0021-843X.95.3.274

Pennebaker, J. W., Kiecolt-Glaseer, J. K., & Glaser, R. (1988). Disclosure of traumas and

immune function: Health implications for psychotherapy. *Journal of Consulting and

Clinical Psychology, 56*(2), 239-245. doi:10.1037/0022-006X.56.2.239

Perel, E., & Saul, J. (1989). A family therapy approach to holocaust survivor families. In

P. Marcus & A. Rosenberg, *Healing their wounds: Psychotherapy with holocaust

survivors and their families*. New York: Praeger.

Petitpas, A. J., Brewer, B. W., Rivera, P. M., & Van Raalte, J. L. (1994). Ethical beliefs

and behaviors in applied sport psychology: *The AAASP ethics survey. Journal of

Applied Sport Psychology, 6*(2), 135-151. doi:10.1080/10413209408406290

Piaget, J. (1932). *The moral judgment of the child*. New York: Free Press.

Pope, K. S. (1990). Therapist patient sexual intimacy as sex abuse. *PsycCRITIQUES, 35*,
678-680. doi:10.1037/028811

Pope, K. S., & Bajt, T. R. (1988). When laws and values conflict: A dilemma for
psychologists. *American Psychologist, 43*, 828. doi:10.1037/0003-066X.43.10.828

Pope, K. S., & Feldman-Summers, S. (1992). National survey of psychologists' sexual
and physical abuse history and their evaluation of training and competence in these
areas. *Professional Psychology: Research and Practice, 23*(5), 353.
doi:10.1037/0735-7028.23.5.353

Pope, K.S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in
psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal
of Clinical Psychology in Session, 64*, 638-652. doi:10.1002/jclp.20477

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of
psychologists' experiences, problems, and beliefs. *Professional psychology:
Research and Practice, 25*(3), 247. doi:10.1037/0735-7028.25.3.247

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The
beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*, 996
-1006. doi:10.1037/0003-066X.42.11.993

Pope, K. S., & Vasquez, M. J. (2016). *Ethics in psychotherapy and counseling: A
practical guide*. John Wiley & Sons.

Pope, K.S., & Vetter, V.A. (1992). Ethical dilemmas encountered by members of the
American Psychological Association: A national survey. *American Psychologist,
47*, 397-411. doi:10.1037/0003-066X.47.3.397

Popper, K. R. (1963). *Conjectures and refutations*. Routledge & Kegan Paul.

Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS procedures for estimating indirect

    effects in simple mediation models. *Behavior Research Methods, Instruments, &*

    Computers, 36(4), 717-731. doi:10.3758/BF03206553

Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Assessing moderated mediation

    hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research,*

    42, 185-227. doi:10.1080/00273170701341316

Procci, W.R. (2007). A cautionary tale about boundary violations in psychodynamic

    psychotherapy and psychoanalysis. *Focus, 5,* 407-411.

Prochaska, J. O., & Norcross, J. C. (1983). Psychotherapists' perspectives on treating

    themselves and their clients for psychic distress. *Professional Psychology,*

    Research and Practice, 14, 642–655. doi:10.1037/0735-7028.14.5.642

Prout, T. A., & Wadkins, M. J. (2014). *Essential interviewing and counseling skills: An*

    integrated approach to practice. Springer Publishing Company.

Proeve, M., & Howells, K. (2002). Shame and guilt in child sexual

    offenders. *International Journal of Offender Therapy and Comparative*

    Criminology, *46*(6), 657-667.

Pseekos, A. C., Bullock-Yowell, E., & Dahlen, E. R. (2011). Examining Holland's

    person-environment fit, workplace aggression, interpersonal conflict and job

    satisfaction. *Journal of Employment Counselling, 48*(2), 63-71. doi:10.1002/j.2161-

    1920.2011.tb00115.x

Psychology Board of Australia (2014, 19 August). *Health profession agreement*

    Psychology Board of Australia and AHPRA. Retrieved from

    http://www.psychologyboard.gov.au/About/Health-Profession-Agreements.aspx

Psychotherapy and Counselling Federation of Australia (2011, 15 December). *Code of*

    ethics: The ethical framework for best practice in counselling and psychotherapy.

Retrieved from

http://www.pacfa.org.au/sitebuilder/resources/knowledge/asset/files/3/2012pacfaco

deofethics.pdf

Psychotherapy and Counselling Federation of Australia (2012, 10 July 2013). *Submission
to the review of the Australian government rebate on private health insurance for
natural therapies: Submission to the department of health and ageing.* Retrieved
from http://www.pacfa.org.au

Psychotherapy and Counselling Federation of Australia (2013, 10 July). *Counselling.*
Retrieved from http://www.pacfa.org.au.

Psychotherapy and Counselling Federation of Australia (2015, 23 January). *Interim code
of ethics*. Retrieved from http://www.pacfa.org.au/wp-
content/uploads/2014/04/Interim-Code-of-Ethics-2015.pdf

Psychology Board of Australia. (2015, 4 October). *Guidelines on continuing professional
development.* Retrieved,
http://www.psychologyboard.gov.au/documents/default.aspx?record=WD10%2f271
%5Bv3%5D&dbid=AP&chksum=e3E96c7g%2bS8Iw135bnsVPw%3d%3d

Psychologists Registration Board of Victoria v. Egan. VCAT 2443 Occupational and
Business Regulation. (14 September, 2011).

Pyszczynski, T., & Greenberg, J. (1987). Toward an integration of cognitive and
motivational perspectives on social inference: A biased hypothesis-testing model.
Advances in Experimental Social Psychology, 20, 297–340. doi:10.1016/S0065-
2601(08)60417-7

Pyszczynski, T., Greenberg, J., Solomon, S., & Schimel, J. (2004). Why do people need
self-esteem? A theoretical and empirical review. *Psychological Bulletin, 130*(3),
435-468. doi:10.1037/0033-2909.130.3.435

QSR International. (2012). *Nvivo 10* [Computer software]. Available from

    http://www.qsrinternational.com.

Quackenbush, S. L. (2004). The rationality of rational choice theory. *International*

    Interaction, 30(2), 87-101. doi:10.1080/03050620490462595

Quadrio, C. (1992). Sex and gender and the impaired therapist. *Australian and New*

    Zealand Journal of Psychiatry, 26(3), 346-363. doi:10.3109/00048679209072058

Quadrio, C. (1996). Sexual abuse in therapy: gender issues. Australian and New Zealand

    Journal of Psychiatry, 30(1), 124-131. doi:10.3109/00048679209072058

Racusin, G. R., Abramowitz, S. I., & Winter, W. D. (1981). Becoming a therapist: Family

    dynamics and career choice. *Professional Psychology, 12*(2), 271-279.

    doi:10.1037/0735-7028.12.2.271

Ralston, N. (2015, 27 September). *Sydney psychologist banned after he encouraged*

    female patient to have sex with a dog. Retrieved from

    http://www.theage.com.au/nsw/sydney-psychologist-banned-after-he-encouraged-

    female-patient-to-have-sex-with-a-dog-20150227-13r3x0.html

Ramirez, J. J., Dennhardt, A. A., Baldwin, S. A., Murphy, J. G., & Lindgren, K. P.

    (2016). Alcohol-approach inclinations and drinking identity as predictors of

    behavioral economic demand for alcohol. *Experimental and Clinical*

    Psychopharmacology, 24(5), 356-366. doi:10.1037/pha0000086

Rasmussen, A. S., & Berntsen, D. (2013). The reality of the past versus the ideality of the

    future: emotional valence and functional differences between past and future

    mental time travel. *Memory & Cognition, 41*(2), 187-200. doi:10.3758/s13421-

    012-0260-y

Raskin, R., Novacek, J., & Hogan, R. (1991). Narcissism, self-esteem, and defensive self-

enhancement. *Journal of personality*, *59*(1), 19-38. doi: 10.1111/j.1467-

6494.1991.tb00766.x

Rawls, J. (2001). *A theory of justice*. Cambridge: Harvard University Press.

Raubenheimer, J. (2004). An item selection procedure to maximise scale reliability and

validity. *South African Journal of Industrial Psychology, 30*(4), 59-64.

doi:10.4102/sajip.v30i4.168

Remley, T. P., Bacchini, E., & Krieg, P., (2010). Counselling in Italy. *Journal of

Counselling& Development, 88*(3), 28-32.

Resick, P. A. (1993). The psychological impact of rape. *Journal of Interpersonal

Violence, 8*(2), 223-233. doi:10.1177/088626093008002005

Richards, B., & Stewart, C. (2013). Professional conduct and making decisions for

minors. *Bioethical Inquiry, 10*, 11-15. doi:10.1007/s11673-012-9410-y

Richardson, J., Sheean, L., & Bambling, M. (2009). Becoming a psychotherapist or

counsellor: A survey of psychotherapy and counselling trainers. *Psychotherapy in

Australia, 16* (1), 70-80.

Rizq, R. (2007). On the margins: A psychoanalytic perspective on the location of

counselling, psychotherapy and counselling psychology training programmes within

universities. *British Journal of Guidance & Counselling, 35*(3), 283-297.

doi:10.1080/03069880701418763

Rodolfa, E., Hall, T., Holms, V., Davena, A., Komatz, D., Antunez, M., & Hall, A.

(1994). The management of sexual feelings in therapy. *Professional Psychology:

Research and Practice*, *25*(2), 168-172. doi:10.1037/0735-7028.25.2.168

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as

    developed in the client-centered framework. In S., Koch (Ed.) *Psychology: A study*

    of a science. New York: McGraw-Hill.

Rogers, C. R. (1961). On becoming a person: *A therapist's view of psychotherapy.* New

    York: Houghton Mifflin Company.

Rogers, C. R. (1965). *Client-centered therapy.* Boston: Houghton Mifllin Company.

Ronnestad, M. H, & Ladany, N. (2006). The impact of psychotherapy training:

    Introduction to the special section. *Psychotherapy Research, 16* (03), 261-267.

    doi:10.1080/10503300600612241

Sakurai, Y., & Smith, R. G. (2003, 1 May). *Gambling as a motivation for the commission*

    of financial crime. Retrieved from

    http://www.aic.gov.au/media_library/publications/tandi2/tandi256.pdf

Samson, G. W. (1861). *Outlines of the history of ethics by a teacher.* Washington: M'Gill

    & Witherow Printers.

Schaffer, M. A. (2009). A virtue ethics guide to best practice for community-based

    participatory research. *Program for Community Health and Partnership, 3*(1), 83-

    90. doi:10.1353/cpr.0.0053

Schofield, M. (2008, 9 September 2013). *Best practice self-regulation model for*

    psychotherapy and counselling in Australia. Retrieved from

    http://www.pacfa.org.au/wp-content/uploads/2012/10/2008-self-regulation-

    report.pdf

Schwebel, M., & Coster, J. (1998). Well-functioning professional psychologists: As

    program heads see it. *Professional Psychology, 29* (3), 284-292. doi:10.1037/0735-

    7028.29.3.284

Secretary of State for Health. (2007, 1 July 2013). *Trust, assurance and safety: The regulation of health professionals in the 21ˢᵗ century*. Retrieved from http://www.official-documents.gov.uk/document/cm70/7013/7013.pdf

Sedikides, C., & Gregg, A. P. (2008). Self-enhancement: Food for thought. *Perspectives on Psychological Science, 3*(2), 102–116. doi:10.1111/j.1745-6916.2008.00068.x

Sedikides, C., & Strube, M. J. (1995). The multiply motivated self. *Personality and Social Psychology Bulletin, 21*(12), 1330-1335. doi:10.1177/01461672952112010

Segen, J. (1992). *The dictionary of modern medicine*. New Jersey: Parthenon Publishing Group.

Seligman, M. E. P. (1998). *Learned optimism.* New York: Pocket Books.

Selye, H. (1976). *The stresses of life*. New York: McGraw Hill.

Shavit, N., & Bucky, S. (2004). Sexual contact between psychologists and their former therapy patients: Psychoanalytic perspectives and professional implications. *The American Journal of Psychoanalysis, 64*(3), 229-248. doi:10.1023/B:TAJP.0000041259.60877.14

Sherif, M., & Sherif, C. W. (1967). Attitudes as the individual's own categories: The social-judgment approach to attitude and attitude change. In C. W. Sherif and M. Sherif (eds.), *Attitude, ego-involvement and change.* New York: Wiley.

Sherif, C. W., Sherif, M., & Nebergall, R. E. (1965). *Attitude and attitude change: The social judgment-involvement approach*. Philadelphia: W. B. Saunders.

Sherman, M. D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review, 16,* 299-315. doi:10.1016/0272-7358(96)00016-5

Sileo, F. & Kopala, M. (1993). An A-B-C-D-E worksheet for promoting beneficence

when considering ethical issues. *Counseling and Values, 37*, 89-95.

doi:10.1002/j.2161-007X.1993.tb00800.x

Singer, P. (1993). *Practical ethics*. New York: Cambridge University Press.

Singh, S., & Ernst, E. (2008). *Trick or treatment: The undeniable facts about alternative

medicine.* WW Norton & Company.

Sinha, R. (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of the

New York Academy of Sciences, 1141*(1), 105-130. doi:10.1196/annals.1441.030

Simon, G. C. (1978). The psychologist as whistle blower: A case study. *Professional

Psychology, 9*, 322-340. doi:10.1037/0735-7028.9.2.322

Simon, H. A. (1956). Rational choice and the structure of the environment. *Psychological

Review, 63*, 129–138. doi:10.1037/h0042769

Simon, R. I. (1989). Sexual exploitation of patients: How it begins before it happens.

Psychiatric Annals, 19(2), 104-107. doi:10.3928/0048-5713-19890201-13

Simon, R. I. (1995). The natural history of therapist sexual misconduct: Identification and

prevention. *Psychiatric Annals, 25*(2), 90-94. doi:10.3928/0048-5713-19950201-07

Skorina, J. K. (1982). Alcoholic psychologists: The need for humane and effective

regulation. *Professional Practice of Psychology, 3*, 33-41.

Slim, H. (1997). Doing the right thing: Relief agencies, moral dilemmas and moral

responsibility in political emergencies and war. *Disasters, 21*(3), 244-257.

doi:10.1111/1467-7717.00059

Smart, J. C., Elton, C. F., & McLaughlin, G. W. (1986). Person-environment congruence

and job satisfaction. *Journal of Vocational Behaviour, 29*(2), 216-225.

doi:10.1016/0001-8791(86)90005-9

Smith, D. (2003, 10 May 2013). *10 ways practitioners can avoid frequent ethical pitfalls: Boost your ethical know-how with these practical tips on avoiding common ethical quandaries.* Retrieved from http://www.apa.org/monitor/jan03/10ways.aspx

Smith, R. G. (2003). Serious fraud in Australia and New Zealand. *Research and Public Policy Series, 48*, 1-79.

Smith, T., McGuire, J., Abbott, D., & Blau, B. (1991). Clinical ethical decision making: An investigation of the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice, 22(3)*, 235-239. doi: 10.1037/0735-7028.22.3.235

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice*, *16*, 1-5. doi:10.1111/j.1468-2850.2009.01137.x

Smith, J. R., & Terry, D. J. (2003). Attitude-behaviour consistency: The role of group norms, attitude accessibility and mode of behavioural decision-making. *European Journal of Social Psychology, 33,* 591-608. doi: 10.1002/ejsp.172

Snyder, M. L., Stephan, W. G., & Rosenfield, D. (1976). Egotism and attribution. *Journal of Personality and Social Psychology, 33*, 435–441. doi:10.1037/0022-3514.33.4.435

Sondheimer, A. (2010). Ethics and risk management in administrative child and adolescent psychiatry. *Leadership and Management Core Competencies, 19*(1), 115-129. doi:10.1016/j.chc.2009.08.002

Somer, E., & Nachmani, I. (2005). Constructions of therapist-client sex: A comparative analysis of retrospective victim reports. *Sexual Abuse: A Journal of Research and Treatment, 17*(1), 47- 63. doi:10.1007/s11194-005-1210-z

Spruiell, V. (1983). The rules and frames of the psychoanalytic situation. *Psychoanalytic*

    Quarterly, 52(1), 1-33.

Stadler, H., Willing, K., Eberhage, M., & Ward, W. (1996). Impairment: Implications for

    the counseling profession. *Journal of Counseling and Development, 66*, 258-260.

    doi:10.1002/j.1556-6676.1988.tb00863.x

Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2001). Phase-oriented treatment of

    structural dissociation in complex traumatisation: Overcoming trauma-related

    phobias. *Theory Therapy and Research, 6*(3),11-53. doi:10.1300/J229v06n03_02

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social*

    Psychology Quarterly, 63(3), 224-237. doi:10.2307/2695870

Stets, J. E., & Carter, M. J. (2012). A theory of self for the sociology of morality.

    American Sociological Review, 77(1), 120-140. doi:10.2307/2695870

Stierlin, H. (1972). Self-actualization and philosophical awareness. In *Twelve Therapists*,

    A. Burton, R Ekstein and A. Ellis. San Francisco: Jossey-Bass.

Story, A. L. (1998). Self-esteem and memory for favourable and unfavourable personality

    feedback. *Personality and Social Psychology Bulletin, 24*(1), 51-64.

    doi:10.1177/0146167298241004

Stovall-McClough, K. C., & Cloitre, M. (2003). Reorganization of unresolved childhood

    traumatic memories following exposure therapy. *Annals of the New York Academy*

    of Sciences, 1008(1), 297-299. doi:10.1196/annals.1301.036

Sullivan, K. (2002). Ethical beliefs and behaviours among Australian psychologists.

    Australian Psychologist, 37(2), 135-141.

Sussman, M. B. (2007). *A curious calling.* Lanham, Maryland: Jason Aronson.

Swann, W. B. (1983). Self-verification: Bringing social reality into harmony with the self. In J. Suls & A. G. Greenwald (Eds.), *Psychological perspectives on the self* (Vol. 2, pp. 33–66), Hillsdale, NJ: Erlbaum.

Swann, W. B. (1987). Identity negotiation: Where the two roads meet. *Journal of Personality and Social Psychology*, *53*, 1038-1051. doi:10.1037/0022-3514.53.6.1038

Swann, W. B., Hixon, J. G., & De La Ronde, C. (1992). Embracing the bitter "truth": Negative self-concepts and marital commitment. *Psychological Science*, *3*, 118-121. doi:10.1111/j.1467-9280.1992.tb00010.x

Swann, W. B., Pelham, B. W., & Krull, D. S. (1989). Agreeable fancy or disagreeable truth? Reconciling self-enhancement and self-verification. *Journal of Personality and Social Psychology 57* (5), 782–791. doi:10.1037/0022-3514.57.5.782

Swann, W. B., & Read, S. J. (1981a). Self-verification processes: How we sustain our self-conceptions. *Journal of Experimental Social Psychology*, *17* (4), 351–372. doi:10.1016/0022-1031(81)90043-3

Swann, W. B., & Read, S. J. (1981b). Acquiring self-knowledge: The search for feedback that fits. *Journal of personality and Social Psychology, 41*(6), 1119-1128. doi:10.1037/0022-3514.41.6.1119

Swann, W. B., Rentfrow, P. J., & Guinn, J. (2003). Self-verification: The search for coherence. In M. R. Leary & J. Tangney (Eds.), *Handbook of self and identity* (pp.367–383). New York: Guilford.

Swanson, B. (2010, 12 September 2013). *Moral identity: Moving toward better understanding the moral judgment-action gap*. Retrieved from http://www.s-r-a.org/announcements/online-newsletter/2010-09-02-moral-identity-moving-toward-better-understanding-moral-j.

Symons, C., Khele, S., Roger, J., Turner, J., & Wheeler, S. (2011). Allegations of serious

professional misconduct: An analysis of British Association for Counselling and

Psychotherapy's article 4.6 cases, 1998-2007. *Counselling and Psychotherapy*

Research, 11(4), 257-265. doi:10.1080/14733145.2010.519044

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics.* Boston: Allyn and

Bacon.

Tabachnick, B. G., Keith-Spiegel, P. & Pope, K. S. (1991). Ethics of teaching: Beliefs

and behaviors of psychologists as educators. *American Psychologist, 46*(6), 506-

515. doi:10.1037/0003-066X.46.5.506

Taber, B. J., Leibert, T. W., & Agaskar, V. R. (2011). Relationships among client–

therapist personality congruence, working alliance, and therapeutic outcome.

Psychotherapy, 48(4), 376 – 380. doi:10.1037/a0022066

Tasca, C., Rapetti, M., Carta, M. G, & Fadda, B. (2012). Women and hysteria in the

history of mental health. *Clinical Practice & Epidemiology in Mental Health, 8*,

110-119. doi:10.2174/1745017901208010110

Tarvydas, V. M., Leahy, M. J., Saunders, J. L., Chan, F., Thielsen, V. A., & Murray, G.

(2001). Beliefs about the ethics of practice among CRCs: A national survey.

Journal of Applied Rehabilitation Counseling, 32, 9-18.

Taylor, C. (1989). *Sources of the self: The making of modern identity.* Cambridge, MA:

Harvard University Press.

Taylor, S. E., & Brown, J. D. (1988). Illusion and wellbeing: A social psychological

perspective on mental health. *Psychological Bulletin, 103*(2), 193–210.

doi:10.1037/0033-2909.103.2.193

Taylor, S. E., & Sherman, D. K. (2008). Self-enhancement and self-affirmation: The

    consequences of positive self-thoughts for motivation and health. In, W. Gardner

    & J. Shah (Eds.) *Handbook of Motivation Science*. New York, NY: Guilford.

Tenbrunsel, A. E., & Messick, D. M. (2004). Ethical fading: The role of self-deception in

    unethical behavior. *Social Justice research, 17* (2), 223- 236.

    doi:10.1023/B:SORE.0000027411.35832.53

Terr, L. C. (1988). What happens to early memories of trauma? A study of twenty

    children under age five at the time of documented traumatic events. *Journal of the*

    American Academy of Child & Adolescent Psychiatry, 27(1), 96-104.

    doi:10.1097/00004583-198801000-00015

Thoreau, H. D. (1849). *Civil disobedience and other essays*. Stilwell: Digireas.com

    Publishing.

Thoreson, R. W., Nathan, P. E., Skorina, J. K., & KIlburg, R. R. (1983). The alcoholic

    psychologist: Issues, problems, and implications for the profession. *Professional*

    Psychology, Research and Practice, 14, 670–684. doi:10.1037/0735-

    7028.14.5.670

Trafimow, D. (2015). Introduction to the special edition on mediation analyses: What if

    planetary scientists used mediation analysis to infer causation? *Basic and Applied*

    Social Psychology, 37, 197-201. doi:10.1080/01973533.2015.1064290

Training.gov.au (2016, 11 May). *Diploma of counselling*. Retrieved from

    https://training.gov.au/Training/Details/CHC51015

Trevino, L. K., & Youngblood, S. A. (1990). Bad apples in bad barrels: A causal analysis

    of ethical decision-making behaviour. *Journal of Applied Psychology,75*(4), 378-

    385. doi:10.1037/0021-9010.75.4.378

Trope, Y. (1980). Self-assessment, self-enhancement, and task preference. *Journal of Experimental Social Psychology, 16*(2), 116–129. doi:10.1016/0022-1031(80)90003-7

Tryon, G. S. (1986). *The professional practice of psychology*. Westport, CT: Ablex Publishing.

Twemlow, S. W., & Gabbard, G. O. (1989). The lovesick therapist. In G. O. Gabbard (Ed.), *Sexual exploitation in professional relationship (pp. 71-87)*. Washington, DC: American Psychiatric Press.

Unregistered Health Practitioners Act 2012 (New South Wales)

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic Stress: The effects of overwhelming experience on mind, body, and society.* New York, NY: The Guilford Press.

van Gennep, A. (1960). *The rites of passage*. University of Chicago press: Chicago.

van Hoose, W. H., & Paradise, L. V. (1979). *Ethics in counseling and psychotherapy: Perspectives in issues and decision-making.* Cranston, RI: Carroll Press.

van Raan, A. F. J. (2004). Sleeping beauties in science. *Scientometrics 59*(3), 467–472. doi:10.1023/B:SCIE.0000018543.82441.fl

Vasco, A., Garcia-Marques, L., & Dryden, W. (1993). Psychotherapist know thyself: Dissonance between metatheoretical and personal values in psychotherapists of different theoretical orientations. *Psychotherapy Research, 3(*3), 181-207. doi:10.1080/10503309312331333779

Velasquez, M., Andre, C., Shanks, T., & Meyer, M. J. (1988). *Ethics and virtue. Issues in Ethics*, 1, (3), 1-2.

Velicer, W. F., & Jackson, D. N. (1990). Component analysis versus common factor-

analysis: Some further observations. *Multivariate Behavioral Research, 25(*1), 97-

114. doi:10.1207/s15327906mbr2501_1

Victorian Department of Health (2011, 24 October 2013). *Options for regulation of

unregistered health practitioners: A consultation paper.* Retrieved from

http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-

%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitio

ners.pdf

Virtue Science (2013, 22 August). *List of virtues*. Retrieved from

http://www.virtuescience.com/virtuelist.html.

Walker, J. (2007). Unresolved loss and trauma in parents and the implications in terms of

child protection. *Journal of Social Work Practice, 21*(1), 77-87.

doi:10.1080/02650530601173656

Wallace, H. M. (2011). In K. W. Campbell, & J. Miller (2011). *Handbook of narcissism

and narcissistic personality disorder: Theoretical approaches, empirical findings,

and treatment.* Hoboken, NJ: Wiley.

Ward, S. J. A. (2010, 22 August). *Ethics in a Nutshell*. Retrieved from

https://ethics.journalism.wisc.edu/resources/ethics-in-a-nutshell/

Warner, J., & Gabe, J. (2004). Risk and liminality in mental health social work. *Health,

Risk & Society, 6*(4), 387-399. doi:10.1080/13698570412331323261

Wason, P. C., & Johnson-Laird, P. N. (1972). *Psychology of reasoning: Structure and

content*. Cambridge: Harvard University Press.

Waterman, A. S. (1988). On the uses of psychological theory and research in the process

of ethical injury. *Psychological Bulletin, 103*, 283-298. doi:10.1037/0033-

2909.103.3.283

Weiss, D. S. (2007). The impact of event scale: Revised. In J. P. Wilson & C. S. Tang

    (Eds.), *Cross-cultural assessment of psychological trauma and PTSD*. New York:

    Springer.

Weiss, D., & Marmar, C. (1997). The Impact of Event Scale -Revised. In J. Wilson & T.

    Keane (Eds), *Assessing psychological trauma and PTSD*. New York: Guildford.

Wenar, L. (2011, 16 September). *Rights*. Retrieved from

    http://plato.stanford.edu/entries/rights/#3

Wheeler, S. (2002). Nature or nurture: Are therapists born or trained? *Psychodynamic*

    Practice, 8(4), 427–441. doi:10.1080/1353333021000038809

White, M. J., Brockett, D. R., & Overstreet, B. G. (1993). Confirmatory bias in evaluating

    personality test information: Am I really that kind of person? *Journal of*

    Counseling Psychology, 14(1), 120-126. doi:10.1037/0022-0167.40.1.120

Wichstrøm, L., Anderson, A. M., Holte, A., Husby, R., & Wynne, L. C. (1996).

    Confirmatory and disconfirmatory family communication as predictor of offspring

    socio-emotional functioning. A 10 to 14-year follow-up of children at risk. *Acta*

    Psychiatrica Scandinavica, 93(1), 49-56.

Wilbert, J. R., & Fulero, S. M. (1988). Impact of malpractice litigation on professional

    psychology: Survey of practitioners. *Professional Psychology: Research and*

    Practice, 19(4), 379-382. doi:10.1037/0735-7028.19.4.379

Wilkins, M., McGuire, J., Abbott, D., & Blau, B. (1990). Willingness to apply understood

    ethical principles. *Journal of Clinical Psychology, 46(4)*, 539-547. doi:

    10.1002/1097-4679

Williams, G. (2007, 9 March 2014). *The Victorian Charter of Human Rights and*

    *Responsibilities: Origins and Sco*pe. Retrieved from

    http://www.law.unimelb.edu.au/files/dmfile/30_3_7.pdf

Williams, E. N., Judge, A. B., Hill, C. E., & Hoffman, M. A. (1997). Experiences of

novice therapists in prepractium: Trainees', clients', and supervisors' perceptions of

therapists' personal reaction and management strategies. *Journal of Consulting

Psychology, 44*, 390-399. doi:10.1037/0022-0167.44.4.390

Witmer, J., & Young, M. (1996). Preventing counsellor impairment: A wellness model.

Journal of Humanistic Education and Development, 34, 141–155.

doi:10.1002/j.2164-4683.1996.tb00338.x

Wood, B. J., Klein, S., Cross, H. J., Lammer, C. J., & Elliott, J. K. (1985). Impaired

practitioners: Psychologists' opinions about prevalence, and proposals for

intervention. *Professional Psychology: Research and Practice, 16*(6), 843-850.

doi:10.1037/0735-7028.16.6.843

World Health Organisation. (1992). *International statistical classification of diseases and

related health problems* (10th Revision). Geneva: World Health Organisation.

World Health Organisation. (2015, 12 August). *International statistical classification of

diseases 11: Beta draft*. Retrieved from

http://apps.who.int/classifications/icd11/browse/l-m/en

World Health Organisation. (2017, 2 March). *Mental and neurological disorders*.

Retrieved from

http://www.who.int/whr/2001/media_centre/en/whr01_fact_sheet1_en.pdf?ua=1

Yates, J., & James, D. (2010). Risk factors at medical school for subsequent professional

misconduct: Multicentre retrospective case-control study. *British Medical Journal,

340*, 1-8. doi:10.1136/bmj.c2040

Yong, A. G., & Pearce, S. (2013). A beginner's guide to factor analysis: Focusing on

exploratory factor analysis. Tutorials in Quantitative Methods for Psychology, 9(2),

79-94.

Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer.

    Psychotherapy, 49(4), 482. doi:10.1037/a0027824

Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm?

    Psychotherapy Bulletin, 39(3), 27-32.

Zur, O. (2009). Power in psychotherapy and counseling: Exploring the inherent power

    differential and related myths about therapists' omnipotence and client's

    vulnerabilities. *Independent Practitioner, 29*(3), 160-161.

Appendices

Appendix 1. Psychometric Analysis of the Ethics of Practice Questionnaire - Revised

Abstract

The present study assessed the psychometric properties of the 47-item Ethics of Practice Questionnaire (EPQ-47) using an Exploratory Factor Analysis (EFA). The original 83item Ethics of Practice Questionnaire (EPQ), developed by Pope, Tabachnick, and Keith-Spiegel (1987), function was to gauge the extent to which participants agreed that particular behaviours occurring during the provision of therapeutic services were ethical. The EPQ requires participants provide at least two responses per item and is quite time-consuming. This is compounded further when administering the EPQ with other instruments. The EPQ was originally designed and administered to a population of registered psychologists in the United States, therefore restricting its use to other populations without modifications. Results from the present study provide support for a five-factor model, comprising the following subcomponents: blurred, dual or conflicting relationships ($\alpha = .83$), competence ($\alpha = .74$), policy, financial and legal ($\alpha = .70$), confidentiality ($\alpha = .73$), and Sexualisation ($\alpha = .64$). Whilst a sixth factor that explored attitudes associated with a counsellor's personal disclosure of information or emotionality ($\alpha = .44$) was removed. The EPQ-R is a reduced item instrument that can be administered with other questionnaires to a diverse population of counselling professionals. Evidence from the present study suggests that the EPQ-R is adequate to assess counsellor's beliefs concerning the ethical status of commonly occurring behaviours in practice.

In Australia, all regulated and voluntarily registered counselling professionals commit to a code of conduct. An important component of membership is that counsellors provide an undertaking to deliver therapeutic services in an ethical manner. For example, the Australian Psychological Society (APS) employs similar guiding principles to those of the American Psychology Association's (APA) code of ethics.

The onus for adhering to codes of conduct falls to the individual professionals, and to a lesser extent their supervisors and managers; and to a lesser extent again to clients able to assert their rights. There are penalties for contravening codes of conduct, including informal or official reprimand or admonishment, financial penalty, suspension or cancellation of the right to practice, or even incarceration (though this would generally apply to a breach of law rather than just a breach of code). However, these penalties are punishment for acts committed, after the damage has already been done. There is value in trying to understand the circumstances that lead to breaches, and determine the elements that make it more likely that a particular professional will breach, as a precursor to halting unethical behaviours earlier and counselling professionals appropriately.

Going beyond official records of breaches, attempts have been made to gain a better picture of the extent of unethical behaviour, particularly amongst those who have not (yet) come to the attention of supervisors, regulatory bodies and licensing boards – comparisons of the difference in behaviours between what various codes of conduct stipulate and what counsellors actually do in practice (Gibson & Pope, 1993; McMinn & Meek, 1996; Oordt, 1990; Petitpas, Brewer, Rivera & Van Raalte, 1994; Pope, Tabachnick, & Keith-Spiegel, 1987). Since 1987, several large-scale surveys have been conducted in the United States and one in Australia. One instrument that has been extensively used is the Ethics of Practice Questionnaire (EPQ; Pope, Tabachnick, & Keith-Spiegel, 1987). Pope, Tabachnick, and Keith-Spiegel (1987) cite the APA code of ethics as a theoretical framework upon which the

items in the original EPQ instrument were developed. The original instrument included five domains —avoiding harm, demonstrating competence, avoiding exploitation, showing respect, and maintaining confidentiality — drawn from the Hippocratic Oath and two additional domains of informed consent and social equity and justice. The EPQ was designed to measure the extent to which participants agreed that particular behaviours that occurred during the provision of therapeutic services were ethical.

A summary of EPQ studies undertaken, predominately within the United States, and a description of the participant groups are in Table 1. EPQ -83 refers to the original 83-item measure as designed by Pope, et al (1987), other numerals relate to the number of items included in adapted versions. The instrument asks participants to rate ("Unquestionably no" to "Unquestionably yes" regarding the appropriateness of behaviour in a professional capacity) their agreement with a series of statements, such as "Being sexually attracted to a client," and "Advertising for services." Then rate ("Never" to "Frequently") the likely occurrence of these behaviours in their practice.

Table 1. *Summary of Studies Administering the Original EPQ and Variants*

Authors	Instrument	Participants
Pope, Tabachnick, and Keith-Spiegel (1987)	The original 83-item instrument (EPQ-83) developed by Pope, Tabachnick, and Keith-Spiegel (1987) using a 5-point Likert scale to assess ethical beliefs about the ethical status, and occurrence of behaviours in practice.	456 Psychologists who were members of Division 29 of the American Psychological Association.
Oordt (1990)	EPQ-83	69 Christian clinicians who were members of the American Psychological Association.
Tabachnick, Keith-Spiegel and Pope (1991)	EPQ-63: adapted for educators.	482 American Psychological Association members whose primary work setting is in an institution of higher education.
Gibson and Pope (1993)	An expanded 88-item (EPQ-88; Gibson and Pope, 1993) instrument using a 5-point Likert scale to assess ethical beliefs about the ethical status, and occurrence of behaviours in practice.	579 Counsellors certified by the National Board for Certified Counsellors.
Petitpas, Brewer, Rivera and Van Raalte (1994)	A modified instrument was developed and administered using a 5-point Likert scale to assess ethical beliefs about the ethical status, and occurrence of behaviours in practice as it relates to adapted for Sport Psychologists.	165 members of the American Association for Applied Sport Psychology.
McMinn and Meek (1996)	EPQ-88	496 Christian counsellors who were members of the American Association of Christian Counsellors.
McMinn, Meek, and McRay (1997)	EPQ-88	498 members of the American Association of Christian Counsellors.
McRay, McMinn and Meek (1998)	EPQ-88	A subset of McMinn and Meek (1996) study of 77 members of Christian Association for Psychological Studies.
Sullivan (2012)	EPQ-88.	633 psychologists who were members of the Australian Psychology Society.

The original EPQ-83 study, Pope, Tabachnick, and Keith-Spiegel (1987) administered the instrument to 456 members of Division 29 of the APA. The authors claim that results from that study provided an important insight into what psychologists believe constituted ethical behaviours in practice across the United States. In 2012, Sullivan administered the EPQ-88 to APS members across Australia and published the results. The commonalities between the APA and APS codes of ethics and the population of interest (regulated psychologists) provided an opportunity to make direct comparisons between the two studies.

The original instrument was developed using several sources as guiding principles (the APA code of ethics, for example). Items were produced in accordance with several predetermined domains — avoiding harm, demonstrating competence, avoiding exploitation, showing respect, and maintaining confidentiality — however little has been done in terms of checking the validity and reliability for the EPQ and various derivative studies. In the one study that did attempt to explore the validity of the EPQ-88, McMinn, Meek and Mc Ray (1997) conducted both exploratory and confirmatory factor analyses on a large sample ($N = 498$) of respondents' data, computing and interpreting factors with Eigen values of 1.5 or greater. The analysis was split to cover both beliefs about the ethical status of items and behaviours in practice. The analysis resulted in the following constructs (and associated Cronbach's alpha). The beliefs analysis included only two factors, Blatant Errors ($\alpha = .97$) and Multiple Roles ($\alpha = .87$). Whilst the behaviours analysis concluded in determining three constructs, Confidentiality ($\alpha = .86$), Sexual Counter Transference ($\alpha = .88$) and Immoral Violations ($\alpha = .83$).

In spite of the lack of validity and reliability analyses, the EPQ arguably has reached a stage in its life cycle that now requires a revision. Test revision is a normal part of the life cycle of any instrument (Cohen & Swerdlik, 2010). Test are deemed ready for revision due to many factors, however several that seem to apply to the EPQ include; that materials may be

out of date, culturally or professionally items may no longer seem relevant to test-takers, testing norms are no longer adequate due to group membership changes in the population of interest, items do not measure the underlying constructs they purport to (Cohen & Swerdlik, 2010).

The development of the original EPQ-83 occurred almost 20-years' ago. Since this time changes in codes in codes of ethics may have occurred and items may not be as applicable today as once they were. In terms of applicability, the EPQ, and derivatives, were constructed with adherence to APA code of ethics. Given that not all ethics codes of conduct around the world are identical to the APA code, this may suggest that there is no universality — to other sectors of the counselling profession — of the EPQ instrument/s. Finally, there appears to be only one study that has attempted to confirm that items developed with the intent of measuring the original domains (avoiding harm, demonstrating competence, avoiding exploitation, showing respect, and maintaining confidentiality) actually measure what they purport to. Therefore, giving due consideration to the aforementioned rationale and a requirement for further analysis, a revised version of the EPQ is required.

The EPQ-47 is a 47-item instrument reduced by the authors. Items were selected from the EPQ-83 on the basis of avoiding repetition of similar items — for example, the removal of 'having a client address you by your first name' and retaining 'addressing client by his or her first name' — and perceived relevance to a diverse population of counselling professionals (general counsellors, psychologists, social works etc.). An example of such an item includes, 'utilising involuntary hospitalisation' which is not applicable to unregulated counsellors and generally registered psychologists in Australia. The aim of the present study was to conduct an Exploratory Factor Analysis to determine the psychometric properties of the EPQ-47.

Method

Participants

Participants were 419 individuals (253 females, 52 males, 3 identified as other, 111 did not record their gender), all were Australian professionals who self-reported being engaged in counselling as a significant part of their job, including counsellors, psychologists, social workers, and psychotherapists with an average of 12 years' practice experience (M = 11 years, SD = 9) ranging in age from 25 to 76 years (M = 52 years, SD = 11). The sample size was over 300 and deemed adequate for Exploratory Factor Analysis (Tabachnick & Fidell, 2001).

Measures

Ethics of Practice Questionnaire Revised (EPQ-R). The EPQ is an 83-item instrument developed by Pope, Tabachnick, and Keith-Spiegel (1987) to measure the extent to which a population of United States regulated psychologists agreed that particular behaviours in the course of providing therapeutic services are ethical. The original 83-item instrument was reduced to 47 items for the current study. Items were selected based on relevance to a diverse population of interest — a population which contains both regulated and unregulated counsellors in Australia. The items removed from the original EPQ-83 (Appendix 7) were considered repetitious in nature and were deemed to be adequately covered by similar items elsewhere within the instrument.

The authors independently reviewed the selection and a consensus was reached about the inclusion/exclusion of items in the EPQ-47. Participants were asked to rate ("Unquestionably no" to "Unquestionably yes" regarding the appropriateness of behaviours in a professional capacity) their agreement with a series of statements, such as "Being sexually attracted to a client," and "Advertising for services." Then rate ("Never" to

"Frequently") the likely occurrence of these behaviours in their practice. The 47-item EPQ-R achieved good internal consistency with an overall Cronbach's Alpha of .86.

Procedure

Before commencing the study, ethical approval was received from Monash University Human Research Ethics Committee (Approval Number CF13/2485 - 2013001319). Approval was given to create awareness of the study through industry associations and direct contact with organisations promoting mental health services online across Australia. Counsellors received an email with a link to access an online survey hosted by Qualtrics (www.qualtrics.com). Professionals willing to participate provided consent and completed the questionnaire within 35 to 40-minutes. Data were downloaded, collated, scored and analysed using Microsoft Excel and IBM SPSS Version 23. All analyses were conducted using a 95% confidence interval. Data were screened for missing values, outliers and normality. Ten outliers were 'winzorized' (Keselman, Algina, Lix, Wilcox, & Deering, 2008), adjusted within +/- two standard deviations from the mean.

<div align="center">

Results

</div>

Exploratory factor analysis

An Exploratory Factor Analysis (EFA) was conducted to determine the number of latent constructs, or factors, reflected in the observed data relating only to the ethical beliefs in practice aspect of collected data from the EPQ-R. First, the factorability of the 47-item questionnaire was examined. A Kaiser-Meyer-Olkin measure of sampling adequacy was .86, above the commonly recommended value of .6 (Neill, 2008), and Bartlett's Test of Sphericity was significant (χ^2 (1081) = 4812.56, p < .001). The communalities ranged between .29 to .72 (see Table 2). Two items were removed, items 2 "Charging a client no fee for therapy" and 8 "Hugging a client", for having very little shared variance with other items. These items indicated communalities below .29. Tabachnick and Fidell (2001) recommend researchers

inspect the correlation matrix for coefficients over .30. Hair, Anderson, Tatham, and Black

(1995) categorised these loadings using a different rule of thumb as +/- 0.30 = minimal, +/-

0.40 = important, and +/- .50= virtually significant. Given an assessment of the

aforementioned indicators, factor analysis was deemed by the author to be suitable for all 34

items.

Table 2. *Communalities for Belief Items within the Initial Extraction the EPQ-R*

Item	Question	Communalities
1	Becoming social friends with a former client	.37
2	Charging a client no fee for therapy**	.23
3	Providing therapy to one of your friends	.50
4	Advertising your services	.29
5	Limiting treatment notes to name, date, and fee	.33
6	Filing an ethics complaint against a colleague	.32
7	Telling a client you are angry at him or her	.33
8	Hugging a client**	.23
9	Terminating therapy if client cannot pay	.34
10	Accepting services from a client in lieu of fee	.50
11	Seeing a minor client without parental consent	.48
12	Having clients take tests (e.g., MMPI, Neo PI-R) at home	.34
13	Altering a diagnosis to meet insurance criteria	.54
14	Telling a client: "I'm sexually attracted to you."	.60
15	Refusing to let clients read their case notes	.29
16	Using a collection agency to collect late fees	.46
17	Breaking confidentiality if client is homicidal	.44
18	Using self-disclosure or rapport as a therapy technique	.32
19	Accepting a client's gift worth at least $50	.30
20	Working when too distressed to be effective	.34
21	Accepting only male or female clients	.42
22	Not allowing client access to testing reports	.29
23	Raising the fee during the course of therapy	.41
24	Breaking confidentiality if client is suicidal	.48
25	Allowing a client to run up a large unpaid bill	.39
26	Accepting goods (rather than money) as payment	.45
27	Using sexual surrogates with clients	.45
28	Breaking confidentiality to report child abuse	.42
29	Inviting clients to a party or social event	.52
30	Addressing client by his or her first name	.40
31	Crying in the presence of a client	.33
32	Asking favours (e.g., a ride home) from clients	.59
33	Accepting a client's decision to commit suicide	.40
34	Refusing to disclose a diagnosis to a client	.33
35	Leading nude group therapy	.38
36	Telling clients of your disappointment in them	.39
37	Discussing clients (without names) with friends	.35
38	Providing therapy to your student or supervisee	.38
39	Giving gifts or commissions to those who refer clients to you	.38
40	Using a lawsuit to collect fees from clients	.49
41	Becoming sexually involved with a former client	.48
42	Avoiding certain clients for fear of being sued	.41
43	Going into business with a client	.72
44	Being sexually attracted to a client	.35
45	Providing services outside areas of competence	.50
46	Engaging in sexual fantasy about a client	.48
47	Directly soliciting a person to be a client	.49

Note. N = 419, Maximum likelihood analysis with oblique rotation. ** items to be removed.

An analysis was conducted using Maximum Likelihood extraction, based on a pre-selection of a maximum of six factors. Velicer and Jackson (1990) contend that using eigenvalues is one of the least accurate methods for selecting factors. Costello and Osborne (2005) suggest that eigenvalues of greater than one may result in the retention of too many factors making interpretation difficult. Given the exploratory nature of this study, an oblique rotation using Promax with a Kappa value of four indicated the first six factors explained (18.54%, 6.69%, 2.27%, 2.21%, 1.84% and 2.02% separately) a total of 31.54% of the variance in the overall model. A scree plot indicates a 'levelling off' of eigenvalues between factors six and seven — Figure 1.
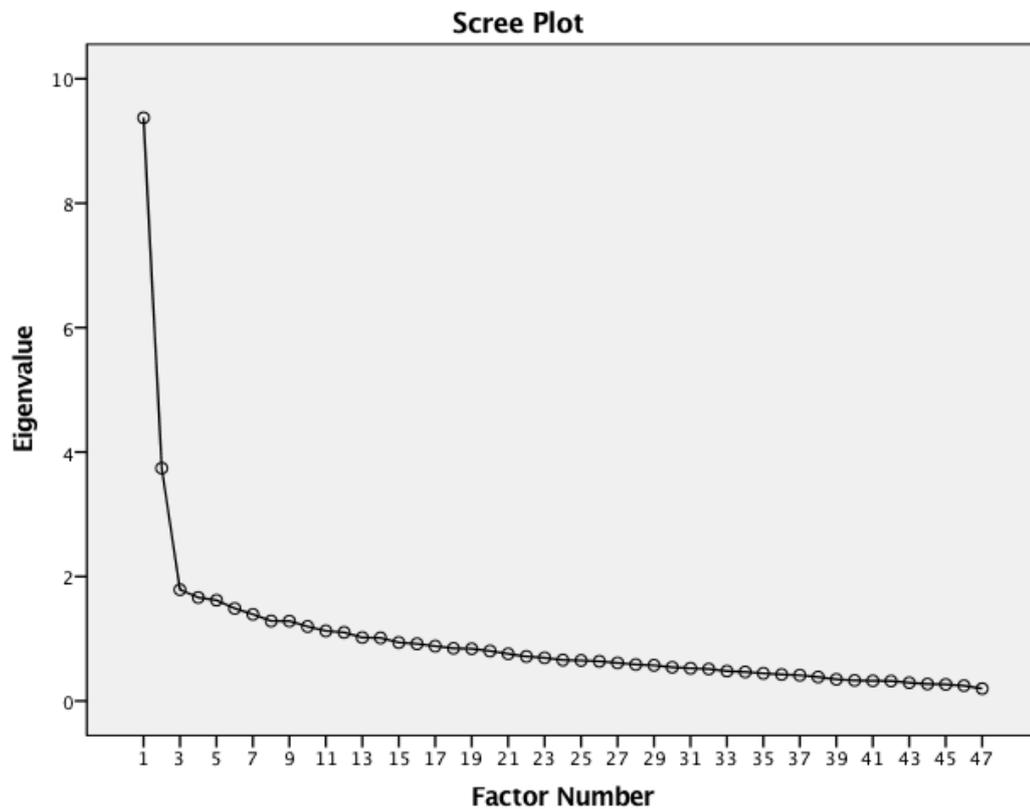
Figure 1. Scree plot for eigenvalues for the Ethics of Practice Questionnaire Revised

Loading patterns

The pattern and structural matrices revealed a similar configuration of loadings. The present study used the structure matrix as it was deemed easier to interpret. Table 3 provides the details of the loadings pattern. Initially, a total of 36 of the 47 items loaded uniquely onto six factors. Item numbers 3. "Providing therapy to one of your friends", 14. "Telling a client: "I'm sexually attracted to you.", 29. "Inviting clients to a party or social event", and 41. "Becoming sexually involved with a former client" indicated cross loadings on multiple factors, however, due to the underlying latent nature of the variable and their relationship with a specific factor each was retained (see Yong, & Pearce, 2013).

The following items were deleted due to cross loadings, 4. "Advertising your services", 5. "Limiting treatment notes to name, date, and fee", 26. "Accepting goods (rather than money) as payment", 33. "Accepting a client's decision to commit suicide", and "Engaging in sexual fantasy about a client". The deleted items were correlated with each other, revealing little or no underlying importance to a single construct (Tabachnick & Fidell, 2001).

Table 3. *Final Factor Loadings for the EPQ-R*

Item	Factor					
	1	2	3	4	5	6
1	.48					
3	.54					
10	.54					
14	.66					
19	.49					
25	.52					
29	.58					
32	.71					
38	.41					
39	.58					
43	.83					
11		.54				
12		.31				
15		.35				
20		.39				
22		.37				
34		.34				
36		.49				
37		.49				
42		.50				
45		.70				
47		.55				
6			.43			
9			.54			
16			.65			
21			.45			
23			.45			
40			.67			
17				-.69		
24				-.72		
28				-.60		
27					.62	
35					.59	
41					.50	
44					.46	
18						.50
30						.53

Note. N = 419, Maximum likelihood analysis with oblique rotation. Items 2, 4, 5, 8, 26, 33, and 46 were removed from further analyses due to significant cross loadings or low communalities.

Construct interpretation

The meaningfulness of latent constructs is ultimately dependent upon the definition imposed by researchers (Henson & Roberts, 2006). The author of the present study combined a number of features (nature of the questionnaire, relationship of the items, and overall context) that, when taken together, explain the majority of the phenomena for each factor.

Items loading onto factor one measure attitudes toward the creation of 1. blurred, dual or conflicting relationships. Those items loading onto factor two measure attitudes toward behaviours considered 2. competence in the provision of services to clients. Factor three explores a counsellor's attitudes toward 3. policy, financial and legal aspects of providing therapeutic services. Items loading onto factor four all relate to matters of 4. confidentiality. Factor five includes items that relate to attitudes toward 5. sexualisation of the client relationship within the working alliance. Finally, factor six explores attitudes associated with a counsellor's personal 6. disclosure of information or emotionality.

Retained factors

In order to determine the number of factors to retain for future use, an internal reliability analysis was conducted. Table 4, below, provides outputs from an internal consistency analysis, the variance explained by each factor, and authors' retention status for each factor.

Table 4. *Factors Retention Status for the EPQ-R*

Factor	Assigned Construct Name	Number of Items	Cronbach's α	Variance Explained	Retained
1	Dual Blurred or Conflicting Relationships	11	.83	18.53%	Yes
2	Competence	11	.74	6.69%	Yes
3	Policy, Financial and legal	6	.70	2.27%	Yes
4	Confidentiality	3	.73	2.21%	Yes
5	Sexualisation	4	.64	1.84%	Yes
6	Disclosure	3	.44	2.02%	No

Note. N = 419

Factor four achieved an alpha of .64. Removing item nine, "Being sexually attracted to a client" would have improved the result (α = .65), yet such a marginal improvement was not deemed worthy, as such all items within this factor were retained. Factor six only achieved an alpha of .44, and each item within the factor achieved relatively low communalities (.32 to .40). In addition, it did not explain very much of the variance in the data and will be removed from future versions of the instrument.

Evidence from an analysis of Table 4 supports the notion that the revised EPQ adequately measures five factors associated with attitudes toward ethical behaviours in practice. Further support for a five-factor model is provided by visually examining the scree plot (Figure 1), which seems to indicate a decline in eigenvalues between factors five and six.

Factor correlations

In order to understand the relatedness of factors to each other a correlational matrix was run. Table 5 provides the output of the analysis.

Table 5. *Factor Correlation Matrix for the Ethics of Practice Questionnaire Revised*

Factor	Dual/Blurred Relationships	Competence	Policy, Regulation & Legal	Confidentiality	Sexualisation	Disclosure*
Dual/Blurred Relationships	-					
Competence	.71	-				
Policy, Financial and legal	.29	.32	-			
Confidentiality	.45	.45	-.10	-		
Sexualisation	.37	.40	.38	.10	-	
Disclosure*	.01	.05	.28	-.25	.01	-

Note. $N = 419$, Pearson correlations, maximum likelihood analysis with oblique rotation, * deleted factor.

The most salient interpretations from the correlation matrix include: factor one dual relationships correlated highly with factor two competence. Assessing items in both these factors further, it would appear that many instances in which dual relationships are created also results in incompetent misconduct. For example, the item "Inviting clients to a party or social event", which originally crossloaded onto both factor one and two, could equally be considered creating a dual relationship and in many circumstances is also consider incompetence. The resulting strong correlation between factor one dual relationships correlated highly and two competence brings into question a concern about discriminant validity. Such is the complexity of ethical issues in practice that even performing a factor analysis does not provide a clear solution to item responses.

There are moderate relationships between factor two, competence, and the other factors in the matrix policy, financial and legal, confidentiality and sexualisation. Whilst a weak negative relationship exists between confidentiality and policy, financial and legal reflects the relationship between breaking confidentiality as a policy or regulation under specific circumstances, such as reporting child abuse.

Factors in review

The aim of the present study was to understand the underlying constructs of a reduced version of the EPQ. In what follows is a discussion about each factor and the rationale for inclusion or exclusion in the final EPQ-R.

Factor One – Dual/Blurred Relationships: Item 25. "Allowing a client to run up a large bill" on first appearance may not seem consistent with other items within this factor. However, Koocher and Keith-Spiegel (2008) suggest that allowing clients to run up a large bill potentially alters the relationship from its therapeutic orientation to one in which the therapist becomes a financier, or lender, and thus blurring the relationship. Therefore, this item was retained. This factor accounted for the largest portion of the variance explained in the overall model. Due to the moderate to high item loadings, the relatedness of meaning for items, and excellent internal reliability result this factor should be retained.

Factor Two - Competence: Concern was raised about this particular factors association with factors one (dual relationships) and five (sexualisation). In essence, many items within these two domains may be classified as an item within the competence factor — for example incompetent behaviours — as such they might form part of a much broader category that currently remains elusive. As with factor one, factor two accounted for a considerable portion of the overall variance in the model. Due to the moderate to high loading of items, the relatedness of meaning of items, and acceptable internal reliability result this factor should be retained.

Factor Three - Policy, Financial and Legal: Items within this factor clearly articulate attitudes towards policies, financial and legal aspects within therapeutic practice. This factor accounts for a moderate portion of the variance explained in the overall model. Therefore, due to the moderate to high loading of items on this factor, the relatedness of meaning of items, and good internal reliability result this factor was retained for future use.

Factor Four – Confidentiality: The three items within this factor clearly all relate to breaking confidentiality in very specific situations. Due to the high loading of items on this factor, the relatedness of meaning of items, and good internal reliability result this factor was retained.

Factor Five - Sexualisation: This factor provides a series of questions concerning sexualized thoughts about clients in addition to actual behaviours associated with engaging in sexual activities with clients. This factor only accounts for a very small portion of the total variance explained and contains a small number of items. However, the alpha is acceptable given the number of items, the items within the factor clearly explore the underlying construct and this factor should be retained.

Factor Six - Disclosure: Overt disclosure by the therapist can lead to a dual relationship situation, as such the items that load onto this factor are somewhat ambiguous and require a more considered approach to produce a more robust factor. This factor accounts for a very small portion of the total variance explained, was after the last drop in eigenvalues — as indicated in the scree plot — and includes an item, 30. "Addressing client by his or her first name", that potentially explores a different construct. Therefore, this factor should be excluded from future use or additional items created and refined.

Taken together, factors one two and five were related to constructs associated with behaviours that effect clients within practice and in the therapeutic alliance. Factors three and four examine behaviours that are external to the therapeutic environment relating to aspects of practice associated with policy, financial and legal considerations.

Limitations and future research

As previously mentioned, unlike other studies in which participants were derived from a single participant pool, the present study sought participation from a multitude of professionals — regulated, unregulated and self-regulated. As such, there may be

considerable debate about the ethical status of behaviours based which code applies to specific behaviours. The factors discovered as a result of the present study provide some guidance for the development of a more robust instrument.

The subjectivity related to the unorthodox removal of items from the EPQ-83 to complete the EQP-47 require validation. Future research may review p-values in combination with Item Total Correlations (ITC) to determine if the correct items were removed. Regardless of the method of extraction, the underlying constructs provide a level of assurance that the EPQ-47 holds considerable promise as a reliable and valid instrument.

In order to produce a more holistic questionnaire, future researchers might consider using a Delphi technique (Dalkey & Helmer, 1963) to create additional items. For example, items might converge onto factor six "Disclosure". Alternatively, an effort might be made to expand the number of factors to cover different constructs. Overall, given the aforementioned commentary concerning limitations, the present study highlights the highly complex nature of ethical dilemmas concerning behaviours in therapeutic practice.

The tentative EPQ-37 consists of a five-factor instrument measuring variables affecting clients within and outside the therapeutic alliance. Factors concerning clients within the therapeutic alliance include the dual relationships subcomponent consisting of 12 items, the competence subcomponent, consisting of 11 items, and the sexualisation containing four items. And factors relating to clients outside the therapeutic alliance, we find the Policy, Financial and Legal subcomponent — consisting of six items — and the confidentiality subcomponent containing three items. The revised questionnaire was reduced by one factor relating to disclosure — containing three items — as it no did not adequately measure the factor.

Evidence from the present study provides support for the EPQ-37 as a five-factor instrument. The sixth factor, relating to disclosure, requires additional items to ensure that

factor delivers a highly valid element within the revised instrument. The EPQ-37 provides an alternative to the more time consuming original EPQ-83. In addition, the EPQ-37 seems to be a valid instrument that is independent of a specific code of conduct or an associations specific ethical principles. The EPQ-37 can be administered to a diverse population of counselling professionals to assess their beliefs concerning the ethical status of commonly occurring behaviours in practice.

There are several potential uses for the EPQ-37, these might include; as a check-up tool for supervisors and supervisees igniting a conversation concerning beliefs about what and what does not constitute ethical behaviours in practice, or and a means of examining issues of an ethical nature during training and education for those wishing to become counsellors.

Appendix 2.

PACFA Complaints Data by Type of Breach 2006-11

Type of Complaint	Number of Complaints		
	PACFA	Member Associations	Total
Breach of confidentiality	1	6	7
Sexual misconduct	0	5	5
Dual and multiple roles	4	7	11
Discrimination	1	2	3
Unsatisfactory service or outcome	1	2	3
Other professional misconduct/breach	5	19	24
Complaint process	1	0	1
Fees/costs	0	2	2
Membership/ functions/activities	3	2	5
Total	16	45	61

Note: Data from four PACFA member associations was not available.
Whilst Table 2 provides the outcome of the breach condition.

Appendix 3.

PACFA Complaints Outcome Data by Type of Breach 2006-11

Type of Complaint	Number of Complaints		
	PACFA	Member Associations	Total
No case to answer	4	8	12
Withdrawn	1	11	12
Referred to another body	3	2	5
Resolution – Professional supervision required	1	7	8
Resolution – Membership & registration revoked	0	5	5
Resolution – Member Association suspended	2	0	2
Resolution – Members Association Action Required	4	3	7
Other	1	9	10
Total	16	45	61

Note: Data from four PACFA member associations was not available.

Appendix 4.

ACA Complaints Data by Type of Breach 2004-13

Descriptor	Number of Complaints		
	ACA	Withdrawn	Total
Breach of confidentiality	8	-	8
Inappropriate Relationship (Sexual misconduct)	9	1	8
Dual and multiple roles	1	1	0
Discrimination	1	-	1
Unsatisfactory service or outcome	8	1	7
Other professional misconduct/breach	7	1	6
Complaint process	0	-	0
Fees/costs	0	-	0
Membership/ functions/activities	7	-	7
Total	50	4	46

Appendix 5

Frequency of Complaints Made by Clients Against Registered Psychologists in New South Wales, Australia, July 2003 to June 2007

Complaint Category	Frequency of notification
Professional—poor communication Confidentiality/privacy breach Rude/insensitive manner Inappropriate communication (e.g., discrimination) Wrong/misleading/inadequate information Not informed and/or consent invalid Failure to consult colleague	35.5 %
Professional—incompetency Wrong/inappropriate diagnosis Inadequate/inappropriate assessment Inadequate treatment Failure to notify government authority Poor record keeping Inadequate supervision Miscellaneous (e.g., not following guidelines)	16.5%
Professional—poor reports General report Workers compensation report Family court report Apprehended violence order report Victim of crime report	14.1%
Poor business practices Commercial disputes Poor billing Plagiarism Overcharging Financial fraud Inadequate private health insurance invoicing Premises inadequate	12.5%
Boundary violation Sexual relationship Non-sexual inappropriate friendship Sexual behaviour (without relationship) Non-sexual business relationship Alleged sexual assault Non-sexual touching	9.7%
Character Poor judgement Illegal activities Criminal matter (non-psychology)	5.6%

Misleading registration claim (e.g., practice while lapsed)	3.2%
Impairment (e.g., mental illness, addiction)	1.6%
False use of Dr/Professor or specialist title	1.2%

Adopted from Grenyer and Lewis (2012)

Appendix 6

Complaint Category	Frequency
Professional—poor communication	
Confidentiality/privacy breach	4
Rude/insensitive manner	2
Inappropriate communication (e.g., discrimination)	4
Wrong/misleading/inadequate information	2
Not informed and/or consent invalid	
Failure to consult colleague	1
Professional—incompetency	
Wrong/inappropriate diagnosis	2
Inadequate/inappropriate assessment	4
Inadequate treatment	4
Failure to notify government authority	2
Poor record keeping	2
Inadequate supervision	2
Miscellaneous (e.g., not following guidelines)	
Professional—poor reports	
General report	
Workers compensation report	1
Family court report	
Apprehended violence order report	
Victim of crime report	
Poor business practices	
Commercial disputes	1
Poor billing	
Plagiarism	1
Overcharging	
Financial fraud	3
Inadequate private health insurance invoicing	
Premises inadequate	

Boundary violation

Sexual relationship	11
Non-sexual inappropriate friendship	7
Sexual behaviour (without relationship)	3
Non-sexual business relationship	3
Alleged sexual assault	2
Non-sexual touching	2

Character

Poor judgement	3
Illegal activities	4
Criminal matter (non-psychology)	2

Misleading registration claim (e.g., practice while lapsed)	1
Impairment (e.g., mental illness, addiction)	1
False use of Dr/Professor or specialist title	3

Appendix 7

Items removed for original 83-item Ethics in Practice Questionnaire

1.	Using a computerized test interpretation service
2.	Performing forensic work for a contingency fee
3.	Inviting clients to an office open house
4.	Not allowing clients access to raw test data
5.	Accepting goods (rather than money) as payment
6.	Earning a salary which is a % of client's fee
7.	Making custody evaluation without seeing the child
8.	Doing custody evaluation without seeing both parents - repeat item
9.	Lending money to a client
10.	Providing therapy to one of your employees
11.	Having a client address you by your first name
12.	Sending holiday greeting cards to your clients
13.	Kissing a client
14.	Engaging in erotic activity with a client
15.	Giving a gift worth at least $50 to a client
16.	Accepting a client's invitation to a party
17.	Engaging in sex with a clinical supervisee
18.	Going to client's special event (e.g., wedding)
19.	Getting paid to refer clients to someone
20.	Engaging in sexual contact with a client
21.	Utilizing involuntary hospitalization
22.	Selling goods to clients
23.	Giving personal advice on radio, t.v., etc.
24.	Unintentionally disclosing confidential data
25.	Allowing a client to disrobe
26.	Borrowing money from a client
27.	Discussing a client (by name) with friends
28.	Signing for hours a supervisee has not earned
29.	Treating homosexuality per se as pathological
30.	Doing therapy while under influence of alcohol
31.	Accepting a gift worth less than $5 from a client
32.	Offering or accepting a handshake from a client
33.	Disrobing in the presence of a client
34.	Charging for missed appointments
35.	Being sexually attracted to a client
36.	Helping client file complaint re a colleague