RQ7: Do service providers more appreciate the need to avoid omnipotence to help take responsibility for professional power?

**Background and rationale**

**Professional omnipotence**

In the same way that lack of awareness of racial and gendered power risks unintended but still irresponsible and unethical outcomes, practitioners also have an onus to take responsibility for their professional power. If this is left unchecked, it could lead to a false belief in their omnipotence, and in turn threaten good outcomes for the client.

**Belief in formal services**

There are several ways that professional omnipotence could manifest. One, for example, is when service providers believe that formal services are the only way victims/survivors can ‘recover’ from their trauma. However, for some victims the mental ill-health as a result of childhood sexual abuse may be irreparable, and at best managed, such as some cases of BPD.

**Self-help, family, and group therapy**

Service providers may also believe that the clinical setting is more effective than self-help strategies. Previous research shows that online resources such as books and articles preserve the victim/survivor’s confidentiality (Chien, 2013), and that self-directed music, art, and narrative therapy have roles in developing self-empowerment (Lenette & Sunderland, 2016; Madigan, 2011). If service providers do not suggest these to the client in conjunction with their formal services, it could reflect a bias that reflects the power of their profession over the individual’s power. Encouraging additional self-help assists with putting power back in the hands of victims on their journey toward becoming an empowered survivor.

Finally, family or group therapy can be suggested to the client to help avoid any assumption by the service provider that their assistance is more valuable than the support offered by other family members and other victims/survivors of child sexual abuse. Family therapy is additionally beneficial for the victim/survivor’s carers. While the child is the primary victim, families can also experience secondary victimisation (Royal Commission Final Report, 2017). This could be marked by sadness or helplessness that the abuse has occurred at all, or
anger at themselves for not being aware of the abuse at the time and therefore able to protect their child (Taylor & Norma, 2013). As such feelings can interfere with the child getting the support they need, it is critical that in addition to accessing services for the child victim, the family also obtain clinical support. This provides an outlet for them to receive help regarding their own secondary victimisation, but it also represents an opportunity to learn about and develop strategies for protecting their child in the future so that they are not subject to further re-victimisation.

**Measures**

Program attendees were asked two questions in relation to RQ7. The first was, B.11 – ‘In addition to the one-on-one service you provide to clients, do you suggest to them additional...?’ (a) Self-help strategies (e.g. reading relevant books or online resources; engaging in music, art, or narrative therapy; etc.), (b) Family therapy, (c) Group therapy, (d) None of the above, and (e) N/A (I am not a service provider). Participants could tick all that were relevant, and option D provided an internal check on the logical consistency of participants’ responses. The second question was, B.12 – ‘Do you think that all mental illnesses can be successfully treated with formal clinical services (e.g. psychiatrists, psychologists, social workers, counselors, etc.)?’ with forced options Yes or No.

**Changes over time**

**Belief in formal services**

**By cultural background of service provider**

In relation to B.12, one participant at T1 did not answer the question instead saying ‘N/A’, and two participants ticked both Yes and No. One of these said, Undecided (Baseline Survey_94) and the other said Some people do not feel comfortable to go to counselors (Baseline Survey_54). Thus, these three participants were henceforth excluded from analyses. Two participants at T2 did not respond to this question.

As can be seen from Figure 10 (and Data Table G.6), most service providers at both T1 and T2 do not think that all mental illnesses can be successfully treated with formal services (CALD T1 84%, CALD T2 71%; Anglo T1 79%, Anglo T2 71%). This suggests that these beliefs are strongly held among service providers from both cultural backgrounds. Nevertheless, they proportions decreased over time, suggesting that as a result of the program, hope for and belief in the effectiveness of formal services for their clients increased (counter to the main message of the program that not all mental illness can be effectively treated).
Figure 10: Percentage distribution on whether all mental illnesses can be successfully treated with formal services by cultural background of service provider (T1 and T2)

Qualitative data

The relevant qualitative data was sparse but important for elucidating the views of service providers who do think that all mental illnesses can be successfully treated with formal services. They said:

“Mental health may never recover” – this is not trauma informed. We must always give hope (Satisfaction Survey_87).

Please rewrite the point about borderline personality disorder. Your verbal explanation was better but the [illegible] stigmatising [illegible] that recovery is possible. See ProjectAir.org\(^1\) (Satisfaction Survey_31).

My answer to B.12 is ‘no’ as I believe that spiritual/religious/social connections are very powerful for healing and recovery – I don’t think current MH (mental health) services interventions are holistic enough. But I do believe strongly in the ability for

---

\(^1\) This suggestion was followed up for the online version of the program.

© Copyright 2019 Pooja Sawrikar
people to recover and be successfully treated with culturally appropriate, safe, respectful services and interventions. I hold a lot of hope. Our current MH interventions do not necessarily support victims the way it’s needed – medical model etc. (Baseline Survey_58).

This project took the position that some mental illnesses may be chronic in the same way that physical illnesses could be (such as life-long asthma). Using this analogy, false hope of recovery could be an ‘enabling disservice’. Instead, it is seen as better to provide an understanding to clients that the mental illness is not their fault – and in this way, use a trauma-informed approach that further takes responsibility for the FAE by locating its cause to the traumatic event rather than personal failure to manage its traumatic consequences – but that the resulting episodic or cyclical symptoms of severe emotional distress can be managed.

Moreover, the focus was on service providers’ beliefs about formal services as a way of mitigating the risk of professional omnipotence; to help ensure they do not believe that formal services are the only way victims/survivors can improve their mental well-being. It was not about removing hope for clients. Undoubtedly, this is difficult terrain to navigate ethically. Although most service providers do seem to understand that formal services are not the only way victims/survivors can improve their mental well-being, there is a conflation among some about its role in giving hope and how that hope can or should be given. Importantly, the service space serves many different and sometimes opposing functions depending on the client and their needs. Thus, any ‘debate’ about the role of hope in the service setting may not need to be resolved, but simply described comprehensively.

Overall, the findings show that many professionals are already using their professional power responsibly (most especially in relation to self-help), and that positively there were no real reductions in this as a result of the program (see section on ‘Self-help, family, and group therapy’). However, the role of age or work experience was further explored to help unpack the data (while acknowledging the unbalanced or small sample sizes). As can be seen from Table 17, there is a small observable trend that practitioners who do not believe that all mental illnesses can be treated with formal services are older and have more work experience.
Table 17: Descriptive data on belief in formal services, age, and work experience for total sample (T1 and T2)

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>All mental illnesses can be treated with formal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>39.6</td>
<td>12.3</td>
</tr>
<tr>
<td>Work experience</td>
<td>12.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Not all mental illnesses can be treated with formal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>42.7</td>
<td>12.0</td>
</tr>
<tr>
<td>Work experience</td>
<td>14.0</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Self-help, family, and group therapy

Three participants of the total sample\(^2\) at T1 did not answer B.11, and one of these said *I can ask this team but am not part of this team (I'm in education)* (Baseline Survey_44). This indicates that they did not answer the question because it was not relevant to their direct line of work, which may have also been the case for the other two participants. At T1, 6% selected ‘N/A’ and therefore explicitly indicated that they were not in relevant frontline service delivery. One of these participants did say, *N/A (I do very little 000 work but suggestions will depend on literacy, person, etc.)* (Baseline Survey_48). Similarly, 3% selected N/A at T2.

Only 5% selected ‘None of the above’ at T1, which had further reduced to 2% at T2.\(^3\) This positively indicates that many service providers (between 26–37%) use professional power responsibly by sharing it with clients in ways that could empower them rather than seeing themselves as omnipotent in the therapeutic process.

As can be seen from Figure 11 (and Data Table G.6), the proportion of service providers who suggest additional self-help strategies did not really change from T1 (37%) to T2 (35%), nor the proportion who suggest additional family therapy from T1 (27%) to T2 (26%). However, the proportion who suggest additional group therapy did increase from T1 (26%) to T2 (33%), suggesting that the program was somewhat effective in promoting this form of responsible use of professional power.

\(^2\) Data has been presented here for the total sample, rather than by the cultural background of the service provider, because the cross-cultural differences are negligible (see Data Table G.6).

\(^3\) Statistical tests examining if this change over time is significant has not been conducted due to the small numbers.
Figure 11: Percentage distribution on measures of professional omnipotence for total sample (T1 and T2)

Qualitative data

Overall, service providers appear less willing to implement responsible use of professional power when it is in a group-based setting. Participants said:

*Yes (suggest additional family therapy) – (but) without perpetrator (Satisfaction Survey_14).*

*Talk about family therapy within collectivism may require additional attention (Satisfaction Survey_45).*

*Yes (suggest additional family therapy) – counseling with survivor and non-offending family members (Satisfaction Survey_54).*

*Yes (suggest additional family and group therapy) – with non-offending family members (Follow up Survey_34).*
Yes (suggest additional group therapy) – (but it) depends on the client stage, never in the beginning (Follow up Survey_4).

Some clients will not be ready to engage in any formal counselling so self help is the best place to start (Follow up Survey_5).

Yes (suggest additional group therapy) – This is a tricky one also, however, as levels of shame will determine group disclosure (Follow up Survey_23).

Yes (suggest additional family and group therapy) – (but it) depends on the specific needs/risk and protective factors of the clients (Satisfaction Survey_29).

Unable to answer this (B.11) as the therapy needs to fit the victim in the context of culture and family. There is intersectionality (Satisfaction Survey_102).

Yes (suggest additional family therapy) – (but) only if they wish to include other victim’s sisters and brothers/cousins together. I refer to a CSA specialist team who do family therapy/healing together if wanted (Satisfaction Survey_104).

Thus, it appears that a substantial proportion of service providers are aware of their professional power and willing to use it responsibly by avoiding omnipotence, but that group-based help may be seen to increase risk of harm to clients rather than empower them. In-depth future research examining when and why service providers suggest additional family and group therapy to CALD victims/survivors is evidently required.

Finally, two participants highlighted the issue that some CALD women may not engage with any talk therapies, and that the evidence for its effectiveness is currently lacking and also calls for important future research:

Re talking therapies: love to have review about the evidence of those for CALD (even just one slide) re those with no evidence vs some evidence with CALD communities (Satisfaction Survey_32).

Yes (suggest additional family therapy) – however, “therapy” in itself is not always the answer for CALD communities. It can be a strange concept and needs to be provided by a specialist CALD service provider (Follow up Survey_23).
Summary

- Practitioners have an onus to take responsibility for their professional power, or it could lead to a false belief in their omnipotence. For example, they may believe that formal services are the only way victims/survivors can ‘recover’ from their trauma, but this is not always the case. Sometimes it is not possible to recover from mental illness (e.g. some cases of borderline personality disorder), and informal self-help strategies (e.g. music, art, or narrative therapy) may also be effective because they are empowering. Assistance from family members during family therapy and other victims/survivors of child sexual abuse during group therapy may also be effective; and family therapy can additionally assist secondary non-offending victims.

- Most service providers (approximately 75%) do not believe that all mental illnesses can be treated with formal services, and are thus using their professional power responsibly. This attitude was independent of cultural background, but somewhat related to age and work experience, and the proportion did not substantially change over time as a result of the program, indicative of it being a strongly held view.

- Service providers who do believe that all mental illnesses can be treated with formal services seem to view this attitude as an implementation of a trauma-informed, hope-inspiring, approach. It highlights that how hope is given within clinical service differs between practitioners, and that resolution of any such debate including conflicting and opposing attitudes about the role and nature of hope would be challenging if not impossible.

- This project took the position that some mental illnesses may be chronic, so false hope of recovery would be an enabling disservice. Instead, it was seen as better to provide clients with an understanding that their mental illness is not their fault – it is the result of trauma – but that severe emotional distress can still be managed. In this way, a trauma-informed, hope-inspiring, approach is still being used, while also mitigating the risk of professional omnipotence – that formal services ‘can fix everything’.

- Approximately a third of service providers suggest additional self-help strategies, but there appears to be reluctance to suggest additional family and group therapy, as ways of using professional power responsibly and avoiding omnipotence. This suggests that group-based help may be seen to increase risk of harm to clients rather than empower them, and that in-depth future research is required.