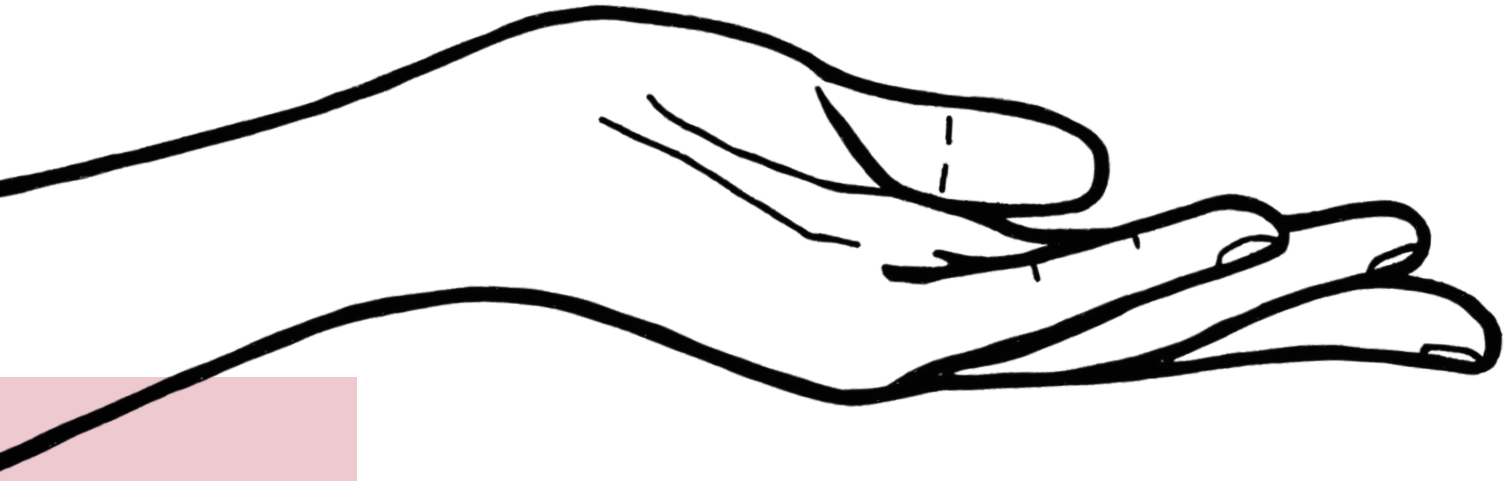
Back to Basics:

Moderating iatrogenic harm by identifying and measuring mental health practitioner behaviours associated with interpersonal violence



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NOT ALONE COLLECTIVE

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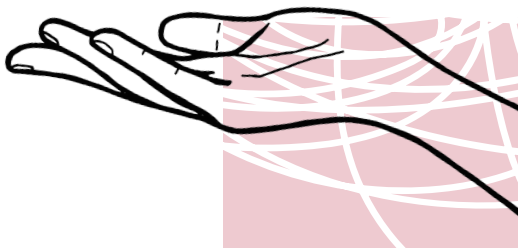


RESEARCH **SUMMARY**

BACKGROUND

There is little public or professional knowledge regarding the scale of negative events that are encountered when seeking mental health care, known as 'iatrogenic harm'. Although there are professional guidelines, policies and standards in place, prior research and documented events suggest that these are not always adhered to in practice. With up to 65% of practitioners delivering ineffective or harmful outcomes. Those seeking to remedy this are often dismissed and current tools for identifying adverse events or measuring clinical outcomes are not accessible to those accessing services ('service-users'), nor do they adequately empower them or capture their lived-experiences.

AIMS

Preliminary demonstration for the validity of the Adverse Behaviours in Clinicians (ABC-11); The first standardised method of identifying and measuring adverse practitioner behaviours in order to moderate iatrogenic harm and improve outcomes in mental health services.

METHOD

An eleven question checklist was adapted from a domestic violence resource currently supplied to service-users who have experienced abuse. The resulting questionnaire was made available online and on paper to explore if it was a reliable method of documenting and measuring encounters of harmful behaviours enacted by mental health practitioners.

RESULTS

94% of the 251 participants selected 'Yes' to at least one of the checklist items. Overall the average number of checked items (the ABC Score) was 6. There were some notable differences across location and service type but the ABC Scores remained above 6.

CONCLUSIONS

The ABC-11 has been demonstrated as a valuable and necessary tool for identifying practitioner behaviours that could result in iatrogenic harm toward service-users. It also validates and empowers them to advocate for the appropriate standards of care required for establishing and maintaining their wellbeing when seeking healthcare. Future research is recommended to further explore the practical uses of the ABC-11, including its application to specific demographics, diagnoses, treatments and settings. It is a public health priority for those with professional, political and regulatory responsibility to address adverse behaviours in clinicians and provide services that meet the needs and rights of service-users.

RESULTS INFOGRAPHIC

PERCENTAGE OF 'YES' ANSWERS BY QUESTION

1. Criticism and verbal attacks
75.3%

2. Coercive control
70.5%

3. Abuse of authority
69.3%

4. Belittling and dismissing
76.1%

5. Breaching trust
60.6%

6. Breaking agreements
61.8%

7. Withholding support and rights
73.7%

8. Deny, deflect or downplay outcomes
76.9%

9. Controlling or affecting finances
22.7%

10. Isolating from other support
45.8%

11. Making unwanted contact
12.3%

251
participants

94%
answered '**Yes**' to one or more questions

6
average number of '**Yes**' answers across the eleven questions

24
countries included

RESEARCH
INTRODUCTION

The therapeutic relationship has consistently been demonstrated as the most reliable determinant of positive outcomes within mental health care, regardless of discipline or modality (Lambert and Barley, 2001; Moyers and Miller, 2013). While medications may be effective for the management of some symptoms their administration remains situated within a relational context, between a professional and a service-user. Mental health practitioners should therefore be conscientiously aware of the power imbalance present within this relationship and the responsibility that this entails. Unlike pharmacological research, harmful aspects occurring within the therapeutic alliance receive minimal attention academically, professionally or publicly (Jonsson et al., 2014; Parry, Crawford and Duggan, 2016; Scott and Young, 2016). Attempts to measure and moderate these iatrogenic effects record significant variations in results and can rely solely on reporting by clinicians (Crawford et al., 2016; Kraus et al., 2011; Vaughan et al., 2014; Schermuly-Haupt, Linden and Rush, 2018) although many were found to be unable to accurately assess when harm had occurred to service-users or have a lack of knowledge regarding such circumstances (Bystedt et al., 2014; Castonguay et al., 2010). Prior research and proposed solutions consider negative outcomes in hindsight rather than seeking methods for timely prevention, including for malpractice (Linden, 2012). This study goes 'back to basics' by acknowledging interpersonal behaviours that can lead to negative outcomes. Utilising current clinical guidance regarding harmful relational dynamics and drawing directly from the lived-experience of those at risk of being affected. Thereby proposing the first standardised method of measuring adverse practitioner behaviours within a clinical setting that is user-led, with the aim of identifying and preventing harm across mental health services and improving standards of care.

It is expected that mental health care staff act in accordance with the professional and ethical standards placed upon them by their employers and regulators. However, between 33% and 65% were identified as ineffective or harmful by Kraus et al. (2011) in a large-scale study across multiple professions. Public awareness of malpractice within in-patient facilities is increasing (Gawne and O'Neill, 2024) but negative outcomes are quietly widespread, with little immediate accountability when even the most irreparable harm occurs to service-users (Department of Health and Social Care, et al., 2023; INQUEST, 2023; Langley and Price, 2022). The dynamics within therapeutic relationships, including the efficacy and risks of psychotherapy, go mostly unscrutinised (NHS, 2021; Nutt and Sharpe, 2007; Parry, Crawford and Duggan, 2016; Scott and Young, 2016). There is a presumption of safety in comparison to pharmacological interventions which is bolstered by the use of the terms 'gold standard' and 'evidence-based'. Although this pursuit for the prestige afforded to scientific legitimacy in public and professional discourse, alongside delivering cost-effective solutions, can lead to dogmatism, reductionism and the rigid application of one-size-fits-all approaches to mental wellbeing (Cook, Schwartz and Kaslow, 2017; Harvey et al., 2023; Kuyken, 2023; Smail, 2005). In contrast, there is resistance in the field towards the standardised recording and publication of clinical outcomes. Preventing an accurate picture of care quality standards from being formed, particularly where there is a lack of data collection and/or evidence of manipulation (Audit Scotland, 2023; Liptzin, 2009; Surviving Work, 2020).

While financial and political constraints pose challenges for publicly funded services this would not adequately explain iatrogenic harm occurring within the private sector or charities. Consideration then must be given to variables such as compassion fatigue

(Marshman, Munro and Hansen, 2021), burnout (Morse et al., 2012; NHS Employers, 2022), lack of expertise (Kraus et al., 2011), shifting into a role of 'persecutor' when 'victims' do not respond to the 'rescue' attempts of practitioners (as per transactional analysis theory) (Johnstone, 2000), a lack of fit between practitioner and service-user (Hardy et al., 2017) or an ingrained culture of negligence (Langley and Price, 2022). All have been identified as present, systemic and problematic to varying degrees. Such variables can make the mental health care landscape precarious for service-users to navigate, with challenges that increase based on gender (Mumford, Fraser and Knudson, 2023; Nicki, 2016), race (Jackson, 2002; Thornton, 2020), psychiatric diagnosis (Langley and Price, 2022; Sheppard, Bizumic and Calear, 2023) disability (Artman and Daniels, 2010), physical health (Spandler and Allen, 2017) and neurodiversity (Hallett and Kerr, 2020).

Power and control are inescapable features of the therapeutic relationship (Proctor, 2002). In the simplest terms, mental health related disciplines cannot exist without making distinctions between 'normal' and 'abnormal', 'rational' and 'irrational'. Their *raison d'etre* is to modify the thoughts and behaviours of individuals to fit within these parameters, based on the interests and norms of the dominant culture. Across mental health care and associated well-meaning institutions is a conviction that 'trying to do good cannot be bad'. Which contributes towards a resistance to confront or reflect on the role practitioners, systems and wider society may have played, or continue to play, in harmful actions towards citizens (Department for Levelling Up, Housing and Communities, 2023 p.27). This hinders the implementation of progressive initiatives, training and effective regulation. The authoritative silencing of uncomfortable sources of dissent prevails even when concerns increasingly come from within the field itself (Ahsan, 2022; BBC, 2023; Beale, 2021; Cotton, 2016; Hill, 2022; Mendel et al., 2010; Marriage, 2024; Royal College of Psychiatrists, 2023). The academies of psychology and psychiatry have historically been inconsistent with the best interests of oppressed individuals and minority groups by maintaining the societal status quo under the guise of science (Oppenheim 1991; Scull, 2023). As evidenced by the treatment of non-male (Tone and Koziol, 2018), non-white (Jackson, 2002), non-working (Cromby and Willis, 2013) and non-heterosexual (Uyeda, 2021) people. Experiencing much less severe forms of ostracisation has been found to activate the same neural pathways as physical pain (Eisenberger, 2003); The antithesis of a positive therapeutic outcome. Furthermore, Hardy et al., (2017) identified a significant risk for negative outcomes when unmanaged tensions within the therapeutic relationship create a fault line between 'safety and containment' and 'power and control'. Progressive practices and policies have gained traction over the past century, encouraging more conscientious awareness of human rights and the holistic determinants of wellbeing (Frances, 2021; World Health Organisation and United Nations, 2023). But a lack of acknowledgement towards service-user experiences and of meaningful involvement in decisions about their own health remains an epistemic injustice within a complex and undemocratic system (Beresford, 2023; Crichton, Carel and Kidd, 2017; Gawne and O'Neill, 2024; Langley and Price, 2022; SAMH, 2020; Strang, 2020). Succinctly articulated by Smail (2005) as:

> " The criterion of validity is not truth, but power. "
>
> (p.16)

The current social and political climate continues to inseparably influence our approaches to mental health, treatments and care standards (Frances, 2021; Frazer-Carroll, 2023). This includes the blanket advice of seeking out professional/expert help for distress although medications and therapy are not universally beneficial. While there is some public awareness of limitations and potential side effects of psychoactive drugs (Jofre, 2018) it is commonplace for accounts of therapeutic interventions to be devoid of risk assessments and presented in a wholly positive light (Nutt and Sharpe, 2007;

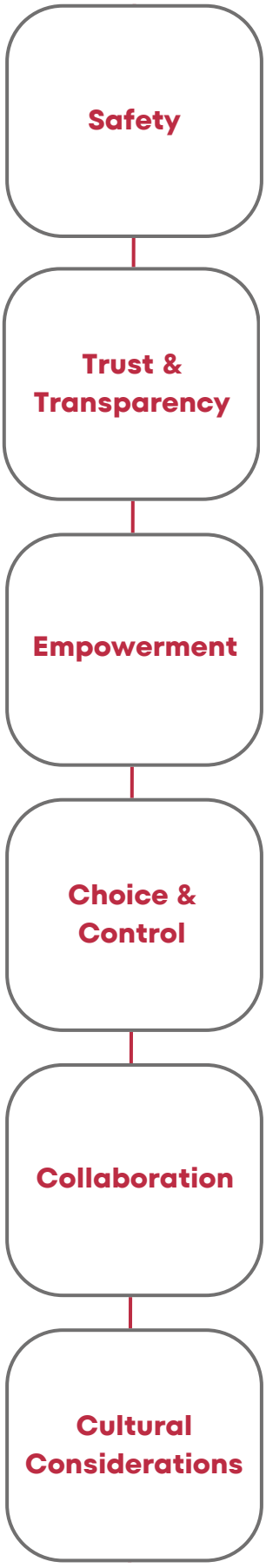


FIGURE 1: TRAUMA-INFORMED PRACTICE

Parry, Crawford and Duggan, 2016). This is not reflected in the research, whereby up to 40% of individuals may find no benefit and between 5.2% to 52.6% experience negative outcomes, including side effects and incidents of malpractice (Crawford et al., 2016; Moritz et al., 2019; Lambert, 2007; Harvey et al., 2023; Marriage, 2024; Schermuly-Haupt, Linden and Rush, 2018). Findings made further problematic by the individualisation and internalisation of responsibility for illness, disability and/or distress relating to 'problems in living' (Szasz, 1960; Mcgrath et al., 2016). An outlook valued by neoliberalism in its decimation of community, solidarity and government assisted support (Brittan, 2013; Greener and Moth, 2020). This means that social, political and ableist factors need neither be considered, nor addressed, as problems can be attributed to *within* the individual only. Left unchecked those seeking help can find themselves vulnerable to discrimination and mistreatment in an environment prone to victim-blaming (Garimella et al., 2000; Gawne and O'Neill, 2024; Kenny et al., 2018; Langley and Price, 2022; Moyers and Miller, 2013; Sheppard, Bizumic and Calear, 2023). The 'back to basics' approach taken by this study acknowledges power and control as the aetiology of oppression and abuse (United Nations, 2020), and considers how this relates to service-user experiences.

Circumstances that lead individuals to seek mental health support are multifaceted and necessitate that an ethical duty of care (*primum non nocere*) is foundational to service delivery:

> " First, do no harm "

Adverse and traumatic events are widespread across society but are experienced unequally due to their inseparability from structures of social and economic oppression (Becker-Blease, 2017). Providing trauma-informed practice in healthcare settings is therefore considered crucial for creating environments of safety. One barrier to its successful implementation is a lack of agreement over what this constitutes in practice (Department for Levelling Up, Housing and Communities, 2023; Wren, 2022). For clarity, this study refers to the principles defined by the Substance Abuse and Mental Health Services Administration (2014), the Office for Health Improvement and Disparities (2022) and the Transforming Psychological Trauma Framework (NHS Education for Scotland, 2023) when referring to 'trauma-informed practice', not to modalities designated as 'trauma-specific' or pertaining solely to childhood (see Figure 1). This distinction is necessary as 'traditional' ways of working have been found to contribute to negative outcomes by perpetuating oppressive practices. Such as rigid rules, punitive punishment, lack of confidentiality, coercion and engaging in methods of forceful compliance (Department for Levelling Up, Housing and Communities, 2023 p.25).

Service-users with a history of trauma are at risk of re-traumatisation when encountering similar dynamics, including powerlessness (Dallam, 2010; Proctor, 2002). In documenting their lived-experiences Rosenberg et al. (2001) found:

> " an emphasis on victimisation or re-traumatisation at the hands of providers or the mental health system itself, including events that served as triggers, re-evoking memories of trauma. Providers were often seen as insensitive or demeaning in their responses to trauma survivors. Consumers suggested that clinicians needed to be more aware of trauma-related difficulties and that the treatment system should develop better mechanisms to ensure that trauma survivors receive humane treatment and that their personal rights are respected. "
>
> (p. 1454)

It is crucial to moderate the allostatic load of service-users by collaborating to create a holistic biopsychosocial blueprint of their needs (Not Alone Collective, 2023). One that actively resists exposure to single or prolonged instances of stress, trauma and adversity due to the consequences for physical, mental and social wellbeing (Craig, 2017; Guidi et al., 2020; Lauderdale, 2006; McFarlane, 2010; Mcgrath et al., 2016). Applying trauma-informed safeguards across general practice serves as a good standard of care for all and in turn reduces the likelihood of iatrogenic harm. The principles illustrated in Figure 1 are also in alignment with person-centred care which is central to modern healthcare service provisions (World Health Organisation, 2016) and inclusive of existing ethical expectations set by health and social care regulators globally.

However, knowledge of these concepts and professional standards may be elusive to service-users and their experiential judgement may be compromised by past experiences, coercion or that safety is widely presented as inherent within healthcare environments. In an attempt to bring detrimental occurrences of power and control within therapeutic relationships into focus this study draws from an eleven item checklist supplied by the National Health Service (NHS) in Scotland which is distributed to assist individuals in identifying potential domestic violence situations and seek support (see Appendix 1). For this study the questions have been adapted to apply to a clinical setting by referencing potential encounters with mental health practitioners and providing examples for clarity. The resulting Adverse Behaviours in Clinicians (ABC-11) tool utilises the same straightforward method of assessing the therapeutic relationship as professionals currently encourage service-users to apply to their personal relationships. Thus reducing sole reliance on clinician assessment of outcomes and empowering service-users to be able to identify and advocate against treatment that could negatively affect their wellbeing. The original NHS handout advises that help should be sought if any of the behaviours are encountered in domestic situations. Therefore ticking 'Yes' to any item on the ABC-11 indicates that good standards of care are not being provided and alerts to potential harm. In turn, the absence of these behaviours suggests practitioner practices are in alignment with person-centred and trauma-informed care, and the human rights based approach outlined by the World Health Organisation and United Nations (2023).

There is growing recognition for the value of co-design and co-production in healthcare (Point of Care Foundation, 2020; Springham and Robert, 2015) but the involvement of service-users in academic or service design research has been described as a purely tokenistic or a 'tick box' exercise (Batty, Humphrey and Meakin, 2023; Beresford, 2023; Lomani, 2020). In light of this it is pertinent to note that the NHS checklist was originally identified by those with lived-experience of services as a useful prototype for describing events that had led to iatrogenic harm. Adaptations then allowed for its potential to be explored by the wider community. This study therefore seeks to provide an initial demonstration for the validity of the ABC-11 across clinical settings whilst also serving as an exercise in raising awareness where it is currently lacking due to the silencing of dissenting voices. Future application opportunities for the ABC-11 include uncovering standalone and systemic incidents that require attention to prevent iatrogenic harm and improve outcomes across the sector.

RESEARCH METHOD

DESIGN

A questionnaire design with open recruitment of participants was used to establish if the eleven question checklist was a reliable descriptor and measure of adverse practitioner behaviours. Geographic location and service provider were optional questions after survey completion in order to explore cultural validity by comparing scores across location and service type.

PARTICIPANTS

251 individuals participated in the study, which was open to anyone who has previously sought mental health support from professionals. Recruitment was random and demographic details were not requested as the key focus of this research is validating the questionnaire as a useful tool to uncover potential sources of iatrogenic harm resulting from practitioner behaviours across the field of mental health, not making demographic comparisons at this stage. Individuals were made aware before participation that the survey was going to ask specifically about negative experiences. Data protection, benefits, risks and safeguarding information related to participation were provided prior to completing the checklist (see Appendix 2). This research adhered to the British Psychological Society code of human research ethics (Oates et al., 2021).

MATERIALS

The checklist was based on an eleven item resource created by EVA Psychology for NHS Scotland as part of their Survive and Thrive course (see Appendix 1). The intended purpose of this list is to allow survivors of interpersonal abuse to identify behaviours that could lead to harm within relationships and advises them to seek help if they encounter any of the scenarios. To limit researcher bias or the use of leading questions, Chat-GPT was used to reword the scenarios into questions and provide examples relating more specifically to behaviours that may occur within a clinical mental health setting. Google Forms was used to host the questionnaire online, with paper copies available at a local exhibition open to the public.

PROCEDURE

Individuals with lived-experience identified a support document relating to interpersonal violence as a useful prototype for describing interactions with mental health practitioners that led to iatrogenic harm. It was then adapted into a questionnaire that applied to a clinical context. The study was open for three weeks on Google Forms, making it widely accessible online. It was shared across social media and on mental health related forums. Paper copies were available at a local exhibition open to the public. Consent was sought before participants proceeded to complete the questionnaire and full information regarding the study was provided, alongside risk and safeguarding details to limit adverse outcomes during participation. Participants were then shown the eleven scenario questions (with examples of what these behaviours may look like in a mental health service setting) and asked to select 'Yes' or 'No' to each based on their personal experiences of seeking help from professionals. Upon completion, participants were given the opportunity to submit their answers or continue to answer optional geographic and service provider questions. They were then thanked for their participation and for contributing to bring greater understanding to negative experiences, with the hope that the research could lead to change across the sector for those who have been affected. Contact details to find out more information and keep up to date on publication of the results were provided. Please note: The word 'ever' has been removed from the finalised version of the ABC-11 (see Appendix 3) to avoid potential confusion when it is applied to a specific service or time period.

Adverse Behaviours in Clinicians (ABC-11) *

1. Have you ever felt criticised or been verbally attacked by any mental health professionals?

Some examples:
- Repeatedly telling you that your thoughts or feelings were wrong.
- Raised their voice at you.
- Made unkind comments about your struggles.
- Used offensive or discriminatory language or stereotypes (i.e about your age, race, gender, culture or religion).
- Made fun of your difficulties.

2. Have any mental health professionals used pressure tactics, guilt trips, or threats to influence your choices or decisions (including about treatments)?

Some examples:
- Made you feel like you had no choice but to follow their advice.
- Pushing you to make treatment decisions without giving you choices or explaining your options.
- Made you feel guilty for considering other treatments or services.
- Threatening to stop your mental health support if you didn't do what they wanted.
- Giving you ultimatums to make you comply with their recommendations.

* Finalised worksheet version provided in Appendix 3.

3. Have you encountered any mental health professionals who abused their authority, consistently claimed to be 'right', told you what to do, or spoke negatively about you to other people?

Some examples:
- Acted like their way was the only right way, dismissing your ideas and opinions.
- Talked down to you, acted superior and belittled you.
- Told you how to think or feel on a regular basis.
- Spoke or wrote letters to other professionals in a way that made you look bad.
- In group therapy, publicly criticising or making fun of what you shared.

4. Have any mental health professionals disrespected you, interrupted you, not listened to your concerns, twisted your words, or criticised your friends or family?

Some examples:
- Often interrupting you when you were speaking during appointments.
- Treating you differently because of your gender, age, religion or culture.
- Talking over you and not letting you finish your sentences.
- Disregarding your opinions and needs and treating you as if they are wrong.
- Ignoring what you said, dismissing your concerns, or twisting your words.
- Speaking negatively about your friends or family, making you uncomfortable.

5. Have you ever experienced breaches of trust by a mental health professional, such as them behaving in a way that is unexpected and hurtful towards you?

Some examples:
- Not telling you about important information or decisions (such as a diagnosis).
- Sharing information or their opinions with other professionals without you knowing.
- Breaking confidentiality by discussing your care with others who were not involved.
- Invading your privacy by accessing your personal information without consent.
- Displaying jealousy or crossing professional boundaries during your sessions.
- Attempted to have an inappropriate relationship or physical contact with you.

6. Have any mental health professionals failed to follow through on agreements, broken their promises or prioritised their own plans over your needs and wellbeing?

Some examples:
- Making promises about your treatment but not keeping them.
- Changing your treatment plan or medications without informing you.
- Not sticking to the agreed-upon treatment schedule or number of sessions.
- Their commitments or preferences were more important than your scheduled appointments or goals.
- Cancelling or rescheduling appointments without giving you enough notice.
- Not offering appointments for a very long time without an explanation.

7. Have any mental health professionals withheld emotional support, not expressed their own feelings or opinions to you, failed to provide support or compliments, or ignored your rights and feelings?

Some examples:
- Not showing understanding or support during your appointments or when you contact them.
- Compliments or positive feedback were infrequent or nonexistent.
- Not seeming to care about your rights or feelings, focusing only on their own agenda.
- Rarely providing encouragement or emotional support.
- Not acknowledging your progress, achievements or strengths.

8. Have mental health professionals minimised, denied, or blamed you when their behaviour, medications or therapies are not helpful (or have been harmful to you) and so did not take your concerns seriously?

Some examples:

- Blaming you when their treatments are not helpful or cause you harm.
- Refusing to acknowledge if they made a mistake (including misdiagnosis).
- Denying that their actions or treatment decisions had a negative impact on you.
- Downplaying or denying their problematic behaviours or blaming them on you.
- Dismissing your concerns as insignificant or only your 'perception'.

9. Have any mental health professionals attempted to control your financial resources or decisions?

Some examples:

- Attempting to influence your spending decisions.
- Trying to limit or restrict your access to your own money.
- Not providing helpful supporting information for welfare assessments (such as Universal Credit and PIP)
- Preventing you from being able to work because of a lack of access to services or making incorrect treatment decisions that prolonged your recovery.

10. Have any mental health professionals ever made you feel isolated from your family, friends, other healthcare professionals or denied you access to other services or treatments?

Some examples:

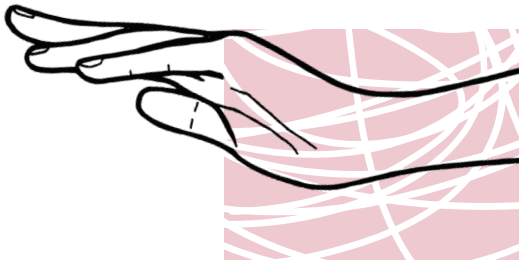
- Making it difficult or impossible for you to access other healthcare services or treatments by creating barriers, withholding necessary information or not making referrals for you.
- Distancing you from other healthcare professionals or treatment options, implying that they were the only source of support or treatment you needed.
- Making it difficult for you to spend time with loved ones or telling you not to see them.
- Not considering or involving loved ones in your treatment plan or care.
- Reacting negatively to input or opinions from your friends and family about your needs and healthcare.
- Failing to support you to leave harmful relationships and create new ones.

11. Have any mental health professionals engaged in harassing behaviour, such as making unwanted phone calls or visits?

Some examples:

- Unwanted phone calls, text messages, or emails that were not required for your healthcare.
- Visited your home without your consent.

FULL **RESULTS**



Of the 251 participants 94.42% reported encountering at least one of the adverse behavioural scenarios listed in the checklist. The ABC Score (average number of 'Yes' answers recorded across the 11 questions) for all participants was 6.45 (*SD* = 3.11). The total number of answers to each question are illustrated in Chart 1. Table 1 also lists the percentage of 'Yes' answers per question in order of prevalence.

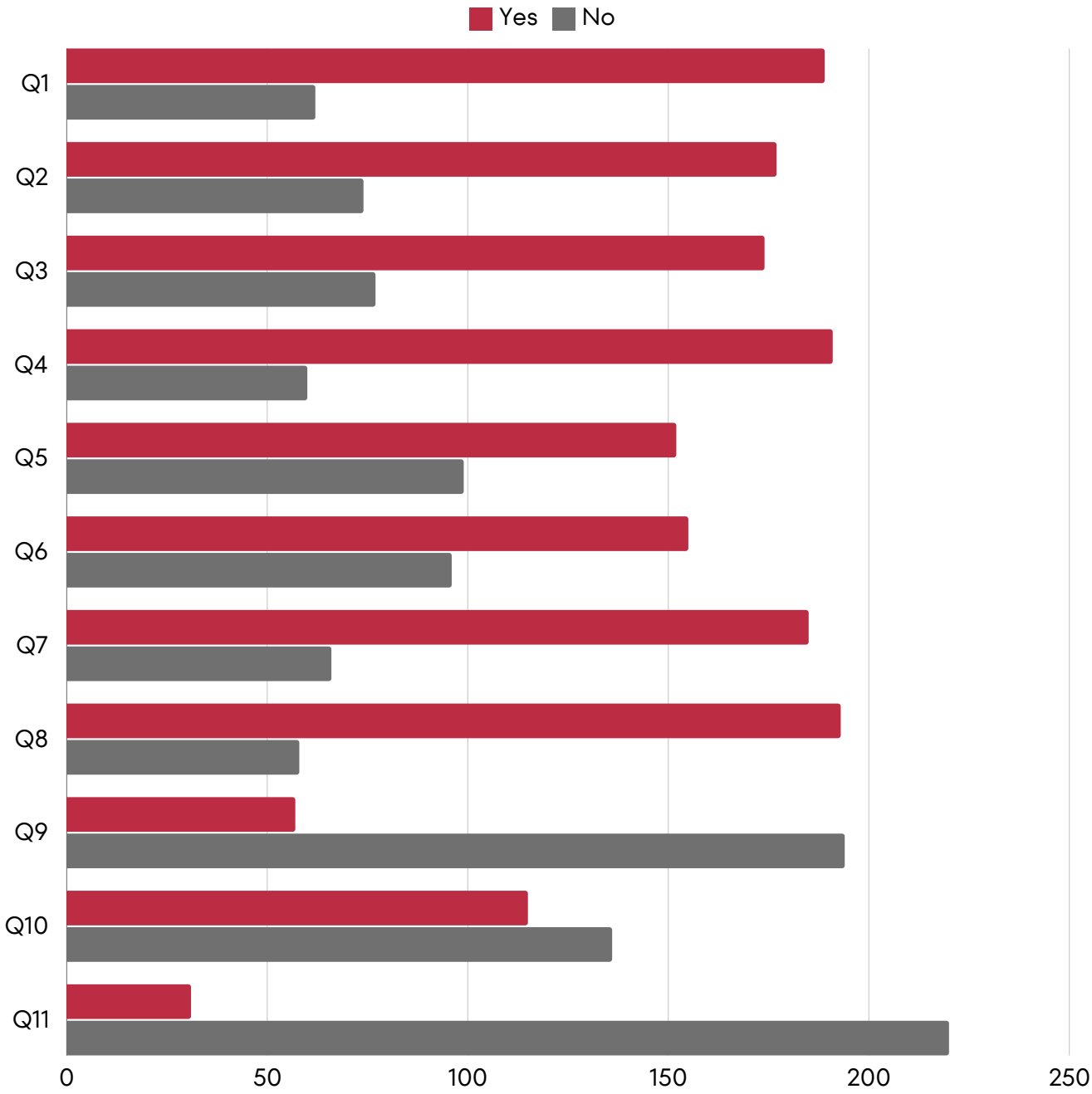


Chart 1: Total *number of 'Yes' and 'No' answers to each question*

#	Question Text	'Yes'	%
8	Have mental health professionals minimised, denied, or blamed you when their behaviour, medications or therapies are not helpful (or have been harmful to you) and so did not take your concerns seriously?	193	**76.89%**
4	Have any mental health professionals disrespected you, interrupted you, not listened to your concerns, twisted your words, or criticised your friends or family?	191	**76.10%**
1	Have you ever felt criticised or been verbally attacked by any mental health professionals?	189	**75.30%**
7	Have any mental health professionals withheld emotional support, not expressed their own feelings or opinions to you, failed to provide support or compliments, or ignored your rights and feelings?	185	**73.71%**
2	Have any mental health professionals used pressure tactics, guilt trips, or threats to influence your choices or decisions (including about treatments)?	177	**70.52%**
3	Have you encountered any mental health professionals who abused their authority, consistently claimed to be 'right', told you what to do, or spoke negatively about you to other people?	174	**69.32%**
6	Have any mental health professionals failed to follow through on agreements, broken their promises or prioritised their own plans over your needs and wellbeing?	155	**61.75%**
5	Have you ever experienced breaches of trust by a mental health professional, such as them behaving in a way that is unexpected and hurtful towards you?	152	**60.56%**
10	Have any mental health professionals ever made you feel isolated from your family, friends, other healthcare professionals or denied you access to other services or treatments?	115	**45.82%**
9	Have any mental health professionals attempted to control your financial resources or decisions?	57	**22.71%**
11	Have any mental health professionals engaged in harassing behaviour, such as making unwanted phone calls or visits?	31	**12.35%**

Table 1: ***Number and percentage of participants who answered 'Yes' to each question in order of prevalence***

RESULTS BY LOCATION

174 participants (69.32%) consented to answer further questions relating to the location of the mental health service(s) they referred to when answering the questionnaire. The UK includes England (45), Scotland (10) and Wales (2). The EU includes Austria (5), Denmark (2), France (1), Germany (5), Ireland (3), Italy (3), Lithuania (1), Luxembourg (1), Netherlands (3), Poland (3) and Sweden (1). The Other category includes Australia (4), Brazil (1), Israel (1), Mexico (1), New Zealand (2), Russia (2), Senegal (1) and Turkey (1). 2% of participants selected multiple locations, where this bridged categories their answers were recorded under each.

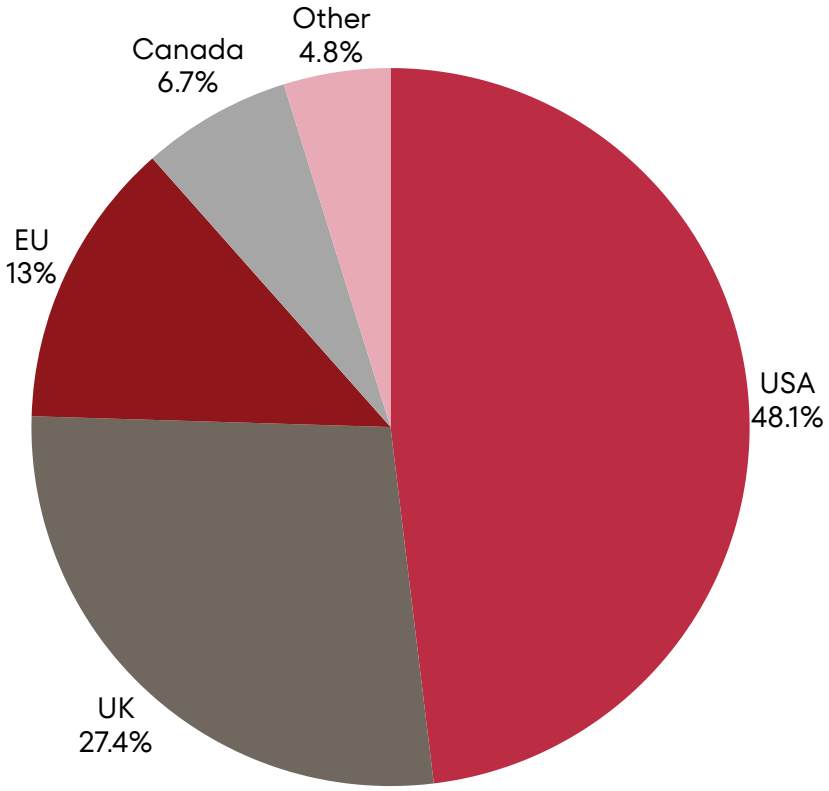


Chart 2: ***Percentage of consenting participants by location***

Location	Total Responses	Avg. 'Yes' Answers Per Participant	Standard Deviation
United States	100	**6.25**	2.85
United Kingdom	57	**6.47**	3.31
European Union	27	**6.78**	3.21
Canada	14	**5.29**	2.79
Other	10	**9.10**	1.52

Table 2: ***Average number of 'Yes' answers (ABC Score) by location***

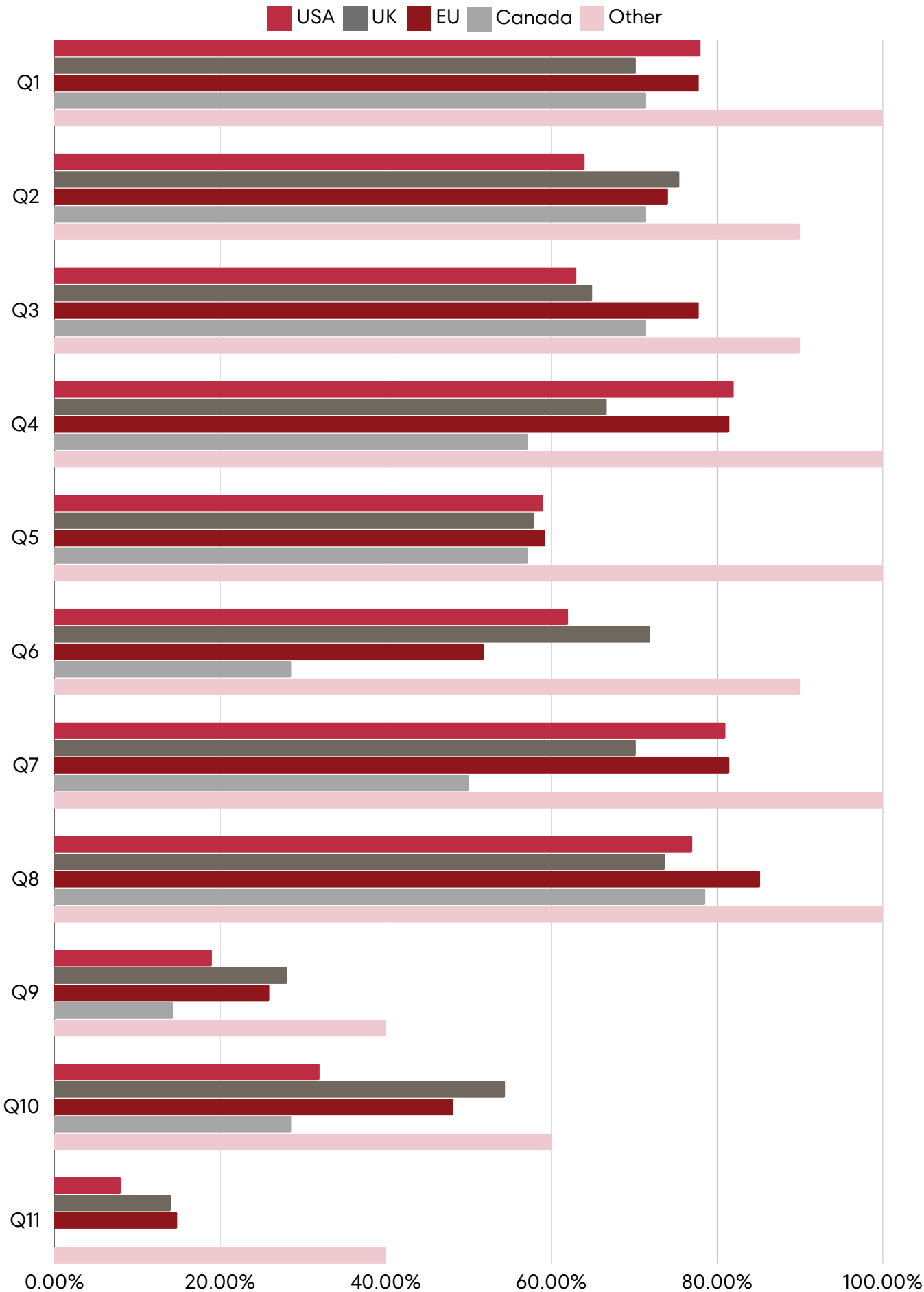


Chart 3: ***Percentage of 'Yes' answers per location to each question***

RESULTS BY SERVICE TYPE

173 participants (68.92%) consented to answer further questions relating to the type of mental health service(s) they accessed. The service options available for selection were National Health Service, Private Sector, Charity and Unsure / Prefer not to say. 25% of participants selected more than one type of service and their answers were therefore recorded under each category.

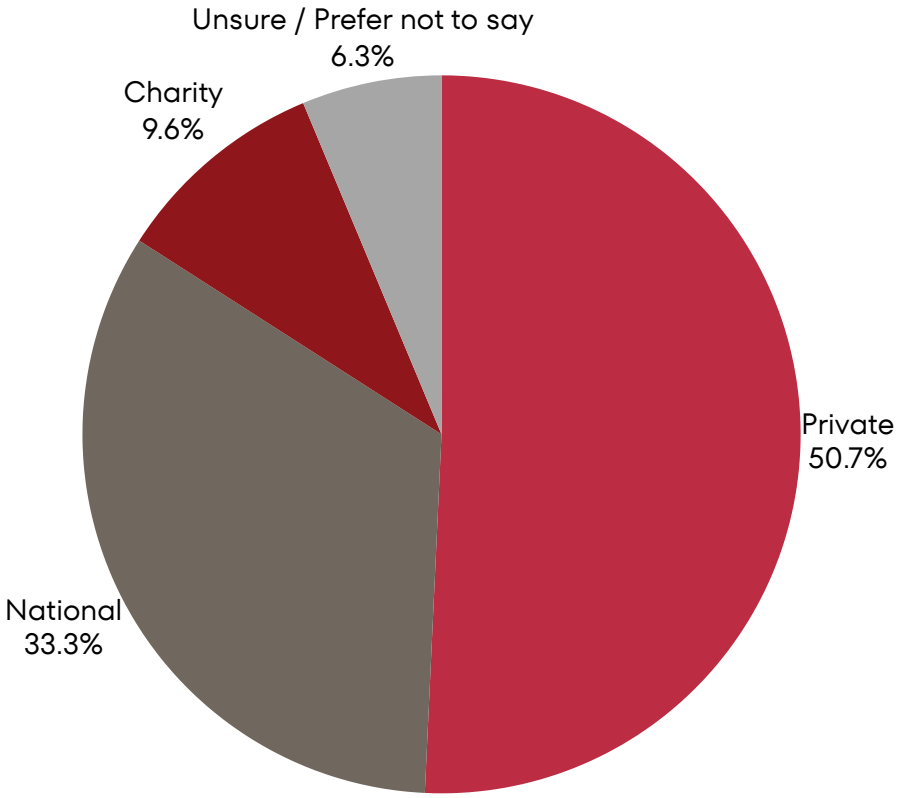


Chart 4: ***Percentage of consenting participants by service type***

Service Type	Total Responses	Avg. 'Yes' Answers Per Participant	Standard Deviation
Private	137	**6.47**	2.89
Nationalised	90	**6.79**	3.10
Charity	26	**7.58**	2.28
Unsure / Prefer not to say	17	**7.82**	2.94

Table 3: ***Average number of 'Yes' answers (ABC Score) by service type***

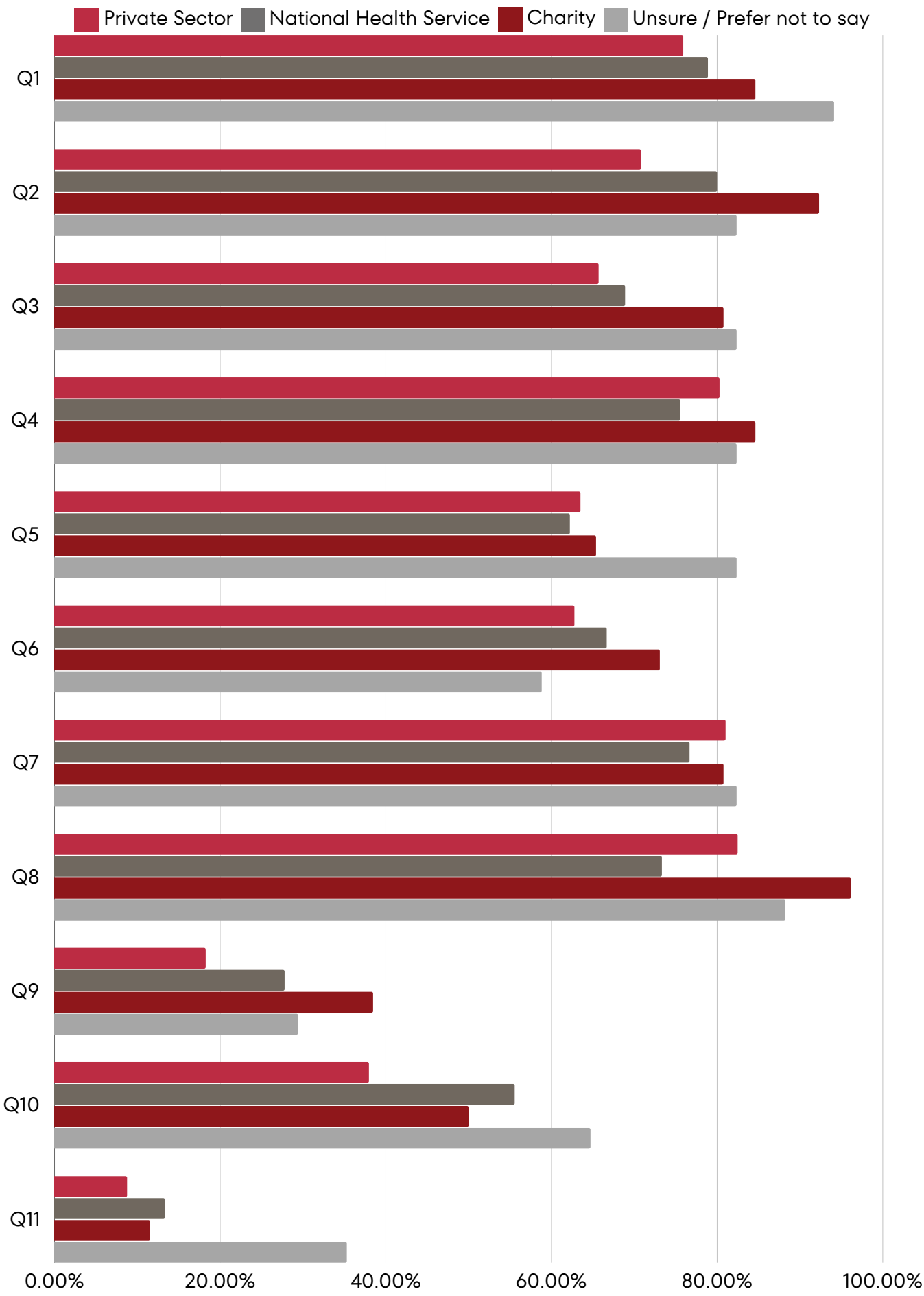


Chart 5: *Percentage of 'Yes' answers by service type to each question*

PARTICIPANT **FEEDBACK**

" It was powerful and validating to fill this in, I have been downplaying how my therapist treated me but it shocked me how many of those things I experienced "

" I felt like a broken record for answering so many Yes's, I was actually relieved when I could answer No to a question. I'm curious about the results! "

" It's so common and it's time that the field addressed it "

" I have not encountered these problems with my councillor as a teen but I wish for young people's mental health [things] get better "

" I'm glad you're doing this "

" As a former fancy academic researcher, I don't trust academics in related professions to put together this survey. Thanks for doing this! "

" Thank you. I clicked yes to every question. I have at the top of my head at least one of the examples of each question "

" I think you should have had a question about therapists victim-blaming you, that's been my biggest problem with them other than most of them knowing absolutely nothing about autism "

FEEDBACK FROM PARTICIPANTS ABOUT THE ABC-11

" I'm so grateful that you are studying this! I'm so weary getting gaslit about my previous experience with a therapist and I know there are many others out there who have had these experiences too "

" The survey is high quality and easy. I'd recommend filling it out if you're considering it "

" Thank you for doing what you are doing! "

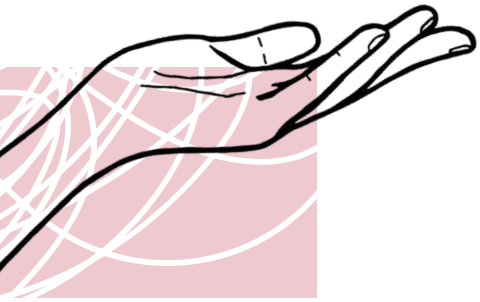
" I didn't expect to go in answering yes so much [...] I've never taken a survey that's critical of therapy "

" The example about being distanced from other sources of help and the one about controlling your money made me realise I was mistreated in this category as well "

" I was surprised at how many times I clicked yes, when I wouldn't consider my experience abusive "

" You all hit the nail on the head on asking what constitutes as harmful therapy "

" Thank you!! Great survey "



RESULTS
DISCUSSION

Due to the serious professional, regulatory and public health implications of the findings this discussion of the results begins by identifying the strengths and limitations of the research. This is the first known study that attempts to recognise adverse practitioner behaviours within a mental health setting and provide a standardised method of measurement. The ABC-11 is based on current clinical guidance issued to assist with navigating interpersonal violence. The results support the validity of its application within clinical settings to identify and address practitioner behaviours as sources of potential iatrogenic harm. This discussion does not incorporate location results for Canada or the 'Other' location category as larger sample sizes are required. High scores for charity services in comparison to nationalised and private services may be suggestive of unaddressed regulation challenges within the sector but further exploration is recommended due to the limited sample size. While this study can urge caution it cannot speak to the odds of encountering adverse practitioner behaviours and therefore does not discourage individuals from seeking mental health care. Participants were aware that the questionnaire related to negative experiences prior to completion and this may have meant that those with positive experiences chose not to participate.

94.42% of the 251 participants reported encountering at least one of the adverse behavioural scenarios listed in the checklist. The average number of 'Yes' answers per participant was six (out of eleven), which held across location and service type. The original document issued by a national health service advised that experiencing *any* of the scenarios may be indicative of abuse in domestic relationships. That they are present at all within therapeutic relationships is a significant cause for concern. The average score within a clinical setting should be zero but this was only true for fourteen participants (5.58%). These findings correlate to prior research, including professional and service-user accounts, that suggest mental health services are not facilitating an environment conducive to positive therapeutic outcomes, leaving service-users vulnerable to iatrogenic harm (Ahsan, 2022; Cotton, 2016; Kraus et al., 2011; Langley and Price, 2022; Marriage, 2024; Mendel et al., 2010; SAMH, 2020; Strang, 2020; Wren, 2022). The results also mirror previous concerns regarding a lack of awareness among clinicians about the limitations and potential negative side effects of treatments, alongside deficits in reflective practice and acknowledgement of iatrogenic harm (Castonguay et al., 2010; Linden, 2012; Marriage, 2024; Nutt and Sharpe, 2007; Parry, Crawford and Duggan, 2016; Scott and Young, 2016; Schermuly-Haupt, Linden and Rush, 2018). Prior studies highlighting the unreliability of clinicians when identifying and recording outcomes are further supported by the high prevalence of adversity (Bystedt et al., 2014; Vaughan et al., 2014) which poses challenges for future data collection (Audit Scotland, 2023; Liptzin, 2009; Surviving Work, 2020).

This research confirms the presence of epistemic injustices (Crichton, Carel and Kidd, 2017) and indicates that the mental health sector is not providing a recognisable standard of person-centred, trauma-informed or human rights based care, regardless of location or service type (NHS Education for Scotland, 2023; Office for Health Improvement and Disparities, 2022; Substance Abuse and Mental Health Services Administration, 2014; World Health Organisation, 2016; World Health Organisation and United Nations, 2023). Participants were not asked to disclose treatment type or profession (such as psychiatrist, psychologist, counsellor, social worker, nurse, etc.) but it is clear that a significant number of clinicians with responsibility for establishing and maintaining therapeutic relationships are failing to adequately address service-user rights, needs, concerns and adverse outcomes; Clinical evidence as to the importance of the therapeutic relationship seems neglected

(Cook, Schwartz and Kaslow, 2017; Lambert and Barley, 2001; Moyers and Miller, 2013). The use of power and control by practitioners over service-users is a continuation of the historical nature of the field (Oppenheim 1991; Proctor, 2002; Scull, 2023; Smail, 2005). While this study cannot provide a full commentary on the reasons behind adverse practitioner behaviours it can begin to create a formulation of the current landscape of mental health service provisions based on the prevalence of 'Yes' answers collected for each scenario:

Practitioner denied, downplayed or deflected responsibility onto the service-user when poor outcomes or iatrogenic harm occurred (Qu.8)

- 76.89% of participants answered 'Yes' to this scenario.
- Notable difference across locations with higher prevalence in the EU (>10%) in comparison to the UK, where a minor difference was found to the USA (<5%).
- Minor difference between nationalised and private services (<10%) but higher prevalence in charity services (>10%).

Practitioner dismissed or belittled the service-user and/or advocates (Qu.4)

- 76.10% of participants answered 'Yes' to this scenario.
- Notable difference across locations with higher prevalence in the USA and EU (>10%) in comparison to the UK.
- Minor difference across service types (<10%).

Practitioner criticised or verbally attacked the service-user (Qu.1)

- 75.30% of participants answered 'Yes' to this scenario.
- Minor difference across locations (<10%).
- Minor difference across service types (<10%).

Practitioner withheld communication, support and rights from the service-user (Qu.7)

- 73.71% of participants answered 'Yes' to this scenario.
- Notable difference across locations with higher prevalence in the USA and EU (>10%) in comparison to the UK.
- Minor difference across service types (<10%).

Practitioner engaged in coercive control over the service-user (Qu.2)

- 70.52% of participants answered 'Yes' to this scenario.
- Notable difference across locations with higher prevalence in the UK and EU (>10%) in comparison to the USA.
- Notable difference across service types (>10%) with charity services showing the highest prevalence, followed by nationalised and then private services.

Practitioner abused position of power/authority (Qu.3)

- 69.32% of participants answered 'Yes' to this scenario.
- Notable difference between locations with higher prevalence in the EU (>10%) in comparison to the USA and UK.
- Minor difference between nationalised and private services (<5%) but a higher prevalence in charity services (>10%).

Practitioner broke agreements and promises or prioritised their own plans (Qu.6)

- 61.75% of participants answered 'Yes' to this scenario.
- Notable difference across locations (>10%) with the UK showing the highest prevalence, followed by the USA and then the EU.
- Minor difference across service types (<10%).

Practitioner breached trust of the service-user (Qu.5)

- 60.56% of participants answered 'Yes' to this scenario.
- Minor difference across locations (<5%).
- Minor difference across service types (<5%).

Practitioner isolated the service-user from other sources of support (Qu.10)

- 45.82% of participants answered 'Yes' to this scenario.
- Notable difference between locations with higher prevalence in the UK and EU (>10%) in comparison to the USA.
- Notable difference across service types with higher prevalence in nationalised and charity services (>10%) in comparison to private services.

Practitioner controlled or affected the finances of the service-user (Qu.9)

- 22.71% of participants answered 'Yes' to this scenario.
- Minor difference across locations (<10%).
- Notable difference across service types (>10%) with charity services showing the highest prevalence, followed by nationalised and then private services.

Practitioner made unwanted contact with the service-user (Qu.11)

- 12.35% of participants answered 'Yes' to this scenario.
- Minor difference across locations (<10%).
- Minor difference across service types (<10%).

Previous research offers varying explanations for adverse behaviours by practitioners and poor clinical outcomes (Gawne and O'Neill, 2024; Hardy et al., 2017; Johnstone, 2000; Marshman, Munro and Hansen, 2021; Morse et al., 2012; NHS Employers, 2022). To explore this the ABC-11 can be applied alongside practitioner and service provision variables. Such as profession, funding level, training, modality, workload, burnout, personality and service delivery environment. It may also be a useful resource for reflective practice and aid against negligence. Prior studies indicated differential outcomes across gender, race, psychiatric diagnosis, disability, neurodiversity, physical health and environmental stressors (Artman and Daniels, 2010; Becker-Blease, 2017; Craig, 2017; Hallett and Kerr, 2020; Jackson, 2002; Langley and Price, 2022; Mcgrath et al., 2016; Mumford, Fraser and Knudson, 2023; Nicki, 2016; Spandler and Allen, 2017; Szasz, 1960; Sheppard, Bizumic and Calear, 2023; Thornton, 2020). Capturing the demographics of service-users is therefore pertinent to further research. This will not only improve outcomes through meaningful co-design, it is also necessary for pinpointing where discrimination, victim-blaming, coercive control and exclusion are present. Prevalence of the scenarios when seeking mental health support from outside of Westernised services is a further avenue that can be explored. Alongside generating academic learnings to direct the course of future studies, the practical application of the checklist by teams and organisations can also precipitously highlight areas of improvement to those in regulatory, policy, managerial or educational positions of responsibility. Including indicating where practices or protocol benefit the interests of a dominant ideology, culture, profession, clinician or organisation, rather than those seeking healthcare (Beale, 2021; Beresford, 2023; Dallam, 2010; Frazer-Carroll, 2023; Greener and Moth, 2020; Oppenheim 1991; Scull, 2023; Smail, 2005).

While psychiatric and psychological treatments can be efficacious for many individuals in distress it is imperative to acknowledge that those seeking mental health care are being put at significant risk by the presence of adverse practitioner behaviours. The ABC-11 provides service-users and their supporters with a much needed mechanism of validation, solidarity and advocacy. Along with clarity about narratives regularly imposed by those in positions of power and perpetuated as conventional wisdom by wider society regarding services. This preliminary validation for the ABC-11 as a standardised tool for use in clinical settings allows for a straightforward benchmark to be known and therefore expected. Empowering service-users to identify circumstances that may result in iatrogenic harm and facilitating access to mental health care that is safe and beneficial to their rights, needs and wellbeing.

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APPENDIX 1
ORIGINAL NHS CHECKLIST

WARNING SIGNS OF DOMESTIC ABUSE

Domestic abuse is abuse by a partner or ex-partner. It is often subtle and can take place over a long time. This can make it difficult to clearly see what is happening. Warning signs that a partner or ex-partner's behaviour may be abusive are:

- Criticism or verbal attacks
- Pressure tactics to make you make decisions, guilt trips, threatening to withhold things
- Abusing authority, always claiming to be 'right', telling you what to do, putting you down in public
- Disrespecting, interrupting, not listening, twisting words, putting down friends or family, or in front of friends or family
- Abusing trust, cheating on you, being overly jealous
- Breaking promises, not following through on agreements, their plans are more important than yours
- Withholding emotionally, not expressing feelings, not giving support or compliments, not respecting your rights or feelings
- Minimising, denying and blaming, making light of their behaviour, not taking your concerns seriously, saying you are to blame for abusive behaviour
- Controlling the money
- Isolating you from family and friends
- Harassing you, phoning, visiting when you do not want them to

If you recognise any of these, you may find it helpful to phone one of the useful numbers.

Assertiveness after trauma and abuse 21

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APPENDIX 2
PARTICIPATION INFORMATION

Why are we doing this survey?
We are conducting this study to better understand people's experiences with mental health services and raise awareness of any negative aspects so that services can be improved.

Who can participate?
This survey is open to anyone over 16 who has used any kind of mental health services for support, therapies or medications.

What do I have to do?
You will be asked to answer 'yes' or 'no' to eleven questions about negative experiences you may have had when using mental health services. We won't ask you to provide details about any events. We will also ask where you received mental health care but this question is optional.

How long will it take to complete?
You can answer all the questions and submit them in less than ten minutes.

What are your rights?
Your participation in this study is entirely voluntary and you have the right to decline to participate or to withdraw from the study at any time without any consequences. At the end of the survey you will be given a link to be able to change your answers or withdraw them if you have logged in to a Google account.

What are the risks of taking part?
- Participation in this study poses minimal risks.
- Some people may find the questions to be upsetting because they ask about negative experiences related to mental health services.
- Some people may find the questions to be upsetting because they have been adapted from an NHS resource used to identify harmful behaviours in relationships.
- If you experience any distress you can stop and close the survey at any time. Your wellbeing is very important to us.

What are the benefits of taking part?
- Direct benefits to you for participating in this research are knowing that you are not alone if you have experienced any of the negative events.
- Your contribution will help improve our understanding of mental health services.
- This research will be shared with the public to raise awareness.
- We hope that this can be used to inform policies and improve services for everyone.

Are my details confidential?
Your participation in this study will be confidential. We will not ask for your name or any personally identifiable information. This is a Google Form but even if you are logged in to your Google Account we won't receive that information. Your answers to the questions will be stored securely and will only be accessible to the research team. Your responses will be anonymous and only reported collectively along with those of other participants.

Will I find out the results?
Yes! We plan to share the results on our website and social media following the Scottish Mental Health Arts Festival.

Is there anything else I need to know?
This survey does not ask about positive experiences with mental health services but if you would like to share those too you can submit them to the NHS Care Opinions website. Although this study is running during the Scottish Mental Health Arts Festival it is not affiliated with them and open to people outside of Scotland.

Who can I contact to find out more?
If you have any questions or concerns about the study you can contact us at: [email]
A list of free support services and resources are also available on our website: [link]

APPENDIX 3
ADVERSE BEHAVIOURS IN CLINICIANS (ABC-11)

Adverse Behaviours in Clinicians (ABC-11)

Please tick the appropriate answer to each of the following questions based on your experience when accessing mental health services.

Service(s) Accessed: _____	**Yes**	**No**
1. Have you felt criticised or been verbally attacked by any mental health professionals? Some examples: • Repeatedly telling you that your thoughts or feelings were wrong. • Raised their voice at you. • Made unkind comments about your struggles. • Used offensive or discriminatory language or stereotypes (i.e about your age, race, gender, culture or religion). • Made fun of your difficulties.	☐	☐
2. Have any mental health professionals used pressure tactics, guilt trips, or threats to influence your choices or decisions (including about treatments)? Some examples: • Made you feel like you had no choice but to follow their advice. • Pushing you to make treatment decisions without giving you choices or explaining your options. • Made you feel guilty for considering other treatments or services. • Threatening to stop your mental health support if you did not do what they wanted. • Giving you ultimatums to make you comply with their recommendations.	☐	☐
3. Have you encountered any mental health professionals who abused their authority, consistently claimed to be 'right', told you what to do, or spoke negatively about you to other people? Some examples: • Acted like their way was the only right way, dismissing your ideas and opinions. • Talked down to you, acted superior and belittled you. • Told you how to think or feel on a regular basis. • Spoke or wrote letters to other professionals in a way that made you look bad. • In group therapy, publicly criticising or making fun of what you shared.	☐	☐
4. Have any mental health professionals disrespected you, interrupted you, not listened to your concerns, twisted your words, or criticised your friends or family? Some examples: • Often interrupting you when you were speaking during appointments. • Treating you differently because of your gender, age, religion or culture. • Talking over you and not letting you finish your sentences. • Disregarding your opinions and needs and treating you as if they are wrong. • Ignoring what you said, dismissing your concerns, or twisting your words. • Speaking negatively about your friends or family, making you uncomfortable.	☐	☐

	Yes	No
5. Have you experienced breaches of trust by a mental health professional, such as them behaving in a way that is unexpected and hurtful towards you? Some examples: • Not telling you about important information or decisions (such as a diagnosis). • Sharing information or their opinions with other professionals without you knowing. • Breaking confidentiality by discussing your care with others who were not involved. • Invading your privacy by accessing your personal information without consent. • Displaying jealousy or crossing professional boundaries during your sessions. • Attempted to have an inappropriate relationship or physical contact with you.	☐	☐
6. Have any mental health professionals failed to follow through on agreements, broken their promises or prioritised their own plans over your needs and wellbeing? Some examples: • Making promises about your treatment but not keeping them. • Changing your treatment plan or medications without informing you. • Not sticking to the agreed-upon treatment schedule or number of sessions. • Their commitments or preferences were more important than your scheduled appointments or goals. • Cancelling or rescheduling appointments without giving you enough notice. • Not offering appointments for a very long time without an explanation.	☐	☐
7. Have any mental health professionals withheld emotional support, not expressed their own feelings or opinions to you, failed to provide support or compliments, or ignored your rights and feelings? Some examples: • Not showing understanding or support during your appointments or when you contact them. • Compliments or positive feedback were infrequent or nonexistent. • Not seeming to care about your rights or feelings, focusing only on their own agenda. • Rarely providing encouragement or emotional support. • Not acknowledging your progress, achievements or strengths.	☐	☐
8. Have mental health professionals minimised, denied, or blamed you when their behaviour, medications or therapies are not helpful (or have been harmful to you) and so did not take your concerns seriously? Some examples: • Blaming you when their treatments are not helpful or cause you harm. • Refusing to acknowledge if they made a mistake (including misdiagnosis). • Denying that their actions or treatment decisions had a negative impact on you. • Downplaying or denying their problematic behaviours or blaming them on you. • Dismissing your concerns as insignificant or only your 'perception'.	☐	☐

	Yes	No
9. Have any mental health professionals attempted to control your financial resources or decisions? Some examples: • Attempting to influence your spending decisions. • Trying to limit or restrict your access to your own money. • Not providing helpful supporting information for welfare / benefits assessments. • Preventing you from being able to work because of a lack of access to services or making incorrect treatment decisions that prolonged your recovery.	☐	☐
10. Have any mental health professionals made you feel isolated from your family, friends, other healthcare professionals or denied you access to other services or treatments? Some examples: • Making it difficult or impossible for you to access other healthcare services or treatments by creating barriers, withholding necessary information or not making referrals for you. • Distancing you from other healthcare professionals or treatment options, implying that they were the only source of support or treatment you needed. • Making it difficult for you to spend time with loved ones or telling you not to see them. • Not considering or involving loved ones in your treatment plan or care. • Reacting negatively to input or opinions from your friends and family about your needs and healthcare. • Failing to support you to leave harmful relationships and create new ones.	☐	☐
11. Have any mental health professionals engaged in harassing behaviour, such as making unwanted phone calls or visits? Some examples: • Unwanted phone calls, text messages, or emails that were not required for your healthcare. • Visited your home without your consent.	☐	☐
Total		

Date Completed: ___/___/_____

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