A Mechanism for Competency

ABSTRACT

The principle purpose of the New Zealand Health Practitioners Competence Assurance Act (2003) is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health professionals are competent and fit to practice their profession" (s 3(1)). This paper reviews some of the evidence on whether such legislation is protecting the public, and whether the current mechanism developed by the NZ Psychologists' Board (NZPB) is adequate. The paper begins by drawing on a wide range of evidence on the licensing of occupations in general; suggesting licensing protects occupational guilds far more than it protects the public. The paper then reviews the current mechanism as a form of panopticism, which in turn has been subject to criticism by Foucault and other scholars. Both sources of evidence conclude that currently innovation is being limited and the public misled. An emerging alternative mechanism is examined with the suggestion that it could be either used alongside the current one, or preferably replace it. The claim is made that this alternative mechanism has stronger empirical and philosophical support.

KEY WORDS: Professional Regulation, Competence, Risk Management, Panopticism, Outcome Monitoring, Enactivism

"The intellectual was rejected and persecuted at the precise moment when the facts became incontrovertible, when it was forbidden to say that the emperor had no clothes" (Foucault, 1973, p. 105)

Professional Regulation

Regulation of various occupations has evolved to be seen as a culturally and politically acceptable method of quality assurance, although, as we shall see, there is not a lot of evidence that quality improvement has occurred. The political context is such, that since 1950 union membership has been declining as a shift occurred from production to service industries; and with that shift has been a steady growth in the regulation of occupations (Kleiner & Krueger, 2010). Bauman (2007) has described this rapidly changing landscape, as we move from industrial to post-industrial society, as 'liquid modernity' due to the increases in uncertainty it has brought. For the past 30 years this has been accelerated further under the neoliberal agenda, where everyone is cast as an entrepreneur; and with that, wealth disparity, the generator of all manner of social ills, has become a prominent feature. Risk management has risen rapidly to deal with these growing uncertainties (Beck, 1999; Power, 2007). One aspect of this is occupational regulation, which ranges from minimally restrictive forms of peer membership to highly restrictive forms of licensing, where title and scope of practice are prescribed and

monitored in some manner (Macleod & McSherry, 2007). To date about 20 (depending on how one counts) health professions in New Zealand have this highest level of restriction under the HPCA Act. The protection of the public and the professional titles is administered under the Act by "responsible authorities" (RA's) such as the Psychotherapists Board of Aotearoa New Zealand or the Psychologists Board (NZPB).

This tightening of government regulation of psychologists in Aotearoa began in 1981 with the Psychologists Act, which brought the Psychologists Board into existence. Globally, such tightening of regulations set off much academic discussion, which has continued since, on the politics of regulation (e.g., Gross, 1978; Koocher, 1979, Tudor, 2013). Some have expressed concern that regulations like our HPCA Act align psychology, psychotherapy, or counselling too strongly with "health", and this may unduly 'medicalize' these professions, and stifle creativity (Hogan, 1979; Hogan, 2003; Musgrave, 2009; Postle & House, 2009). Such a concern is not unwarranted when the Ministry of Health says: "Having one legislative framework allows for consistent procedures and terminology across the professions now regulated by the Act" (MoH, 2015). Thus, (over-) medicalization of our profession may be an iatrogenic risk with the HPCA Act, as many of the estimated 250 or so schools of psychotherapy (Duncan & Reese, 2013) do not lend themselves easily to the 3-step medical model of diagnose (or formulate), plan, and then treat. Health professions are not alone with

concerns that occupational licensing can curtail innovation; new procedures in any occupation may not be in accord with the ("best practice") standards established by a licensing board or RA (Kleiner, 2015). Just as air bags in cars may save adults, but can kill children, there are increasing calls on legislators to recognise and address the iatrogenic risks of this kind of risk management legislation (Power, 2007).

Another issue raised by those concerned by professional regulation is that the profession has given away its own professional authority to the state (Tudor, 2013). However in practice, what has occurred is that factions within an occupation utilise the procedure to obtain dominance. Kleiner (2015) has suggested reforming licensing boards so they are dominated by lay people, who would be required to monitor for the dominance of any interest group from within the profession. Usually this dominance has been from those involved in teaching that occupation locally, and what is considered 'best practice' in one part of the world is not in another (Kleiner, 2006). Given the large number of different schools of psychotherapy in the world today, it is something psychology needs to be particularly mindful of. As Kleiner (2006) notes, the professions have responded to the calls for professional regulation not by actually ensuring safety of the public in an evidence-based manner, but as an opportunity by some to elevate their own standing. If psychodynamics and not cognitivism was the dominant school of psychology in New Zealand we may have seen a

different set of 'core competencies' issued by the Board. This 'capture' of an occupation also serves to restrict market competition. In turn, these considerations give rise to concerns about the current 'International Project on Competence in Psychology', as their drafts to date appear to be placing a strong emphasis upon the medical model or further expressions of cognitivism. There appears to be no room for more maieutic approaches where intervention and assessment are never separated.

A Protection Racket?

As far back as 1974 Pfeffer concluded that empirical studies on occupational licensing does not show them to be in the interests of the consumers or the general public. Although a public outcry, like our Cartwright inquiry or the Lake Alice adolescent unit scandal might fuel the movement, the initiative for licensing has more frequently come from within the professions themselves (Kleiner, 2006). Many see licensing as folly. In our own field Carl Rogers (1973) was saying that "…tight professional standards do not, to more than a minimal degree, shut out the exploiters and the charlatans" (p.383). British social workers argued that the cart was being put before the horse when competence dominated training, for this was antithetical to social work principles (Kemshall, 1993). Whatever 'core competencies' were identified, these were expressions (the cart) of the social work principles (the horse) that needed to be learnt. Historically we can

even go back to Adam Smith, who saw such guild activity as little more than a protection racket claiming to protect the public but actually benefitting the guild. In his *Wealth of Nations* (1776/2003, Ch. 1) he says it is "impertinent" and "oppressive" for the lawmaker to "encroach upon the just liberty" of the workman and his [sic] employer to decide whom the employer employ, and questionable that crafts lengthen the apprenticeship to ensure higher earnings.

Even when licensing has been imposed on a profession by the government, it has not shown itself to be particularly effective in addressing the initial problem. Kleiner (2015) for example, cites the US Federal Trade Commission finding that parts fraud (the use of substandard repair parts) was not prevented by licensing repairers of televisions. Questions have also arisen over the effectiveness of licensing mortgage brokers across the US at the turn of this century, ostensibly to prevent fraud and loan foreclosures, in the wake of 2008 global financial crisis (Kleiner, 2006; 2013; Nguyen & Pontell, 2010). Furthermore, as Kleiner (2006) shows, it is usually the academic interests that dominate licensing and benefit from it; they all too frequently, as Adam Smith warned, ratchet up the entry requirements. As we have seen here, entry to clinical psychology moved from bachelor degree, to masters; and now the Psychology Doctorate is happening in some programmes, and talk of a PhD is becoming more frequent. Schon (2001) argues that partially due to extended training, young professionals are being infected with a hunger for technique,

and a loss of appreciation for the art our practices require. As a result the 'law of the instrument' comes into play, if your tool is a hammer then everything is either treated as a nail, or only cases resembling a nail are taken on.

Ratcheting up entry also tends to restrict supply, reduce entry by the poor, and in turn drives up the price of services. Milton Friedman saw this when occupational licensing was just starting to grow in the 1940s, questioning whether there were such things as unbiased gatekeepers and enforcers, and of how we have an "aristocracy" forcing themselves upon us "reminiscent of the medieval guilds" (1945, p.12). Malouf (2012) has summarised the unfortunate finding, for psychologists driving entry restriction, that there are now several studies showing that highly trained mental health professionals are no more effective than paraprofessionals.

On average the price of services increases by about 15% as occupations became licensed (Kleiner, 2015). Not only that, but this is contributing to the wealth disparity problem, that we know, through the work of Wilkinson and Pickett (2009), generates a lot of the social ills we are called upon to address. During the manufacturing era the unions forced managers to share the profits, and at the time of maximum unionisation of the workforce (1950), wealth disparity was at its lowest. The move to service industries reduced unionisation, and increased occupational licensing. The costs of having a licensed

professional perform the service are passed on to the service user as an extra cost. Kleiner and Krueger (2010) show that the growth of wealth disparity matches the rise in occupational licensing. As this wealth disparity increases poorer consumers either can't afford services or turn to "home remedies". Kleiner (2000) cites the case of the consumer who performed a root canal upon himself! Professionals working in this escalating wealth disparity environment are left with the dilemma of providing themselves an ethical rationale that makes this acceptable.

In the search for harm reduction through licensing, Kleiner (2006) argued that if licensed practitioners were making fewer mistakes because of ongoing competence programmes, then their indemnity insurance should be lower. However he found little evidence for this when he compared various occupations that were similar in some way, or where there was licensing in one state but not another. Indemnity insurers here in Aotearoa that insure both psychologists and counsellors (who are not registered) charge the same rate. Critics of Kleiner's argument suggest that as we cannot find unlicensed orthopaedic surgeons, we cannot make comparisons. Kleiner would no doubt agree, but this is not evidence that it is the licensing that has brought about the public safety.

Proponents of occupational licensing legislation frequently cite high profile public scandals like the Cartwright Inquiry as the type of issues

the public would have been protected from had the HPCA Act been in place. However reviews of the evidence have not found much support that the public are any better protected by licensing, nor that registered/licensed practitioners are less harmful than unregistered (Kleiner, 2006; Postle & House, 2009). Critics of licensing claim that these problems can be dealt with through other legislature (e.g. Health and Disability Commissioner and the Human Rights Review Tribunal) (Postle & House, 2009; Tudor, 2013). Power (1999; 2007) argues that this type of occupational auditing is just another expression of the neoliberal agenda of greater individualization and "responsibilization", which began with Thatcher and Reagan (and Rogernomics here). An expression of what Ulrich Beck (1999) calls the 'Risk [averse] Society'.

Scott Miller and colleagues (2013), in their review of the evidence, conclude there has been no improvement in the performance of psychotherapy in over 40 years. Despite more emphasis by licensing boards to attend continuing education workshops and learning the newest treatment models, the dropout rates and the number of clients getting better has not changed. He amusingly described this as like riding an exercise bike, working up a sweat, but not getting anywhere (Thomas, 2014).

Panopticism and the Boards Mechanism for Ensuring Competence

Power (1999) claimed that by the late 1990s there was a foucauldian turn in professional accounting/auditing research as displaced sociologists found homes in business schools. They readily identified that from the end of the nineteenth century when the management class began in the factories, there had been an increasing use of *panopticism* throughout the twentieth century, to monitor deviation from what were considered the most economic behavioural 'norms'. Panopticism is a method of governance developed by the 18th and 19th century politician and architect Jeremy Bentham (Foucault, 1977). The original "panopticon" was a prison design he drew up, where the guards could look into the cell of each prisoner, but the prisoners could not observe the guards. The prisoners are thus forced to gaze upon themselves, and discipline themselves, as they knew what they would be rewarded and punished for. Bentham claimed it was generalizable as a perfect model for the governance of the whole population. All it needed was to ensure that the rules and norms of society be widely known, and reward and punishment for deviation be visible. Foucault's claim is that this mechanism has been so successful we now have a self-surveilling society where we all 'gaze' into the mirror of 'normalizing judgements', which are distributed in everyday conversations and institutional practices. He claims it is so pervasive that we are now all 'fabricated' docile subjects disciplining ourselves. Foucault indicts the 'psy' disciplines in particular, which arose out of this form of governance, for their contribution in this 'fabrication' of people (Rose, 1990). By and large Foucault saw most of the 'psy'

practitioners as polemicists 'encased' within discourses or 'truths', which they "will never agree to question" (Foucault, 1991, p.382). In other words, we make up a large percentage of the guards in the panopticon, utilising a form of discourse (polemics) found amongst the judiciary or clergy, where the "truth" is told in a form of judgement, and not as a collaborative search with other to construct the most useful 'truth'. It would seem that psychologists have also been amongst the major authors introducing the term "best practice" to the public lexicon over the past hundred years or so.

Looking at the NZPB (2012) requirements for competency maintenance, a NZ psychologist could be forgiven for believing that the Board do not trust that practitioners learn sufficiently from their clients, each other, and natural curiosity; but instead need to look into a mirror of 'core competencies' to judge themselves, and then plan and engage in any training(s) that will address any performance deficits. It is claimed that this not only assists psychologists monitor and maintain competence, but it also provides the Authority with "a mechanism to check that individual practitioners are meeting their professional obligations to actively engage in doing so" (p.2). Unfortunately there is no empirical evidence that this panopticonian mechanism makes for more competent practitioners. Indeed, like those mentioned above with concerns about stifled creativity, Foucault argues that panopticism arouses anxiety and conformity, and has 'sterilizing effects' upon creativity (1991, p. 383). In many ways

practicing psychologists are not in a dissimilar position to students in training. In order to be accredited universities need to provide students with training in empirically supported psychotherapy methods, but as Malouff (2012) makes clear, the accrediting authorities have not applied the scientific method to the standards themselves. To date the evidence does not show that highly trained psychologists are any more effective than paraprofessionals (in some studies the paraprofessionals have done better!) (Malouff, 2012); or that continuing education makes more effective or less harmful practitioners (Miller et al, 2013).

With regards to the self-assessment lying at the heart of the Board's mechanism is the self-deception finding by Hiatt and Hargrave (1995); where therapists five times as ineffective as the most effective in their sample rated themselves as on a par with the most effective. The Board's suggested solution to such self-deception is to seek feedback from a colleague, and in its recent reforms of the CCP process it advocates doing less audits itself and relying more on supervisors. But again the empirical basis for supervision itself is weak (Malouff, 2012), and the "importance of supervision rests mostly on faith" (Storm et al, 2001, p. 227). There seems to be only one recent study finding support for supervision as an outcome variable (Callahan et al, 2009), but it offers no evidence that supervisors and other colleagues are not prone to a folie à deux.

Continuing education requirements are a common mechanism for dealing with the risk of incompetence across a range of health and non-health professionals. However, as Kleiner (2006) notes, once the initial credentialing exam is passed at the accredited training institute, there is seldom any further exams for these continuing competence education courses. So there appears to be no check that competence has actually been maintained or enhanced, only that a process has been undertaken.

What is Competence?

The New Zealand Psychologists Board has drawn upon Epstein and Hundert's (2002) definition of competence in medicine, which defines 'competence' as the interaction and integration of four components (knowledge, skill, judgement, and diligence); which was then drawn upon to develop the 'core competencies'. These 'core competencies' are the values (or 'normalizing judgements') practicing psychologists are to measure themselves against in the panopticonian mechanism.

It is noteworthy that Epstein and Hundert refer to Polanyi's (1974) argument "that competence is defined by tacit rather than explicit knowledge". In a similar vein Wittgenstein (1922/1961) attempted to show that everything of importance, especially anything of an ethical and aesthetic nature (which he claimed were the same), *show* themselves to us far more than anything we can *say* about them. So

from this philosophical perspective, 'competence' is something that is *shown* to us, or better, a kind of virtue that might be revealed to us in performance (and sometimes in good fiction) (Moyal-Sharrock, 2016).

Alan Watts (1977) points out that the Taoists see the highest form of competence as a virtue called *te*, where "power is exercised without the use of force" (p.121). There, it is well illustrated in Chuang-tsu's story of Prince Wen's cook, who has never had to sharpen his knife in nineteen years, for instead of cutting or hacking at the meat, he allows his knife to find its way through the gaps in the meat, and when it comes to a piece of gristle or bone, he allows it to slow down and find its way through the gaps there too. There is something effortless in this highest level of competence.

In Aristotle' *Nichomachean Ethics* he offers us some heuristic devices (artificial constructs that can assist understanding, but are later thrown away, like Wittgenstein's ladder in the *Tractatus*, once elucidation has been achieved) or aspects for understanding 'competence' and 'expertise'. The first of these is '*episteme*', a word used frequently in Foucault's writings, and which comes close to Kuhn's 'paradigm'. Closely related to 'epistemology', or theory of knowledge, '*epistemes*' can be found in the assumptive base of various schools of psychotherapy. For example, it could be said that some educationalists work appears to assume John Locke's idea of the mind being a 'tabula rasa' or blank slate, and thus humans need to be

socialised or taught various skills and knowledges. This can be seen in their favouring of a 'Theory of Mind' (ToM) as a necessity to social navigation (Leudar & Costall, 2009). By contrast, some psychotherapists, e.g. Jung, Lois Holzman, or Harlene Anderson, are more attracted to Socrates' 'maieutics'; therapy as a matter of drawing forth from the client what they already know (albeit they are unconscious of knowing it). The second aspect for Aristotle is '*techne*', which can be considered a rule following activity; and we can think of the 250 or so schools of psychotherapy as various *techne*s or techniques. Solution-focused brief therapy (SFBT) or object relations theory seem to be more aligned with maieutics, whilst CBT (Cognitive Behaviour Therapy) and other psycho-education methods seem closer to Locke. Again this difference can be seen in their affiliation with (or rejection of) ToM. The third heuristic device for Aristotle is '*phronesis*', which can be considered as practical wisdom, or perhaps prudence or good judgement. This is the material of what are considered "the common factors" to all forms of therapy (Wampold & Imel, 2015). We see it in therapy as the wisdom to use a bit of SFBT there, and now a bit of CBT here. But it also contains a lot of value questions, like where are we going with this *techne*? Who benefits from these *techne*s? So it is a "figuring out", or better, "sensing", not only what to do in any given moment, but also knowing (sensing) what is worth doing.

Developing Competence and Expertise

The Dreyfus brothers (1980) developed a five-stage model of skill acquisition based on the philosophy of the later Wittgenstein (1958). They described qualitative shifts occurring in the development of competence; from the use of rules as a beginner, then a gradual letting go of these until we are following intuitions as an expert. "Trust the force, Luke". In their original paper, written for the US Air Force, they describe this expert level for pilots: "rather than being aware they are flying an airplane, they have the experience they are flying" (p. 12). Thus the pathway from novice to expert has us moving towards a place where the skill "has become so much part of him [sic] that he need be no more aware of it than he is of his own body" (Dreyfus & Dreyfus, 1986, p.30). This oneness, where say, the car feels like part of me, is Heidegger's "dasien" (1962). Shotter (2012) talks of the therapeutic conversation taking on a life of its own at this level; and Carl Rogers remarked on observing the oft-cited "Gloria films" (Shostrum, 1965) that he was so engaged he had difficulty recalling particular facts of the session (reported in Sharpless & Barber, 2009). (The TV show *In Treatment* raised the question in one episode, whether taking notes may actually be a hindrance to effective therapy.) *Phronesis*, we might say, is the letting go of the rules of a *techne* as competence increases; as we move from the "know that" of rule-following to the "know how" of intuitions. Keeney calls psychotherapy conducted at this level a "performative art" (Keeney et al, 2012).

This model contrasts sharply with the thinking of Plato, Kant, and Piaget (amongst others) who had proposed that 'expertise' is the abstracting and internalising of increasingly sophisticated rules. Cognivitism, from which CBT springs, is based on this Piagetian *episteme*; as are chess playing robots capable of learning how to become more proficient. However, as Wittgenstein (1958, 1969) showed us, this is not so for living creatures; certainty is to be found in know-how and not in know-that. Similarly, Ericsson's (2009) work on expertise claims that pattern recognition replaces rule-following as we acquire skill: the chess grandmaster can recognise 50,000 patterns, which he says takes 10,000 hours of *deliberate* practice to achieve. Not only that, but in the accounts given by both the Dreyfus brothers and Ericsson, the expert's 'gaze' is staying more present and on the road so to speak, and not taking it off to look at the dashboard of rules. The Dreyfus brothers had a chess grandmaster playing multiple games whilst counting out loud. This is also in keeping with embodied cognition research, which challenges Piaget's claim that cognitive proficiency increases as one moves from the concrete to the abstract. Skill acquisition is in shifting from abstract formal rules to concrete performance (Hutto & Myin, 2013). Ericsson (2006) also notes that the experts "often cannot articulate their knowledge because much of their knowing is tacit" (p. 24).

In the model proposed by Dreyfus and Dreyfus (1986) they suggest we go from a rule focus to noticing recurring aspects in the world that we

now react to automatically. Once this is occurring regularly, we start noticing the relevance of these aspects to our goals, and give expression to these intuitions as maxims. Later these maxims are dropped too, as we now have such a vast repertoire of these automatic responses we can react intuitively to most situations. Returning to Prince Wen's cook, when we come to a piece of "gristle" or "bone", we don't wrestle with such difficult situations by referring to the rules, but slow down and 'sense' our way through these too. But we do see people who have become "short-circuited" at the rule-following stage with problems like left-right confusion or other neuroses. I would suggest that this is what the current continuing competence mechanism generates – anxiety and a loss of trust in self.

A Mechanism for Competence

Over the past fifteen years there has been a growing interest in client self-assessed outcome monitoring and management tools (Duncan & Reese, 2013). There is now an impressive array of empirical evidence that their use leads to massive reductions in drop out rates as well as improved outcomes for most psychotherapists (Duncan et al, 2010; Lambert, 2010). This evidence shows that large public mental health services that utilize continuous feedback of "patient reported outcomes" (without clinician interpretation) can achieve levels of effectiveness that match or exceed those of clinical trials (Reese et al, 2014). Currently most services are not using these tools and members

of the public put at risk, as they are being led to believe that if psychologists (and other practitioners) are delivering an empirically supported treatment (EST) they have an 80% chance (or whatever the clinical trial outcome figure was) of benefitting from it; when in fact most 'real world' clinics are only achieving a 15% recovery rate on average (and some much less) (Drury, 2014). There are few pure "nails" in the 'real world'. With these outcome tools psychologists now become more directly accountable to the clients, rather than to third party (NZPB) protocols. It's a shift from process-based accountability to outcome-based accountability. With growing emphasis on being transparent to the public (and referrers) just what our outcomes are, we are able to provide potential clients with probably the most important informed consent information most will want; not "are you doing it by the book", but "how effective are you?" That is to say, the purpose of the Act, competence assurance, is *shown* by outcome rather than assessed by recipe compliance; for "the proof of the pudding is in the eating" (Duncan, 2010, p. 45).

With the development of appropriate statistical techniques and computer programmes it is now possible to generate trajectories of change on a session-by-session basis, and compare client progress with similar clients utilising large databases of client change scores. Agencies with large databases can now develop new outcome measures "on the trot" so to speak, allowing greater flexibility in making comparisons or for dealing with specialist populations

(Lambert et al., 2013). Through the use of the Reliable Change Index (RCI) the individual therapist can not only monitor their comparable effectiveness with colleagues, but also their own for different periods of the year, or compare their effectiveness on client variables such as gender, age, or a specialist population. Some are arguing for case mix to be allowed for, as perhaps surprisingly, the "worried well" do not make as much progress as fast as the more distressed (Brown et al., 2001). (There seems to be no evidence to support the claim, made by some stepped care proponents, that their effectiveness is hampered by them taking the more "difficult" clients.) Also in favour of outcome feedback management systems being a more preferable mechanism for competence assurance, consider Bohanske and Franczak's (2010) finding where the number of below-average therapists dropped by 80% after its introduction. Further, as Sparks and colleagues (2011) note, clients now come to the front of the classroom as the teachers of how to be of assistance to those seeking change.

Some have expressed concern that outcome measurement is vulnerable to 'gaming' (Bevan & Hood, 2006; Hood, 2011; Mays, 2006; Saul, 2013). This is obviously considerably reduced when it is the clients who complete the outcome monitoring forms, rather than the clinicians. Nonetheless, it is a necessary consideration that will require further consideration and discussion. Perhaps a further check to the system would be to implement 2- and 5-year follow-ups of outcomes, as Seikkula and his team do in their work with psychosis

(Seikkula et al., 2006). The NZPB might consider doing this on a random basis? Although 'gamed' results would be covered by false advertising laws, this could be a future duty for licensing boards. Further consideration would also need to be given to how closely practitioners who perform poorly in long-term follow-ups, but now show good immediate feedback results need to be monitored. It is also beyond the scope of this paper to reflect on how feedback monitoring might be brought to non-therapeutic work, such as report writing.

Reputational Risk and Resistance to Outcome Management

Outcome (and not output) accountability to the customer is becoming more widespread throughout the world. The Uber taxi phenomena, for example, is partially due to the use of a telecommunication app that allows both drivers and passengers to rate each other immediately after a trip. Although this is leading to legal disputes with the taxi licensing boards, the costs of fares and licenses are coming down (Kleiner, 2015). Elsewhere, companies and professionals are increasingly being ranked on scales of 'Best Employer', 'Most Admired Companies', 'Most Trusted Professions', 'World university rank', etc., usually by popular magazines, and this is having a Hawthorne effect (Espeland & Sauder, 2007). We have seen the growth of the 'No Cowboys' website in New Zealand, where customers rate businesses (NoCowboys, 2015). Recently a number of health professionals have begun appearing on that site. Power and colleagues (1999, 2007)

argue that these are features of 'reputational risk', or concern with appearances, which has emerged as a new task for risk managers over the past twenty years.

Sociological analysis indicates reputational risk stems from the 'Risk [averse] Society' (Beck, 1999), or what Bauman (2007) calls the 'liquid modernity' of post-industrial society. In this fast changing or 'liquid' world Power claims risk managers are not distinguishing between 'risk' and 'uncertainty' well; resulting in more attempts to legislate or impose a set of practices upon all members of that organization or profession. The cart is getting ahead of the horse, as possible signs of competence or effectiveness are being prioritized over actual effectiveness. This is particularly concerning to psychotherapy with our estimated 250 plus schools of psychotherapy. As noted above these different *techne*s may be based upon different *epistemes*, and what might be considered unethical and inappropriate by one school might be considered ethical and appropriate by another. Sharpless and Barber (2009) note, in the treatment of trauma a "… behavior therapist would likely begin prolonged exposure by the third session, … and waiting months …would be considered incompetent, if not unethical…..a psychoanalyst, on the other hand, would likely view such early exposure … as a re-enactment of the trauma, and therefore an incompetent (if not unethical) action" (p. 5).

Power and colleagues (2009) detail how 'best practice' regimes were increasingly forced upon universities in Britain under the banner of reputational risk management. The description offered is highly reminiscent of the demands being made on the 'psy' disciplines to follow the 'best practice' guidelines being suggested by SAMHSA (Substance Abuse and Mental Health Services Administration) in the US, or NICE (National Institute of Clinical Excellence) in the UK. But as we have seen, the empirical evidence does not support the blind application of ESTs (empirically supported treatments) or EBP (evidence based practice) but instead supports PBE (practice-based evidence), which allows any school of therapy (or mixture or none) so long as it shows itself to be effective with this client at this time (Duncan & Reese, 2013). As mentioned above, we are now witnessing this effort to find unifying procedures in the International Project on Competence in Psychology, which looks destined to further restrict competence in the name of improving competence.

Reputation is a multifaceted construct, and there is growing agreement that it is better dealt with by engaging more strongly with those who can offer immediate environmental feedback, especially those others who have the capacity to amplify or attenuate various issues (Power, 2007). For example, some oil companies have rebranded themselves as 'energy companies', thus facilitating a better relationship with Greenpeace. When organizations and professionals become decoupled from environmental feedback, there is more gaming of KPI targets and

other variables to create an appearance of competence that is hollow (Bevan & Hood, 2006; Espeland and Sauder, 2007, Power, 2007; Saul, 2013). Organizations and professionals that resort to defensive mechanisms for reputational management by 'keeping up appearances' are at risk of harming their reputation as this gaming becomes publicly known. By contrast, organizations that have opened themselves to 'double-loop' learning (Argyris, 2004), or what Senge (2006) popularised as 'learning organizations', are being seen as more trustworthy. As mentioned earlier, a counter to gaming is to introduce further feedback mechanisms, such as Seikkula's 2- and 5-year outcome follow-ups. Organizations are more ecologically responsive when they allow their core values to be changed, as a result of feedback. They now fit their world better, rather than carry on as psychopathic entities (Bakan, 2004). This should have been a 'no-brainer' to psychotherapists where interpersonal trust is paramount.

Babies and Bath Water?

We have seen that the Board's panopticonian mechanism would have us gazing into the mirror of the core competencies guidelines, in order that we might judge whether we are competent or not. We have seen that the theme developed by this paper is that competence is better shown than said. There is less room for self-deception when we use real-world or client-rated progress monitoring systems rather than our own judgement in the panopticonian mirror. We have seen that as

expertise develops there is less reliance on rules; we no longer mediate what we do through the rules of a *techne* ("trainer wheels" – Hoffman, 2002) but by displaying an immediate intuitive responsivity. However expertise is not just a matter of the rules of the *techne* becoming less dominant as *phronesis* takes over; for as Ericsson (2007) notes, the longer surgeons have been out of training "the less they are able to identify unusual diseases of the lungs or heart" (p. 117). Such observations have given rise to concerns in other professions, fuelling the call for continuing education. Here in Psychology Aotearoa, Seymour, Nairn and Austin (2004) have provided a description of the culprit of many professional complaints; it is one who trusts their intuitions more than the rules. As we have seen, this is the description of the competent expert. Seymour and his colleagues go on to claim that the error of these culprits is that they are not referring to the Code of Ethics or best practice guidelines in their decision-making. However the expert, as described by Dreyfus and Dreyfus, is not neglecting the rules, as some might imagine, but embody the rules. This doesn't mean the rules have become internalised, as Piaget thought, but they have developed a performance knowledge that could be described by the rules, but also could be described in other ways. As noted above, superior virtue is shown rather than said. (Seymour and colleagues comments were in response to a paper by Williams (2004), who pointed out that the preamble to the NZ Psychologists Code of Ethics sets an impossible

standard, by claiming that cognitively explicit, linear, rational decision-making is required.)

The solution offered to this dilemma of "unusual diseases" by Ericsson (2006), and given much emphasis by Scott Miller, is of course via real-world feedback with outcome management tools. Despite extensive enquiries in journals, on-line, including therapist bulletin boards, and asking colleagues, this author has been unable to find any empirical evidence to show any superiority to the procedure recommended by Seymour and colleagues (i.e. conducting a comprehensive assessment prior to intervention, in case something has been overlooked), compared to the procedure recommended by the outcome monitoring proponents. Their recommendation is to be highly responsive to lack of progress (something Seymour followers may not be aware of), and if there has been no progress for five or six sessions, then either do something radically different or refer the client on to someone else. There is less chance this way of becoming wed to our models and formulations. In our world, it is not so much a better understanding of "unusual diseases of the lungs and heart" (the problem), as it is of collaboratively discovering with the client a way forward (a solution). A more maieutic practitioner might be inspired by real-world feedback to develop new lines of solution-focused inquiry, whereas the more medical model practitioner would want to learn more about the problem. What is being advocated here is a shift from the command

system of the Board's panopticonian mechanism to 'incentive-based' learning to regulatory requirements.

The suggestions made by Seymour and colleagues appears to be an expression of 'cognitivism'; the *episteme* that dominates clinical psychology in many parts of the world. Despite its proponents suggesting it could be the *episteme* for unifying psychology, it has been found wanting as it overcommits psychology to individualism, and a far stronger case exists for embodied enactive approaches to cognition, which take their inspiration from the self-organizing activities of living things, including swarm intelligence (Hutto, 2013). As noted above, cognitivism lends itself readily to a form of the 'medical model', with the search for a diagnosis or formulation preceding the implementation of the treatment. Seymour and colleagues cognitivism is not only at risk of throwing out the competent intuitive therapist with the bathwater, but of also throwing out those psychologists whose episteme is more Socratic. Such therapists do not separate 'assessment' from 'intervention', as each question is an intervention that reveals aspects of the client to both the therapist and (more importantly) the client him- or herself. As Milton Erickson once put it, the client brings to therapy their own solutions, and the therapists job is to reveal these to him or her.

The Cultivation of Ethical Subjects

Cognitive science has in the past decade or two made a shift from 'I-psychology', characterised by notions of an 'internal mind' that is 'individualistic' and works by 'intellectualism' (processing representational symbols), to 'E-psychology' where mind is 'enactive', 'embodied', 'extended', and 'embedded' (Hutto, 2013). E-psychology takes its inspiration from the self-organizing activities of living beings and groups of living beings. It has been said that E-psychology is no longer the barbarian at the gates of cognitive science, but now occupies the cafes and wine bars (Hutto, 2012). Even its critics admit it is "sweeping the planet" (Adams, 2010).

The notion that we need a Theory of Mind (ToM) to socially navigate has been dropped as a relic of I-psychology, as we recognise that as we 'give ourselves' to the conversation, the conversation will take on a life of its own (Leudar & Costall, 2009; Shotter, 2011; 2012). In the clinic we don't always need an assessment or formulation, or treatment plan, for as we have seen in the development of expertise, our intuitive responsivity facilitates a seamlessness as an extended mind comes into play. The therapeutic task is to attune to the client as they attune to the world (Drury, 2013). Progress monitoring and alliance monitoring tools, such as FIT (or PCOMS) facilitate this process (Duncan & Miller et al, 2010).

What is required of the therapist is a purging of counter-transference or the cultivation of an ethical subjectivity so our intuitive responsivity

is therapeutic for the client. Many of the philosophers E-psychology draw upon, have provided descriptions of this ethical subjectivity (or 'personalist ethics') and how it is cultivated (Hanna, 2013). Foucault (2001; 2010; 2011) for example calls it the cultivation of *parrhēsia*, an ancient Greek word meaning 'fearless speeech', which requires discipline or ascetics to achieve. However this form of ascetics or what Foucault calls 'self-care' is not a struggle against oneself, as it is for people 'fighting' addictions; for it occurs within a context of care of other. As such it is like the experience of many (not all) women, who on discovering they are pregnant find no difficulty to stop smoking and drinking instantly. Wittgenstein and Levinas also indicate that the 'call of the other', especially when they are suffering, is a reflex, and the basis of our humanity, and giving it its due fosters a compassionate 'self' (Overgaard, 2007). This is not a panopticonian exercise, but the discipline that comes with love. Descriptions of therapists being humbled, but more present, as a result of utilising outcome monitoring tools appears consistent with this (Duncan, 2010).

Foucault tells us that Galen saw *parrhēsia* as necessary for physicians, as they needed their own ethical authority if they were not to be subject to the influences of the 'Big Pharma' of their day (Foucault, 2011). Galen claimed it could be cultivated in an open and serious conversation with anyone; and is essential "for the man [sic] who is responsible for directing others, and particularly for directing them in their effort, their attempt to constitute an appropriate relationship to

themselves" (2010, p. 43). Foucault (2010) tells us that following the death of the statesman Pericles in 429 BC, *parrhēsia* and democracy no longer got on so well in government, and rhetoric, the art of persuasion by polemicists took over. With *parrhēsia* there is more opening of oneself to others, and thus a risk of violence to oneself. It is highly noteworthy that Martin Luther King 's "creative maladjustment" speech to the American Psychological Association, was in galley proofs for the Journal of Social Issues on the day he was assassinated. In that speech King urged us to see our clients as the "coalmine canaries" to an unjust and sick society, rather than as sick themselves (Robbins & Friedman, 2014).

Conclusion

We have seen that the evidence to date does not show strong support that licensing of occupational groups better protects the public. Economists as far back as Adam Smith have been suggesting licensing is something of a protection racket for guilds, and the evidence appears to support this. Meta-analytic studies have shown no improvement in therapeutic effectiveness over the past 40 years, despite licensing boards growing in legislative power and emphasising continuing education. It would seem that 'competence' is not easy to define, and is perhaps best described as an arbitrary mark on the line between novice and expert. Philosophical analysis, supported by empirical research, indicates that as expertise develops there is an

increasing reduction on the use of rules and an increasing use of intuitive or tacit "know how". Because the Psychologists Board here in New Zealand have adopted panopticism as their mechanism to monitor competence, they are in effect retarding the movement of psychologists towards that state of expertise where they don't need rules. Foucault had warned us of the panopticon being a "cruel, ingenious cage" (1977, p. 205), and "diabolical" (1980, p. 156), with "sterilizing effects" upon creativity (1991, p. 383). Panopticism keeps the subject constantly monitoring the rules. An alternative mechanism lies in outcome monitoring or feedback informed therapy (FIT); and for that there is now a considerable body of empirical evidence showing it improves performance.

It is argued that a major reason for the slowness of our RA to consider this alternative has been their capture by 'cognitivism', an approach to cognitive science that finds attraction to computer metaphors for 'mind'. In the past decade or more cognitive science has made a paradigm shift to enactive or extended cognition where 'mind' is embodied in the pathways attention travels around. As such therapists do not need manuals or techniques to refer to so much as cultivate within themselves an ethical way of being so their responsivity is ethical. Outcome monitoring tools and the shift to expertise can facilitate this. Such a shift allows RA's to monitor psychologists on their effectiveness, as well as effecting a shift of accountability more directly to the client, rather than on judging their

adherence to a set of procedures called 'core competencies'. Proponents of this shift towards a more enactive or embodied cognitive style, might see further steps to what Bateson (1972) called an "ecology of mind". I have endeavoured to show in this paper that such a shift in cognitive style is being hampered by current regulatory mechanisms; but can be enhanced when accountability is more directly to the client.

It is suggested that this alternative pathway at minimum be placed alongside the current mechanism. As further evidence and argument is developed it may well eclipse the necessity of the current mechanism.

Post script.

As Saul points out in *Voltaire's Bastards* (2013), Voltaire was amused by how the British navy found it useful from time to time to hang or shoot an admiral, "in order to encourage the others". A case could no doubt be brought against the "admirals" of New Zealand psychology, who under the flag of cognitivism led us into the cul-de-sac of panopticism. However Saul notes that from 1914 onwards western nations took to hanging medals on the chests of incompetent commanders and encouraging them to retire. Far more civilized.

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