# Talking back to my Inner Critic

# The challenges of being a Process Oriented Therapist in a world where Empirically Supported Paradigms rule

## *Following the Process versus following a Manual*

A Thesis submitted in partial fulfilment of the requirements of the Diploma of Process Oriented Psychology Australia New Zealand Process Oriented Psychology Inc. Australia, April 2020.

**“If we don't grapple with the shadow:**

Our self-knowledge remains shallow.

We deny, dismiss, and white-wash the social ills of our families and culture, insisting on a naive optimism.

Our moral conscience is not strengthened by the heat of opposition that comes when we confront the deeper forces that drive us.

Our intimacies become a matter of trying to be good instead of being real and working through conflict.

Our ethics devolve into rules and dogma instead of the cultivated wisdom and compassion that comes from years of experience and often great suffering.

Our spirituality becomes a means of escape, injuring by bypassing.

And what of soul, what of love? They wander off, looking for a deep pain or grief so that they can feel themselves as real again, so that they can be re-membered.”

***David Bedrick, Facebook Post 6th of January 2020***

# Contents

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## Abstract

This thesis is a response to my inner critic's push to address the question: How to be a Processworker in a world where only so called 'evidence based' therapy models get approval from mental health funding bodies?

It is also a battle with my inner critic as he has tried to stop me writing this thesis at every step. And it is a personal exploration of my inner world and ancestry and how this has shaped my critic, particularly as it applies to my work as a psychologist and psychotherapist.

To address that question, in Section 1 I review the background of evidence-based paradigms in general and in particular the paradigms that have conducted large randomised studies in an attempt to demonstrate efficacy. I examine the conflicting empirical evidence that indicates those paradigms do not produce better outcomes for clients.

In Section 2 I discuss the research about what works in therapy, the Common Factors and 14 qualities of good therapists - and how the Processwork paradigm and training aligns to these factors and suggests effectiveness. I also investigate how effectiveness is measured.

In Section 3 I use the lens of World Work to explore the roles and ghost roles in the field of mental health and how the regulating and funding bodies enact these roles. And I discuss how this intersects with Evidence Based Practice and Outcome Measures.

In the final Section I explore my own Inner Critic, his origins and his purpose.

## Glossary

- **Channels of perception** - Processwork describes six channels of perception through which we experience the world. It identifies four singular channels:
    - Auditory, the things we hear both internally and externally
    - Visual, the things we see
    - Movement
    - Proprioception, the things we experience as body sensations, including heat, taste, and feelings.

    Processwork identifies two composite channels:
    - Relationship channel. This includes all kinds of relationships with fellow humans.
    - World channel. The world channel is expressed through comments in regards to organisations or bodies in the field, for example, the government, schools, hospitals, nature etc.
- **Dreamfigures** – Diamond and Sparks (2004) describe: "The term "dreamfigure" is often used interchangeably with "role", "part" and "ghost". As a process unfolds, dreaming signals may develop either into a dreamfigure or into an interaction between two or more dreamfigures" (p.86,87).
- **Dreaming** – Diamond and Spark (2004): "'Dreaming', capitalized, is used to denote the realm of undifferentiated experience, what Mindell also called sentient reality by Mindell. The lower case 'dreaming' refers to noticing and following dreamlike experiences" (p. 13).
- **Edge** – an edge is the energetic boundary between the known and unknown parts of our identity. The edge describes the limit of what we are identified with as who we are and the potential meeting of the more unknown aspects of the

person. Processwork helps individuals and groups to explore the edges of their identity to possibly gain easier access to parts beyond that edge.

- **Ghosts** – 'Ghosts' are roles in the field that are talked about and present in the field, but not represented in groups. For example, 'the government' might be talked about in a group but not represented by participants.
- **Primary Process** – These are the parts of ourselves we are identified with, who we think and say we are.
- **Processwork** – also known as Process Oriented Psychology – is a multilevel awareness practice for individuals, relationships, and groups. Dr. Arnold Mindell developed this still-evolving modality, which has its roots in Jungian psychology, Taoism, Shamanism and indigenous wisdom, as well as quantum physics.
- **Rank** – refers to different levels of power and privileges (earned and unearned) and is often depending on the context. Processwork defines four kinds of rank:
    - Social Rank - social status based on the mainstream culture. Some factors are: gender, class, race, religion, sexual orientation.
    - Structural rank – the rank given by positions of power. Teachers, CEOs, leaders of organisations, and bosses have structural rank. Hierarchies in businesses and government, where certain positions are elevated over others, define structural rank.
    - Psychological rank – our self-esteem is reflected in psychological rank - how we feel about ourselves. People who are depressed, lonely, and suffering hold lower psychological rank than individuals who are centered, and are able to be fluid, open and expressive.

    - Spiritual rank – a feeling attitude that connects us to an energy source bigger than ourselves and gives a sense that we are supported by the energy.
- **Secondary Process** – The parts of ourselves that we are not identified with. The ‘not-me’, marginalized aspects of individuals or groups.
- **Three levels of reality**
    - Consensus Reality – on this level things are measurable, and we can reach consensus on these aspects of reality (for example, temperature).
    - Dreamland – experiences and events that are subjective, such as deep feelings, visions, transgenerational events, projections, polarities, and fantasies.
    - Sentient – Taoism refers to this level as ‘the Tao which cannot be said’. It is the deeper, non-dualistic level of reality that is intangible and dreamlike and not easily expressed.
- **Worldwork** – Process work applied to large or small groups, organisations or communities with Deep Democracy as the core principle.

# Introduction

*"Anything worth doing is worth doing badly." – G.K. Chesterton*

My critic is a powerful force and has been with me for as long as I can remember. My critic is a male figure, patriarchal, autocratic, tyrannical, despotic and sarcastic. I have worked on him and with him for many years in therapy – and I can hear him jeer as I write this, saying things like "and how far did that get you – I am still here, right. So much for effective psychotherapy!". While I still deal with my critic, I also know that I have discovered many ways to protect myself; my general anxiety has reduced and overall, I live a happy life. As life does not have control groups I will never know where and how I would be if I had never set foot in a therapy room.

Nowadays, when I am challenging myself to do new and important things in my life, my critic shows up in all his glory and 'throws spanners in the works'. Writing this thesis is such a situation. Spanners wherever I look, and credit to me, I persist ("there, take that critic, I just praised myself in public!"). I admit writing the thesis feels like "Groundhog Day" sometimes, and just like Bill Murray as Phil Connors in Punxsutawney, it seems I still haven't quite got the message and there are moments of despair. In the movie "Groundhog Day" the message is love, at least for Connors, so maybe my critic has the vital role for me to continue to ensure I explore love and my own road to freedom and self-acceptance. My own personal road to my own personal 'enlightenment'.

My critic is a one-dimensional figure; he believes in right and wrong, pretty and ugly (that one is important for him!), worthy and unworthy, better or worse; he likes to point

fingers and blame. It is a world of opposites and duality, and judging is the one thing he does best. I generally do not fare well when it comes to his judgements of me. He likes to point out my shortcomings and he keeps telling me that I am not good enough. I am a hoax and a fake. “A psychotherapist” he scoffs. He sneers and quotes Hans Eysenck (1952), stating that the whole profession is useless and people recover just as well if they are left alone, and even if there are some people who might be good at what they do, I am most certainly not one of them.

Because the field of psychotherapy is such a wide field, with many different approaches, and many varying views with a multitude of different subjective experiences, it is impossible to prove him wrong. He can ‘come at me’ from all angles and attack my abilities, or lack thereof. Whenever things work out well in the therapy room it is either luck or the client themselves (both are certainly parts of the truth), and when things do not go well it is clearly and exclusively my lack of skill that is to blame. And he likes to attribute guilt and hold me responsible. Which, in so many ways, is also a clear reflection our society as a whole, where guilt and blame are hallmarks of our legal and judicial system and they are also freely used in the political arena. These chronic cultural narratives of guilt and blame are partly how we internalise critical roles in our psychology in the first place. Arnold Mindell writes in his book “Sitting in the Fire” (1995):

> “In democratic countries, politicians are allowed to engage in public abuse as a campaign or lobbying strategy. It’s called “mudslinging” – making demeaning personal remarks about the opponent. … Public abuse goes hand in hand with an adversarial legal system whose goal is to determine who’s right and who’s wrong instead of how to improve relationships. An adversarial system supports power, supports right and might, rather than understanding and connection to

> others. An adversarial system works toward increasing conformity and productivity, not compassion" (1995, p. 133-134).

My work as a psychotherapist is embedded in a cultural, social and political context. We are marinating in a field of neo-liberal capitalism and consumerism, which informs our values and expectations, creating its own dynamics and a variety of different and opposing interest groups. Health systems, including mental health, are measured by their effectiveness, by how the person 'functions' in society, and how the therapist has managed to facilitate the societal functioning of the client/patient. This world of outcomes measures, re-establishing client functioning and return to work pressure is a heaven for my critic. Whenever I am questioned by an external agency, or criticised by a funding body or psychiatrist, my critic laps it up and rubs it in my face and leaves me feeling rotten.

Processwork, the paradigm I love and work from, has a different way of being in and seeing the world. Arnold Mindell's teaching is to follow nature instead of dominating nature as instructed by Christian-Judaic scripture: "Be fruitful and multiply, and fill the earth, and subdue it; and rule over the fish of the sea and over the birds of the air and every creature that crawls upon the earth" (Genesis 1:28). I believe this approach to nature underpins the capitalist values of the western 'civilised' world, including mainstream psychology, in exploiting and denigrating nature, as well as our own nature. Processwork does not rule or subdue; it follows, it notices and it brings awareness to what is happening. Processwork invites us to follow the river, to find meaning in the unusual, the disturber, in our dreams, and our longings. Processwork reminds us to reconnect with our own nature.

It is difficult to measure how following nature supports your life. How is following nature therapeutic and healing for the client? How fast and effective is it? How much do we trust the process? How do I negotiate that with funding bodies?

This thesis is an attempt to ‘talk back’ to my inner critic and all the organisations, insurers, and funding bodies who regulate and dictate psychological approaches in an attempt to make the field of humanity, human connection and interaction, human suffering and healing more measurable, less ambiguous and devoid of mystery.

# Methodology

I have applied a qualitative and heuristic mixed methods approach, combining the following research tools:

## Literature Review and Discussion

I reviewed and discussed the existing literature researching the efficacy of different therapeutic approaches to therapy with their own (often biased) views. Empirically backed therapy approaches are a big focus, as it remains a methodological ideal in the western world that empirically backed therapy approaches seemingly provide critical and 'objective' outcomes. These approaches favour large randomised empirical studies, often in isolation, and laboratory experiments, peer reviewed in scientific journals and frequently culminating in clinical recommendations. I have researched literature stating that some therapeutic approaches are more effective than others, and literature looking at the quality of the therapeutic intervention and other therapeutic factors determining positive outcomes for the clients. Feedback-informed practice and a variety of outcome measures (as an indication of quality services) are also discussed.

## Focus Group

In the search for answers to the question 'What makes good therapy?', I conducted a focus group. Kitzinger (1994, 2007) describes focus groups as group discussions with the aim to explore and discuss a particular set of issues with focus on the interaction of the participants.

The focus group consisted of a mix of people with experience and interest in Processwork. Some of the participants were experienced Processwork therapists

and members of the faculty, others were students with differing years of experience. The group had members with varying levels of experience in the field as well as a variety of professional backgrounds.

I facilitated the group with the main research question: 'How do you know that you are providing a good service to the client?' And, 'How do you know your service is worth the money you are charging?'

A lively discussion ensued, and participants shared a variety of approaches and ways of accessing success in therapy, outcome measures, internal legitimacy versus legitimisation through the system, and formal education and training.

## Inner Work, Reflections and Intuitive Inquiry

Intuitive Inquiry (Anderson & Braud,1998) invites everyone involved in research to consider the possibility that the participation in the research may transform them in some way.

Anderson et al (1998) writes:

> "In attending to the particulars of data, intuitive inquiry joins intuitive and compassionate ways of knowing to the intellectual rigor of human science research. Methodologically, intuitive inquiry does not replace linear, left-brain attributes with imaginal right-brain attributes. Rather, "in the union of [conventional] masculine and feminine perspectives, the method seeks to balance structure and flexibility, exterior and interior, reason and emotion, thinking and feeling, discernment and holism" (Dorit Netzer, pers. comm.)" (p 16).

This approach balances the somewhat limiting empirical research methods with intuitive inner work and allows for a broader and more inclusive form of research.

In this thesis I have used both my inner critic, and the requirements for psychologists by the Australian funding bodies, as the main instructors and informers. I have worked with my moods and procrastination, also mostly a result of inner criticism. I have taken this inner struggle to therapy and supervision, and unfolded body symptoms and dreams. Through the course of writing this thesis I have gone more deeply into aspects of my inner critic, learned more about myself, and understood more about my historical background and national influences. This process has transformed my understanding of myself and my relationship with my inner critic, as well as aspects of my experience as a practicing psychologist.

It has also allowed me to see more clearly both the limitations and the political and financial interests of some involved parties.

# Background

## Hans Eysenck

Hans Eysenck was a controversial psychologist who created waves in the psychotherapeutic field when he published an article in 1952 on the effects of psychotherapy. In this article, Eysenck reported that two-thirds of therapy patients improved significantly or recovered within two years, regardless of whether or not they received psychotherapy. He was particularly critical of psychoanalysis and dismissed it as ineffective and unscientific. Meares et al (2002) discuss Eysenck's attack:

> "The offensive he launched against the dominance of psychoanalytic thought in the field of psychotherapy was not strongly based in scientifically gathered data. At that time, there was little appropriately acquired information available. Eysenck used it for the purposes of what was, in essence, a polemic. Although Eysenck provoked censure for the use of inadequate data upon which to mount his argument, the consequence was that, for the first time, serious attempts began to be made to estimate the effect of various kinds of psychotherapeutic intervention" (p. 812).

Eysenck's attack was challenged and rebuffed repeatedly in numerous studies. However, in some ways Hans Eysenck can be seen as an initiator of empirical research into the efficacy of psychotherapeutic interventions. His polemic and challenge have led to the production of significant data which furthered ongoing challenges, as well as a smorgasbord of discussions, opinions and new approaches. And even though I disagree with his method of making bold and unsupported statements, he can be seen as a useful critic.

# SECTION 1: Evidence Based Practice and Evidence Based Therapy

Evidence Based Practice (EBP) finds its origin in Evidence Based Medicine (EBM), introduced by Sackett et al (1996). Sackett et al (1996) define evidence-based medicine as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research" (p. 71).

David Sackett and his colleagues have made two important concessions to their original position relating to evidence-based medicine. One is that they recognised clinical skill as important and secondly, they allowed other forms of evidence to be considered and not exclusively insisted on randomised controlled trials. Today's evidence-based medicine includes three key components: research-based evidence, clinical expertise, and the patient's values and preferences.

Evidence-Based Therapy (EBT), is any therapy based on peer-reviewed scientific evidence, achieved through large scale randomised controlled empirical trials. The Association for Behavioural and Cognitive Therapies (ABCT) in the USA states: "For therapists to truly engage in evidence-based practice, they must anchor your treatment in the best scientific evidence available and use the techniques and psychological approaches that have scientific support." (ABCT, 2020). Over time, just as Sacket et al have broadened their definition of Evidence Based Medicine, the definition of EBT now includes the client's values and preferences as well as the practitioner's clinical expertise. The American Psychiatric Association and the

American Psychological Association (2006) both consider EBT to be ‘Best Practice’ and ‘preferred’ approaches for psychological symptom treatment. Levant (2005) refers to ‘evidence-based practice in psychology’ (EBPP) as: ”The best available research with clinical expertise in the context of patient characteristics, culture and preferences” (p. 273).

The interest in ‘symptom treatment’ is an interesting aspect of mental health care. As a Processworker we would not want to treat ‘psychological symptoms’ with the intent to remove the disturbing symptom, but would instead work with the underlying patterns or causes of the symptom by unfolding it to understand deeper meanings. Other psychologists and psychotherapists also criticise the manualised approaches and the focus on symptoms. Todd Essig (2019) states:

> “Imagine you go to your doctor with a high fever caused by a fulminating bacterial infection. If you were treated by the rules of managed mental healthcare you would merely be given an aspirin to reduce the acute symptom of fever rather than a more expensive antibiotic to address the underlying cause. Pretty crazy, I know. But, that’s what’s happening. By saying time-limited instruction-manual treatments are the generally accepted standard of care insurance companies get around complying with parity legislation that mandate mental illnesses and injuries be treated on par with physical ones. But the more algorithmic and the less human the treatment, the more profit” (online article).

EBP is held as an ideal within psychological research. Practitioners are expected to rely on the experimental research field to support treatment decisions and clinical interventions and priorities. EBP removes personal responsibility to some degree and attempts to introduce certainty in positive outcomes of treatment. EBP is promising

some objectivity in a field of vastly different treatment approaches, opinions and attitudes. Morstyn (2010) states in his conclusion:

> "Evidence-based psychotherapy, which requires that psychotherapists ignore their thoughts and feelings with individual patients in favour of following standardized manuals and guidelines, is being increasingly promoted as part of evidence-based medicine (EBM). However, this represents an inappropriate extension of logical empiricist philosophy and significance testing methodology, on which evidence-based medicine is founded, to psychotherapy. It sacrifices a search for truth in psychotherapy, for an illusory search for certainty. The inevitable consequence of this is that psychotherapy becomes a commoditised pseudo-relationship." (p. 221)

Large randomised studies rely on manualised therapy approaches in order to be empirically evaluated. These manuals instruct practitioners to follow standardised interventions with a particular script to address particular symptoms. The emphasis is on academic and laboratory studies, often endorsed by major research institutions and journals, which lead to summarized recommendations for clinical interventions. Cognitive Behaviour Therapy (CBT), for example, is one the most widely researched treatment approaches, and has been tested in many randomised controlled trials. Based on this, CBT is continuously promoted to be an effective treatment form, and this includes promotion by the Australian Psychological Society, the professional body that should also address my interests as a counselling psychologist. An article by Kylie Murphy (2010) in the Bulletin of the Australian Psychological Society InPsych reviews the effectiveness of 14 psychological interventions:

- Cognitive behaviour therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Narrative therapy
- Family therapy and family-based interventions
- Mindfulness-based cognitive therapy (MBCT)
- Acceptance and commitment therapy (ACT)
- Solution-focused brief therapy (SFBT)
- Dialectical behaviour therapy (DBT)
- Schema-focused therapy
- Psychodynamic psychotherapy
- Emotion-focused therapy
- Hypnotherapy
- Self-help
- Psychoeducation

The author almost exclusively names CBT as an effective treatment form for a number of psychological difficulties. Two other treatment modalities mentioned, DBT and Eye-Movement Desensitation and Reprocessing (EMDR), are also manual based therapy approaches. Interpersonal Therapy and all the other mentioned therapy approaches have a short-term focus. See the table below, Table 2 in Murphy's article:

**Murphy (2010) Table 2. Psychological interventions with Level I Evidence**

| Mental Disorder | Psychological Intervention | |
|---|---|---|
| | Adults | Adolescents and children |
| Depression | CBT<br>IPT<br>Brief psychodynamic<br>Self-help[c] | CBT<br>IPT[A]<br>Family-based interventions |
| Generalised anxiety | CBT | CBT |
| Panic disorder | CBT | |
| Specific phobia | CBT | |
| Social anxiety | CBT | |
| Obsessive compulsive disorder | CBT | CBT |
| Posttraumatic stress disorder | CBT<br>(EMDR)* | |
| Substance use disorders | CBT | CBT[A]<br>Family-Centered |
| Anorexia nervosa | | Family-based interventions |
| Bulimia nervosa | CBT | |
| Binge eating disorder | CBT Self-help | |
| Sleep disorders | CBT Self-help | |
| Sexual disorders | Self-help | |
| Chronic fatigue syndrome | CBT | CBT |
| Somatisation disorder | CBT | |
| Hypochondriasis | CBT Psychoeducation | |
| Body dysmorphic disorder | CBT | |
| Borderline personality disorder | DBT | |
| Psychotic disorders | CBT<br>Family-based interventions | CBT<br>Family-based interventions |
| Attention Deficit Hyperactivity disorder | | CBT |
| Conduct disorder | | CBT<br>Family-based interventions |
| Enuresis | | CBT |

A = Adolescents only C = Primarily CBT-based

* EMDR was not systematically included in the APS review of psychological interventions but does have Level 1 evidence of effectiveness according to the Australian guidelines for the treatment of adults with acute stress disorder and PTSD.

The belief that some forms of therapy are more effective than others appears extremely appealing, as it provides the illusion of being able to provide quality services to clients, regardless of who delivers the service. Having a third party validating a particular therapeutic approach provides the illusion of a certain safety, clients seem to be getting value for money and a positive outcome appears more likely. This is reassuring for funding bodies. However, it is not a true reflection of the ambiguities and social context people live in and it does not contribute to the understanding of how humans heal, grow, change, and explore the diverse possibilities of meaning.

While the desire to reduce uncertainty and increase predictability of therapy outcomes is understandable, this apparently biased focus on CBT is in stark contrast to decades of research into the efficacy of psychotherapy. These metastudies consistently show that there is no measurable link between therapeutic effectiveness and empirically validated treatments (Howard et al,1996; Johnson & Shaha, 1996; Miller et al, 1997).

According to Wampold (2010), specific therapeutic treatments - like CBT - should no longer be mandated by funding bodies or insurers. Wampold (2010) found that the effectiveness of all treatment forms is largely based on the therapeutic alliance between client and therapist, and found no evidence that a given technique or approach is superior in effectiveness to another: “The notion of requiring clinicians to use empirically supported treatment or evidence-based treatments simply is not supported by the research evidence” (p.72). In another article Wampold et al (2006) stated: “Not a scintilla of evidence to support empirically supported treatments as more effective than other treatments” (p. 299). In this article he argues the case with Ollendick & King, who respond to his statements by claiming that “Empirically Supported Treatments Typically Produce Outcomes Superior to Non-Empirically Supported Treatment Therapies” (p. 308). Wampold replies to their arguments with

"Dialogue: Convergence and Contention" (p. 317-322), and challenges their assumptions and research methods. Finally, Wampold makes a case for therapists to become accountable for the outcomes of the treatment and for this to be based on implicit and explicit client feedback.

Yet, despite these findings, manualised 'validated' EBT therapy approaches continue to be accepted as the gold standard in psychological treatment and have been adopted as preferred treatments by funding bodies not only in Australia but also in the USA.

Processwork does not have support of large empirical studies to date. Staszewska (2009) wrote a thesis at the Processwork Institute and summarised a large body of qualitative research studies. She also included quotes from few larger empirical studies in relation to Processwork. She conducted a pilot study measuring the effectiveness of therapy sessions by Processworkers. Staszewska calls for further research and states:

> "… if Process Work wants to be closer to mainstream psychotherapy it is necessary for Process Work to refer to outside standards while evaluating outcomes from therapy. One way of doing this is by testing if Process Work therapy actually *works*. Because Process Work lives in a world where quantitative data is dominant, Process Work research methodologies need to also speak the same language, or at least some of them." (p.10).

## The Illusionary Truth Effect

In the face of the evidence that there is no measurable link between therapeutic effectiveness and empirically validated treatments, it seems remarkable that the claims of the 'empirically backed treatment forms' are still widely accepted and supported by the funding bodies. It may be an 'illusionary truth effect'.

The illusionary truth effect was first identified in 1977 in a study by Villanova and Temple University. The study showed that people, when assessing truth, rely on their feeling of familiarity with the information, or if it concurs with their current understanding. People will compare new information with existing knowledge, and if a statement is frequently repeated then it is processed more easily. This ease of processing then leads people to believe that the statements are more truthful.

Until recently it was believed that the illusionary truth effect was limited to ambiguous statements, which are open to interpretation or not easily checked. However, Fazio et al (2019) in their article "*Repetition increases perceived truth equally for plausible and implausible statements"* reported: "Our results indicate that the illusory truth effect is highly robust and occurs across all levels of plausibility. Therefore, even highly implausible statements will become more plausible with enough repetition" (p. 1705). A frightening finding and obviously important information for advertisers, politicians, demagogues and anybody with a vested interest. Repeat a statement often enough and people will believe it to be true.

The support of empirical and scientific backing of any of the researched therapy approaches (such as CBT, EMDR and Prolonged Exposure Therapy) is used repeatedly to impress the efficacy of these approaches over other approaches; by repeating the support, it becomes more and more accepted as truth. It is also convenient for funding bodies to believe in the truth of the statement, as these forms

of therapy state aims to be short term interventions and as such more financially viable, particularly for insurance companies.

I am always struck by the confidence of the representatives of these 'empirically validated' therapy approaches. When I attended a training for EMDR, the trainer emphasised the importance of using an empirically validated treatment form, firmly stating that adhering to the 'best practice' models are also a matter of professional ethics. With the backing of large, randomised studies, they state they have 'science' behind them, not just the 'biased conclusions' of a practitioner. I want that. I want to be able to back myself and have the same confidence as this trainer and as a colleague – also a psychologist - who is working for WorkSafe Victoria (WorkSafe Victoria is the trading name of the Victorian WorkCover Authority – for more information see chapter 'WorkSafe Victoria). This colleague called me unsolicited, suggesting I use a manualised therapy (in this case Prolonged Exposure Therapy) when working with my clients. He knew I was working with clients whose treatment was paid for by a WorkSafe insurer, and that these clients presented with Post Traumatic Stress Disorder (PTSD) as a result of the work they were doing. He queried which empirically backed approach I was using. He then proceeded to tell me that "Prolonged Exposure Therapy" is by far *the* most effective treatment for clients with PTSD and he strongly urged I familiarise myself with it. Prolonged Exposure Therapy is an 'evidenced-based', manualised therapy approach and is stated as effective for the treatment of PTSD. Proponents of Prolonged Exposure, like many other cognitive behavioural therapy approaches, claim that numerous well-controlled studies over a long time have shown that this approach not only significantly reduces the symptoms of PTSD but also addresses many of the co-morbid symptoms of depression, anger and anxiety. This colleague of mine was satisfied when I stated I would look into it and

that I was using Eye Movement Desensitation and Reprocessing Therapy (EMDR) when working with clients with PTSD and funded by WorkSafe. EMDR also refers to numerous randomised controlled studies reporting the effectiveness of EMDR in the treatment of trauma. EMDR even quotes the World Health Organisation as only recommending Trauma informed CBT and EMDR for the treatment of PTSD. I completed training in EMDR as it became more and more obvious that I needed to be able to show that I was able to administer a therapy methodology that has been empirically researched if I wanted to continue working for these funding bodies.

## The Dodo Bird Effect

The 'Dodo Bird Effect', termed as such by Saul Rosenzweig as early as 1936, postulates that all psychotherapeutic approaches are equally as effective and that in fact, there are other factors that determine a positive outcome in therapy.

Rosenzweig adopted the term from the novel, "Alice in Wonderland" by Lewis Carroll (1865). Some characters in the book got wet and the Dodo bird engaged all of them in a competition to run around the lake so they would dry themselves. Nobody measured how far each person ran or for how long, yet when they had finished, they asked the Dodo bird who had won. After solid contemplation the Dodo bird said: "Everybody has won and all must have prizes."

Rosenzweig found that common factors were more important than specific therapeutic approaches, which made all therapies winners as they all produce equally effective outcomes.

The Dodo Bird Effect remains controversial in Psychotherapy and with the introduction of treatment outcome studies it appeared to be obsolete. Yet with the development of meta-analysis, the debate was brought back to life. Bruce Wampold (1997) analysed

more than 270 scientific studies with respect to this question, and found that if there was a difference in one mainstream therapy's effectiveness over another, it was minimal. The debate continues on and Elliott et al (2015) conclude that, as a result of the development of meta-analysis in the 1980s, the debate peaked. Researchers argued for or against the verdict and would even cite the same empirical data for their opposing views. Arguments continue to focus on the methodology used and the interpretation of the data, yet no definitive answer has been agreed on.

Thus, getting a definitive answer, a yes or no, an on or off (the things my critic likes so much) seems impossible in the field of psychology and psychotherapy. Different interpretations of outcomes of the same studies can lead to different conclusions, the methodology can be questioned, different arguments can shed a different light on different aspects and lead to different conclusions. Different researchers support different approaches and bring forward their own biases and opinions.

It is interesting to me that ambiguity is part of life and our current research methods are not sufficiently robust to find unilateral definitive answers. There just might be no unilateral and definitive answers in the world of psychotherapy, not on a consensus reality level. This means that my critic will always be able to criticise me, because as long as I can't 'prove' him wrong, he will continue to pester me, or at least attempt to get me down and doubt myself.

## The Psychotherapy and Counselling Federation of Australia

Interestingly, the Psychotherapy and Counselling Federation of Australia (PACFA) – the counselling federation and not the psychological body - has incorporated the evidence and research indicating that the most important factors for change are 'the common factors', including the client's resources and the therapeutic relationship.

PACFA has adopted the therapeutic relationship as the pivotal point for therapeutic effectiveness. PACFA does not follow the more medically oriented paradigm of large randomised controlled studies of EBP, and views the empirical approach to psychotherapy more critically.

'Psychologist' is a protected term and can only be employed if the person has demonstrated academic qualifications and registrations. This gives psychologists higher rank and access to provide government funded services not permitted to counsellors and psychotherapists. The terms psychotherapist or counsellor are not protected through government regulation. Not all psychotherapists and counsellors are members of an accrediting body, such as PACFA or the Australian Counselling Association, which leaves these fields open to people putting a sign on their door without monitored training and registration requirements. Being a member of the accreditation body gives assurance to the public that the practitioner satisfies the registration requirements and allows for grievance procedures if required. Yet, competition between the professions exists.

The Australian counselling bodies appear less interested in attempting to fit into the medical model than psychologists and their professional body. The 'soft' science of psychology and the lower rank of psychologists compared to medical practitioners and psychiatrists makes us competitive and insecure, and psychologists have been struggling with their low status for decades (see Ausubel (1956), Geist (1956)). This in turn drives efforts to show that psychologists are also able to participate in a medicalised way of treating clients, by diagnosing and then treating accordingly. The field of Psychology attempts to fit in with the Western society view of medicalisation of issues and competes with medical practitioners. In the USA, psychologists nowadays are advocating for medical prescription rights.

PACFA members are required to access other funding avenues, for example private health insurance, Employee Assistance Programs (EAP), the National Disability Insurance Scheme (NDIS) and self-funded clients, and are as such in a different position. All of these funding options are also open to social workers and psychologists. It appears easier for PACFA members to see that psychology does not follow a medical paradigm and their approach to therapy focusses on the relationship to facilitate change, "The philosophical influences in psychotherapy and counselling that form the basis of depth relational work are based in ontological forms of knowledge production, while the science-practitioner approach, taken largely from psychology, is based in positivist empirical forms of knowledge production" (Day, 2015 p.2).

PACFA has its own accreditation process and their training focus revolves around the 'common factors' as mentioned above. Interestingly, they add another point:

> "recognition that practitioner self-awareness and self-development are central to effective and ethical practice, and to the capacity to utilise the self of the practitioner effectively in the therapeutic relationship" (PACFA, n.d.).

PACFA also require that their trainees complete a minimum of 20 hours of therapy, (group, family or individual) as component of self-awareness. The more medicalised and manualised approach to therapy in CBT, Prolonged Exposure Therapy, or EMDR does not require any such thing, and psychologists are permitted to work with people without ever having been a client themselves.

## SECTION 2: What works in Therapy and How do we Know

This section explores research around what works in therapy and how Processwork measures up. It also addresses different outcome measures and the importance of feedback.

### 'The Common Factors'

*"I used to think bearing witness was a passive act. I don't believe that anymore. I think that when we are present, when we bear witness, when we do not divert our gaze, something is revealed—the very marrow of life. We change. A transformation occurs. Our consciousness shifts" -Terry Tempest Williams*

The Common Factors have been widely researched in the field of psychiatry and psychotherapy and have a long history, originating with Rosenzweig (1936) suggesting in his article "*Some Implicit Common Methods in Diverse Forms of Psychotherapy"*, that common core features are:

> (1) the operation of implicit, unverbalized factors, such as catharsis, and the as yet undefined effect of the personality of the good therapist;
>
> (2) the formal consistency of the therapeutic ideology as a basis for reintegration;
>
> (3) the alternative formulation of psychological events and the interdependence of personality organization" (p. 415).

The Common Factors are more than just a set of therapeutic elements but instead shape a theoretical model of change in psychotherapy. The meta research incorporated forty years of outcome data across a large number of different

therapeutic treatment modalities to identify effective treatment factors. Hubble, Duncan and Miller (1999) and Duncan et al (2010) found that the quality of the therapeutic relationship as well as the client's own life space are the most significant factors in effective therapy. The theory of the common factors proposes that all psychotherapeutic approaches share common factors that account for change and effectiveness of therapy. I will discuss this further within the next chapter.

## The Contextual Model

To understand the evidence supporting the common factors, Wampold (2015) outlined a contextual model of psychotherapy. The Contextual Model is a particular Common Factor Model presenting evidence for common factors, which are found to be important for producing a positive outcome in psychotherapy.

The contextual model assumes three pathways leading to a positive outcome in therapy.

1. A real relationship. The therapeutic relationship has many unique facets. Clients are free to express and disclose very personal and difficult content in a safe environment, where confidentiality is assured. If the therapeutic setting has offered an empathetic and caring connection, then the risk of rejection, as a result of the disclosure, is minimised. The client can instead experience emotional support and acceptance.
2. Expectations of the client that things will get better as a result of attending therapy. This may in part be a placebo effect, but also the belief that by participating in therapy and complying with tasks, whatever they may be,

clients' problems will reduce and they can cope more effectively. This in turn is empowering, as clients learn that they are not helpless but able to address and overcome their difficulties.

3. Specific ingredients. Different psychotherapeutic approaches use a variety of interventions, with the aim of assisting the client to reduce suffering. Wampold mentions changing maladaptive thinking and reducing dysfunctional schemas in CBT, improving relationships in Interpersonal and some dynamic therapies, being more accepting of self in self compassion approaches or Acceptance and Commitment Therapy, or taking the perspective of others in mentalization therapies.

Processwork addresses all the above-mentioned approaches - and the aim of Processwork is to increase awareness and thus the choices of the client. I will discuss the first two points later in the chapter "14 Qualities of Effective Therapists". In regards to the third point, the specific ingredients, Processwork offers a smorgasbord of interventions with no limit on creativity or possibilities, which are always guided by the client and their unique way of being in the world.

Processwork works with different levels of reality we can access to solve a problem if suggested by the client's process. We work with different channels of perception and we invite dreamfigures, night-time dreams, and flirts in our environment. We notice subtle signals like a pause or a sigh, an unintended body movement, body symptoms or a general mood. Processwork has an endless supply of 'specific ingredients' and works with the unexpected and the unknown, and identifies the channel in which the process wants to unfold.

According to the contextual model, it is the 'healthy' action taken by the client that is one of the most effective components of therapy. However, proponents of particular

therapy forms would argue that their specific way of managing and dealing with the client's issue is the effective ingredient.

A strong therapeutic alliance is required for pathways two and three, as the client is then more likely to allow the therapist 'in' and disclose difficult material, and for the client to take positive 'healthy' action outside of the therapy room. The therapeutic alliance is the cornerstone, as well as the prerequisite, for healthy action, effective therapy and positive outcomes.

Therapeutic alliance is a well-researched factor and one of the best predictors in connection with the outcome of therapeutic intervention.

Empathy expressed and demonstrated by the therapist is a primary common factor and has a strong impact on achieving the clients' goals for change (Horvarth & Symonds, 1991). Figure 1 shows the positive impact of the therapeutic alliance and empathy within the contextual model of therapy.

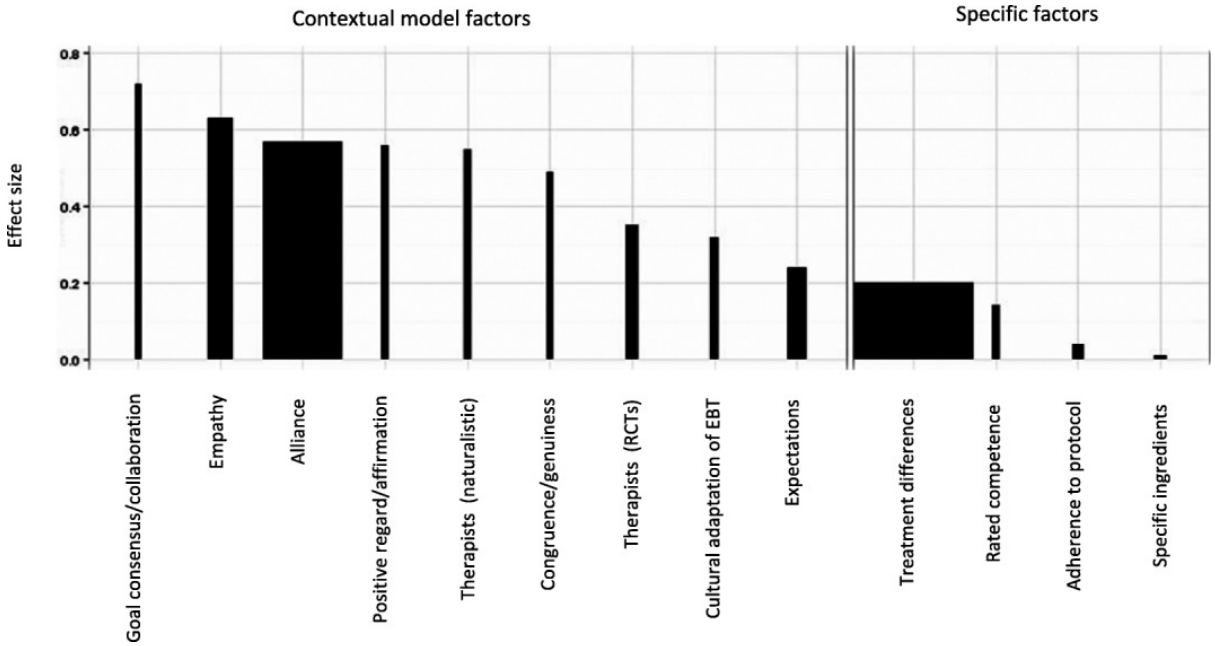


*Figure1: Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs –randomized controlled trials, EBT – evidence-based treatments. In Wampold (2015)*

Duncan et al (2010) noted four main factors accounting for change based on the common factors meta research. This research focussed on identifying the common factors in effective therapy by analysing forty years of outcomes data across a diverse range of practice modalities.

These four main factors are:

1. Client/Extra-therapeutic 40%
2. Relationship 30%
3. Placebo, Hope, Expectation 15%
4. Model or Techniques 15%

Duncan et al (2010) define 'client factors' as the resources clients bring to therapy, including the supports, relationships and networks they have in their lives. They also identify personality traits such as persistence, openness, faith, and optimism. Also included are lucky life events (e.g. finding a new job) in the lives of the clients as being a contributor to change.

Alexandra Batchelor (1995) examined clients' perceptions of the therapeutic alliance. She identified three different aspects of the relationship as valued by clients:

1. An empathetic understanding, with respectful, and attentive listening from the therapist;
2. Improved self-understanding as a result of the therapist explaining and making sense of the clients' material;
3. Collaboration with the therapist. Some clients understood that the work is not the therapist's responsibility alone but that all parties need to contribute.

Duncan et al (2004) described expectancy factors on the outcome of therapy due to the clients' expectations that things will improve for them because they are in therapy.

These are increased hope, and the clients' understanding and trust that the therapeutic technique is credible and useful.

Asay & Lambert (1999) accounted approximately 15 percent of the change as a result of therapy to the individual model and the particular beliefs and approaches unique to the therapeutic model. For example, the miracle question in solution-focussed therapy. Other studies have shown even less of an impact of the particular therapy model, such as Wampold's meta study in 2001. Wampold found that only 13 percent of the impact of therapy was attributed to the specific therapy model, including a combination of general and specific factors of the model. Out of these, only eight percent were specifically attributed to the effects of the models.

Duncan et al (2004) argued that as the effect of the particular therapeutic model appears to be minor, and in light of key research findings that the client's own life space and the quality of the therapeutic relationship together constitute the most significant factors of therapeutic effectiveness, therapy schools would be well advised to teach their students new ways of supporting clients when the therapeutic process is stuck. Duncan et al (2004) stated: "The different schools of therapy may be at their most helpful when they provide therapists with novel ways of looking at old situations, when they empower counsellors to change rather than make up their minds about clients" (p.38).

These points raised by Duncan et al reflect one of the core attitudes of a Processwork practitioner. The beginner's mind (described by Amy Mindell (2006) in "*Alternative to Therapy"*, as "…the Zen phrases *Bare Bones* and *Beginner's Min*d in reference to signals. Having a "bare bones and beginner's mind attitude" means simply noticing and stating *exactly* what you see, without preconceptions or judgements" (p.40)), following the client's signals and feedback, attempting an intervention up to three times

and then dropping it if the feedback is negative; all these are fundamental responses within the Processwork paradigm and they are all built on and around the client's feedback instead of introducing particular interventions according to a therapeutic manual.

The common factors research provides opportunities for psychotherapy to profile the profession in the health space, delivering an alternative to the frequently supported CBT, especially in reference to the continued rise of relational therapeutic orientations. This renewed emphasis on the therapeutic alliance opens doors for relational psychotherapists, and provides the opportunity to show how the therapeutic relationship works. It also is a doorway for me to promote Processwork within my professional body and to various funding bodies with the aim to broaden their scope of accepted therapeutic interventions. And it might help to quiet to my inner critic.

## How does Processwork stack up?

Research continuously points at the importance of the therapist and not the therapeutic modality. Which could bring up the question: Why use Processwork? Studying Processwork is a long journey. To become a 'Diplomate' (the final qualification, named after the European – Swiss university degree 'Diplom', which is equivalent to a Master's degree in Australia) in Processwork, students have to complete an arduous and elaborate journey, much more so than any other therapy training I have ever completed. For example, in 2000 I completed an accredited four-year psychotherapy training program. Throughout the course of the program I had to write essays and study books and articles, and needed to show that I gave ten sessions to a volunteer 'client' and write them up. To pass the program I sat *one* final exam. A student from another cohort volunteered to be a client for me on the day. I

gave him a session with two examiners in the room who assessed me as competent at the end of the session.

## Processwork Training

To satisfy the qualification criteria in Processwork I needed to sit eight one-hour-long verbal examinations on different topics (such as comparative psychology, couples and family therapy, groupwork and working with different channels of communication) before I was assessed in eight practical hands-on assessments, called competencies. The Australia New Zealand Process Oriented Psychology (ANZPOP) Subject and Assessment Guide (2013) outlines the following eight competencies focussed on eight different areas of skill:

1. Inner Work. The students show they are competent in managing their own inner states, by showing skill in tracking, and bringing awareness to and expressing their own inner experience. The aim is to be able to develop an inner 'supervisor' who could be helpful in a challenging situation with a client or group, and to promote self-development and growth.
2. The next step is to show that the student is able to facilitate a conflict with a peer. Rank awareness and power dynamics are considered, and verbal and non-verbal self-awareness in conflict situations are a requirement, to pass this assessment, as well as basic conflict resolution skills.
3. Once a student passes the two above competencies they are invited to sit the remaining six competencies. This can be done in any order. One competency is unspecified and can include working with a dream or mood or any other issue presented by the client.

4. Working with somatic processes, bodywork, a body symptom. Students are required to support the client to access and amplify the symptom, with the intention of unfolding the underlying wisdom of the symptom.
5. Relationship work. Processwork has identified three different levels of relationship work. Intra-psychic, i.e. one person presents with their own personal difficulty and that affects the whole relationship. Interpersonal, i.e. communication challenges between the couple and the mythical level of relationship, which describes the essence of the relationship. The level of relationship difficulty informs the interventions for the couples' work. Rank and power dynamics in relationships are also to be taken into consideration when working with couples.
6. Working with movement. The student has to show that they are competent in unfolding the client's process in the movement channel. This includes being aware of intended and unintended movement of the client and supporting the client to express the unintended movement until they are able to derive meaning from it.
7. Working with extreme and altered states of consciousness. This includes working with addiction or addictive tendencies, altered states and extreme states. Unfolding the state, and integrating and grounding it in the client's everyday experience. A trauma informed approach is essential when working in this area.
8. Worldwork, groupwork. The student has to demonstrate their awareness of dynamics in group processes, their own responses, awareness of roles and rank and power, recognition and intervention in potentially abusive encounters,

show ability to explore potentially difficult processes and bring awareness of cultural and racial backgrounds.

Over the years I have worked with fellow students in front of examiners and in front of groups of students so many times that I honestly can't say how often. I completed most of my competencies in front of a group of students with one or more examiners present. I had feedback in front of the group too and I did not always pass straight away, which meant I also 'failed' in front of my peers. Showing my 'underbelly' and 'failing' in front of my peers became less stressful the more I did it, even though I admit, I preferred to do an amazing job. However, I have learnt every time I 'failed', and learnt that I learn *more* when I don't shine by presenting a good piece of work.

I have spent many years studying, learning, being challenged and having to negotiate relationships, including with myself, my peers, my teachers, my assessors and my study committee. It has been an incredible and deep journey for me and I am grateful for all the intense moments, the deep love and support, the challenges and the personal growth I experienced. The training far exceeded the requirements of my professional body in terms of professional development. And it exceeds the requirements of any other training institute I know.

It has been a journey of self-discovery, of - more of less – boldly approaching and stepping into the unknown and of learning to trust myself - and nature - more. All of this in the face of my critic who constantly challenges me and feels compelled to remind me along the way how much of a mess I made at certain times and how I continue to make a mess, according to him. To him this training program is all too wishy-washy, airy-fairy, mumbo-jumbo and he loves to remind me that the paradigm has no empirical backing and that the funding bodies are not interested in my personal experiences. However, I know that this training program has taught me much about

myself and the world, has made me a better therapist and more at peace with myself. I have also learned that there are no simple answers to life and that living with ambiguity and the unknown is part of life, even though my critic does not like it.

## Fourteen Qualities of Effective Therapists

Bruce Wampold is one of many researchers investigating the qualities and actions of effective therapists. In his article in 2010 he identifies 14 qualities in therapists that guide them toward continual improvement. I believe my training in Processwork has prepared me to meet most of those qualities. In Processwork client feedback is the 'King and Queen' of the therapeutic session. Reading the non-verbal feedback as well as responding to verbal feedback, and following the client's lead are an important part of being a Processworker.

Wampold outlines the 14 qualities of 'effective' therapists and I will respond to them in terms of how training in Processwork addresses these qualities:

**1. Having a sophisticated set of interpersonal skills, like being perceptive, warm and accepting, able to show empathy and focus on the client.**

Amy Mindell describes her book "Alternative to Therapy" (2006) the Metaskills of a therapist as:

> "The feeling attitude and qualities that support and bring to life our ordinary skills. … the feeling with which we interact with clients is the most crucial part of our work. Important meta skills of Processwork include *compassion*, the sense of openness to and respect for all parts of the person; a *beginner's mind* that does not know what experiences mean but allows them to unfold with an

open and curious heart; the *fluidity* to follow the unique flow of the process; and the perceptual *precision* of a scientist" (p. 133).

Metaskills of the therapist may set the tone of the session and support the interventions through the particular way the therapist relates to the client in the moment. Depending on appropriateness of the situation, this may be compassion, empathy, care, gentle sensitivity, humour, curiosity, playfulness or many other ways to relate in a meaningful way with the client.

The training goals in Processwork are – amongst others – increased awareness of our rank and power, and our verbal and non-verbal means of communication. As mentioned earlier, focus on the client's feedback is paramount in Processwork training. We learn to observe non-verbal feedback and identify whether it is positive (energetic and indicating the direction of the intervention and interaction), negative (energetically flat and indication to take a different approach), or edge feedback. Edge feedback can either look like positive or negative feedback - the client's energy suddenly changes, he/she gets very tired (that may look like negative feedback) or giggles nervously (which could look like positive feedback). Edge feedback is often the hardest to discern for me.

Being perceptive and responsive to the client, acknowledging that *they* know best, their feedback leads the way in the therapy, is one of the fundamentals of being a Processworker. It feels almost absurd to read that showing empathy and focus on the client is a quality of an effective therapist, as this seems like a basic prerequisite for any therapist.

**2. Facilitate trust and a sense of understanding and support of the client's belief that the therapy can help them. Wampold interestingly also outlines the**

**importance of the first moments of the therapeutic interaction, as he believes the initial contact to be vital to ensure the client is met with sensitivity and acceptance, and that this is effectively communicated.**

Arnold Mindell postulates that the entire relationship is reflected in the first three minutes of an encounter, regardless if it is a therapeutic encounter or any other meeting. As a Processwork student I have learnt to pay close attention to the first minutes of meeting the client and I am doing my best to meet them with warmth and with awareness of the rank I hold in this situation. Clients are frequently nervous when they come to therapy, particularly if it is their first time in such a setting. I believe that the training and skills I have acquired from studying Processwork translates into my communication to the client that therapy can help them. I have learnt for myself that therapy has changed my life, which means I personally know that therapy helps.

**3. The ability to form a working alliance with a broad range of clients. This involves a therapeutic bond as well as agreement about the goals of therapy. The effective therapist is collaborative and purposeful.**

Processwork is the only therapeutic paradigm I know of that brings awareness to rank and power dynamics. Through the years of studying Processwork I have been exposed to marginalised groups and have been privileged to learn about and feel the challenges they face. This has opened my eyes to a number of issues including my own rank and privileges, and makes it easier for me to work with clients from a broad range of backgrounds.

In my view, the purpose of therapy as a Processworker is to increase awareness, to follow the client's secondary process, while respecting and holding the primary process. Working on this thesis has made me more aware of the potential benefits of

setting goals, mainly set by the primary process of the client. Actively working towards these goals with regular checking of the progress has been helpful, as the client can also track how they are progressing, which in turn motivates them to continue to work on what is challenging to them. This can be done in a process-oriented way, yet it brings some clear direction, and my critic likes that very much. Some parameters we can measure and track. Funding bodies like it too.

**4. Being able to explain to the client the reason for their distress as well as means of overcoming it. This is delivered in the psychosocial context of the client (e.g. ethnicity, culture) and must be compatible with the client's values. The client's acceptance of the explanation leads to purposeful collaborative work.**

Awareness of rank and power dynamics play an important role in this particular quality. This is also mainly aimed at the primary process of the client, and the need to place their distress in an understandable context. I personally highly respect this, as I have often struggled in non-verbal classes (dancing and movement in particular), when a lot of feeling was released and images surfaced that made no sense to my primary process, yet there was nobody around to support me to integrate the experiences. This left me feeling confused and bewildered. A respectful approach to the primary process and the individual needs of the client are basic learnings in Processwork.

**5. Providing a treatment plan that is consistent with the explanation provided to the client. The treatment plan involves psychologically healthy actions, in the best interest of the client.**

The development of treatment plans is a general counselling and psychotherapeutic direction. This can be done in a process-oriented way, working on unfolding a more secondary way of relating to the world, which allows for greater awareness and new ways of relating to the world and the environment. The client may also access a more sentient state which can inform a new way of relating and engaging, including healthy actions.

**6. Being influential, persuasive, and convincing. Wampold asserts that the client needs to be convinced that the treatment plan is beneficial to ensure compliance, as well as client's hopefulness and their enactment of healthy actions.**

As a Processworker I struggle with this particular quality. I would want to collaborate and follow the client's feedback rather than persuade or convince. When it comes to working on an edge I might be holding the client gently and bringing awareness to the edge. In order for me to persuade clients that the developed treatment plan is of benefit to them, would require that I am first convinced that this is of benefit. As a Processworker, I am open to learning new way of working with people and as such am prepared to consider this.

**7. Monitoring client progress, not simply by administering scales – although that may be useful if done authentically. Monitoring of progress achieved via sensitively communicating and showing genuine interest in the client's wellbeing. The effective therapist integrates progress into the treatment and is particularly attentive to evidence that their clients are deteriorating.**

Formally monitoring client progress is something I am taking more action on as a result of writing this thesis and from learning over the years. Generally, I follow the client and invite them to direct the session, and work on what they bring to the session. I do also, however, ask more direct questions in regard to their symptomatology, PTSD for example, and how they are traveling with that. I was working with a client, who, following a motorcycle accident, presented with symptoms of PTSD. His family had insisted he see someone as he was very moody at home and they did not enjoy that. The client was reluctant to attend sessions and was surprised to find that he enjoyed coming to see me and we developed a good relationship. His life changed dramatically as a result of the accident, and sadly not in a desirable way for him. He was out of work, had no income, his role and status at home changed, his relationship fell apart, his physical condition prevented him from ever going back to the kind of work he wanted to do and the family ended up selling the house. I saw him regularly and did not apply the PTSD checklist for civilians a second time after the initial screening. Towards the end of our sessions together I gave him the checklist again and found to my shock that his symptoms had not reduced. When I asked him why he had never mentioned that, he replied that he did not want to talk about it and thought if he just ignores it long enough it will go away. He said that it had been incredibly helpful for him to come to see me, to have me support him through all these major life changes and critical life events and he did not want to have to deal with the symptoms. This was a lesson to me. I was upset that I had not checked his symptoms more regularly as this would have informed me of the difficulties he had on top of his life falling apart. I applied for more sessions and – with his consent - worked more specifically on reducing his distressing symptoms.

I have learned to follow up on these things more diligently and if the client does not want to address these difficulties, that is fine too. However, I feel I need to know how things are developing and if they are worsening I need to raise it with the client.

**8. Flexibility and adaptability to client's progress or resistance to treatment. The effective therapist is aware of verbal and nonverbal cues indicating that the client is resistant to the explanation or the treatment and takes in new information and is willing to be 'wrong'. This may lead to the use of a different approach to meet the client's needs more effectively, or referral of the client to another practitioner.**

As mentioned under the first quality, client feedback is our number one guiding factor. Processwork does not use the term 'resistance' as it implies that the therapist knows better and knows what would be good and right for the client. The Processwork paradigm suggests that we might attempt an intervention three times, and if we get negative feedback we drop it and look for other signals and channels until the client responds with positive feedback. To be willing the be 'wrong' is something I have learnt so many times over the course of the training, that being 'wrong' is just part of being a person. Thomas Edison, in response to a question about his unsuccessful attempts to build a light bulb, once said: "I have not failed 10,000 times—I've successfully found 10,000 ways that will not work." This attitude is helpful when working with clients, and being able to adapt to the client's feedback is one our most important training goals.

**9. Ability to attend to difficult material and to use it therapeutically. The effective therapist notices potential avoidance of difficult material from the client and**

**facilitates a discussion thereof which may address the client's core issues. Seeing that these kinds of situations are likely to bring up strong emotion, the effective therapist needs to be comfortable with strong affect. If there is a difficulty between the therapist and the client, the effective therapist addresses this in a therapeutic way.**

As a Processworker we might notice 'difficult material' and then negotiate the edge of the client to the difficult area. The client is in charge of how close to the edge they want to get, how long to explore the edge, and if and when they want to cross it. Bringing awareness to the edge and the difficult issue, how the client manages it, and how they want to be supported around this, is the therapeutic task of a Processworker. Expression of strong emotion is something we learn to manage in ourselves through the course of the training. Being present with our peers and their intense emotion is also part of the training. 'Burn your wood' is an expression I have often heard through the course of the training. This expression was originally used in relation to public abuse and how to transform the traumatic experience of public abuse (Mindell 1995, p. 125-129). Amy Mindell describes it in her book "Alternative to Therapy" (2006):

> "… such inner work is called "burning your wood". Originally, this method referred to the issues that arise in group situations that push the facilitator's buttons. *Burning your wood* means taking your time to process your reactions to "hot" issues that touch us personally. It means allowing ourselves time to open up to and consciously get into our affects and feelings, to let go and react as strongly as we feel about those issues "(p. 320).

Opening ourselves and letting it affect us with the aim of working through it so we don't have to react to the issue in an unconscious way makes us safer as therapists, as we bring more awareness and can respond with greater awareness to the client.

**10. Ability to communicate hope and optimism with both clients who are making progress as well as with clients who present with severe and/or chronic problems. The effective therapist communicates a firm belief that together the therapist and client will work successfully, i.e. that the client can achieve the goals and the therapist can work successfully with the client. Effective therapists support the clients to solve their problems, and mobilize their existing resources, and ensures the clients attribute the success to their own actions.**

Holding hope for the client is part of the job of the therapist and included in the teaching of Processwork. The act of coming to therapy is a signal of hope in itself from the client, however Processwork also values and holds the client's hopelessness as we work with the high and low dream of the client. 'High dreams' are what we aspire to and hope for as the best possible outcome, whereas the 'low dream' is reflected in hopelessness when the high dream does not seem to come true. Holding and addressing the low dream in therapy can be a powerful tool.

**11. Awareness of the client's social context, such as race, ethnicity, spirituality, sexual orientation, age, physical health, etc., as well as the resources available to the client depending on the social context. This involves coordination of other services in order to provide best care. The effective therapist is also aware of how their own socio-economic background interacts with the client and the other way around.**

As mentioned earlier, awareness of rank and power dynamics is an important part of the training. Loving and sharing our privilege, being aware of our own low and high

rank and how that influences our interaction, and being able to track our own responses are fundamental learnings in this program.

**12. Therapist's awareness of their own psychological process and only bringing their own experiences into the session if it supports the therapeutic process. Self-awareness and ability to reflect on their own reactions to the client (i.e., counter transference) and the ability to assess if their reactions are a response to the client presentation or are a result of the therapist's issues.**

Over the years as a Processwork student I have learnt to open myself up to and consciously notice experiences I am picking up from the client, or as we say in Processwork, noticing when I am being 'dreamt up'. I sometimes feel the client's disavowed emotions or body symptoms and I bring them into the session if that is useful. It is information for me in any case. My internal responses to the client are also important and I have learnt to trust that they are meaningful.

Self-disclosure is something I use when I aim at reducing shame and stigma for the client and to ensure they know they are not alone in their experience.

**13. Awareness of the best research evidence in relation to clients, particularly in regards to the client's biological, social, and psychological bases of the difficulty they encounter.**

Processwork looks at client's symptoms in the social context and the field we are living in. Our culture with instituted hierarchies and values creates a variety of problems, including internalised oppression. By internalizing mainstream views, we measure ourselves against those standards, and frequently fall short. A very obvious example

is the body image of women in the Western world. I can honestly say that I don't know a single woman who is genuinely happy with her body, regardless of how well it functions and does what a body needs to do. Arnold Mindell (1995) writes:

> "Most chronic self-criticism stems from the internalization of mainstream views. People put themselves down if they don't meet the standards of the local government, their religion, their school, or their social class. When self-critical people do innerwork, they are apt to meet a figure who puts them down because they are not valuable in some culturally defined way: They have the wrong physical appearance, skin colour, hair, health, race, religion, age, gender, occupation, training or economic status. The outer world and its value system dominate them internally" (p 38).

Awareness of the best research evidence is not a specific training objective, however regular supervision and peer support ensure Processwork students and practitioners are well informed.

**14. Continuous skill development and seeking to continually improve with ongoing client feedback. Client feedback is most useful if it is in the context of a coherent model, so that the therapist can assess if the changes they make lead to a positive outcome. The effective therapist uses information to establish if there are general patterns regarding lack of satisfactory progress for their clients.**

As mentioned earlier, client feedback is the central point of the training and the paradigm. Processwork is a coherent model so definitely satisfies this criterion.

## Outcome measures

*“If you can’t measure it, it doesn’t exist” - Brené Brown quoting a research professor in her Ted Talk ‘TedxHuston’*

My critic is in the background, gnawing away at me and undermining my sense of effectiveness, and joins a host of critics of psychotherapy who challenge us to look at how to measure effectiveness and to potentially improve practice. This is also demanded by funding bodies and their clinical guidelines specify measurable outcomes of my services.

My critic has a party, and says things like: ‘you might think you’re a good therapist, but how do you actually know’. So, in the interest of protecting myself, in the interest of providing the best possible service, and in the interest of my clients, I will explore deliberate practice and feedback informed practice (FIT) as well as outcome measures.

As mentioned earlier, the ‘Clinical Framework for the Delivery of Health Services’ sets out a number of the guiding principles for the delivery of health services. Number one of the guiding principles is that the outcome of the treatment is to be measurable and effective.

So far, the funding bodies and the ‘Clinical Framework’ do not regulate which measures to use, other than measures of return to work or the ability of the client to work as this is a significant measure of success in the eyes of third-party payers.

Measures like the Anxiety and Depression Checklist (K10), Beck’s Depression Inventory, the Depression Anxiety Stress Scales (DASS 21) and the PTSD Checklist are not outcomes measures, but diagnostic tools and measures of characteristic attitudes and symptoms. However, some practitioners use these measures to be able

to determine if the symptomology reduces over the course of the treatment and report back to the funding bodies or GPs.

Practitioners in private practice still have freedom to measure outcomes their own way, compared to all clinical mental health services in Victoria, who must routinely submit outcome measures.

When introducing Routine Outcome Measures (ROM) for the purpose of improving quality of treatment in private practice, it is important that it is easily administered and scored at low cost. The measures have to be sensitive to changes of psychological state over a short period of time and be able to measure relevant aspects of mental health functioning. Miller & Duncan (2000) developed the Outcome Rating Scale (ORS), an ultra-brief measure, designed to assess the change in clients' experiences in four key areas: Individually (personal wellbeing); Interpersonally (family, close relationships); Socially (work, school, friendships); and Overall (general sense of wellbeing).

Clients are asked to place a mark on a ten-centimetre long scale corresponding with their experience in the last week. Marks to the left represent lower levels of functioning and marks on the right are indicating higher levels of wellbeing. The maximum score on the ORS is 40. The clinical cut-off for the ORS is 25, with 18-19 being the average outpatient mental health score. The cut off provides a reference point for assessing the client's distress as well as defining a boundary between normal and a clinical range of distress.

Over time the measures on the ORS should increase, and Miller et al (2003) have identified a 'Reliable Change Index' (RCI) of five points with regard to the ORS. The scores on the ORS allow the development of individual client trajectories and as such make it easy to identify those clients at risk of no positive or even negative outcomes.

One of the difficulties in regards to outcomes measures is if the client enjoys the sessions, appreciates the time with the practitioner, feels well when they are with their therapist and feel better for coming, yet their clinical presentation does not improve markedly. Duncan et al (2004) are very clear in relation to this question in their book "The Heroic Client", and state that "when clients do not achieve results in one format, it is not of the severity of their problems, or a lack of what it takes to get better. Rather it is due to a less than optimal fit between the helper and the client; with a better fit, clients readily achieve results. Continuing in a therapy where change is not happening may contribute to a problems chronicity, short-circuiting the natural progression from crisis to more or less problematic everyday life" (p. 208).

## Public Enemy Number One

This view appears quite simplistic and one-dimensional. Client have to 'achieve results' and improve. If they don't improve, something is wrong. Everybody has to get better, and get better fast. Even in Western medicine that expectation would have to be seen as grandiose? What about the clients who are stuck, who suffer chronic pain, clients who get ill and die, and clients who have had long standing mental health conditions? It also assumes that clients access services only when in crisis and not after years of chronic difficulty and having been medicated for decades.

It is in the interest of both client and therapist that the client improves, their quality of life increases and their suffering is reduced. But it is really true that this is a guarantee if only we have the right 'fit' between client and therapist?

Interestingly Duncan et al (2004) also describe:

> ” … change is an essentially highly idiosyncratic process; it remains one of the most mysterious and widely studied events in all of psychotherapy. … The body of empirical data we have about change takes nothing away from this mystery. It gives us nothing about the unique content of change as personally experienced. What it does do, however, is point to common themes. These themes might be best summarised as follows: (1) change does happen; and (2) it’s all about the client” (p. 209).

This seems contradictory to their earlier statement.

Marie-Louise von Franz’ (1998) describes her view on change and healing:

> "The healing experience of meaning, the encounter with the numinous, because of its evolving and creative uniqueness, cannot be grasped by statistical methods. It can only be proven by exposing oneself directly to it. Moreover, as Jung points out, even then although something might happen, it will not necessarily happen. Otherwise, the action of the divine principle would not be free; it would be bound to the laws of nature" (p. 60).

Arnold Mindell (2004) considers:

> “Sometimes the client may ask for help and yet, in another world, want friendship instead. Therefore, thinking you must simply help because that is what you think the person is requesting can be a mistake, and your helping hand can fail because the person may simply be lonely” (p. 232).

Outcome measures and returning the client to ‘function’ in everyday reality, large randomised studies, empirical evidence, all of this, while valid and important, is exclusive of other dimensions and Mindell (2004) describes this as Public Enemy Number one:

> "Public Enemy Number One (PENO) tells you that consensus reality is all there is. PENO says: Forget the other worlds! You can't measure them. You can't prove they exist. Forget dreamland, forget your deepest tendencies, there is no quantum world; it's just math! There is no emptiness, no force of silence. There is only that which can be measured, medicated, seen on an x-ray, felt as a lump, measured with an instrument, and found in a virus!"
>
> PENO says:" I am the way. The only things we can be certain of are centimetres in space, seconds of time and grams of weight. .... PENO is a downer denigrating that which cannot be formulated." (p. 241)

The world of PENO states with a level of almost absolute certainty that their way of measures is the *only* way. The world of connection, interconnectedness, entanglement and mystery is very secondary in this world.

PENO is a powerful force in the consensus reality of my work as a psychologist and Processworker. Processwork acknowledges other levels of reality and offers access to them, even if the access might be for a short time only. This can enrich experiences and allows for new ways of being and relating.

PENO drills down the relational experience in the therapeutic encounter to numbers in improvement measures. Looking for outcome measures definitely is valid as well as the endeavour to find what works in therapy. It is very helpful to find what makes a 'supershrink' and it is personally also very interesting to me. Yet it appears there are interpersonal and interwoven aspects that cannot easily be measured in the mystery of human connection, interaction, healing and change.

## Feedback Informed Therapy (FIT) and the Cycle of Excellence

Miller et al (2003) describe the 'cycle of excellence' as three interdependent steps which are working in tandem:

- determining your baseline of effectiveness
- engaging in deliberate practice, and
- getting feedback

Determination of the baseline is done via the ORS. The ORS alone however is not enough to inform the practitioner as to what area they need to improve on.

The Session Rating Scale (SRS) is equally brief as the ORS, a four-item therapeutic-alliance measure, completed by the client after the session. Like the ORS, the score is a ten-centimetre scale, reflecting the classical definition of alliance as stated by Brodin (1979).

The four categories are:

1. Relationship - the client scores between 'I did not feel heard, understood and respected' on the left to 'I felt heard, understood and respected' on the right;
2. Goals and Topics – 'we did not work on or talk about what I wanted to work on or talk about' on the left and 'we worked on and talked about what I wanted to work on and talk about' on the right side of the scale;
3. Approach and Method – on the left it states 'the therapist's approach is not a good fit for me' to the right 'the therapist's approach is a good fit for me'; and
4. Overall – 'there was something missing in the session today' to 'overall, today's session was right for me'.

Scott Miller describes in his course "Feedback Informed Clinical Work: The Basics" from the International Centre for Clinical Excellence (ICCE), how to administer the forms, how to discuss them and how to enter the data from the ORS. The difficulty for

clients to be honest when they are critical with the service provided is mentioned and acknowledged and this is one of the reasons why the cut off is so high. But the outcome measure also needs to be filled in carefully, with time spent on explaining to the client on how to fill it in. They also discuss how to respond if the scores drop, which would affect the effectiveness score of the therapist.

The cut-off for this alliance measure is 36, the highest possible measure of 40. Miller and Duncan (2004) state that the cut-off for alliance is particularly relevant, as it indicates a possible rupture in the alliance and as such alerts to the possibility of drop out or negative therapy outcome for the client.

In applying these measures and developing a cycle of excellence, it is paramount to create a 'culture of feedback', an atmosphere where the client is free to rate their experience during therapy openly without fear of retribution. Miller and Duncan state that more effective therapists are able to elicit more negative feedback from their clients and that their constructive response to the client's feedback contributes to the strength of the alliance. If a therapist genuinely wants honest feedback and is able to communicate that to the clients, they will create an environment to receive useful quality feedback from their clients.

Feedback informed therapy in this context is based on these outcome measures. Given the data from these measures, the therapist has information about their 'baseline' and from there can work on improving specific skills. Prescott et al (2017) suggest that the therapist can also consistently monitor clients' progress and ensure the therapeutic alliance is strong.

Miller et al (2007) found that a large percentage of clients (25-50%) drop out of therapy without showing significant improvement in their condition and that therapists cannot predict when the treatment is not improving the client's condition or when they are

dropping out. Furthermore, Walfish et al (2012) found that mental health professionals tend to rate themselves above average regarding their overall clinical skills and performance and they overestimate their effectiveness. Miller et al (2007) state that feedback informed practice corrects these biases and allows practitioners to increase their performance by measuring outcomes, identifying specific areas for professional development, plan for how to work on this area, and then measure the outcome of the training. Miller et al (2007) see this as a way of working with professional development in a much more focused way and being able to measure if the efforts are paying off.

## Feedback and Processwork

*"Feedback is the cornerstone of process work and determines which current to ride on the river" Amy Mindell (2006, p.137).*

Feedback in Processwork terms is the energetic response of a client to an intervention. Watching and responding to the client's feedback is our number one training. The energetic response of the client emerges as an expression of the more unknown, secondary aspect of the client and opens doors for new experiences. Diamond & Spark (2004) state: "Feedback is like an excitement gauge. A facilitator excites the signals of the dreaming process by talking directly to them. The dreaming process either responds positively or negatively" (p. 73).

Positive feedback is expressed by an energetic, excited response to the therapist's suggestion. Negative feedback can be noted when the client's energy drops - the client might smile politely and agree to an intervention, but their energetic response is slow and downbeat, indicating that the direction suggested by the therapist is not right, at least at the moment.

Another form of feedback is edge feedback. When the client is at an edge to express a more unknown part of themselves, the energetic response is a mix of dynamic positive and negative signals, for example excitement at the same time as hesitation and fear. This indicates that the edge is important and well worth exploring.

Energetic feedback responses are often noted in double signals, which are unintended responses and mostly out of awareness of the person. For example, the client may tell a sad story but smiles on occasion while sharing some details. This kind of response or feedback, which is further away from our awareness, can potentially connect us to a part of our process we were unaware of, and once unfolded and explored can enrich our everyday experience. This form of energetic feedback is largely non-verbal and deeply meaningful. It also determines the interventions and the way to progress in the session.

The agreed on and expressed goals of the sessions and the more 'primary' feedback are, however, equally as important, because all levels of reality are meaningful, and we learn to attend to and value both parts of the client. Processwork respects the whole person, the more known parts as well as parts we are less aware of and less familiar or comfortable with.

And as Processworkers we do more than actively looking for feedback, verbal or nonverbal, intended or unintended. We are also interested in giving, receiving and transforming the feedback and closing the feedback loop. This pertains to the feedback we give to clients and we observe how the feedback is received and processed, integrated or rejected. Processwork is interested in the transformational power of feedback. If the client can attach meaning, purpose, or associations to the feedback, integrate it in a relevant way in life, they can increase their learning and transform their concepts of struggle or aspects of their lives. An example is grief

counselling, where we assist the client, who is challenged by loss, to reconstruct their personal world of meaning.

Handing a client a feedback form (SRS), as suggested by Miller and Duncan (2004), is one method of eliciting feedback. It is verbal feedback, largely based on consensus reality measures, and aligned with the primary process of the client. Change in the client's life is measured against the declared and identified consensus reality goals, which are established in cooperation with the client.

From a Processwork lens we could look at this question and ask 'who in the client fills in the form?'. What part of the client is answering the question, what part felt heard and understood etc.? And is the expectation expressed by the therapist, that the client's score shall improve, potentially pressuring the client? Will the client feel under performance pressure which might potentially be abusive? And how would the measures change, if at all, if the client was to fill them in a day or a week later?

One of the skills described in the FIT paradigms is that practitioner is able to skilfully elicit feedback about the experience of the client in the session. The aim for the therapist is to get as much detailed information as possible about what the client was missing in the session or what they would have preferred. The therapist shall create an environment where clients are free to give honest feedback and feel safe from repercussions. As a Processworker we are constantly looking for feedback, verbal and non-verbal, intended and unintended, and responding accordingly. As such we are well prepared to engage in active gathering of feedback.

# SECTION 3: The Therapeutic Field in Australia

It makes good sense to me that funding bodies want to ensure that the service they are paying for is up to standards, provides a positive outcome, and is safe for their clients. Self-funded clients want to know that they receive quality services and they are working with a skilled and caring professional who knows how to support them through difficult times and facilitate positive change. As a service provider, I want to be sure that the work I do is useful and supports positive change for the clients.

I also agree that vulnerable people seeking psychotherapeutic support need protection from potential charlatans or snake oil merchants who do more harm than good and who are not accountable to a governing body.

## Using World Work to Explore the Field

The field of mental health care is populated by a number of bodies and roles, all with their own position on service delivery, interests, and beliefs. In this section I use the lens of the Processwork World Work paradigm to discuss the dynamics and pressures in the mental health field and how some of these roles help to arm my critic.

Processwork is an awareness paradigm and can be applied to work with small and large groups, organisations and communities. 'Worldwork' is a process-oriented approach to group-work with Deep Democracy as the fundamental underlying principle of any conflict work.

Arnold Mindell (2002) describes Deep Democracy as:

> "Democracy insists only that every person be represented. On the other hand, when we extend democracy with the idea of "deep democracy" to organise our interactions, networks and the well-being of our communities and nations, each

> of us – not only the leaders or facilitators – deal with outer facts and problems, and also the subtlest feelings and dreams of everyone concerned. …For Organisations, communities and nations to succeed today and survive tomorrow, they must be deeply democratic – that is, everyone and every feeling must be represented." (preface vii).

Mindell (2002) includes in his concept of deep democracy the inner experience of an individual as well as the social encounter:

> "I have never even met one person who is able to sustain an egalitarian, democratic form of consciousness towards self or others for more than moments. Without some form of awareness training, within the privacy of our inner autonomy, most of us behave like tyrants. When it comes to recognising different aspects of ourselves, we become dictators who simply refuse to do so. If we are strong, we ignore our shyness. If we are harmonious, we repress and/or deny our anger. … This "dictatorial" viewpoint makes sure that we do not listen to the various parts of ourselves, our feelings, longings, desires, fears, and powers. … To make democracy an inner experience, we need to engage in some form of innerwork or inner dialogue to create a deeper democracy" (p. 9,10).

Deep Democracy also includes three levels of reality. Mindell speaks of Consensus Reality, Dreamland, and the Essence/Sentient Level of experience.

Consensus Reality is what we understand as everyday reality, things that can be measured using facts and figures. The things we mostly agree upon and with which we identify, such as gender, age and education.

Dreamland refers to experiences that are subjective - fantasies, feelings, ways in which we experience things. These things can be talked about but can't be proven.

The Essence Level pertains to our deepest experiences. This level relates to what others call 'soul', 'flow' or the 'the Tao that can't be spoken'. On this level are invisible powers and peak experiences, and meditative states. Mindell (2019) states: "Quantum waves are a bit like the essence level. The waves are both empirical and theoretical. What those quantum waves are, no-one knows for certain. … those quantum waves, when looked at transform from wave-like forms into particles. Quantum waves in physics are like the essence level in Processwork" (p. 255).

Rank and power dynamics are explicitly considered in the Processwork paradigm. Diamond and Sparks (2004) outline: "Mindell identified multiple dimensions of power and rank as having an important role in group dynamics. These included psychological and spiritual rank (inner strength such as self-esteem, ease in conflict and spiritual beliefs) as well as socio-cultural status (based on a person's social and material circumstances)" (p. 12).

Mindell (1995) describes the importance of becoming aware of our own power, rank and privilege; unconsciousness of rank irritates others and escalates conflict. "Rank doesn't show in the mirror. It results in a subtle state of mind. …Rank shows up in countless ways, in feeling confident, for example. The subconscious influence of rank determines how we feel about ourselves and others" (p. 52).

With growing awareness of rank, we are invited to embrace and celebrate our rank and use it to support people in lower rank positions and/or marginalised groups.

Mindell (1995) also mentions roles in the field that are talked about and present in the field, but not represented in groups (so-called *ghosts)*. The ghosts are roles that are mentioned and implied but not represented by governing bodies, regulators or individuals.

The mental health care system is an important component of our community and informs my work as a psychologist and psychotherapist – and the complex interplay between roles, interests and regulations provide ammunition for my critic.

In the following section, I will introduce a number of roles in the field and explore how they are enacted by the influential bodies affecting my work practice.

## Ghosts in the Field

### The Scammer

The Cambridge dictionary defines a scammer as: “Someone who makes money using illegal methods, especially by tricking people”. I would like to widen the definition for the purpose of this thesis to a person or organisation who deliberately and dishonestly exploits and takes advantage of the system for their own financial or other benefit or interest.

Scammers are out to take advantage of something or someone. Their own interest is valued highly and they may think they are (secretly?) entitled to what they scam, or they believe they are not causing harm or do not care.

Scammers are considered amoral and unlawful; however, our neo-capitalist system defends exploitation of nature and natural resources, including other animals as well as other humans, and most extensively occurring in developing countries.

The wealth in the Western world is based on exploitation of other living beings. Living in Australia as a white person, as I do, is based on colonialism, and the occupation and theft of land belonging to the Indigenous peoples of this continent.

It appears that some scamming is socially accepted and even valued, and it allows companies or individuals to make a profit.

**The Abuser**

The abuser is a relative of the scammer, however the abuser does not necessarily seek financial advantage. The abuser instead frequently abuses power, and engages in power over others that leads to abuse.

The abuser is a villain, may or may not enjoy exerting power over others, and is likely to defend their actions with justifications, similar to the scammer.

The abuser may have a number of sub-classes, such as the one who is out to terrorise and destroy and may be 'evil' personified. Or the abuser may be a henchman, doing the dirty work for others, or a fanatic who is driven by their ideology.

For the purpose of this thesis I will mainly focus on the abuser who is interested in holding on to their position and gain without consideration of the larger field, or the effects of their actions on others.

**The Protector**

The protector role is archetypal. Protectors are motivated to protect others and what is important to them. Superman could be seen as a symbol of the protector; his primary concern was the welfare of the Earth and all its people.

Interestingly, protectors protect what is important to them, yet what is important is a whole other conversation. While Superman defines it broadly, when it comes to the mental health sector, different parts of the sector aim to protect different parts and bodies. Are we interested in protecting the wellbeing of individuals, the community, profits, organisations, workplaces, the economy, individuals' income, or our own status? Or a combination of the above, and for how many roles does that apply?

Some of the protector roles seem obvious and will be discussed further, for example the regulator and the helper. The role of the protector features in a variety of bodies

and they influence each other; due to the complexity of the role, the protector features frequently in the therapeutic field.

**The Enforcer**

The role of the enforcer ensures compliance with rules, law, obligation, particular interest or even morals. The enforcer may have the power of the state, groups, organisations, and even gangs behind them. The rules are generally fairly clear to all involved, even if based on criminal activity.

**The Helper/Healer**

“To heal” according to the Miriam Webster Dictionary means

- to make free of injury or disease: to make sound or whole
- to make well again: to restore to health
- to cause (an undesirable condition) to be overcome: Mend
- to restore to original purity or integrity.

The healer archetype presents with a passion to serve others to repair their body, mind, and spirit. The Helper/Healer role is complex, and is generally fuelled by good intention.

Healers can assist someone through crisis, and bring peace or lasting cure. They might be able to bring back balance and positive change for another person or group. Important here is that the helper or healer is changing the condition for others – which is a profound and humbling power to have. With that, the helper holds power and authority – high rank. This power can seduce the healer to think they know best and turn into a patriarchal figure who stops listening to the client and may deliver diagnoses

and assessments that are disempowering and damaging – and suddenly the healer has turned into an abuser.

The wounded healer Chiron is an archetype of Greek mythology who opened his heart to other beings suffering the same fate as he did - and that implies understanding of agony. Most helpers/healers I have come across fit this archetype to some degree. Chiron teaches us that the wounded healer does not need to be healed to be effective.

As mentioned, being able to help or heal brings a particular power with it. It may validate us and give a sense of purpose. The high rank of it can be seductive and, as Mindell (1995) says, “rank is a drug that makes us feel good. We forget we are on it.” (p.53). There is a risk that helper/healers need to heal or help in order to source their sense of self-worth and self-esteem – which would be at least in part the role of the scammer.

The primary role of medical practitioners and allied health professionals is to support people through tough times, and encourage healing and positive change. This role brings with it all the complexities mentioned above.

Another problematic part of this role of the healer/helper is the ‘‘Pseudo-shrink” as described by Miller et al (2008) in their article “Supershrinks: What is the secret of their success?” Miller et al quote D.F. Ricks (1974), who coined the term ‘supershrinks’. Ricks studied the long-term outcomes of ‘highly disturbed’ adolescents and found that some practitioners provided far better long-term outcomes for their clients than others, the ‘pseudo-shrinks’, as Ricks called them. Alarmingly, the pseudo-shrinks did not know that their services were ineffective - they thought they were as effective as other therapists.

**The Client**

The client presents with a problem or a wound, and asks for help or healing. This is in itself a low rank position and as a result is seen to need protection - so the regulator gets into action.

The client is also a customer who pays for a service which gives them the power to choose the service provider and move elsewhere if they are dissatisfied with the service they received - if they feel empowered enough to take that step.

It may add a different dimension to the field if the client does not pay for the service provided. The injured worker or road traffic participant is client to the insurer as well as the health care professional, and the insurance company is also the client to the health care professional.

**The Victim**

Caroline Myss (2002) identified the victim archetype as one of the four survivor archetypes. The survivor focusses on matters of survival, but also on evolution. The struggle of the survivor archetypes can teach us about a deeper connection with ourselves and nature.

The victim is exposed to powers it can't control, and that can destroy and change the world of the victim for the worse. The victim experiences powerlessness, helplessness and terror, and suffers hopelessly from the experience. The victim is vulnerable and undefended.

Feeling powerless is the state of the victim, and is a low rank position. This victimisation and suffering invites compassion from the helper and protector.

Compassion means to love and support, to sit beside the victim and to bear witness to the pain.

Victims who survive the destructive powers may develop a spiritual connection and a greater detachment from their everyday experience, and may find refuge in nature. This may connect victims with high spiritual rank while experiencing the low rank of the victim.

## Regulating and Funding Bodies

*"While equating health with the norm can be helpful in making diagnoses and maintaining harmony, it can also turn psychology into the practice of norm enforcement, pathologizing ourselves and others to serve these ends. In short, psychology can make us sick" Bedrick (2013, p 14).*

In this section I am addressing the different bodies in the field of mental health care in Australia, and the way in which the ghost roles are enacted by them.

### Australian Health Practitioner Regulation Agency (AHPRA)

Regulating professions and registering practitioners ensures practitioners are aligned with professional standards and policies. It is also an attempt to ensure adherence to codes of conduct. The Psychology Board within AHPRA regulates and enforces training requirements for practitioners, attempts to ensure quality professional standards, and requires professional indemnity insurance. All of this intends to provide protection of the public. It also allows clients with grievances an avenue for complaint, and a body to monitor practitioners' conduct.

Regulatory bodies such as AHPRA implement rules with the intention to protect and safeguard the public, and while this makes good sense, providing this structure also comes at a cost. They provide the idea of safety, yet don't encourage awareness or greater responsibility. Human touch, for example, is not allowed if you are a psychologist in Australia. I understand this has been introduced to keep clients safe from boundary violations, yet it limits our common humanity and does not value, for example, the importance of a comforting hand on someone's back. Instead of

ensuring adequate training and feedback awareness of practitioners, a blanket rule is implemented, ruling out any kind of physical contact.

The main and declared role of the regulator is the protector of the public and the client. It also empowers the client to complain if the services they received did not comply with regulations. If a complaint is accepted, the mental health care provider has to face consequences, and may even get struck off the practitioners' register. In this case the role of the enforcer is activated to ensure the practitioner abides by the given rules.

Yet, even though not explicit, the regulator also protects psychologists' interests, as other professions are excluded from access to funding sources and Medicare rebates, for example psychotherapists or counsellors. It also serves to protect the reputation of the profession in the community through narratives of rigour, science and ethical frameworks.

Even if the assumption can be made that most health care professionals have the best intentions, not all of them enable positive change for the client. While regulations can ensure that funding bodies only engage persons with appropriate formal qualifications, they might still fund pseudo-shrinks. The dilemma continues, as the desire to ensure the clients get quality services through qualified and registered practitioners or application of particular approaches does not seem to solve the problem.

**Medicare**

Many of my clients are on a Mental Health Care Plan. This is granted by their General Practitioner and allows them to access funds from Medicare, Australia's publicly funded health care insurance scheme, to subsidise the cost of therapy sessions.

Under the Better Access to Mental Health program, clients are entitled to up to ten subsidised sessions per calendar year.

Medicare, and other funding bodies (as mentioned below), have stipulated that psychologists are to work under the 'Clinical Framework for the Delivery of Health Services'. This outlines a set of guiding principles for the delivery of health services as stated in the Worksafe Victoria government document 'Clinical Frame of Delivery of Health Services' (2012).

The principles are:

- Measurement and demonstration of the effectiveness of treatment
- Adoption of a biopsychosocial approach
- Empowering the injured person to manage their injury
- Implementing goals focused on optimising function, participation and return to work
- Basing treatment on best available research evidence

Medicare has identified and approved a range of acceptable 'Focussed Psychological Strategies' (FPS) for use by allied mental health professionals (Department of Health, 2011). The specific therapy approaches accepted under the Medicare Benefit Schedule (MBS) are:

- Psycho- education (including motivational interviewing)
- Cognitive-behavioural Therapy
- Relaxation Strategies
- Skills training
- Interpersonal Therapy (especially for depression)
- Narrative Therapy (for Aboriginal and Torres Strait Islander people)

These Focussed Psychological Strategies (FPS) are validated by large, randomised empirical studies and are all short-term focussed.

Medicare's primary role is that of the protector and regulator, by protecting health via offering subsidised or full payment for medical treatment. It is an egalitarian system, offering medical assistance to everybody in the country, regardless of financial privilege.

Medicare funds are limited, so there is a need to ensure Medicare is a viable service to protect the coffers. As a consequence, Medicare only offers brief psychotherapeutic interventions, with a maximum of ten sessions per calendar year regardless of the mental health condition or decades of untreated trauma. Obviously, that is far short of adequate for people with longstanding difficulties or significant trauma. The system looks like it is offering a service, yet it is grossly inadequate and in view of this disparity the role of the scammer comes to mind.

By limiting the sessions to a maximum of ten per year, there is an impression that mental health challenges can be treated with few sessions and anybody who attends long term therapy has either serious problems or is otherwise a 'less functioning' person in our society. These funding limits create an expectation and pressure on clients and therapists that is unreasonable and unhelpful – and has the potential to be abusive.

Interesting to me is that all funding bodies have adopted the 'Gold Standard' of the large empirically validated therapy approaches, despite the vast evidence indicating that the specific approaches do not lead to better outcomes for clients.

Scientific evidence is quoted and practitioners are required to use 'evidence based' approaches, while any scientific evidence is ignored if contrary to the popular belief that short term and manualised therapy approaches are superior to others. It appears

that the funding bodies are not truly interested in the quality of service provision. Which makes me wonder, why do the funding bodies continue to insist on this form of service? Why are they cherry picking empirical research and ignoring outcomes that don't support their requirements? This could fall into the category of the scammer.

It may be that the neat, clean, simple, and empirically validated approaches are enough support for the funding bodies, as these also support short term intervention and that is in their interest to save money. It is good to have an answer, a guideline that can be supported, some research to fall back on, and to then be able to close the books to all the unanswered questions brought by the messiness of life and human behaviour.

Elizabeth Day (2015) states:

> "Governments are more swayed to fund practices that are subject to predictability and repeatability, with quantifiable outcomes. This is misleadingly referred to as evidence-based practice, as though practices that do not readily submit to measurability are not evidence-based and implicitly lack effectiveness. As a result, they influence an over reliance on the outcomes of positivist empirical forms of research, at the cost of knowledge production from other methods. (p.4).

It is interesting that despite the introduction of the "Better Access to Mental Health" program in 1997 and the associated cost, there appears to be little or no evidence that the mental health outcomes for the Australian public have improved (Jones, 2018).

The government does not seem to spend any energy to reform the system despite the evidence of disappointing outcomes of the scheme. Unless the public demands change, politicians are unlikely to change existing schemes. Victoria is the only state

in Australia that has acknowledged the mental health system is failing its people, and has called for a Royal Commission. The final results will be delivered by October 2020. The other states may claim that they are doing 'something', yet do not seem to care much about the effectiveness of the Medicare system.

Even the Medicare mental health contribution, while it primarily appears to be protective, only pretends to care while it is in fact in parts neglectful, and thus abusive.

**The Transport Accident Commission (TAC)**

The TAC is funded through compulsory payments by Victorian motorists through the annual registration of their motor vehicles in Victoria. The TAC is the statutory insurer of third-party personal liability for road traffic accidents, with the purpose to fund treatment and support for people injured or killed in traffic accidents. TAC offers a variety of services for the injured party, including medical expenses as well as income support for those who cannot return to work as a result of an injury. TAC also funds psychotherapeutic support for the injured party and family members if required. The TAC is government owned and has adopted the same clinical framework as Medicare.

The TAC is clearly taking the protector role, as it also works on road safety to reduce the number of injuries on the road. Preventing death, trauma, and injury on the roads seems to be a straightforward positive mission, and the TAC runs emotional and educational campaigns to improve road safety.

The TAC is also in the helper role, as it offers financial assistance on many levels to injured road users. Medical costs as well as loss of income are covered (up to 80%) and the recovery of the injured person is a high priority.

A more secondary motivation could be to save money, as death and injury are associated with enormous financial cost to the governments and community. This does not only include the immediate cost of emergency and health services, but also the estimated future years' loss of taxation revenue. It also may result in the need for additional income support and health services due to death and disability caused by road accidents. It is clearly in the financial interest of the government to reduce road trauma and establish a compulsory insurance scheme to alleviate some of the cost. The TAC is not just protecting individuals, but also the coffers of the government. Keeping the roads and thus the workforce safe is not just a philanthropic endeavour, it also has clear cash value.

When it comes to mental health services, the TAC also acts as a regulator and oversees the services provided to the injured person. Health care professionals are accountable to the TAC under the specified funding guidelines.

**The WorkSafe System in Victoria**

WorkSafe oversees Victoria's workers' compensation system for workers who have been injured in the course of their work. The system is funded through a premium paid by Victorian employers, and is designed to improve safety for workers as well as support and compensate workers injured while at work. It is a compulsory insurance scheme; each state has their own jurisdiction and is responsible for regulating and enforcing health and safety laws.

WorkSafe, like Medicare and the TAC, fulfils a number of roles, yet a conflict of interest makes for an even more complex scenario concerning the role of this body.

WorkSafe identifies with the protector role as well as the role of policing workplaces and employers to enforce the implementation of safe work practices. As with the TAC, WorkSafe also aims to reduce cost to the government by maximising workers' safety. Workers disabled or killed at work possibly mean years of education and training are lost, and will leave future taxation revenue reduced. This means WorkSafe also protects the government's financial interests.

Whilst I strongly support the need to protect workers and compensate them should they get injured at work, the system has a number of inherent difficulties.

1. Employers don't like it when staff make Workcover claims, as every claim increases their insurance premiums. If you made a claim as an employee and you are later applying for a job, you can be asked if you ever made a claim to WorkSafe. If the claim related to psychological injury or bullying, the prospect of getting employment is reduced. This won't be openly admitted as it is unlawful to discriminate, but through the recruitment stages a person with a WorkSafe claim history is likely to be excluded.
2. The insurance system is problematic as it has a conflict of interest. WorkSafe Victoria outsources the management of compensation claims to five claims agents: Allianz, CGU, EML, Gallagher Bassett and Xchanging. These organisations are all private companies and have a primary aim of maximising profits for their shareholders. At the same time these companies are in charge of providing services to injured staff, are entrusted with ensuring appropriate (sometimes very costly) medical treatment and compensation to injured workers, and encouraging appropriate return to work arrangements.

In my years of practice, I have repeatedly witnessed workers suffering psychological injury as a result of this system. The clients feel they are not believed and often this

feeling is validated by the fact that the insurer sends out private investigators and puts the worker under surveillance – the insurer accuses the injured worker of being a scammer. Clients have to frequently and repeatedly attend appointments with Independent Medical Examiners (IME) as the assessment of their doctor is not accepted as sufficient by insurers – which on some levels also placed the GP in the role of the scammer, as their assessment is not deemed trustworthy. The IME is paid by the insurer to assess the needs of the patient and validity of the claim. The IME determines whether or not the client was in fact injured through the workplace and how long they need to be off work. The IME outlines the treatment needs of the person and predicts outcomes. I often wonder how they have the confidence to make such far reaching assessments based on a one-hour interview with a person. Also, they are called 'independent' medical examiners, but as pointed out by a client, they are paid and employed by the insurer, which could place some doubt on their impartiality and raise the possibility of a conflict of interest.

The level of suspicion from insurers is a significant source of difficulty and stress for particular people. The inherent accusation that the claim is bogus or inflated is hurtful and offensive to injured workers - they may identify as very moral and honest people and being accused of scamming a system is devastating. A lot of my clients feel they are treated like criminals by the insurer and that in itself causes enormous stress and adds to their psychological injury. In many cases the injured worker continues to get injured in the process by the abusive way insurance companies go to all lengths in their efforts to reduce cost and maximise profits. They often deny—or delay in approving—expensive medical treatments such as surgery, and the injured worker has to fight for treatment.

Paradoxically this has the opposite effect, as the level of mutual distrust leads to the involvement of lawyers, which in turn makes the whole process acrimonious and drives up the cost. 'No win - no fee' lawyers like Maurice Blackburn, Slater & Gordon and Shine Lawyers are representing the workers' rights. These law firms present as the 'knight in shining armour', a strong representative of the protector and helper, defending the rights of the little person. They often achieve positive outcomes for the injured worker - and make a good profit in the process themselves.

A recent report in December 2019 by the Victorian Ombudsman Debra Glass slammed the Workcover system in Victoria, stating the system is failing long term injured workers. Following an 18-month investigation the ombudsman released a scathing report, stating that she has been investigating the same issue twice as no appropriate action was taken after her first report in 2016. Glass acknowledges the emotional toll on workers and found that some decisions of WorkCover agents were immoral and unethical "Agents are still unreasonably terminating complex claims: cherry picking evidence, doctor shopping, relying on Independent Medical Examiners (IMEs) over treating doctors even when evidence is unclear, contradictory or inconclusive – or ignoring it if it didn't support termination" (2019). She stated that the balance between financial sustainability and fairness has tilted too far away from supporting injured workers, and concluded: "The system is failing to deliver just outcomes to too many people. WorkSafe agents continue to make unreasonable decisions, the dispute process can be time consuming, stressful and costly, and WorkSafe is too often unwilling or unable to deal with it" (Glass, 2019).

Many different roles are presented in this body. The primary brief by WorkSafe to the insurer is to provide a service to the injured worker – and this is as such a protector role. However, an equal primary brief is to accumulate a profit from the payments

made to the insurer to satisfy the shareholders. This constitutes a direct conflict of interest and brings out a vast array of roles.

The insurance industry also presents as the enforcer with surveillance and private detectives, as it is vigorously defending against any attempts of fraud. Fraud is an illegal activity; the fear of scammers is apparently not unfounded. According to the Insurance Council of Australia, up to ten percent of insurance claims are fabricated or inflated. Some insurance policies (e.g. travel insurance) have an even higher claim rate believed to be fraudulent (Baldock, 1997). This role goes hand in hand with the role of the protector of profits, although in general the cost of fraud is calculated into the insurance premiums and as such paid by the insurance policy holder.

At times, in its defence against being scammed and the interests of the shareholders, the insurance sector steps into the role of the abuser. Neglect of care for the injured person, active and wilful withholding of needed care, and relentless distrust, in the interest of profit, harm the very people they were entrusted to provide care for.

*Workcover Clinical Panel*

WorkSafe defines the clinical panel on their website as: “The Clinical Panel undertake clinical reviews and provide clinical and rehabilitation support and advice to WorkSafe's claims staff, agents and healthcare providers” and “Panel members provide advice to WorkSafe and Agents on individual claim level and contribute to the broader development and implementation of WorkSafe's policies and initiatives to improve health service provision (WorkSafe Victoria, 2019). They support health providers in “applying the principles of the Clinical Framework for the Delivery of Health Services when treating injured workers and review outlier provider performance to manage health risks and quality safeguards” (WorkSafe Victoria, 2019).

Whenever I work with clients funded by WorkSafe I am called to attend clinical review meetings. They are generally conducted over the phone by a fellow psychologist, most of whom have a PhD which leaves me formally outranked. Also, even though the WorkSafe definition states they are there to provide support and advice, they only contact me to ensure my client's mental health is improving and they can reduce the number of sessions they are funding.

The clinical panels expect that I adhere to the treatment modalities prescribed in the given framework and have outlined that the treatment goals should be SMART.

- Specific
- Measurable
- Achievable
- Relevant
- Timed

I recently received an email from a senior case manager of one of the insurance companies in relation to a client under WorkSafe. I raise this here as I find the language telling. The case manager writes: "It would also be beneficial if you could provide a short report detailing XYZ's current treatment plan, making note of current barriers, goals and estimated timeframes for an increase in capacity." They are interested in his "increase in capacity", I am more interested in his wellbeing and recovery.

The role of the protector of profit can here be identified again, in conflict with the helper/healer role. Another client whose sessions had recently been 'reviewed' by the clinical panel received a letter outlining that the treatment "must show improvement in your condition" as the first point. The system does not allow for clients not to get

better and applies pressure to improve, as though that was not also in the client's primary interest.

Again, the primary, expressed role of the clinical panel is to be of support and present in an advisory role – the protector of the client and the supporter of the clinician. More secondary and driving, is the role of the enforcer and protector of profit. The possibility of the role of the abuser is also present, as pressuring clients and clinicians to show positive results can be abusive.

**Money**

*"When money speaks the truth keeps silent" - Russian Proverb*

Money is defined by the Miriam Webster Dictionary online as "something generally accepted as a medium of exchange, a measure of value, or a means of payment". Money represents energy, power, freedom, and rank.

While most other means of trade like food will spoil over time as they age and lose value, money is one of the only means of trading that does not devalue over time. In fact, people with money expect that it grows more money for them, for example in interest or dividends or rental payments. Having sufficient money in a western society means better health outcomes, safer homes, better access to education and as such enhances the potential to make more money. Having access to money can influence politics and reinforce the interests of the persons with money. Money is a powerful tool to obtain choices and increase influence.

Interestingly money seems to be something that individuals and groups can never get enough of, regardless of how much they have. This was also illustrated by the archetypal Disney character Scrooge McDuck, as he was sitting on a large mountain of coins, bathing in it and wanting more and more.

Money brings forward a complex interplay of interests, as all parties presented within the mental health system are involved and affected. We all have a financial interest, from the funding body to the doctor and therapist, and from the independent medical examiner to the client.

Kouchaki et al (2013) studied the likelihood of unethical outcomes after activating the construct of money through priming techniques. They found that research participants primed with money were more likely to present with unethical intentions, and that they were more likely to adopt a business decision frame that led to greater likelihood to unethical behaviour. It appears that the mere exposure to money can trigger unethical intentions and behaviour. Additionally, money may be a surreptitiously corrupting factor, as it influenced decisions after research participants' subtle exposure to money. This study suggests that the scammer is always in the background and easily activated, and the abuser might not be too far away either.

The protector of the coffers is also present and the regulator is involved. Money brings out all the ghosts and may affect individuals more than they like to acknowledge.

*Earning an Income*

Returning to work and earning an income is often very important for clients who were injured. For many people, being able to work means being able to participate in life and contribute to society, and this is closely linked to self-worth and self-esteem. I have seen clients who have been unemployed or unable to work following an accident and this left them depressed. They expressed a sense of worthlessness and reported lack of purpose. Not being able to contribute to the family income left my clients feeling "useless" and it also – at times - affected their status within the family or relationship.

Having and keeping a job appears to be a key part of our identities, and the way we view our individual role in society.

While I do not agree that return to work should be the only and main outcome measure, I acknowledge that it is often a very important goal for the client. Being able to generate an income through work, and not depending on payments of WorkSafe or the TAC, has been very important to many of my clients. Additionally, the time limit imposed by the funding bodies and insurers also means people are under a certain pressure to get 'better'. However, if it is not the client's process to return to work as quickly as possible, and if the therapist also applies pressure on them to 'optimise function' in order to be seen to be an effective therapist, the situation can easily become abusive.

The Western medical system tends to objectify people (Timmermans & Almeling 2009), and makes it the therapists' task to both improve the function of their clients and for them to return to work. This in itself reinforces the often-held belief that we are only valued as a person if we contribute to society through paid employment. In 2014, in his federal budget speech, the then Australian Federal Treasurer Joe Hockey, divided Australia into a nation of 'lifters' and 'leaners', reflecting his view of the value of people who do not financially contribute and pay tax in this country.

Having to earn an income and 'contributing' financially to society can be abusive, as people who are unable to contribute are regarded as 'less than'.

**Psychiatry and Psychiatrists**

*"He Who Marches Out Of Step Hears Another Drum" - Ken Kesey, One Flew Over the Cuckoo's Nest*

When I was a student in Germany, a group of us went to a psychiatric facility near the university. It was an old building, set on a large and beautiful property. I remember seeing a lot of very unwell patients and it reminded me of the movies, where people were cooped up, drugged, and wandering about aimlessly. Some patients keenly approached me and talked to me, looking for someone who will listen to them. One young man attached himself to me, followed me around, and wanted to go out with me. A young woman told me, a total stranger only briefly visiting this psychiatric hospital, that she had been sexually abused by her uncle. I was shocked and I relayed what she had told me to the psychiatrist. He in turn advised me that the patient was psychotic and making things up, that she cannot be believed and that I should ignore her.

This psychiatrist spoke to us, a group of mainly young, female students, and told us that we are not the suitable clinicians to treat people with serious mental health concerns. Psychologist do the 'soft' stuff, the 'neurosis', he said. I was shocked by the uncaring way he was treating his patients and experienced him as condescending and arrogant. I was also very critical of him and his drug treatment approach. I was horrified by his unwillingness to listen to his patients and his readiness to label and pathologise the patients' accounts.

Barry Duncan describes in the preface of the book "The Heroic Client" (2004) how he began his mental health career in a state hospital. It sounds very similar to the experience I had in the facility in Germany. He states:

> "I experienced firsthand the facial grimaces and tongue wagging that characterize the neurological damage caused by antipsychotics and sadly realized that these young adults would be forever branded as grotesquely different, as 'mental patients'. I witnessed the dehumanization of people reduced to drooling, shuffling zombies, spoken to like children and treated like cattle. I barely kept my head above water as hopelessness flooded the halls of the hospital, drowning staff and clients alike in an ocean of lost causes" (preface xvii).

I continue to strongly disagree that the 'treatment' provided to the patients in this clinic in Germany in the 1980's cured the patients or was in any way adequate for them. They were drugged and subjected to electroshock treatment and contained in this old building, where they had to share bedrooms. The treatment they received did not enable them to participate in life. Long term hospitalisation was still the norm back then, where drugs were administered in a top down approach. Drug treatment for mental health conditions continues to treat the symptoms only. Drug treatment often sedates the clients, and limits and shortens their lives without treating the underlying condition, as there still is no appropriate drug treatment for mental illness.

Today, I agree with the psychiatrist in the German clinic in so far as an individual psychologist in private practice, with limited resources and ten Medicare funded sessions per calendar year, would not be sufficiently equipped to work with someone in an acute extreme state or with chronic and severe mental health concerns. It takes a committed team of (mental) health practitioners, to be able to support and keep the person in a critical condition safe.

The attitude of this psychiatrist to treatment of people with serious mental health conditions and his arrogance towards psychologists, who are assisting people with the

'talking cure', still sits with me today. Over the years in my practice as a psychologist, I have met psychiatrists who are warm, kind, and engaged. Their approach to clients is caring, they are interested in a team approach and they value input from psychologists. Yet, the rank difference remains and I also receive reports from psychiatrists, mainly those who are employed by insurance companies to assess my clients, that are condescending towards psychological treatment in general and me in particular. They may write things like "the client will need lifelong psychiatric intervention; however psychological input can be seized over time".

Psychiatrists, in their standing as medical practitioners, are not as limited in their ability to support clients as psychologists are. They are not just 'allied health practitioners', they are medical specialists and as such have much higher rank and access to Medicare funded sessions without limits. This leaves me outranked by psychiatrists on many levels; their assessment and 'verdict' has powerful impact.

Very few of my clients have ongoing psychiatric involvement. However, my relationship with treating rather than assessing psychiatrists is mostly positive. Sometimes I despair because of the trigger-happy approach to prescription of medication and anti-psychotic medication in particular. Clients with difficulty sleeping are frequently prescribed – off label - Seroquel (an atypical antipsychotic drug) with all the predictable side effects. It also seems to be the 'go-to' drug for clients with symptoms of Post-Traumatic Stress Disorder.

Psychiatrists, like psychologists, are primarily identified in the helper role. However, when reading the description of Barry Duncan's experience, the role of the abuser comes to mind. The power over people's lives is quite pronounced, and combined with the influence of the pharmaceutical industry this makes for a dangerous mix.

The helper role easily changes into the role of the abuser and the role of the enforcer of social norms.

The helper as the patriarch who knows better, who knows what is right for the client better than the clients themselves, who operates in a top-down approach, enforcing social norms without question (as shown in gay conversion therapy as just one example), can easily switch roles and turn into the enforcer of social norms and abuser.

**Medication and the Pharmaceutical Industry**

*"If antidepressants were books, they would be runaway bestsellers" (Duncan et al 2004, p.164)*

The idea of a 'chemical imbalance' in the brain causing a variety mental health conditions has reduced the stigma for many people, who would ordinarily think of depression as 'weakness' and something to be ashamed of.

While I believe that this reduction of stigma is a positive aspect of the 'medicalisation' of mental health conditions, it also completely disregards the social aspects of human suffering of depression or anxiety, and attributes the problem to the individual and their brain chemistry. Duncan et al (2004) state:

> "… in the evolving biological narrative, depression and other human problems are not a bundle of miseries shaped by many forces: a sedentary, lonely, impoverished life; the loss of love, health, or community; feelings of powerlessness arising from unsatisfactory work, oppressive socioeconomic or cultural factors, troubled children or a difficult relationship; or frustrated ambitions. No, it is a chemical imbalance. Its resolution does not require one to get meaningful support from others, to establish a collaborative relationship

> with a therapist, to change attitudes and actions, or to make any personal effort. There is only one solution needed: the passive consumption of a magic pill" (p. 170).

Many of the people who come to see me have been taking anti-depressant medication for decades. If the client returns to the doctor with ongoing or increased symptoms of depression or anxiety, medical practitioners often increase the dose over years or change the brand of anti-depressant. Solving problems with pills assists with separating difficult and painful emotions from ongoing life events and removes the necessity to change circumstances and ways of living. Yet the fact that clients take medication for years or decades, increasing dose and adjusting drugs, indicates that the drugs do not solve the problem but that they may in fact mask the cause and prevent positive change – which would place medication in the role of the scammer and abuser as it prevents real healing.

In the Processwork framework, based on Jung's theories, emotional suffering may be meaningful, not just pathological. If the client learns to unfold the symptoms they might move to more wholeness as a person, with more flexibility of responses to adverse life events and awareness of their needs and dreams. The depression or anxiety may be a call to change circumstances and develop new ways of connecting with self and others.

I also often witness the readiness of medical practitioners to prescribe anti-depressant medication when people present with painful human emotions like grief or stress caused by difficult relationship break-ups. Whilst I am no doctor, I imagine that they feel the need to help a person in distress and seeing there is little else they can do, they prescribe a pill to assist in managing the pain of loss and human suffering.

Duncan et al (2004) mention a large national survey in the USA which showed that anti-depressant medication was the number one treatment approach of medical practitioners in 72% of cases of depression, compared to only 38% of referrals to mental health practitioners (Williams et al 1999 in Duncan et al 2004).

In light of the numerous studies suggesting that psychotropic medication has little or no effect on the mental health of a person (Goldacre 2014, Kirsch 2009, Kirsch & Saphirstein 1999), it seems remarkable that so many clients are taking medication without questioning it and that so many doctors are prescribing these drugs to their patients for years and even decades. I recently saw a woman in her mid-30s who has been prescribed Seroquel and Citalopram for over ten years following a diagnosis of Bipolar Disorder. She recently was prescribed Mirtazapine for good measure to top it off, as she experiences 'anxiety' as well. I believe her medical practitioners will continue to prescribe this cocktail of powerful drugs to this client for even more decades of her life, without questioning the significant side- and long-term effects. In my view it is grossly negligent and abusive to only manage people with drugs for decades, and add more of the same when the person continues to experience difficulty.

The influence of the pharmaceutical industry cannot be underestimated in this context and highlights the role of the scammer in regards to medication.

Kraus Whitbourne (2015) writes: "Echoing the concern that we are an overmedicated world when it comes to psychological disorders, he notes that even the newer and supposedly better new drugs are no more effective than the old ones. Almost all (95%) of the federal dollars spent on mental health research go to drugs, not psychotherapy, in clinical trials" (online article).

In my years of working in private practice I have seen many clients who are taking anti-depressants regularly and who firmly believe the drugs are making a positive change in their lives. The same is true for a good friend of mine who went through a very difficult break-up with her partner. She was prescribed anti-depressants and felt a marked positive effect one day after taking it.

Anti-depressant medication seems to be the go-to option when life is getting hard. There have been situations when I have been relieved myself that drugs are a treatment option. I remember I contacted a GP straight after a session with an acutely suicidal client. The client had promised during the session that he would make an appointment with his GP and once he was prescribed anti-depressant medication he reported he felt much better - and moved on following another four sessions with me without psychotherapeutic support. Miraculous change happened for the client with very little input. I was somewhat unconvinced that he had in fact improved as much as he reported, but seeing he is the expert on his life I was glad to hear he felt so much better. These reports suggest that medication is in fact a helper and while it is not the healer it has a positive effect on the client and their suffering.

It appears we are marinating in a world where pain and suffering need to be alleviated as soon as possible and as simply and quickly as possible. When I started my own therapy many years ago, I had this idea that I would be taking all the bothersome issues and feelings, packing them in a box and with the help of my therapist, be tossing them overboard from a ship. Getting rid of it all, never to be seen again, swallowed up by the ocean, quickly and easily, please. Needless to say, it didn't work like that and I am very grateful for that as there have been a lot of hidden treasures in that box. But this has not been a quick process, it has not always been easy or painless.

**The Therapist – Me**

I see my role as the therapist is to primarily facilitate change for my client. In my role as a Processworker I am more identified as an awareness facilitator, change may or may not happen, depending on the process of the client. In any case my primary identity as therapist is the role of the helper.

I can see how many of the roles described above could also apply to a therapist, or how the therapist could be accused of them. Funding bodies monitor the progress of the clients – mostly to ensure the client returns to work and improves 'functioning'. When that goal is not achieved the therapist can be seen as a scammer, by making the client 'dependant' on the therapist - that way the therapist can ensure a source of income is guaranteed. In this context the 'pseudo-shrink' could also be mentioned, not facilitating positive change despite their best efforts and intentions. Another potential scam could be non-compliance to funding agreements, which stipulate the use of empirically researched short-term therapy approaches.

Of course, therapists need to earn an income through their work. Money affects us too and financial interest can corrupt anybody.

The therapist could also, like the psychiatrist, turn to be an enforcer of social norms and thus do harm rather than good. A friend of mine saw a therapist and when she told the therapist that she felt angry, she was advised to visualise to put the anger in a box, close the box, put it away in a cupboard and close the door firmly. What a shocking recommendation. She needed her anger to mobilise her, and to finally create a boundary and act to end an abusive situation.

It appears that mainstream psychology deals with anger as an emotion or energy that needs to be managed and packed away - rather than explored and utilised for change.

## SECTION 4: My Critic

*"It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat." - Theodore Roosevelt, The Man in the Arena*

As mentioned earlier, my critic is a mighty figure. He always has an opinion and is generally not very kind when it comes to me, my skills and my ability to add value to the world.

My critic is one dimensional; he knows what is right or wrong, and good or bad. He blames, points the finger and calls me names. When I find myself blaming others or find they are bad or guilty, I feel good. It is so good to know that this is 'not me' and that I 'would never do anything like that'. I too am guilty of that at times, and when it comes to horrendous cruelty I still like to think that I would not do anything like that. I also know that things are more complex - I know that the one-dimensional approach of my critic is simple and convenient, but it is not doing this world justice. If I look more deeply and closely, I can see why people are the way they are. This means a more complex and in-depth way of seeing the humans and their ways of surviving in our world.

Interestingly, when it comes to my approach to the critic, I also was one dimensional. I decided that my critic is mean and obstructive and needs to shut up. While I still stand by that in general for the abusive part of my critic, I also am starting to get a

deeper understanding of the critic as this part of me is also more complex and has a specific function.

Whilst my critic is very critical of psychology in general, 'talk therapy - bah humbug, soft science', he might acknowledge that some people have some good results. But that would not be me, I have no proof or evidence otherwise. I would need to have hard evidence that the work I do is effective and actually improves peoples' lives by their standards. Here we come back to outcome measures. However, my critic states that this sitting around and talking cannot really do much good. He thinks that psychologists have nothing new to offer. What would they know? My ability to sit and talk with people, deeply listen and be present to their emotional expression and needs, is not what my critic values. As a matter of fact, he would call that 'total rubbish'. Anybody can talk to people. Really. People can talk to their friends. Or the letterbox. That's what he says. Which makes me think he might be just a tiny bit threatened? Threatened by a more wholesome approach to this complex and mysterious life.

My critic laps up any form of criticism of psychology from the outside world. Psychology is a very young profession. The science of it is questionable, and outcomes are hard to measure. There are some outcome measures that are relevant to mainstream society and funding bodies, and my critic agrees with them. My critic loves Hans Eysenck and his bold challenge to psychotherapy.

My critic was instrumental in my writing of this thesis and this process has left me feeling more empowered and aware of my rank and skills. So, a little bit like Hans Eysenck, while I don't like my critic's nastiness, his ongoing putdowns motivated me to do some research and take positive action.

## The Inherited Critic

I feel a lot. I can't help it. Feelings come in my body and flow out of me, mostly my eyes, without me doing anything. But I don't want to feel all the time, even though feeling is my 'superpower'. During my inner work I explore, 'who is against all these feelings?' Well, my father is, of course. He didn't like it. Could not deal with it.

My father had a major influence on my life, as most parents do. We had a very complicated and painful relationship. He is no longer here in body and writing this thesis is helping me to be more at peace with him.

I am about to speak of my German ancestry and German history and devastation from the perspective of two boys growing up under fascist rule. I am aware that Jewish people, and others who have suffered greatly under the Nazis, might read this. Please know that I am mindful of you and your suffering. No extra hurt or offence is intended in any of my words. The Holocaust was horrendous, and the systematic mass murder committed by Nazi Germany caused unspeakable suffering. The effects are still ongoing for everyone involved.

My father was born in 1930 in Berlin. He was raised in Berlin under Nazi rule. He had just turned 15 when Germany 'lost' the war and the Russian soldiers marched into Berlin and occupied the part of Berlin where he lived. That was horrendous. For thousands and thousands of people, women and girls first and foremost.

My father was who he was and he glorified these years as the 'most exciting' years in his life. The stories he told were gruesome, but he recalled them as matter of fact or even as exciting. Berlin was heavily bombed and as a growing boy he was called to pull bodies out of rubble and drag them along the cobblestone roads. After the war, the Russian soldier held a gun to my father's head and pulled the trigger when he caught my father – a 15-year-old – cutting out (and stealing for food) a piece of meat

from a dead pony on the street. The gun was not loaded and the soldier probably knew that…my father didn't. There were suicides of people all around him when the war was over, and mass gang raping of females was ongoing and seemingly never ending. People endured the fear and fascistic government during the war, the plundering and degradation after the war, and then the shame and the horror once they discovered the endless monstrosities committed by German soldiers and German troops. There was unspeakable horror and shame.

Today I realised that my father most likely suffered from Post-Traumatic Stress Disorder, as did probably a lot of the kids that were raised under Nazi rule and then experienced Germany 'losing' the war (as if there was anything to win, as if there ever can be any 'winners' when it comes to war).

My father survived by glorifying the times. My godfather, a few years younger than my father, would talk about the years when he was raised under Nazi rule as "destruction of the soul". The trauma was easier to see in him, as he would speak of his suffering and it was also physically obvious. He lost his right hand when his mother cut his and his four siblings' wrists in an attempt of suicide prior to the Russians marching in. The mother also cut her own wrists. She – like many others - was too scared to face what was coming. My godfather's mother survived without losing a limb, my godfather and one or two of his siblings lost a hand but survived. One sibling died. Ironically the family was found and rescued by Russian soldiers as they marched into Berlin. 1945 was a year of mass suicide in Berlin. My godfather lost one hand, a sibling and much more I imagine.

I come from a people of trauma and shame. No wonder I struggle with a massive inner critic. No wonder my father had to divorce himself from his feelings and have a

strong reaction to his daughter, a feeler. I am like a lighthouse, any feelings which are disavowed, marginalised, or looking for a home come to me. I pick them up and give them expression.

My ability to feel – which I had to recover from underneath a lot of 'rubble' and it was hard and tender work – now serves me well when working with clients. I hated my feelings and struggled against them all my childhood, adolescence and young adult years. When I was 25, and studying psychology, I started my journey into healing and feeling, and I am still on the path. I am profoundly grateful to all the healers and friends who have helped me – and are still helping me - along the way.

As I am in the process of continuous and painful procrastination of writing this thesis, I wonder how much my relationship with my critic has to do with it. I observe myself doing lots of things but write, I see myself not doing what a big part of me wants to do and get done too, and I feel almost paralysed to do anything about it. I then can't sleep at night, as I feel the pressure of this project which just does not get done. My critic is going crazy, and a big part of me agrees that this really is not working. When I finally write, I can almost feel him coming in from the left-hand side into my head, saying things like: "this is shit" or "you don't know what you are doing" or "you don't have a proper concept, this is a waste of time, none of that will matter in the end". I ignore him and I say I just need to keep going, I can edit later, and I push on. Sometimes I do stop, and wonder …. Is he right? Am I writing and later I will have to edit it all out again?

## The Critic as an Ally

Seeing that Processwork as a paradigm values and honours the difficulties we encounter, the parts of us that don't cooperate or function, I wonder if this thesis is my

opportunity to focus on my relationship with the critic. As I contemplate this, I have a big reaction. I don't want to have to deal with him.

Arnold Mindell (1995) states: "Abused people have only two choices: either they go numb or they become abusers themselves" (p79). In my practice as a therapist I see it all the time and I have compassion and understanding.

My critic has haunted me, belittled me, shamed me, pointed out my shortcomings, and found me lacking in all domains. This, of course, continues in my work, work that is so multifaceted and hard to evaluate. And the critic is on my back as I procrastinate and then pressures me at night, when I am attempting to sleep.

I do my best not to blame, point fingers, or see things as right or wrong. Overall, I identify as being a compassionate person. I believe in the complexity of lives, that we all have parts we ignore and marginalise and, when pushed in a corner, are capable of doing things we would not normally do. My critic sneers at the concept of complexity. When it comes to my critic, I also tend to blame him and want him gone. Interesting. How do I negotiate that? How do I negotiate compassion and understanding towards the critic who has been relentless in his putdowns and accusations?

Brené Brown, in the course of studying shame and vulnerability, states that when we are ready to take a risk (making ourselves vulnerable), the "shame gremlin" comes into action and says things like "Uh, uh … you are not good enough. You are not pretty enough or smart or talented or powerful enough. I know your Dad never paid attention to you even when you made CEO" (Brown, 2010, The Power of Vulnerability, TEDx Huston). I find it interesting that Brené Brown frames what I call the critic as "shame". I also have learned over the years that whenever I endeavour to do

something new that is important to me and leaves me feeling vulnerable, the critic comes in, all guns blazing.

I also think I am on an edge to accepting my own skill, my own power, being held accountable, and standing for what I think is right and what I believe in. That might mean to 'grow up', and to be seen and be counted.

When I was stuck again, I asked for a dream to help me get this thesis done. I had the same dream three times in one night. I remembered most of it, even though I thought it did not make sense at all. I took it to therapy.

I dreamt I was watching a YouTube presentation from a woman who instructed how to manage the ultra-right. She said it was possible to do it; precautions were necessary of course, as the ultra-right are dangerous, but it can be done. In the dream I watched this presenter. I was amazed by her courage and I was fearful for her and me, should I decide to take her advice. As I unfolded the dream I realised that my critic, in his incredible nastiness, was there all along to protect me. What a way to be a protector.

It was extremely dangerous to speak out under Nazi rule. 'Managing' this ultra-right rule was life threatening, and many people were executed by the Nazis if they did not toe the line or were actively resisting. Mock trials and executions by guillotine or hanging were not uncommon. Resistance in a household had to be done secretly as it was too dangerous for the children to know anything.

My paternal grandfather was a royalist who did not agree with Hitler, this shouting upstart from Austria. He was somewhat involved with other royalists who resisted Hitler and they had secret meetings in my grandparents' house. My father could not

know about these meetings as that would have been extremely unsafe. Being quiet, not standing out, not speaking out was vital for anybody who wanted to survive the fascist rule – and whoever resisted had to do it extremely carefully or they would be executed.

My critic continuously tells me that I am not good enough and that I shall be quiet. When I feel vulnerable my critic goes crazy, gets super mean, and tells me even more to shut up and not do whatever it is that leaves me feeling vulnerable. I always thought he was an abusive terror, but I finally understand that he wants me to be safe, to not stand out and not speak out.

I know that this is common with critics. My clients report that, as well as Brené Brown. My critic blares in my ear that I shall not try to make a connection to my ancestors and people in order to justify my own shortcomings. Yet I can only speak for what is true for me; others have other histories and come from a variety of backgrounds, and their connection to their heritage might unfold. `

I am born and bred in Germany and it appears my ancestors have an influence on me and my life today. I am reminded of the Bible again: "The Lord ... *visits the iniquity of the fathers on the children and the children's children, to the third and the fourth generation*" (Exodus 34:6-7, Deuteronomy 5:8-10).

Our western world disregards these considerations, and PENO would scoff at the consideration of the influence of our ancestors on our current way of being in the world. However, research suggests that trauma might be intergenerational and epigenetically inherited. Rachel Yehuda with her research team at Mount Sinai hospital have studied genetic changes stemming from trauma suffered from Holocaust survivors and the

possibility of these being passed on to their children (Yehuda et al, 2016). Studies on mice, where they were subjected to electroshocks in combination with the smell of cherry blossom, showed that the offspring of the initially traumatised mice showed a fear response to the smell of cherry blossom alone, without ever having been subjected to electroshocks, as did some of their offspring. The fear of the smell of cherry blossom could be seen in two generations after the event (Dias & Ressler 2013). Even though scientists are still puzzled as to how this can happen, the fact that modern science has shown these effects indicates that our world of PENO slowly catches up with ancient wisdom of indigenous peoples around the world.

# Conclusion

*"You may agree or disagree with my conclusions. In a universe of parallel realities, all your arguments are bound to be correct in one of those realities – just as mine are correct in another" (Mindell, 2004, p. 242).*

It appears that there are no right or wrong answers in life. Whenever someone states something with conviction, someone else will state the opposite with conviction, and both sides will quote research and studies to back their views. This is also the case in the field of mental health and psychotherapy. Claims of efficacy and superior outcomes by one paradigm are argued and debunked by other research. The debate goes on and my critic is not impressed.

My endeavour to stand my ground in a world where PENO rules will likely be a lifelong journey. I understand that the mental health field is populated by a large number of bodies with conflicting interests, and being aware of these interests is helpful to me. The complexity of the roles, financial interests, and the desire to have clear answers in a field where ambiguity and vagueness are to expected makes for a dynamic mix. Through this research project I have come to understand not just the complexity of my own role, but also the complexity of the other roles - and that more than anything role fluidity is required of me to navigate this landscape.

The process of writing this thesis has repeatedly brought me to my edge to speak out and have an opinion. I would get over the edge and then have backlash the next day, with yet again more procrastination. My critic will do whatever he can to prevent me from stepping into my own rank and backing myself publicly in an attempt to protect myself. Throughout the writing this thesis I was holding myself to my edge of exploring

my critic - and to find the protector role in him was a new and important insight that has changed my relationship to my critic.

I have come to understand that I am not a mainstream therapist. I have learnt to trust that our disturbing feelings and experiences can be the key to a greater understanding of ourselves and a fuller life. Anger, pain and body symptoms - if trusted and unfolded - can open doors that would otherwise stay closed. It takes courage to go down that path as it is counter-cultural. Understanding that we are more than the body and mind that presents in the room, that we are part of a bigger whole and driven and influenced by energies we are not generally conscious of, makes life more interesting and less isolating - and not easily measured.

If I want to continue to work for the existing funding bodies I will have to use outcome measures and questionnaires more diligently. At times, this kind of feedback has added data that has proven to be useful, as well as satisfied funding requirements. 'Hard data', while not everything, can in fact add to the whole. Yet for me personally, this in itself will not be a sufficient outcome measure, and I am dedicated to following feedback in as many forms as possible.

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