**Psychology and Private Practice in Australia – Some Inconvenient Truths**

**Abstract**

Professional Psychology is experiencing one the most tumultuous times that I can recall. In 2010 there have been calls for additional qualifications, arguments about what good science based practice is and isn't, and the unfortunate dichotomy between those in clinical practice with those with a Masters in Clinical Psychology while the majority of psychologists, irrespective of qualifications, experience and competency being regarded by the newly formed Psychology Board of Australia contemptuously as "generalists".

In this, the first of three parts, the causes of this disquiet are suggested as being due to what seems to be a rather unholy trinity between academia, the Australian Psychological Society (APS) and the Psychology Board of Australia (PBA). The egalitarian ideals and ethical robustness demanded of an independent professional regulatory board have been eroded by the self interest of academics and the APS.

This essay points out that as a profession we have not adequately addressed many of the anomalies and inconsistencies that have impeded the growth of psychology, in particular private practice in Australia. It is further suggested that these problems have in fact been amplified due to the position the PBA has taken on several matters.

**Part 1**

Australia's foremost professional body for psychology is undoubtedly the Australian Psychological Society (APS) with 19,000 members, of an estimated 30,000 registered psychologists in Australia. The main driving force behind the APS and thus psychology more generally is academics. In short the profession of psychology is driven by Australian universities, some more influential than others. The problem is that most of these academics do not practice Psychology.

It is well known and understood that there have been complaints for many years that the teaching of psychology in Australia has been dictated not by the needs of practitioners, or consumers, but by the research interests of academics. Even more strange is the fact that the APS (i.e., predominantly academics) has created a system by which University courses are accredited by this "Professional" Body, ultimately forcing non academics to conform to the rules of the APS. As a consequence government bodies such as the NSW Workcover Authority, Medicare and more recently the Psychology Board of Australia (PBA) have been advised by the APS and thus by academics (and in most cases taken that advice) rather than by practitioners who are more directly concerned with clinical needs.

In this way academics don't just dictate how psychology should be taught and how the development of curriculum might proceed, but strongly influence the ideology of any

number of government agencies. I am thinking here of health and workers' compensation insurers especially. Simply put the APS is the vehicle that allows academics to influence not just the teaching of psychology, but the delivery of treatment to the consumer in Australia.

Previously, state based registration boards, and now the PBA, have been made up almost entirely of APS members, (even current or previous executive or office bearers of the APS). While the PBA would probably claim its primary role is to protect consumers, it does this only secondarily to protecting the interests of psychology academics in Australian Universities.

For the past 50 years there have been regular complaints about academic Psychology programs from students of psychology, their primary concern being that they are not being taught what they need to know in preparation for practice. The complaints of psychology students are mirrored by the complaints of perspective employers who think that graduates are undertrained for the tasks they will be expected to accomplish in practice. It's more than an irony that academics involved in the training also agree, and suggest that students who complete their courses remain undertrained to be practitioners.

Of course if psychology courses are driven by teaching staff trained primarily to do research, it follows that graduates will as a consequence be poorly qualified to enter the field of private practice. Academics cannot teach what they do not do themselves know or have experienced. Courses are invariably designed around the research interests of the academic teaching them. As Associate Professor Don Munro said last year[1] *"The development of the debate on training for psychologists in the latest InPsych (June 2009) shows an encouraging move to a coherent set of qualifications. What disappoints me, however, is the continued reluctance to recognise that psychology is now a profession, and not just an extension of academic study into the various applied fields. It seems to me that the best way to prepare our future professionals is to admit to training as professionals from the beginning.*
*As a retired academic psychologist myself, I believe that an important reason that we have traditionally been reluctant to encourage the development of professional skills in the undergraduate years is that we lack these skills ourselves. Furthermore, the increased emphasis on research in universities has led us to overvalue it as the basis for good psychological practice. This is not to say that science and research are not important in the wider scheme of things - far from it - but that professional training ought not to be held back by the concerns of one part of it".*

Consider the investment, (read self interest) that academics have in this emphasis on qualifications, especially maintaining tenure if nothing else. Today increasing pressure is

[1] Don Munro, was a teaching colleague from Newcastle University now retired, this was a portion of a letter to the Editor of APS **InPsych** 2009

being placed on Universities to become “profit centers”, each faculty, for that matter becomes an earning centre, and my local University announced, for the first time that I can recall, a large surplus. This is the very university who “sells” courses in aviation, where so many students don’t actually get to be professional pilots. Or nuclear medicine courses that pump out year after year graduates who will never find placement for their Professional Year. Indeed, a psychology department which produces graduates who will never find supervision.

When I taught at University the pressure was on us to get WSUs (weighted student units), so as to access federal funding. Today it’s to attract paying students! To this end some universities have developed so called “Mickey Mouse” courses, not to improve professional standards or bless the industries or professions they are supposed to support, but simply put to be self serving! It would be interesting to conduct a *truly* independent survey of the graduates of these courses and find out just what they thought of them!

Of course when the questions of qualifications in psychology are raised academics are not just responding to a need, but actually generating the demand! Co-opting APS, the circuit is again complete APS demands more qualifications, universities provide them and they become pre-requisites to entering practice.

There are few fields where a graduate has not been taught the basic tools of trade required outside an academic environment, i.e., where most are destined to go. Imagine if you will an accountant who graduated couldn’t complete a trial balance, or an architect who couldn’t design a toilet block. A trained psychologist completes a three year degree followed by a fourth that later allows for graduation, but not allow the graduate to practice, an internship of two years follows, (which more often than not has to be paid for by way of a supervision fee). Then after 6 years of training (regarded as the “4+2” entry) registration can be sought.

Now the very academics who design these courses, as I commented earlier, regard those who graduate even after an internship as having been inadequately trained for private practice. They suggest that a Masters course as a bare minimum is essential. Universities in Australia offer courses approved by the APS, including distance learning in some cases. In this way the cycle is complete, with academia demanding more training, gaining the support of the APS who in turn authenticate a range of post graduate courses. These include the clinical masters, a course that has been held up as the pinnacle, along with a clinical doctorate, as the most important component in any training for psychologists who work in private practice.

In fact such influence is imposed by academia via the APS that Medicare gives more sizeable rebates to those clients[2] of psychologists who hold clinical Masters degrees

[2] It never ceases to amaze me how this is not seen for what it is, i.e. it is the client who is disadvantaged by such discrimination.

compared to those who are now condescendingly referred to as “generalists”. Yet here is the rub. **This is all in the absence of any scientific evidence that shows that qualifications such as the clinical Masters degrees on offer guarantee clinical aptitude or skill.** It is a painful paradox some might say hypocrisy that this discrimination against “generalist” Psychologists is being enforced by a profession that claims the science practitioner model is sacred. As overwhelming proof of this consider if you will the following data from Chapter 5 of the Better Access Care – “changes on outcome measures from pre-to post treatment (2)

## Changes on outcome measures from pre-to post-treatment

Tables 18, 19 and 20 present outcome data for participating consumers who were recruited by clinical psychologists, registered psychologists and GPs, respectively and appear in Chapter 5: Outcomes of Better Access care for consumers report. They used paired t-tests to examine the difference between mean pre- and post-treatment scores on the range of outcome measures, excluding consumers who did not have a “matched pair” of pre- and post-treatment scores.

*Table 18: Outcome data for consumers seen by clinical psychologists through Better Access*

| | **Participating consumers for whom pre- and post-treatment outcome data were available** | | | |
|---|---|---|---|---|
| | **Pre-treatment mean (s.d.)** | **Post-treatment mean (s.d.)** | **Mean difference (s.d.)** | **P-value** |
| **K-10 (n=193)** | 28.63 (7.57) | 19.06 (6.96) | 9.53 (7.84) | 0.000 |
| **DASS_Depression (n=205)** | 21.02 (11.00) | 9.66 (9.63) | 11.37 (10.92) | 0.000 |
| **DASS_Anxiety (n=205)** | 14.75 (9.44) | 7.58 (7.32) | 7.17 (8.73) | 0.000 |
| **DASS_Stress (n=205)** | 22.85 (8.58) | 12.93 (8.48) | 9.93 (9.50) | 0.000 |

*Table 19: Outcome data for consumers seen by registered psychologists through Better Access*

| | **Participating consumers for whom pre- and post-treatment outcome data were available** | | | |
|---|---|---|---|---|
| | **Pre-treatment mean (s.d.)** | **Post-treatment mean (s.d.)** | **Mean difference (s.d.)** | **P-value** |
| **K-10 (n=192)** | 29.44 (7.33) | 18.86 (7.13) | 10.58 (8.83) | 0.000 |
| **DASS_Depression (n=204)** | 20.41 (10.58) | 8.96 (8.99) | 11.46 (11.43) | 0.000 |

| | | | | |
|---|---|---|---|---|
| **DASS_Anxiety (n=204)** | 15.34 (9.59) | 6.55 (7.01) | 8.78 (10.09) | 0.000 |
| **DASS_Stress (n=204)** | 23.91 (9.41) | 12.22 (9.28) | 11.69 (11.01) | 0.000 |

*Table 18: Outcome data for consumers seen by clinical psychologists through Better Access*

| | **Participating consumers for whom pre- and post-treatment outcome data were available** | | | |
|---|---|---|---|---|
| | **Pre-treatment mean (s.d.)** | **Post-treatment mean (s.d.)** | **Mean difference (s.d.)** | **P-value** |
| **K-10 (n=177)** | 30.89 (7.94) | 22.88 (8.54) | 8.01 (8.72) | 0.000 |

In the light of these almost identical outcomes how can there be any justification for this false dichotomy between so called “clinical” psychologists and “generalists”?

This distinction between clinical and generalist was initially accepted by the NSW Workcover Authority, but after considerable lobbying by “generalist” psychologists Workcover saw the folly of the distinction and rejected this false dichotomy. In doing so turned the focus back to where it belongs on training, experience and competency rather than qualifications.

Regrettably, the Psychology Board of Australia has though been persuaded by the APS to accept this dichotomy, one based on qualifications, rather than competence. As I have indicated earlier perhaps the composition of the Board and its allegiance to APS betrays the reason this is the case. Psychology in Australia seems destined by this situation to remain embroiled in a counterproductive wrangle not based on science or the science practitioner model, but reflects a dispute that is about territory and ownership.

In the next and second part issues pertaining not to just qualifications but the controversy in respect to what constitutes evidenced based treatments and just what counts towards therapeutic efficacious outcomes will be discussed.

**Roger Peters PhD**
**December 2010**

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**Part 2**

In the previous and first part of this three part essay I suggested that the newly formed (2010) Psychology Board of Australia (PBA) was being unduly influenced by the Australian Psychological Society (APS) who I suggested are dictated to by academia. It should be of no surprise that Universities emphasis the importance, even necessity of courses that "bring them home the bacon". In one sense of course the importance of qualifications makes intuitive sense, and obviously I am not advocating that they are unnecessary, but rather that we as a profession boast that we are a science based profession, then let's put competency well ahead of some benign belief that qualifications to any significant degree influences therapeutic outcomes. I will shortly undergo an ankle operation, the decision I made in respect to a surgeon, was very simply, how many times has he done this procedure and what's his success rate? I don't really give a fig about what qualifications he gained 40 years ago, I presume, based on reputation, he is the "ankle man". An added bonus is I like and trust him.

So whereas qualifications seem to rate poorly as an active ingredient in therapeutic outcomes, perhaps the same can be said for the now tiresome and excessively cited mantra of "evidence based practice". There is some spiteful wrangling going on about one treatment modality over another and this was no better highlighted by Ronnebeck in this months in InPsych when he says; "Yet when I look at the recent advertisements for professional development in psychology bulletins I encounter a dismal situation. I see an ideological war instead of professional focus on presenting problems"[3] Indeed he is correct a war of wrangling about ownership and claimed superiority of one treatment modality over another. Yet what the science says, as I will expand on later, is that treatment modality or the model accounts for very little when compared to the essential active ingredient the client- therapist alliance.

By way of example a war of words has been continuing for years between those who regard psychoanalysis as a bogus science and those who do not. Mario Bunge a long standing critic of psychoanalysis sums up the argument for the opponents of psychoanalysis[4].

> *Over the past 30 years psychoanalysis has quietly been displaced in academic psychology. But it persists as a popular culture as well as a lucrative profession. It is the psychology of those who have not bothered to learn psychology and the psychotherapy of choice for those who believe in the power of the immaterial mind over body.*

[3] Reinhard Ronnebeck INPsych page 22 December 2010

[4] Mario Bunge Should Psychoanalysis be in the Science Museum? ***New Scientist*** pages 22-23 October 2nd 2011

Psychoanalysis is a bogus science because its practitioners do not do scientific *research. When the field turned 100, a group of psychoanalysis's admitted this gap and endeavored to fill it. They claim to have performed the first experiment showing that patients benefited from their treatment. Regrettably they did not include a control group and did not entertain the possibility of placebo effects. Hence their claim remains untested (The International Journal of Psychoanalysis Vol. 81 p 513.*
*More recently, a meta-analysis published in American Psychologists (vol.65, p98) purported to support the claim that a form of psychoanalysis called psychodynamic therapy is effective. However once gain the original studies did not involve control groups.*

*In 110 years psychoanalysts have not set up a single lab. They do not participate in scientific congresses, do not submit papers to scientific journals and are foreign to this scientific community marginality typical of a pseudoscience.*

*This does not mean that their hypotheses have not been put to the test. True they are so vague they are hard to test and some of them are by Freud's own admission, irrefutable. Still most of the testable ones have been soundly refuted.*
*For example most dreams have no sexual content. The Oedipus complex is a myth; boys do not hate their fathers because they would like to have sex with their mothers. The list goes on.*
*As for therapeutic efficacy little is known because psychoanalysts do not perform double blind clinical trials or follow up studies.*
*Psychoanalysis is a pseudoscience. Its concept are woolly and untestable yet are regarded as unassailable axioms. As a result of such dogmatism, psychoanalysis has remained basically stagnant for more than a century, in contrast with scientific psychology which is thriving.*

On the other hand, hold on! Says Mary Target and 54 others psychoanalysts[5].
Psychoanalysis has developed greatly since Freud's time, producing substantial research and productive connections to other branches of science. Many basic psychoanalytic propositions have been widely accepted, such as the formative impact of early childhood relationships on adult personality. Some of Freud's specific propositions have been eclipsed by later formulations. Psychoanalysts have been testing the outcomes of psychoanalytic therapies for decades, using random controlled trials and systematic follow up studies. Most trials have found good evidence of the effectiveness of psychoanalytic therapies, when tested in the same way as other approaches. Contrary to Bunge's assertion, studies included in Jonathan Shedler's review of meta-analyses of therapeutic outcomes of psychoanalytic therapy did, of course have control groups.

[5] Mary Target and others "Letters" New Scientist 27th October 2010

Jon Shedler, referred to above says that following his meta-analysis psychodynamic approaches do not lack scientific evidence. Comparing it with CBT he suggests it fares as well or better, comparing it with medication it does better. Now here is again the inconvenient truth as he suggests the "active ingredients" of therapy are not necessarily those that are presumed by the theory or treatment model at all.

Again he concedes that the working alliance is now widely recognized and often considered a nonspecific or common factor. He later revisits the "Dodo" verdict that suggests that outcomes for different psychotherapies are surprisingly equivalent. In fact he had already said as much early when he claimed that one of the distinctive features in psychodynamic therapy was the "focus on the therapy relationship".

What is an inconvenient truth for many in all of this, especially if you are flogging post graduate courses is that ultimately the treatment model, the qualifications, gender, age, etc all matter very little. Duncan and Miller[6] in both their seminal texts the "Heroic Client", and the "Heart and Soul of Change"[7] suggest that the "heart" is the client's input and the "soul" is the therapeutic alliance, arguing that the <u>treatment model accounts for less than 20% of treatment outcomes.</u>

As I said earlier, of course I do not advocate eliminating training or qualifications, but again seek a strong focus on the real issues of competency, i.e., those skills that can be learned that will improve the therapeutic alliance and result in more efficacious treatments. I expect the answer is of course found in experience rather than some manual or "cook book".

**Predicting the Academic Argument in Reply**

Walter Mischel[8] (a wonderfully gifted North American academic) would undoubtedly strongly disagree with what I have just written. In his recent editorial; he said "Connecting Clinical Practice to Scientific Progress" he writes; "*That there are now numerous state of the science based and empirically supported choices for assessment and treatment, yet practitioners still chose to do whatever they feel like as Mehl describes regardless of the evidence".*

It seems to me the counter argument can be made and academics still claim "scientific" superiority based on the model of treatment rather than being honest about what the actual active ingredients are! Mischel then says in conclusion; "*that our best students enter psychology to become clinical psychologists. They deserve the opportunity to do*

[6] Barry Duncan and Scott Miller. The Heroic Client (2000) Jossey Bass CA
[7] Barry Duncan, Scott Miller, Barry Wampold and Mark Hubble, The Heart and Soul of Change, American Psychological Association Press NY December 2009
[8] Walter Mishel Connecting Clinical Practice to Scientific Progress Psychological Science In the Public Interest (Ed Baker T, McFall, R, Shoham,V Vol 9 Number 2 November 2008 page i

*such work informed and guided by evidence, trained to evaluate it properly and able to add to it themselves.*

I am unable to accept Mischel suggestion that the best students make the best clinical psychologists. That is students who gain a high point grade average after completing a degree (which is bereft of any people training, let alone clinical skills training) are selected for clinical training and go onto become, according to Mischel, the best therapists. Where is the science in that – or better show me the evidence?

How could we ever know whether others, who may be more "people" rather than academically orientated might have been better clinicians but given that they are not given opportunity Mischel's hypothesis cannot be tested? In fact in Australia at present regardless of competence and effectiveness as therapists, almost all psychologists who are not members of the APS Clinical Division, will ever be recognised as clinical psychologists in a deal brokered with the PBA by the APS. They are, and seem destined to remain simply "generalists", irrespective of experience, competence, or success!

Secondly, and I realize Walter Mischel would be a beneficiary as an academic from any increased emphasis in training towards these magical qualifications, but how many students really want to complete what is now up to 8 years training to be recognized as a "clinician" just to earn these same as Senior Constable of Police? The average wage of psychologists is pitiful, and even then, we squabble like children and continue to impose this discrimination which allows one psychologist to be paid more for the same work and irrespective of ability and any real assessment of competency!

> *How this happened Robert Lundin said, was that psychology lacks a clear identity. We follow how society evolves as tribes. He says as psychology has evolved different groups of people who called themselves psychologists have banded together to put forth communities of idea and efforts designed to direct the way psychology should go. When a particular group shared similar ideas and opposed others a "school" of psychology was formed.[9] As Cleeremans says "The single "grand Challenge" for the psychological sciences, as they blossom in the 21st century is integration"[10].*

Obviously the PBA will not be moved by the evidence but by the ideology, mores the pity.

In the third part of this essay I will explore the questions raised by the Australian Association of Psychologists (Inc) (AAPi), in particular whether the PBA are protecting the consumer or rather simply protecting self interest.

[9] Axel Cleeremans "The Grand Challenge of Psychology" Association for Psychological Science: October 2010 Vol. 23 No 9 page 15.
[10] Ibid page 14

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**Part 3**

While attending a recent conference I heard that the AAPi, mentioned earlier, was moving a vote of no confidence in the PBA, I am not sure how. This and other questions I had, in part, motivated me to write this article. How is it that so much rancor and clear hostility has already emerged, in less than 12 months? How is it that a body such as the PBA, one which was set up to protect consumers can get it so wrong? How is it that so many psychologists feel that the PBA has failed them from the outset and yet many issues remain unresolved?

So far I have argued that the PBA have not applied a scientific basis so as to establish appropriate criteria in determining a psychologist's suitability for Psychological Practice. They have placed qualifications in front of the more important issue of competence. I have pointed out several inconsistencies and cited examples of where we, as a profession more generally, fail to apply scientific rigour, and I have argued that there may be various pathways to the development of therapeutic skills.

As I am now writing this final installment, it has been many weeks since I wrote the first two parts of this article. While in 2010 there was a hue and cry from psychologists the matter has somewhat settled down. Even the AAPi with terror stories of de-registration seems to have lost its revolutionary zeal, at one stage it seemed they were going to "storm" parliament. It's still a mess, though, and a valid point raised by the AAPi, that there seems a lack of demonstrable leadership by the PBA. Any letters I have sent to them over the last 12 months requesting information and guidance remain unanswered, presumably ignored, and so it would seem we are all left to muddle on.

In the next paragraphs I suggest that there is a common misunderstanding in respect to what is meant by clinical psychology and what private (clinical) practice entails. I suspect the problem, or lack of clarity may, in part at least, explain the discomfort that so called "generalists" in private practice have with the continuing dichotomy of those with and those without a Clinical Masters in Psychology, or simply put a confusion as to what defines a clinical psychologist.

My private practice, but especially prior to Medicare, mainly services clients who were employed (or well off enough to pay their bill). The typical client was functioning, but perhaps not coping well. They suffered stress which was manifest through anxiety and depression; for the most part they suffered what clinically could be described as a disorder of adjustment. They were not mentally ill.

I would suggest further that this is the type of clinical work found in most private practices.

Those with severe disorders, or mental illnesses, such as psychosis, Bi-polar and certainly the genuine personality disordered clients are not part of the "bread and butter" as the saying goes, of most private practices. Nor, in any case, do I have the competence to treat those patients with severe psychiatric disorders. I have not, nor had a desire to develop a skills base to treat these conditions. However, in any case, it could be suggested that no academically driven clinical training provides the clinician with the requisite skills, as competence is clearly gained through experience.

Clients with serious mental health problems deserve expert care. A Director of Nursing in a major in patient facility said to me that the psychologists she had in her team were too young, too inexperienced and not trained well enough. While it would be inappropriate to generalize this statement, it is clear that training in this type of intervention, is different to that required in general Private Practice.

Unfortunately training clinical psychologists in mental health facilities has two adverse outcomes; first it means that regularly the poor and marginalized, needing the most expert help are provided treatment by undertrained staff. Many having then gained their experience then leave and go into private practice. Secondly the type of work in mental health hardly provides the preparation for the cases they will treat in general private practice, at least as I describe it above.

Those in private practice, on the other hand, find it difficult to provide placement and training for these interns, clients paying $212.00 (APS rate) a session or even a lesser fee hardly want to be "practiced on" by an intern.

Private practice in Australia has morphed into something quite different than what I think academics suppose is "real" clinical psychology practice. It's true that many private practitioners specialize in certain fields, such as Obsessive Compulsive Disorder, or sexuality issues, in my case PTSD, (I was trained before it became an entity in the psychiatric nomenclature of the DSM). However this specialist training is not provided in academically driven courses but most like me have engaged in ongoing professional development, some of us over decades.

Perhaps an example, even if a tad obtuse, David Tolin conducted a meta-analysis and found that CBT was only superior in anxiety and depressive disorders (read

stress).[11] The point worth making here is that when qualifications and superior treatment modalities are argued as important, this doesn't stack up against the evidence. Moreover the question does not seem to be whether a person is a clinical psychologist, but rather what is their commitment to the modality (in this case CBT) and the therapeutic allegiance they establish with a client.

So how can it be that when two psychologists a "generalist" and a"clinical psychologists", deliver exactly the same treatment with the same outcome they are paid differently? A valid question of course raised by many including the AAPi, in addition as I indicated earlier, why should any patient/client be financially disadvantaged by this dumb dichotomy?

In the last few paragraphs I have raised what could seen as better belonging at the beginning or at least in a previous section of this paper. I have included again this question of training and even understanding the broader terms of clinical psychology because it's clear to me that many who make decisions on behalf of our profession are not in touch with what private clinical practice is about.

A change in thinking seems at best unlikely, for instance while science tells us there is no difference in effective treatment outcomes between psychiatrists, "clinical" psychologist, psychologists, as well as licensed clinical social workers, we remain captive to an ideological power base.

I suppose, too, this commentary, for some who are well served by the continuation of the status quo is nothing more than just another opinion. I hope I have raised some pertinent issues, that, if nothing else show how we as a profession can better see how we have arrived at this point in our history.

Roger F Peters PhD

[11] Tonlin. D., (2010). Is Cognitive – behavioural therapy more effective than other therapies? A Meta analytic review. Clinical Psychology Review Vol. 30 Issue