



PO Box 2,
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3 April 2019

Submission to the Mental Health Inquiry, Productivity Commission

Dear Commission,

I would like to make the following submission regarding the current state of Mental Health services in Australia.

Executive Summary

This submission addresses a few issues that have concerned me for some time. Firstly an appeal to recognise and accept the value of Couple Counselling and have Medicare accept referrals for same. Secondly a suggested change to the treatment of Domestic Violence based around Attachment Theory. Thirdly a request that the Heath Commission give consideration to moving towards the British Psychological Society alternative view of psychotherapy in using the Power Threat Meaning paradigm as opposed to the DSM. Finally is my objection to the segregation of Clinical versus other psychologists and the need to accept other studies outside the university system.

Couple Therapy.

I believe it is way past the time that couple therapy/relationship therapy/marriage counselling (however you wish to conceive it) should be recognised and included within the Medicare costing models.

There is huge body of research showing how much impact on mental health can be achieved by creating a safe secure attachment bond in couple relationships. Improving couple/family relationships will impact many other health issues such as Domestic Violence, Suicide, Divorce, employment productivity (reduced sick leave), cardio-vascular issues, eating disorders, as well as general depression, anxiety, and stress. Not only do all these issues impact the Health budget but also the legal court systems, incarceration rates, and general society/community feelings of wellbeing.

I believe that the reason the APS ignores these facts is because the APS is largely dominated by Clinical psychologists who for whatever reason mostly concentrate on Cognitive Behavioural Therapy (CBT). CBT has an 80% failure rate with couple counselling or relationship counselling and perhaps the APS dismisses couple counselling as being inconsequential.

However the efficacy of the more modern and effective Emotionally Focused Couple Therapy (EFCT) which has the evidence to demonstrate an 85% success rate with couple therapy, (research evidence attached). Please access the TED talks by Dr Jim Coan (Why Do We Hold hands?) <https://www.youtube.com/watch?v=1UMHUPPQ96c> and his talk on Experts in Emotion. <https://www.youtube.com/watch?v=I7DjRXB0tWk> where Dr Coan has illustrated with fMRI studies the effects on the brain with a safe secure attachment. Dr Coan has worked with Dr Susan Johnson and can demonstrate with clear statistical fMRI data that EFCT can reduce depression, anxiety and stress, and improve the relationship.

A safe secure attachment has been illustrated to reduce pain, improve the immune system and therefore lower illness rates, improve recovery rates from accident or illness, reduce anxiety and



stress around other issues such as financial stress, as well as protect against PTSD. Soldiers who experienced a safe secure attachment in childhood, or who have a safe secure attachment at the time of deployment are less likely to develop PTSD symptoms than those who do not have a Secure Attachment style.

Most referrals I receive from Doctors or self-referred come down to relationship issues, not feeling appreciated, acknowledged, loved, cared for, and experiencing anxiety around that.

I suggest that couple counselling has been ignored to a large extent because up until the development of Dr Sue Johnson's Emotionally Focused Couple Therapy (which also incorporates all the research around Attachment Theory), other therapies had not had a high efficacy rate with couples, (with the exception of Dr John Gottman's Family Therapy).

However Dr Johnson's research over 36 years has clearly demonstrated a success rate of up to 85% with making couples feel much more secure and safer in their relationships. Dr Jim Coan's function MRI research demonstrates that in a very visual and indisputable way. Given that we now have a therapy with a high efficacy rate for close interpersonal relationships, I would hope that Couple Therapy should be included in the Medicare provider model. I do believe that couple therapy should be a minimum of ninety minute sessions the extra time is needed to balance the time spent on each of the couple.

Domestic Violence.

Domestic Violence (DV) is on the increase in Australia and other parts of the world. One could hypothesis that it is because it is being reported and recognised more, or one could hypothesis that it is because we are not addressing the issues correctly. It is probably a little of both.

I believe that while we continue to treat DV as a Power and Control issue we will fail to reduce the occurrence and the severity of DV.

I believe (and there is research to back up the belief) that DV is an Attachment issue. Looking at the research around Attachment Theory it is evident that "from the cradle to the grave" we seek a safe, secure attachment bond. As a baby if no one responds to our cries for assistance we suffer a basic fundamental fear of dying and our emotional systems escalate the cry to demand assistance. As an adult if our secure bond looks at all under threat, we suffer the same emotional fear of dying, (Sue Johnson calls it "primal panic") not logical, rational or cognitive, but the emotional impact is experienced nevertheless. In experiencing the threat of death the secondary emotion is anger and we respond with a fight/flight response that can make us grab our partner and try to pull them closer in many maladaptive ways. In other words we escalate our cry. If you look at this unreasonable behaviour from a CBT perspective it certainly looks like Power and Control – no argument there, but if you look at it from an attachment perspective it looks to be perfectly understandable - not acceptable but understandable.

I have seen a number of couples where the man is 6'4" or more and his wife is a diminutive 5'4" and his complaint "she uses me like a punching bag". The lady is not trying to use "Power and Control" over her husband with physical violence she is trying to make connection she needs reassurance that he is there for her, albeit she is using all the wrong strategy. So too do many men use the wrong strategy because they never learned how to express their emotions.

Looking at a counselling session, if the therapist approaches the client with the preconceived belief that "this is all about power and control" it is pretty easy to see that an adversarial relationship is easy to create. Whereas when the approach to the client is with the belief that this person is really hurting and they have never learned how to express those softer primary emotions, then the



therapist can create a much more compassionate and empathetic therapeutic relationship with the client.

Expanding on the issue with teaching boys from an early age to be able to express softer emotions and that that is OK for boys as well as girls. We need to educate parents and teachers as well as children to get rid of the old phrases used on boys – “get over it, toughen up, boys don’t cry, be a man, don’t be a sook or sissy”, those are concepts our men learned in World War I and World War II, to be stoic and to not show fear or pain. Those are the beliefs that create Domestic Violence. How can we teach boys to push down softer emotions and hide their pain and then expect them as adults in a close interpersonal relationship to suddenly be able to express those emotions? An Emotionally Focused Therapist (EFT) teaching them in counselling sessions not only has to overcome the limits on the vocabulary but also the social norms. It is accepted and expected that females can be vulnerable and express softer emotions, but the social norm is that males will not, so clients have to exhibit extraordinary courage to overcome verbal limitations as well as social norms, to allow themselves to be vulnerable enough to express their emotions in a constructive way. DV has a huge impact on families, friends, society, the economy and the health system. Recently I saw a client who had been incarcerated for breaching a DV order and according to him in that particular jail 65% of the inmates were there for breaching a DVO. Surely if we can redirect these men to a therapy that addresses the underlying cause of their DV everyone will be better off? Teaching these men about negative thinking patterns and behavioural modification may be of some validity, but research by Daniel Siegel and Dr Jim Coan’s fMRI’s studies have indicated that once the amygdala has fired the fight/flight response the pre-frontal cortex (where those skills have been learned) is off-line and of little use.

In making this hypothesis I am using the 80/20 rule, I accept that not all DV is necessarily an Attachment issue, but if addressing DV with an EFT/Attachment perspective can assist 80% of the DV cases then we must be able to gain better results than we are at present.

DSM-V versus Power Threat Meaning Framework;

While many psychologists work within the DSM framework, it has been controversial for decades and psychologists when meeting and during peer supervision agree that the current system is not the best for our clients. The latest iteration has caused more controversy to the extent that the British Psychological Society has now rejected the DSM and proposed their own paradigm of Power, Threat, Meaning. This framework fits much better with my own Humanistic framework. Where the DSM asks “What is wrong with you?” and places a label of a dysfunction on the client, I see that as abuse heaped on abuse, the British model asks “what happened to you?”, “How did it effect you?” (or how did you cope?), “what meaning did you make of it?” and how is that effecting your behaviour now?

This appears to me to be a much more empathetic and compassionate approach to assisting our clients. I realise that we are unlikely to switch suddenly to a new paradigm, there are too many health providers heavily invested in the DSM, but I would like to see the government and Medicare start to accept alternative ways of looking at clients presentations, especially as so many that I see boil down to a traumatic Attachment Injury in the past or in the present and I have found little to no practical use of applying a DSM label to them.

Lastly I would like to state that I do not agree with the current segregation of Clinical and Generalist psychologists. Within the APS Ethical Guidelines adopted in 2007, Clause C.2.3 (c) “Statements must not contain any statement claiming or implying superiority for the



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psychologist over any or all other psychologists”; Clause C.2.3. (f) “Statements ... must not contain any claim unjustifiably stating or implying that the *psychologist* uses exclusive or superior apparatus, methods or materials.”

It appears to me that the APS support for segregation of Clinical psychologists is in breach of its own ethical guidelines.

At the same time I am concerned at the more recent proposal of the APS to create a three tiered service delivery. In my own circumstances, I am a Vietnam Veteran, who has been married, had four children, been divorced, has owned several properties and experienced several different professional and trade employments. I have worked for Open Arms (previously known as VVCS) in their offices, and currently contract with them as an outreach counsellor. Before, during and after my divorce I experienced several years of counselling myself. To compare my experience and qualifications with someone who has gone straight from high school to university and come out with a Clinical Psychologist qualification and tell me I am no longer able to work with veterans or emergency workers with PTSD, and yet they can, is quite ludicrous to my way of thinking. As Einstein said “experience is knowledge, everything else is just information”.

My initial training and experience was with Lifeline and that assisted me greatly in my university studies. I questioned a clinical psychologist once what made her refer to the people she saw as “patients” rather than “clients” and she rather angrily snapped back at me “because they are sick people and should be treated as such”. I found that an arrogant statement and could detect little room for the compassion and empathy that I learned so well in Lifeline. At the same time I have seen Social Workers at VVCS and in private practice who are very effective as counsellors. Clinical psychologist claim they should be paid more because they have completed more study. That does not take into account the studies undertaken outside of the University system, for example EFCT training has included four x four day intensive courses at a considerable cost, plus lengthy supervision of practice and I have purchased, watched, and reviewed an additional 65 hours of DVD presentations on EFT alone, as well as a large number of books on the same subject.

Thank you for your consideration of my ideas,
Yours sincerely,

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