

This document was written by Dr Shona Tudge, Psychologist in response to feedback regarding recommendations for the current Medicare rebate system.

Identified key issues:

- Abolish any two-tier system that involves psychologists. It is unfair, is not aligned with evidenced based practise and is causing a divide in the profession, which is embarrassing and appalling role modelling to young psychologists and the community as a whole.
- Do not disadvantage general psychologists who have taken an experiential pathway of learning. This is an equivalent pathway to registration, assessed by AHPRAH, and requires at least the same if not more written and practical requirements than Masters students. We have been working effectively with complex clients for years and decades. It is not fair or justified for us to be paid less than endorsed areas.
- If we want competent professionals to stay in the profession, we need to be proud of it. The tier system has caused many professionals with years of experience to feel disadvantaged, disillusioned and are starting to drop out of the profession, leave the APS and to disengage with the direction of the profession.
- I request recognition for; research PhDs that are relevant to clinical practise, years of experience in the field of psychological practise, recognition that all psychologists progress to professional development as mandatory requirements. I would like trust rather than distrust in the profession generally in the competency of psychologists.
- A flat structure that does not prioritise a medical model of diagnostic labelling as superior. There is no evidence to support this notion and in fact there is evidence to the contrary. See the literature below.

General Psychologists need justice

On a personal level, I am a general psychologist who has over 10 years of experience and a PhD related directly to complex trauma. I see all sorts of complex cases through my practise. A number of the complex clients who I see have involved long-term trauma work over a period of years. Many of these same clients present initially with anxiety and depression. It is during the therapy sessions that the trauma emerges and becomes accessible to work with. In my experience clients do not present to me with childhood sexual abuse, addictions of all sorts or anorexia initially from the GP. It is kept hidden by the clients until they trust enough to bring these issues forward in sessions. It is unfair and irrational that my clients receive less medicare rebate than either newly graduated clinical psychologists or experienced ones.

Theoretical support the alliance and equality of psychological services

On a theoretical level, there is no empirical evidence that clinical psychologists are superior in the treatment of any particular sort of clients to other practitioners that I am aware of. In fact there is substantial evidence that the therapeutic alliance is what correlates with outcomes, an area that is scarcely emphasised in the training of clinical psychologists. Please see research evidence below.

We currently live in a climate of progressive emphasis on evidence based practice to achieve symptom reduction within a limited time frame, with increasing pressure to perform to a medical model within the psychology profession (Moloney & Andrew, 2016; Norcross & Lambert, 2011). The competitiveness in striving for political gain, included proving particular therapeutic approaches as superior to others for specific diagnoses (Norcross & Lambert, 2011). Recently, clients who met prerequisite criteria for specific interventions received Medicare and insurance company rebates making psychological services more affordable, however this medical model approach fuelled

competition among therapeutic orientations. It also encouraged highlighting of the *most* effective evidence based practice to guide treatment for specific conditions and manualised treatment programs. This risked simplification of the psychotherapeutic process, and overlooked the considerations for relating with each person as individuals with unique concerns (Moloney & Andrew, 2016; Norcross & Lambert, 2011).

Manualised treatment in therapy was designed to increase therapy effectiveness. Structured step by step treatment approaches were outlined for specific diagnostic criteria. However, it was the unique relationship with the individual clients that has been found to be arguably an important contributing factor to good outcome (Erskine, 2015; Hubble, Duncan, & Miller, 1999; Moloney & Andrew, 2016). As an example, survivors of childhood trauma most often present meeting multiple, rather than single, diagnoses and with numerous problems (Weathers, Keane & Foa, 2009), and hence these clients frequently have a more complicated path to recovery and do not fit neatly into simple diagnostic boxes.

Wampold (2001) questioned whether the medical model had suitability crossing over into the psychotherapy field at all. Through meta-analyses and a review of 1100 research articles on the alliance, he concluded that 60% of the outcome of treatment was attributable to common factors, (including alliance and therapist effects), 30% to allegiance and 8% to model or technique used, giving support to the significant contribution of the alliance. Ahn & Wampold (2001) provided evidence to support the common factors approach purporting that characteristics of clients, therapists and psychotherapy which were the same across different psychotherapeutic approaches (e.g. Insight, corrective experiences, expressing emotions, sense of mastery achieved, therapeutic alliance, client expectancies, and change processes) were significantly more important therapeutically than specific ingredients of manualised treatments, symbolising and questioning the medical model. The results supported a contextual model emphasising a focus on clients' worldview and clients' sense of meaning in the world, rather than relying on scientifically proven manualised evidence based treatment methods aimed at reducing symptomatology (Wampold, 2001; Wampold & Imel, 2015).

Meta-analyses research has affirmed an absence of support for the benefits of specific ingredients (Ahn & Wampold, 2001; Norcross & Wampold, 2011; Wampold & Imel, 2015), and unspecific variables have been shown to contribute to therapeutic change (Bohart, 2000; Messer & Wampold, 2002; Norcross & Wampold). In quantitative reviews of research and in meta-analyses, specific techniques only accounted for 5-15% of outcome variance (Beutler, 1989; Shapiro & Shapiro, 1982; Wampold, 2001). Most research has been for single diagnoses of DSM (Norcross, 2001), whereas many clients presented with a complex array of symptoms, particularly those with childhood trauma histories (Najavits, Ryngala, Back, Bolten, Mueser & Brady, 2009; Paivio & Pasual-Leone, 2010; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Norcross and Wampold asked whether it was more productive to determine who the client was rather than which diagnostic boxes they fit into.

The notion of therapeutic equivalence was first put forward by Rozenzweig (1936) through the labelling of the Dodo bird effect that states "everyone has won and all must have prizes" (Hunsley & Di Giulio, 2002, p12). Numerous meta-analyses have supported the Dodo bird effect with findings supporting that different approaches have resulted in similar outcomes (Luborsky, Rosenthal, Diguier, 2002; Wampold, Mondin, Moody, 1997). Specific techniques were seen as less important. Vandenbergh and Aquino (2005) outlined three types of reactions to this outcome. Firstly, that there was a need for further controlled studies exploring variables that contributed to change (Chambless, 2002; Eysenck, 1994; Elliot, 2010); secondly, finding unspecific variables that were contributing to therapeutic change (Bohart, 2000; Messer & Wampold, 2002) such as core relationship variables

(Norcross, 2002), self-disclosure (Hill & Knox, 2002), alliance ruptures (Safran, Muran, Samstag & Stevens, 2002) and relationship interpretations (Crits-Christoph & Gibbons, 2002); thirdly, the process by which therapies affect clients, for example through acceptance (Heffner, Sperry, Eifert, & Detweiler, 2002).

Supporting alliance research findings, the American Psychological Association's (APA) Division of Psychotherapy and Division of Clinical Psychology performed meta-analyses on correlates between the therapeutic relationship and good outcomes, finding that the alliance was as significant as any particular treatment method in contributing to positive outcomes (Norcross, 2011). Outcomes guided recommendations and emphasised attending to the therapeutic relationship regularly throughout treatment, and to actively address alliance ruptures to improve the alliance and to prevent client dropout (Muran, Safran, Samstag, & Winston, 2005). Furthermore, regardless of the treatment approach being used, the therapeutic alliance needed to be addressed collaboratively with the therapists and clients to foster optimum treatment (Moloney, 2016; Norcross). Overall, there was convincing empirical evidence urging practitioners to attend to the alliance during therapy.

The issues around diagnostic labelling

Furthermore, diagnostic labelling has both positive and negative aspects that need to be addressed within psychological treatment particularly with complex trauma clients. My thesis discovered that both complex trauma clients and experienced psychologists described mixed experiences in relation to diagnostic labelling. Many clients did not appreciate being categorised or diagnosed. Many clients experienced being pathologised by mental health professionals, which elicited a sense of being judged and labelled, while scratching at surface symptoms rather than resolving the underlying trauma (Tudge, 2017).

Psychologists in my study generally focused on broadly understanding their clients in contrast to pathologising them, although they sometimes used clinical diagnostic labels during interviewing to categorise and share understanding. They described how traumatic childhood experiences resulted in clients finding various ways to cope with their situations, which often became pathologised by significant others. Some therapists used the diagnosis of borderline behaviours to show the depth of trauma and possibilities for recovery and shared a respectful attitude these clients. The psychologists were non-judgmental and tentative in their description of diagnostic labels, which clients appreciated (Tudge, 2017).

Pathologising of clients by previous health professionals in general frequently left clients feeling like there was something wrong with them and that they were being judged. This reinforced childhood schemas of dysfunction and a sense of being flawed. This also impacted on the alliance negatively. The clients' priority was to be heard and cared for, rather than being labelled (Tudge, 2017).

Research has shown evidence to adopt caution around the use of diagnostic labelling. For example, Lebowitz and Ahn's (2014) study examined the effect of biological categorisation on clinicians' empathy, finding evidence towards the use of diagnoses being linked with reducing the clinicians' empathy. A mix of doctors and allied health professionals working in mental health read vignettes of client cases, half of which were described with biological underpinnings and the other half with psychosocial explanations. The clinicians were asked to score empathy related adjectives to the vignettes. Clinicians demonstrated reduced empathy towards clients with biological explanations than with psychosocial ones, aligning with the findings of the current study. One suggestion for this finding was due to the dehumanising that can occur through biological approaches that can lead to problems with being seen as fixed and potentially unable to change. (Haslam, 2006; Yalom, 1980). It created arguably a larger gap between people with mental health issues and the rest of the

population through the dehumanising of those with issues (Haque & Waytz, 2012; Lebowitz & Ahn, 2014). Yalom (1980) encouraged diagnoses with more severe pathology such as with Schizophrenia, Bipolar Disorders and Major Affective Disorders. In the current study psychologists worked with clients who were diagnosed with severe pathology and used these labels to guide treatment, however they maintained an openness to their clients and their possibilities for change.

In Leahy's (2015) operationalisation of Emotional Schema Therapy, she encouraged therapists to put themselves in their clients' shoes and to avoid pathologising and being critical in attitude towards them, because of the negative effect this may have. Emotional Schema Therapy used diagnostic categories to guide treatment, however also recognised individual differences in thoughts and emotions. Aligning with this practice Kudler (2009) within the psychodynamic field recently questioned whether psychodynamic principles may be more useful with PTSD than medical model categorisation, due to the deeper understanding and humanness required. These broader means of understanding aligned with the findings of the current research, in which the psychologists avoided labelling their clients as it risked reducing clients' experiences to a set of symptoms with a rigid focus on diagnostic categories. Yalom (1980) in addition cautioned against the potential narrowing of therapists' vision when diagnosing, which may have resulted in aspects of the clients being overlooked, as described by Jessica (C), above.

A number of researchers emphasised being attuned to emotional states and to the needs of the clients, while responding attentively through the therapists' presence (Elliot et al., 2005; Erskine, 2015; Paivio & Pascual-Leone, 2010). Erskine (2015, p46) suggested responding to sadness through compassion, anger through "attentiveness, seriousness and responsibility, with possible acts of correction" and offering security and protection to a frightened client while sharing the pleasure of happiness and joy. He also highlighted the importance of attuning and responding attentively to clients' needs, which varied from one client to the next. Some required validation and affirmation, while others needed confirmation of self through the relationship. Some clients needed to express love, while others needed to have an impact on others (Erskine). In this sense, he cautioned against pathologising clients and encouraged therapists to understand the underlying needs of the clients (Elliot et al.; Erskine; Paivio & Pascual-Leone). For example, if a client gave a gift, it may be because they needed to express love in the relationship rather than violating a boundary or trying to manipulate the therapist. A more trusting stance was taken of the clients' motives and needs, as well as an openness, compassion and acceptance of the clients, similarly to Geller and Greenberg (2002, 2012). This stance aligned with the findings of the current study (Tudge, 2017).

The research or literature in the area of clinical diagnosing was not found to explain how to manage the dance of labelling mental disorder categories, which on the one hand had the potential to be problematic while on the other hand was a requirement for working within the healthcare system. Furthermore, clients frequently presented to counselling with diagnostic labels that were already imprinted, having been referred from general practitioners who practise within a diagnostic medical model. This needed to be managed carefully, to maintain connection to clients' identity and to empower them rather than reinforce dysfunctional roles (Tudge, 2017).

Thank-you for the opportunity to share these ideas. I hope for return to a one tier system which will reinstate equality into the profession, and reignite my interest and engagement in the profession politically, as well as ensure that I continue to be a member of the APS, who I have not felt supported by since the 2 tiered system began.

Kind regards
Dr Shona Tudge (Psychologist)