© Kamla-Raj 2014
Ethno Med, 8(3): 259-267 (2014)
PRINT: ISSN 0973-5070 ONLINE: 2456-6772
DOI: 10.31901/24566322.2014/08.03.08

Deterrents of Complaining: An Empirical Study of Inpatients

Fezeena Khadir and R. Swamynathan

Institute of Technology Mayyil (Affiliated to Kannur University), Kannur 670 602, Kerala, India

KEYWORDS Complaining Behavior. Perceived Disempowerment. Non-complainers. Hospitals. Inpatients

ABSTRACT The purpose of the present research is to identify the reasons behind non-complaining behavior of inpatients, despite their dissatisfaction with the hospital services. This paper also looks into the various responses of non-complainers after a dissatisfaction episode. This is an empirical research done in the various districts of one of the southern states of India, Kerala. A self-administered structured questionnaire was used to collect primary data that was analyzed using SPSS (version 16.0). The research found that majority of non-complainers opted to switch to another hospital the next time they had an illness after confronting with a dissatisfaction episode with hospital services. Using multiple response scale, it was found that 'perceived relative inability' was the major reason that dissuaded non-complainers from overt complaining behavior. In addition, using Likert scale, it was found that majority of the non-complainers fell in the moderate level of perceived disempowerment category. Besides, using t-test and ANOVA, it was found that there was no true statistically significant difference between perceived level of disempowerment of non-complainers and their socio-economic and demographic variables. This would help private and cooperative hospitals, who are cautious about revenue generation and goodwill, to develop better complaint management and service recovery strategies for tracking consumer dissatisfaction and further actions of consumers. Above all, it is also hoped that this research would add more inputs to the existing CCB literature on healthcare sector in general and hospitals in particular.

INTRODUCTION

The observation of behavioral process of consumers has given rise to the studies of their complaining behavior and its effect on businesses. Nyer (2000) studied complaints of consumers would be useful for companies to make strategic and tactical decisions with the purpose of improving their business. Today's market scenario is not only concerned about gaining new customers, but also about retaining them to a long-term relationship. To understand consumer expectations, desires and requirements, marketers are ready to spent time and money. Klaus et al. (2013) explained experience as a consecutive evaluation process founded on past, current and expected experiences. As no organization works perfectly to keep their customers happy throughout, it becomes pertinent for them to be alert about how satisfied their valued customers are.

Address for correspondence:
Ms. Fezeena Khadir
25/ K.K.P. Nagar,
U.C. College, P.O.
Aluva, Kerala, India
Pincode: 683102
Telephone: +91 9847470230
Fax: +91 484 2609398
E-mail: fezeena@gmail.com

Here comes the prominence of Consumer Complaining Behavior(CCB) as an integral part of understanding consumer dissatisfaction. Most of the existing literature analyzes the dissatisfaction of consumers and the reasons of dissatisfaction, generally representing the Western developed countries. Tam and Chiew (2012) observed that majority of dissatisfied consumers take actions silently and make unpleasant word-of-mouth complain. Jugenissova et al. (2014) studied about the unpleasant banking experiences and complaint behavior in Kazakhstan. They found that long queue, delay in services and impolite staff were the top three unpleasant banking experiences faced by customers. Majority of males were found to exit without complaining when dissatisfied, while most of the females exited after complaining. Their age group, marital status and education level were not found to be strong determinants of complaining behavior. Staff training and monthly customer surveys turned out to be the major solutions for service providers.

Nimako and Mensah (2014) in their research on complaining responses of banking customers in Ghana analyzed that dissatisfaction was more prevalent among non-complainers than complainers. Ghanaian banking customers were found to be more reserved and quiet and thus

refrained from making their complaints public. They were found boycotting bank's services, discouraging friends and family from using the bank's services and engaging in switching behavior.

Salo and Makkonen (2014) observed that very few studies have investigated on why people do not complain. Their Grounded Theory approach to analyze the non-complaining behavior of information systems users identified eight reasons, out of which three were not present in extant non-complaining studies. First one was the anticipation of *updates* that are expected to improve the services and applications and solve some of the problems faced by mobile service users. *Poor device-complaining fit* in which the mobile device does not give the complainer enough support to navigate through complex complaining process was the second reason. *Perceived low sacrifices* due to low prices, easy availability and unnoticeable spending that tend to generate low expectations which may prevent formation of complaining intentions was the third reason evolved from their research work.

Mahapatra (2014) studied about 'enduring dissatisfaction', a term he used to explain non-complaining behavior of consumers of products and services (cable TV, banking, land-line telephone services, cell phone services, postal and electricity services) in Uttarakhand, India. Reasons for dissatisfaction mentioned in this research study are chiefly firms' consumer commitment and care. He investigated that the reason why consumers are not reporting dissatisfaction was because they were enduring dissatisfaction due to cost of services and warranty. He observed in his research that the non-complaining behavior of dissatisfied consumers was not a good sign for the firm and further suggested the providers to encourage their customers to express their grievances candidly than engaging in NWOM. Showing more commitments towards warranty, paying attention to consumer complaints and respecting consumers' time were other suggestions put forth in this study.

Very little has been studied about what consumers do after the occurrence of the dissatisfaction episode, especially in the healthcare sector in developing Asian countries. In a country like India, where the doctor-patient ratio is alarmingly low, the post-dissatisfaction complaining episodes may have a limited scope and that is exactly why the studies in this area are very less.

Bodey and Grace (2006) observed two categories of people who indulged in complaining behavior, the complainers and the non-complainers. Responses to dissatisfaction also depend on the nature of product or service in which the dissatisfaction has occurred. Taking the service sector into consideration, consumer responses to perceived dissatisfaction may not be the same in hotels, restaurants, airlines, telecommunication services, retail services, rental services, automobile services, hospitals etc. Depending on credence property of the service, responses may differ.

Singh (1988) studied about the multiple responses to dissatisfaction like behavioral and non- behavioral responses. Day and Landon (1976) analyzedthe three options available to a dissatisfied consumer as no action (refraining-from any action), private action and public action. Day et al. (1981) explored that consumers indulge in indirect or hidden activities after a dissatisfaction episode, ranging from boycotting the product type or the provider (exit), changing brands (switching) to engaging in negative word of mouth (NWOM). Burnham et al. (2003) classified switching cost as procedural, financial and relational switching costs. These cost types were found to significantly influence consumers' intention to stay with their current service provider.

Extant literature on service quality and relationship marketing reveal that exemplary responsiveness of service providers, result in service recovery which is the process of converting dissatisfied consumers into satisfied ones. Khadir (2012) analyzed dual failures which resulted from double deviation scenarios in the service sector. The words dual or double resulted from the customer being dissatisfied twice, one with the service and the other with the provider's response to the complaint. In that study, the author tried to analyze the presence of a power asymmetry in which buyer is a powerless party and seller is a powerful one. This asymmetry is prominent among the vulnerable and disadvantaged consumers. The more the asymmetry, the higher is the degree of service failure and hence the double deviation scenario.

Kumar et al. (2014) observed the peculiarities in behaviour of Malaysian consumers when their grievances have been redressed. According to the authors, dissatisfied consumers use all possible third party interventions to get their

problems voiced, but may just disappear on getting them redressed without informing those consumer associations who helped them to voice their complaints.

Because of the strong credence property of health care sector in general and hospital services in particular, consumer complaining behaviourin hospitals is different from other sectors. This paper explores the various reasons that refrain inpatients from complaining even though they are dissatisfied. Hence the objectives set for this paper are the following:

i) To study the response of dissatisfied inpatients.
ii) To analyse the various actions of non-complainers after a dissatisfaction episode in hospital services.
iii) To examine why the non-complainers refrain from complaining despite dissatisfaction.
iv) To measure the level of perceived disempowerment of non-complainers.
v) To study the association between perceived disempowered status of non-complainers and their socio-economic and demographic variables.

The present paper has in the following pages methodology, results, discussion, conclusion and recommendations.

METHODOLOGY

Population and Sampling

This is an exploratory study to understand the factors that pull back dissatisfied inpatients from overt actions after dissatisfaction episodes in hospitals. The population considered was in India as it is a collectivistic society where individuals set aside personal goals for the good of the whole. Here, identities are born through family lineage and caste membership resulting in an identified in-group rather than striving for a personal identity. The population of this research consisted of inpatients in the various districts of Kerala who were admitted in a private or cooperative hospital (minimum 100-bedded) for at least two days in the 0-6 month period of the work and who were dissatisfied with any of the hospital services. All those inpatients who were not dissatisfied with the services of the hospitals were dropped out of the research.

Respondents were asked to give an overall satisfaction / dissatisfaction assessment. They were asked to recall episodes related to three major items- patient care, hospital infrastructure and formalities. Potential respondents were contacted at diagnostic research centers, X-ray and scanning centers, blood test laboratories and inpatient wards. While the first three units either happened to be an auxiliary department of the hospitals visited or exclusive organizations run and managed separately in the neighborhood of hospitals, the last one was an exclusive department of the hospital itself.

In India, patients admitted to the inpatient department are aided by a person who would get them food, medicines, call nurse in case of emergency so on and so forth. This person or a substitute, called the bystander, would always be there to take care of this inpatient till discharge. The sampling technique employed was convenience sampling, a nonprobability sampling method.

Measurement and Scaling

Questionnaires for pilot study were distributed among 75 dissatisfied inpatients out of which 59 filled ones were found useful for the research work. Questions were modified after getting their open-ended responses and categorized under 4 major disempowerment factors mentioned above. The questionnaire was pretested and further refined, reworded and modified to improve validity and clarity. It was then finally administered to the target respondents.

Final questionnaire had the screening question followed by four sections. The screening question asked was “Have you ever been dissatisfied with the services of the hospital where you were either admitted as a patient or were a bystander in the last 6 months?” The first section consisted of questions regarding district of the hospital, nature of the hospital (whether private or cooperative) and number of days of stay as inpatient.

The second section started with the identification of overt complainers. The question asked was the action they did when dissatisfied during their hospital stay. This question had two options, namely, ‘complained’ and ‘did not complain’. All those who ticked ‘complained’ were marked as overt complainers and not included in the paper. The others who ticked ‘did not com-

plain' were termed as non-complainers as they did not complain despite dissatisfaction. Their responses were used for data analysis to form findings of the study. It also had questions to identify the response of non-complainers after dissatisfaction and the reasons of non-complaining using multiple choice questions. Here, the respondents had the option of checking any number of options stating responses and reasons. They were given five options and asked to tick all appropriate choices from among silent exit, switching behavior, indulging in negative word-of-mouth with friends and relatives, sharing with other inpatients and any other actions other than these.

The non-complainers alone were asked to tick the most suitable reason(s) for their decisions to stay away from complaining. These deterrents of complaining behavior were exclusively studied as a pilot study with open ended questions. From the varied answers evolved during this work, four major factors were created, with a total of 25 items. The first factor 'perceived relative inability and disempowered status' had 11 items, the second factor 'perceived negative consequences' had 5 items, the third one 'personal factors' had 4 items and the last one 'environmental factors' had 5 items.

Disempowerment #1: Perceived Relative Inability

1. Lack of confidence to go against such a big establishment.
2. Lack of enough education to fight out.
3. Lack of knowledge to proceed with a complaint.
4. Lack of enough money required to file a case and pursue it.
5. Helplessness due to critical health.
6. Inhibitions about complaining.
7. Non-viability in moving the medical records to another hospital and pursuing treatment.
8. Self- blame- a feeling that one is also responsible for the dissatisfaction episode.
9. Apprehension of getting any support from anyone around.
10. Apprehension of getting any positive outcome after complaining.
11. Losing the already spent money while switching to another provider.

Disempowerment #2: Perceived Negative Consequences

12. A big embarrassment in case of negative outcomes.
13. Creation of conflict with staff or authorities during the stay.
14. Creation of a hostile climate which might affect future dealings.
15. Fear of maltreatment, confrontation and threats.
16. Fear of being labelled as a complainer by family and friends.

Disempowerment #3: Personal Factors

17. Complaining makes me uncomfortable, no matter how bad the service is.
18. Too busy to register a complaint.
19. Too busy to follow up with the case proceedings.
20. Decision to visit antoher hospital next time.

Disempowerment #4: Environmental Factors

21. Didn't find any right person to whom I could tell this openly.
22. Too late to notice the problem.
23. Confidence in the hospital, so I felt I shouldn't complain due to just one instance.
24. Fear that complaining would affect the reputation of the hospital.
25. No matter wherever I go, the same problems will arise.

The third section contained a seven-item scale to measure the perceived level of disempowerment using a five-point Likert scale. This scale had ten items initially, and then reduced to nine and then seven items. The numbers of items were reduced after checking the reliability and validity at each stage. The final scale had Cronbach alpha value of 0.76.

The fourth section dealt with the eight socio-economic and demographic variables of respondents like gender, age, education, occupation, financial status, religion, marital status and area of residence.

Questionnaires were distributed among 239 dissatisfied inpatients out of which 173 filled ones were received. Out of these, 37 respondents turned out to be overt complainers and the rest 136 respondents were covert complainers for which they selected their reasons under

these disempowerment factors. This study looks into the details of the responses of these 136 non-complainers.

Data Collection and Analysis Procedures

The final questionnaire was a self-administered and structured one. It did not have open ended questions, but had multiple choice categories under these four disempowerment factors. The screening question was indicated with a yes/no dichotomous scale. Nature of the hospital was given dichotomous choices as to whether it was a private or cooperative hospital. The respondent was asked to write down the district of the hospital in an open-ended question to identify it as belonging to North, Central or South Kerala. Though the respondents were asked to write the name of the hospital in the pilot study, it was dropped from the final questionnaire due to their resistance to reveal the name of the hospital, either due to loyalty or due to fear. The number of days they stayed as inpatient was collected using dichotomous scale as less than/equal to a week and more than a week.

A set of scores from 7-35 were used to measure the level of perceived disempowerment of non-complainers, for 7 statements measured on a 5-point scale. The respondents were classified into three groups. Those who scored in the range of 26-35 were categorized as having the highest level of perceived disempowerment followed by 17-25 as medium level and 7-16 as having the lowest level of perceived disempowerment.

The data for the fifth objective, to study whether there is any significant difference between the perceived disempowered status and socioeconomic and demographic variables were statistically tested using t-test and one-way ANOVA.

The data collected from patients of different hospitals were combined for analysis. The data were analyzed using SPSS (version 16.0) for descriptive statistics, t-test and ANOVA.

RESULTS

Out of the 239 dissatisfied inpatients to whom the questionnaires were provided, 173 filled ones were received. The overt complainers, that is, the dissatisfied inpatients who resorted to complaining were found to be 21.4% whereas 78.6% of them kept away from complaining as mentioned in Table 1.

According to Table 2, out of the 136 non-complainers surveyed, 20.1% remained silent after a dissatisfaction episode, 38.6% decided to switch provider and opt for another hospital the next time they had an illness, 31.2% engaged in negative word-of-mouth and shared their dissatisfaction with friends and relatives, 7.9% shared their dissatisfaction with other inpatients and the rest 2.1% of them were engaged in other actions.

Table 2: Response of non-complainers when dissatisfied (Objective# 2)

Response	*%*
Remained silent, did not express dissatisfaction to any one	20.1
Decided to switch provider	38.6
NWOM with friends and relatives	31.2
NWOM with other inpatients	7.9
Others	2.1
Total	100.0

According to Table 3, the most frequently quoted reason for non-complaining was 'apprehension of getting any positive outcome after complaining' (37.3% of non-complainers) followed by 'decision to visit another hospital next time' (21.4%) which was followed by 'no interest in creation of any kind of conflict with staff or authorities during the hospital stay' (19.8%) and 'lack of confidence to go against such a big establishment' as well as 'no matter wherever I go, the same problems will arise' (18.3%). Most of the deterrent variables having the maximum frequency fell under the first factor "perceived relative inability". Ranking of the 4 factors based on their frequencies was done as follows.

Table 1: Response rate (Objective #1)

No. of dissatisfied inpatients to whom questionnaires were provided	*No. of filled questionnaires received*	*No. of complainers*	*No. of non-complainers*	*Response rate*
239	173	37 (21.4%)	136 (78.6%)	72.4%

Table 3: Reasons behind non-complaining behaviour(s) (Objective # 3)

Reason	*Frequency*	*%*
Lack of confidence to go against such a big establishment	23	6.4
Lack of enough education to fight out	11	3.1
Lack of knowledge to proceed with a complaint	10	2.8
Lack of enough money required to file a case and pursue it	11	3.1
Health was so critical that I felt helpless	15	4.2
Inhibitions about complaining	21	5.9
Non viability in moving the medical records to another hospital and pursuing treatment	14	3.9
The feeling that it was my mistake too	1	0.3
Apprehension of getting any support from anyone around	12	3.4
Apprehension of getting any positive outcome after complaining	47	13.2
Losing the already spent money while switching to another provider	10	2.8
A big embarrassment in case of negative outcomes	9	2.5
Creation of conflict with staff or authorities during the stay	25	7.0
Creation of a hostile climate which might affect future dealings	11	3.1
Fear of maltreatment, confrontation and threats	10	2.8
Fear of being labelled as a complainer by family and friends	5	1.4
Complaining makes me uncomfortable, no matter how bad the service is	11	3.1
Too busy to register a complaint	16	4.5
Too busy to follow up with the case proceedings	13	3.6
Decision to visit another hospital next time	27	7.6
Didn't find any right person to whom I could tell this openly	20	5.6
Too late to notice the problem	3	0.8
Confidence in the hospital, so I felt I shouldn't complain due to just one instance	7	2.0
Fear that complaining would affect the reputation of the hospital	2	0.6
No matter wherever I go, the same problems will arise	23	6.4
Total	357	100.0

Multiple response scale was used to measure the reasons why respondents stayed away from complaining. A ranking was made on the frequencies as in Table 4 that found that perceived relative inability ranked highest among other factors followed by personal factors, perceived negative consequences and environmental factors in the decreasing order of frequencies.

Table 4: Ranking of the 4 factors based on frequencies

Factor	*Frequency*	*Rank*
Perceived relative inability	175	1
Perceived negative consequences	60	3
Personal factors	67	2
Environmental factors	55	4

While grouping the non-complainers based on their level of disempowerment as in Table 5, only 26.5 % of non-complainers were found to be in the group 1 category of respondents, that is, those in the 7-16 score range, and hence were the ones with the lowest level of perceived disempowerment. A score of 17-25 range was received by 43.4 % of non-complainers and hence they fell in the moderate level of perceived disempowerment category. The 26-35 score range was found for 30.1 % and hence was the category of non-complainers with the highest level of perceived disempowerment.

Table 5: Grouping of disempowered non-complainers

Groups	*Frequency*	*%*
Group 1 (7-16)	36	26.5
Group 2 (17-25)	59	43.4
Group 3 (26-35)	41	30.1
Total	136	100.0

Whereas the extant literature always tried to define the demographic constitution of the complainers, this paper explored the eight socio-economic and demographic variables of non-complainers. The paper further examined the difference in perceived disempowered status in respect of socioeconomic and demographic variables namely gender, age, education, occupation, financial status, religion, marital status and area of residence as in Tables 6a and 6b. Among the eight variables studied, gender was analyzed

with t-test and the rest of the seven variables with one-way ANOVA. It was found that there was no true statistically significant difference between perceived level of disempowerment of non-complainers and their socioeconomic and demographic variables.

DISCUSSION

Out of the 173 filled useful questionnaires received, 78.6% of respondents were found to be non-complainers whereas complainers were merely 21.4%. That means people generally were not interested in complaining to hospital authorities even they were dissatisfied. This could be due to the fear factor of turning against big establishments that might result in not getting expected care from the hospital. Another finding was that majority of non-complainers opted to switch to another hospital the next time they had an illness after confronting with a dissatisfaction episode with hospital services. Though switching barriers have been well-documented by Burnham et al. (2003), this research revealed the patients' propensity to switch. This shows the significance of switching behavior in a hospital setting, irrespective of the intensity of their dissatisfaction and the associated costs. This behavior was closely followed by those who opted to engage in negative word of mouth to friends, relatives and other inpatients. There is no way that providers can find out the intensity of NWOM that is spread out as a result of their service failure. It is therefore established that proper complaint management can help service providers to reduce switching behavior and customer involvement in NWOM.

Using multiple response scale, it was found that 'perceived relative inability' was the major reason that dissuaded non-complainers from overt complaining behavior. The other deterrents were 'perceived negative consequences' and 'personal' and 'environmental' factors in the order of respondent preference. That means lack of confidence, education, knowledge, money and health were the key reasons that dissuaded non complainers though they had encountered dissatisfaction episodes. In addition self- blame, fear of not getting support and positive service recovery, fear of losing money and general in-

Table 6: Perceived level of disempowerment of non-complainers and their socio-economic and demographic variables

Table 6a:T test for gender (Group statistics)

Gender	*N*	*Mean*	*Standard deviation*
Male	77	20.3	5.46
Female	55	21.4	5.87

Table 6b: ANOVA for age, education, occupation, financial status, religion, marital status and area of residence

	Sum of squares	*df*	*Mean square*	*F*	*Sig.*
Age: Between groups	101.855	5	20.371	.633	.675
Within groups	4186.027	130	32.200		
Total	4287.882	135			
Education: Between groups	400.499	7	57.214	1.884	.077
Within groups	3887.383	128	30.370		
Total	4287.882	135			
Occupation: Between groups	367.674	6	61.279	2.016	.068
Within groups	3920.209	129	30.389		
Total	4287.882	135			
Financial Status: Between groups	139.806	4	34.952	1.104	.358
Within groups	4148.076	131	31.665		
Total	4287.882	135			
Religion: Between groups	47.859	4	11.965	.370	.830
Within groups	4240.023	131	32.367		
Total	4287.882	135			
Marital Status: Between groups	213.800	5	42.760	1.364	.242
Within groups	4074.082	130	31.339		
Total	4287.882	135			
Area of Residence: Between groups	77.653	3	25.884	.812	.490
Within groups	4210.230	132	31.896		
Total	4287.882	135			

hibitions about complaining turned out to be other outcomes. The reasons why dissatisfied customers do not complain are well supported by past empirical studies like that of Nimako and Mensah (2012). But healthcare sector, due to its strong credence properties compared to banking sector and its very strong association to a person's physiological and psychological health, perceived disempowerment might have more significance than any other service-related non-complaining behavior. Another possible explanation could be the Indian culture which is a collectivistic society, who refrains from overt complaining behavior. This could also be attributed to the disturbingly low doctor-patient ratios in India.

A 5-point Likert scale was used to measure the perceived level of disempowerment of non-complainers. Adopting three different score ranges, respondents were classified into three groups namely, those with high, moderate and low level of perceived disempowerment. It was found that majority of the non-complainers fell in the moderate level of perceived disempowerment category followed by those with the highest level. This is an indicator that non-complainers are neither too high on their perceived disempowerment levels nor too low. This has high significance in healthcare industry, especially in a country like India.

Using t-test for gender and ANOVA for age, education, occupation, financial status, religion, marital status and area of residence, it was found that there was no true statistically significant difference between perceived level of disempowerment of non-complainers and their socioeconomic and demographic variables. Whereas this is different from earlier studies by Jugenissova et al. (2014) where gender was a strong determinant of complaining behavior, the other variables like age group, marital status and educational level were found to show similar results.

This paper provides information about the causes of dissatisfaction and reasons behind the non-complaining behavior of inpatients. It also contributes to current knowledge by studying what holds back these dissatisfied consumers, though they have all reasons to engage in overt complaining behavior. Like any other sector, hospital industry should also look for ways of relationship management with visitors and train staff to be more courteous in their dealings with each other and with outsiders.

CONCLUSION

This paper explored the reasons behind non-complaining behavior of inpatients and their perceived level of disempowered status. To accomplish these aims, a pilot study was initially done to categorize the varied reasons under four major factors. These four factors became the prime reasons for their non-complaining behavior in the main paper. Also, a scale was developed, pretested and reworded many times before it was brought down to seven items measured using a 5-point Likert scale.

Several important findings emerged from the research work. One of them was the discovery of 'perceived relative inability' as a major deterrent of complaining in hospitals. Another one was the decision to switch provider in the future in case of dissatisfaction with the hospital services.

This paper would help private and cooperative hospitals, who are cautious about revenue generation and goodwill, to develop better complaint management and service recovery strategies for tracking consumer dissatisfaction and further actions of consumers. Moreover, it is also hoped that this paper would add more inputs to the existing CCB literature on healthcare sector in general and hospitals in particular.

RECOMMENDATIONS

Hospitals looking for better patient satisfaction should motivate inpatients/ bystanders to express their dissatisfaction. As a matter of future research, findings of this paper may be applied in various other service sectors, especially those with higher credence properties. Moreover, respondents from different cultures in different research settings might have different reasons to cite about their non-complaining behavior. Studies may also be done to compare the socioeconomic and demographic profile of complainers and non-complainers and see how much they differ in their perceived level of disempowered status.

REFERENCES

Bodey K, Grace D 2006. Segmenting service 'complainers' and 'non-complainers' on the basis of consumer characteristics.*Journal of Services Marketing*, 20(3): 178-187.

Burnham TA, Frels JK, Mahajan V 2003. Consumer switching costs: A typology, antecedent and consequences. *Journal of the Academy of Marketing Science,* 32(2): 213-217.

Day RL, Landon EL 1976. Collecting comprehensive consumer compliant data by survey research. *Advances in Consumer Research*, 3: 263-268.

Jugenissova RS, Benjamin Chan Yin-Fah, Lim Li-Chen, Han Kok-Siew 2014.A study an unpleasant banking experiences and complaint behavior in Kazakhstan. *International Journal of Asian Social Science*,4(7): 835-843.

Khadir F 2012. Dual failures: A study of double deviation scenarios in the service sector.*International Journal of Consumerism*, 2(2): 98-111.

Klaus P, Gorgogline M, Buonamassa D, Panniello U, Nguyen B 2013. Are you providing the right customer experiences? The case of Banca Papolare di Bari. *International Journal of Bank Marketing*, 31(7): 506-528.

Kumar P, Mokhtar SSM, Al-Swidi AK 2014. My problem solved, that's all !!: A phenomenological approach to consumer complaint redressal in Malaysia. *4th International Conference on Marketing and Retailing*, 130: 431-438.

Mahapatra Satya Narayan 2014. An empirical analysis of cause of consumer dissatisfaction and the reasons why consumers enduring dissatisfaction.*Serbian Journal of Management*, 9(1): 71-89.

Nimako SG, Mensah AF 2014. Exploring customer dissatisfaction/ satisfaction and complaining responses among bank customers in Ghana.*International Journal of Marketing Studies*, 6(2): 58-71.

Nyer UP 2000. An investigation into whether complaining can cause increased customer satisfaction. *Journal of Consumer Marketing*, 17(1): 9-19.

Salo M, Makkonen M2014. Why Not Complain, A Paradoxical Problem for Mobile Service and Application Providers.*22nd European Conference on Information Systems*, Tel Aviv.

Singh J 1988. Consumer complaint intentions and behavior: Definitional and taxonomical issues.*Journal of Marketing*, 52(1): 93-107.

Tam Y, Chiew T 2012. Profiling complaint behaviour among adults: A case study in Sabah, Malaysia. *International Journal of Business, Economics and Law*, 1(1): 171-179.