

Mental Health is an Abominable Mess: Mind and Nature is a Necessary Unity

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A review of the empirical literature on mental health outcomes, when a strict criteria of 'recovery' is taken, shows recovery rates in most 'real world' mental health services to be poor. At the same time trials from a large number of 'laboratories' are showing that very high recovery rates are achievable. This paper suggests the 'lab-clinic' gap may well be bridged by reviewing the philosophical foundations underlying the delivery of mental health services. In the 1930's the philosopher Ludwig Wittgenstein noted that philosophical confusions by Freud had led him and his disciples into making "an abominable mess" (Wittgenstein, 1993, p.107). A number of Wittgensteinian scholars hold these confusions remain pervasive today throughout the 'psy' disciplines (e.g., Cioffi, 1990; Bouveresse, 1995; Winch, 2007; Heaton, 2010). A new paradigm for the 'psy' disciplines is emerging from these philosophical elucidations, which now has a body of empirical evidence supporting it. This not only shows much promise for dissolving the 'lab-clinic' gap in mental health, but also has strong implications for our ecological health. At the heart of this paradigm is a recognition of the necessary unity Batson (1997) identified between mind and nature.

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Abominable Outcomes

A strong argument can be mounted, on the basis of the available evidence, that besides offering an increasing amount of employment, mental health services are not doing a great deal of good. Lambert (2010) claims that 75% of people entering community mental health centres in the USA are either not responding to treatment, or worse, deteriorating whilst in care. The Centre for Social Justice (2012) in Britain, reviewing the effectiveness data generated by the National Health System, found only 15% of people entering Britain's mental health are achieving 'recovery'. In the United States, Hansen and colleagues (who also found a 'recovery' rate of only 14%), along with others, found that about 5-10% of clients in adult services appeared to get worse during treatment (Hansen et al 2002; Lambert & Ogles,

2004; Lilienfeld, 2007). Warren and colleagues (2009, 2010) found a staggering deterioration rate of 24% amongst children in public community mental health settings. There have also been worrying comments in Australia, with claims that despite increases in pharmacological, psychological, and population interventions over the past 16 years there seems to have been no improvement in the adult mental health of the population (Jorm & Reavley, 2012). Reflective of this phenomena, mental health services of King County, Seattle sought and were granted a waiver in 2004 to no longer monitor 'recovery' outcomes (based on GAF scores), after finding for three years in a row that less than 8% of those with a 'serious mental illness' (SMI) ever move out of that category, and of those that did, many regressed back (CCHR Seattle, 2004).

The Hansen study (2002), (65% 'not improved' or 'deteriorated'), often considered the benchmark study of effectiveness in a variety of 'real world' treatment centres, did not include many who dropped out after the initial session; hence Lambert's claim of 75% not responding or deteriorating. Hansen and colleagues cited a number of possible causes for the paucity of results, including limitation of services "...as a result of physician gate-keeping process" (p. 329). Numerous prominent psychiatrists have been more publicly critical in their attribution of ineffectiveness in mental health being due to the dominance of biological psychiatry (Jackson, 2005; Double, 2006; Breggin, 2008; Moncrieff, 2008; Ross, 2008; Healy, 2012)¹. Investigative reporter Robert Whitaker (2010) made a blistering attack on mental health services by documenting a tripling of the number of disabled mentally ill over the past two decades as the sales of various psychotropic medications soared. Also, numerous writers following in the footsteps of Foucault (1980), have argued that there is a 'looping effect', in that as more psychiatric labels enter the public lexicon more people are self-recruited as patients (e.g. Hacking, 2007; Rose, 2007).

Psychotherapy is Efficacious

Despite such poor results in 'real world' clinics, as documented above, psychotherapy has been shown to be highly effective for a variety of mental health problems, including severe mental illness (SMI). Both qualitative and quantitative reviews show that about 75-80% of people benefit from psychotherapy; outcomes

that surpass many medical treatments for a variety of non-mental health problems (Wampold, 2001; Lambert & Ogles, 2004; APA, 2012). Meta-analyses of a number of psychotherapies, such as CBT (Wykes et al., 2008; Sarin et al, 2011), and psychosocial treatment with antipsychotic postponement (Bola et al, 2009), have been shown to have a strong evidence base in the treatment of so-called 'schizophrenia' or 'SMI'. Seikkula and colleagues (Aaltonen et al, 2011; Seikkula et al, 2011) have set the benchmark in the treatment of psychosis with a psychosocial intervention. They have shown themselves, at two- and five-year follow-up, to be the most effective mental health service in the world, in terms of having the most clients (approximately 80%) in full-time work or study, medication-free, and lowest residual psychotic symptoms. As Klingberg and Wittorf (2012) conclude in their review of evidence for psychosocial interventions for SMI, "psychosis psychotherapy does not have an evidence problem but an implementation problem". As one wit remarked, "the anaesthetists have taken over the theatre of mind preventing the therapeutic 'surgeons' from doing their task".

Resolving the Efficacy-Effectiveness Discrepancies

As much of the evidence for the efficacy of psychotherapy has stemmed from tightly controlled clinical trials and the paucity of effectiveness from 'real world' clinics, Weisz and colleagues (1992) have called this a 'lab-clinic gap'. This 'lab-clinic gap' has sparked much research and speculation (e.g., Barlow, 2010; Castonguay et al, 2010; Dimidjian & Hollon, 2010; Duncan et al, 2010; Webb et al, 2010). Although most efficacy trials ('lab') are conducted with homogenous highly motivated clients, and effectiveness studies with heterogeneous mixed motivation clients ('clinic'), the difference cannot be attributed solely to this, as there are variations between clinicians and clinics, with some achieving outcomes as high as those in efficacy trials (Minami et al, 2008; Duncan et al, 2010). Those attracted to the Empirically Supported Treatment (EST) position explored the question of therapist adherence

or competence in delivering an EST as the cause of the difference. This has resulted in ambiguous findings (Bumbarger & Perkins, 2008; Coull & Morris, 2011; Weck et al, 2012). Some found high adherence and rigidity in deliverance correlated, thus impeding beneficence (Castonguay et al, 1996; James et al, 2001); whilst others found a positive link (e.g., Huey et al, 2000). Whilst those attracted to the EST position marshalled evidence on the nuances of adherence, those favouring the 'common factors' or 'contextual' position (Wampold, 2001; Frank & Frank, 1991), marshalled evidence to show that there is no demonstrable differences between 'bona fide' treatments (the 'dodo bird conjecture'): that the specific ingredients of the EST account for only 1% of the effect size of treatment, that resource activation early in treatment (indicated by early change), the therapeutic alliance, and variations in therapists effectiveness, were the factors driving the 'lab-clinic gap' (Gassman & Grawe, 2006; Spielman et al, 2007; Benish et al, 2008; Duncan et al, 2010; Timimi et al, 2013).

In 2005 the American Psychological Association convened a task force of leading researchers from the debate between those attracted to the EST position (specific factors) and proponents of the contextual position (common factors), in order to define Evidence Based Practice in Psychology (EBPP). They concluded EBPP is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p.273). They noted that EBPP is broader than EST, in that although the therapist might consider an EST, they should *not* be limited to the use of them in the intervention. They also noted that "Meta-analytic investigations since the 1970s have shown that most therapeutic practices in widespread clinical use are generally effective for treating a range of problems. It is important not to assume that interventions that have not yet been studied in controlled trials are ineffective" (p.274). Finally they noted that "ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP" (p.280).

About this time, the EST versus Contextual view had generated a 'fidelity-adaptation' debate (Baker, 2000; Ringwalt et al, 2003; Hill et al, 2007). Attempts to improve adherence to an EST via self-report had been found to have low reliability as they were, perhaps understandably, skewed towards the therapist compared to observational ratings (Miller & Mount, 2001). Observational measures of therapist fidelity-adherence with the EST were more reliable, but the costs were obviously problematic (Hansen et al, 1991; Harachi et al, 1999). After the APA task force report, many of those preferring the EST position began advocating for the utilisation of an outcome management system as well, on the claim that if good progress was being made then this would show appropriate and flexible adherence to the EST (Barlow, 2010; Castonguay et al, 2010; Kazdin, 2008; Mozdierz et al, 2011; Persons, 2008). Similarly, those advocating for greater adaptation of ESTs, where we "encourage clinicians to borrow strategies and techniques from the best known treatments" (Chorpita et al, 2007, p.649), also began advocating for outcome management systems (Weisz et al, 2012). Although it is noteworthy that there is a convergence on monitoring progress, it does not appear to have occurred to adherents of the EST position that if progress is being made it matters little if adherence to an EST is occurring or not. As Bickman and colleagues conclude, their study has "shown that mental health outcomes can be improved without necessarily introducing a more usual evidence-based treatment" (2011, p.1429).

There is now a substantial body of evidence supporting outcome monitoring and feedback (sometimes called 'feedback informed therapy') as a means of reducing the lab-clinic gap (Saptyta et al, 2005; Duncan et al, 2010; Lambert, 2010; Newnham & Page, 2010). Results to date show feedback leads to fewer sessions for clients who are progressing, less drop outs or treatment failures from those not progressing, and for many therapists, a more than doubling of their effectiveness (Brown & Jones, 2005; Anker, 2009; Duncan et al, 2010; Lambert & Shimokawa, 2011). This has led to a growing

number of outcome/progress monitoring feedback tools, no doubt fuelled in part by market forces. There appears to be some convergence on a number of core criteria for such tools, although a number of empirical questions can be raised for further investigation. The first of these is a preference for client self-report measures rather than clinician-completed measures, as the client's self-report of distress-wellbeing has been found to be the strongest predictor of change, and clinicians are not so good at picking up clients who are deteriorating (Garb, 1998; Minami et al, 2008; Duncan et al, 2010; Lambert & Shimokawa, 2011). This also fits with the 'recovery' philosophy of giving "authority" to determine outcome to the client. The second is immediacy of feedback; if feedback is to be effective it needs to be timely (Lambert et al, 2001; Peterson, 2005). A third is frequency of administration, with preference given to every session rather than fixed time intervals or session numbers (e.g. every third session) (Duncan et al, 2010; Lambert & Shimokawa, 2011). A fourth is feasibility; it would seem that any measure that takes more than a minute to administer and score gets lower levels of compliance from therapists (Brodey et al, 2005; Duncan et al, 2010). Finally case mix analysis has to be allowed for, as the "worried well" do not make as much progress as fast as the more distressed; indeed many 'worried well' get worse with treatment (Brown et al, 2001; Clarkin & Levy, 2005).

It has recently been suggested that agencies with large databases (e.g. government departments) can develop new outcome measures "on the trot" so to speak (Lambert, Minami, et al., 2013). This allows different agencies to compare outcomes more flexibly even when dealing with specialist populations.

Mental Health Outcomes in Aotearoa-New Zealand

In the U.S.A. the President's New Freedom Commission on Mental Health, declared in its interim report that the public mental health system is in "shambles" (2002, p.ii). Here in Aotearoa a similar declaration was made in the Mason Report a few years earlier, describing our mental

health services as "fragmented" and "under-resourced" (1996, p.100). This led to numerous reforms, including the creation of the Mental Health Commission, an extensive anti-stigma campaign, a 'recovery' focus, and a wider range of services. Funding more than doubled over the ensuing years, and we saw various plans on how we might improve mental health issued by the Ministry of Health and the MH Commissioner. Calls for greater accountability and evaluation of services led to law changes and the development of a managed care environment (MH Commission, 2007). Has it improved? In a co-authored paper with one of our former MH Commissioners, Rosen and colleagues warned: "Accountability or evaluation mechanisms which are internal to or dependent on health departments or ministries, even when quite elaborate, can be used to produce results which are easily gamed or massaged to make even laissez-faire or regressive administrations look good" (Rosen et al, 2010, p.594). The Mason report itself warned against equating service development with quality, as often "improvements" do not affect the wellbeing of the consumer and his/her family (1996, p.178). Further, a couple of years ago, the MH Commission reported that the two key goals of the reforms, decreasing the prevalence of mental illness and increasing the health status of the people affected, have not been met. If anything, mental health issues have increased globally (2007, p.178).

As part of these reforms, MHINC (Mental Health Information National Collection) was established in 2000 to monitor mental health data collection in the public sector, and introduced the Health of the Nation Outcome Scale (HoNOS) (Wing et al, 1998) to NZ mental health services in 2002. In July 2008 the use of this tool became mandatory in NZ District Health Boards (DHBs) with the inception of PRIMHD (Programme for the Integration of Mental Health Data); and Te Pou, an independent trust, began collating the data and training clinicians in its use. Since its inception compliance rates have been poor (but improving), which as Te Pou acknowledges in its reports, means making any meaningful

analysis of whether people entering NZ mental health services are 'recovering' questionable (Te Pou 2013a, 2013b). These reports show that if we were to accept that a 30% compliance rate amongst adult community mental health services at discharge was a representative sample, then a little over 40% are being discharged in a sub-clinical range (i.e. 'recovered') (Te Pou, 2013a, graph 8). Child community mental health scores, with a slightly higher compliance rate of approximately 40% at discharge also indicate a recovery rate of approximately 40% (Te Pou, 2013b, graph 8). Although this appears on the face of it to be a marked improvement on the 15% recovery rates found by Hansen and colleagues (2002); as we shall see it ignores another (besides the question of sampling) fundamental flaw in clinician assessed forms; a criticism that does not appear to have been discussed by those implementing the HoNOS suite in NZ (The HoNOS Working Party, 2010).

Gaming and Questionable Statistics

In Johnson's (2009) review of a multitude of clinician based assessments of clients, there is a consistent finding that although inter-rater reliability between clinicians is often fair (but not good), there is all too frequently a poor correlation with client self-assessment (and, as noted above self-rating is a better guide to improvement and drop-out potential). Further, even if inter-rater reliability can be achieved in the 'lab', questions have been raised as to whether that will flow on in the field. Take for example the Problem Severity Summary (scale) developed by Srebnik and colleagues (2002), where they comment: "tying improvements in PSS ratings to fiscal incentives may cause biased ratings, particularly if clinicians are aware of the incentives. Furthermore, implementing incentives for improved outcomes alone may lead to "creaming", or shifting access to services towards individuals who more easily attain desired outcomes" (p.1016). As talk of fiscal incentives for clinicians (and clinics) achieving better outcomes mounts in the literature (e.g., Centre for Social Justice, 2012; Lambert et al, 2013), clinicians may well come to regard clinician assessed

outcome forms as actually performance ratings of their own skills. As such they will be tempted to score the client as quite dysfunctional on admission, and recovered on discharge. When demand characteristics of quality improvement become service policy, as in the KPI systems currently dominating MoH and the 'pay-by-results' ('social bond' contracts) planned for many government departments, the results will be 'gamed' (Bevan & Hood, 2006; Lowe, 2013; Luchins, 2011). The example provided by Rosen (2010, p.594) of massaging statistics is a paper by the Australian proponents and advisors on HoNOS (Burgess et al, 2006), which claimed that people using Australian mental health services are "getting better". Most of us would read that claim as saying that most people are recovering; but actually the paper shows that a little over 50% are 'improving', not 'recovering', on the basis of some shifts in their HoNOS scores. The only way out of what amounts to a self-referential dilemma of clinician based assessments, is the use of client self-rating². This fits with Standard 9 of the National Mental Health Standards (MoH, 1997), which stipulates consumer participation at "every level of evaluation". This does not necessitate clients having to also invent their own self-rating forms, as some have interpreted this, as there are well-validated measures such as the ORS and OQ45 already in existence.

Further criticism of the HoNOS suite is brought by Happell (2008) who raises the question of whether these forms are in fact a potential risk for impeding recovery. The recovery research makes clear that clients want to be related to as 'persons' and not as 'illnesses', but the HoNOS encourages the clinician to focus on symptoms, thus increasing the risk of the clinician focusing on the client as a cluster of symptoms that need eliminating or reducing rather than a 'person'. Further evidence for treating Te Pou's HoNOS figures, which suggest a recovery rate of approximately 40%, with some suspicion is the growing number of people in New Zealand on sickness or invalid benefits due to mental health reasons. In the US, The National Council on Disability stated "most people with psychiatric disabilities who are poor

are merely being 'warehoused' in the community rather than being helped towards recovery and independence" (2002, p.10). Whitaker (2010) has well documented the tripling of the number of Americans on government disability between 1987 and 2007. A similar trend has happened here (Mental Health Commission, 2007, Whitaker, 2011; and this appears to parallel the increases in mental health budgets. It is hard to reconcile an apparent increase in recovery rates if the number of clients being 'warehoused' is constantly growing. It is noteworthy in this respect that the Ministry of Health proudly reports an 11% decrease in bednights in DHB mental health services between 2001 and 2010, and go on to suggest this may be due to a shift towards a recovery focus and relapse prevention plans. However the massive increase in bednights in NGOs suggests that overall there has been an 81.4% increase in bednights (MoH, 2013, p.33). This growing population of 'disabled' mental health clients are also disadvantaged with regards to affordable housing and the workforce. It is difficult then, not to conclude that on the basis of the evidence, public mental health services are not particularly effective.

Mangled Care

The reforms to mental health following the Mason Report occurred at the time of the neoliberal influences of Thatcher, Reagan and 'Rogernomics'. Arguing that the authority delegated to humanitarian and benevolent health and welfare leaders ('knights') were being swayed by interest groups ('knaves'), leading to uneven or out-of-control expenditure, the neoliberals introduced "market style incentives to root out the pathologies of its bureaucracy" (Kettl, 2000, p.1; Le Grand, 2003). Although there were 'knaves' and pathologies in the system (witness the pre-1992 'Confidential forum for former in-patients of psychiatric hospitals) (Dept. of Internal Affairs, 2005), the 'cure' has generated its own pathologies and 'knaves'. The supposed cure was a form of governance called "(new) managerialism" (Davis, 1997; Munro, 2004; Burton & van den Broek, 2009; facebook, 2013). This has led to the elaboration of

explicit standards and measures of performance in quantitative terms (but no measures of the most important thing of all, the numbers actually recovering), separating funders from providers, thus effectively creating a form of managed care in these countries. Whilst some see efficiencies in such forms of governance, there is a "loss of social intelligence" (Pusey, 1991: p.22), as who decides 'what counts' has shifted from the practitioner and others trained in the humanities, to managers trained in economics (which is why some call it 'mangled care'). Because managerialism sees itself as an antidote to chaos (ignoring the self-organising or manager-less capacities of everything from slime mould colonies and ant nests to some human groups (Parker, 2002; Hazy et al., 2007; Rolling, 2013)), there is little space currently for clinicians within public health to reclaim the autonomy over their practice they once enjoyed. Although practitioners and their professional bodies can lobby for 'what counts'; are they doing so from a philosophical position congruent with, what we might call Bateson's (1997) (and others) "ecological mindfulness", or from a position more Cartesian in form, which are the very assumptions generating this 'abominable mess'? Is it possible that many of the 'knaves' moved from clinical positions to managerial positions? Further, as managerialism, in effect, is placing the authors of its mandated practices in the therapy room alongside the clinician (Krause, 1996), is there not a case for broadening the scope of the NZ Health Practitioners Competence Assurance Act 2003, to include these authors in the accountability process? If HoNOS, for example, is a barrier to recovery, as Happell (2008) contends, who is accountable for this harm?

Managing versus dissolving 'risk'

Although the micromanagement of clinical care may have aimed at eliminating some of the worst clinical practice, it appears to have (unintentionally) prevented the best, as it overrides professional skills and knowledge. One of the most common cited reasons for the form managerialism has taken has been attributed to the rise of

the 'Risk Society'. Beck (1999) argues that many bureaucrats spend a lot of time devising systems and programmes to protect them, their agencies, and their political masters from being charged with a failure the media sensationalises as their responsibility. There is little in the way of empirical evidence that shows that the risk management policies so generated protects the public any better, but it has led to an immense accumulation of pseudo-accountability (Lees, et al., 2013). Not surprisingly, Smith and colleagues (2003) found that British social workers were far more frightened of being blamed by their managers or professional bodies for not adhering to these procedures, than of bodily harm by their clients³.

Managerialism first began tackling risk in the health sector with nurses in Britain, by splitting up the nurse-patient relationship and insisting on ritualised task performance that encouraged them to ignore their professional intuitions in favour of 'doing it by the book' (Lees, et al., 2013). High profile inquiries into deaths of children in welfare services has similarly led to management techniques focused on "correct procedures". Numerous commentators have indicated that one of the major consequences has been clinicians and welfare workers diverting time away from clients to the fulfilment of administrative roles that are primarily defensive. This concern is much wider than health, and is often disparagingly referred to as the "OSH culture" ("Occupational Safety and Health").

In mental health, the consequences of this risk-averse managerialism is seen in the growing number of 'high users'. In less than a decade the 10% of 'high users' went from 50% of mental health expenditure to over 70% of clinical time (Buck et al., 2003). In the 1980s, Assertive Outreach Teams were developed to keep these high users out of costly in-patient beds; and then, later, 'early intervention teams' also. But there have been a growing number of voices contesting the use of coercive services offering 'treatment' to reluctant people, especially where the primary emphasis is upon medication compliance (e.g., Williamson, 2002). When coercive means are used, such as involuntary hospitalization, there is

a loss of trust lasting years, and trust is a key ingredient in successful therapy (Blanch & Parrish, 1993; Laurance, 2003). McGorry (2006) calls this "the iatrogenic effects of standard care"; and Mullen and colleagues (2008) report the growing increase in defensive medicine in NZ mental health. This is also reflected in the growing numbers of people sectioned under the Mental Health Act over the past decade (Ministry of Health, 2012).

As most practitioners know, in one form or another, the way to deal with fear is not to overpower the object of fear, but to transform fear into a more healthy wariness towards the object of fear. Although particularly challenging in crisis situations, engagement with the client is the key to successful therapy (Laurance, 2003; Drury & Munro, 2008). But as we have seen, managerialism of risk in health began with nurses being encouraged to de-emphasize the nurse-patient relationship in favour of ritualised tasks. Behind the fixation on such managerial rituals as risk assessment and risk management plans, Rose (2007) claims, is not a use of clinical judgement for care, but one of control of those who might pose a threat to the community. Leaders in the field of psychiatric risk, such as Paul Mullen (2000), stand much closer to the consumer movement when they suggest that psychiatric risk is best approached as a therapeutic task; making engagement crucial rather than these managerial rituals where something is done to the client. Intuitions, arising out of an empathic relationship are the key to risk assessment and therapy, and as De Becker says "cookie-cutter approaches are dangerous" (1997, p.88). Flannery and Walker (2003) acknowledge that some clinicians have better developed skills in this area than others. Although police crisis negotiation literature (e.g. Greenstone, 2004) and child welfare literature (e.g. Turnell & Edwards, 1999) have highlighted some communication patterns in developing collaborative relationships, with the notable exception of Andreas (2011), there is generally a paucity of case studies in this area. I would suggest that the fear driving managerialism may be considerably ameliorated, by making more 'newsworthy' where our

best 'human horse-whisperers' have been successful.

Like the claims of consumer representation made by managerialism, there is scant evidence that any of the various ritualised tasks managers developed have an empirical basis despite their repeated lip-service to being an evidence based service. There appears to be no evidence that 'risk assessments' or 'risk management plans' have any support from the empirical literature⁴. Further, as the 'recovery' paradigm sweeps the globe, a rationale has developed in numerous services that since there are varying definitions of 'recovery', thus making outcomes difficult to measure, the service will focus on whether 'recovery plans' are being completed as evidence that the service is recovery focused. However there is no empirical evidence that recovery plans lead to more recoveries. Indeed as Seikkula and colleagues (1995), who are achieving 80+% recoveries from psychosis in their service, comment: "Earlier, we thought we first had to devise the treatment plan and then implement it; [but] by opening the boundaries of discussion, the joint process itself started to determine the treatment, rather than the team itself or the treatment plan of the team" (p. 64). The philosophical assumptive base of Seikkula is quite different, a matter of practicing Vygotsky's 'tool-and-result' methodology (where knowledge is not separate from the activity of practice), as opposed to applying the 'tool-for-result' approach that engineers, builders and most doctors take with objects (Holzman, 1999). (Lewis Carroll's croquet with flamingos and hedgehogs is illustrative of the problem using 'tool-for-result' methodology with creatures.) Furthermore there is a lack of empirical evidence that even assessments are a necessary precursor to successful psychotherapy⁵. The philosophical assumptive base of managerialism and its Key Performance Indicators are those of the 'tool-for-result' methodology, which we commonly call 'the medical model'.

A little philosophy

The well-known NZ mental health consumer advocate Jim Burdett once commented: "Mental health services

may have enough doctors, nurses, psychologists and social workers; the question is, are there enough philosophers?" (M.H. Commission, 2007, p.127). Currently mental health services appear to be largely guided by Cartesian assumptions as to the nature of mental processes, approaching 'mind' as another organ to be known via assessment, and do not appear to have familiarised themselves with recent philosophy of mind literature. Eighty years ago Wittgenstein accused Freud and his disciples as having generated an "abominable mess" due to conceptual errors in their thinking (Bouveresse, 1995); these errors are still apparent.

The confusion of 'cause' and 'reason' is a central aspect of this. Generally speaking we know the 'reason' we did something, but a 'cause' is a conjecture. One of the examples Wittgenstein (1958) provided was to consider the situation where I become delighted (or frightened) on seeing a particular face (§ 476). If you were to ask me why I showed delight (or fear), I would say "it was that face", giving you the reason. But as to the cause, we can only speculate. Perhaps it was an association I made as a child between clown's faces and being delighted (or frightened), but I don't remember. This is a speculation, and in our conversations with other psychologists, we might speculate as to the 'cause(s)' of various associations. The confusion between cause and reason is often generated by 'why' questions, as they can be answered either way (Wittgenstein, 1966, p.15). Now desensitization to that face can occur without the cause ever being known. As some schools of psychotherapy (e.g. Solution Focused Brief Therapy) have noted for some time, we don't need to know the cause of a problem to be therapeutic⁶.

This criticism by Wittgenstein was part of his attack on a mechanical 'scientism', which he saw increasingly dominating the Western intellect (Drury, 2013). He thought Freud had been seduced by this 'religion' of the industrial culture (Bouveresse, 1995). Similarly, past president of the American Psychological Association, George Albee, argued that clinical psychology sold its soul to the devil at Boulder, Colorado, in 1948 when it adopted the

'scientist practitioner' model, aligning it with the medical model (1998). This cause-reason confusion has led to the proliferation of hundreds of schools of psychotherapy, each claiming to have the 'true cause' (Lambert et al., 2013, p.6).

Although medicine, by and large, finds it important to make a diagnosis or discover a cause, and can relegate to a secondary place how the doctor reasons with a patient, in mental health this is reversed. Our task is one of engaging with the reasoning process of the client, and the 'cause' is secondary, or perhaps of no importance for the treatment. What led Wittgenstein to take an interest in Freud was that the problems he, as a philosopher, and Freud, as a mental health practitioner, were dealing with were orientational problems; how we might orient to our environment in a more fruitful way (Shotter, 2012). This strongly suggests that mental health services need to make more space for counselling psychologists as they work more within the 'tool-and-result' methodology, as the quote from Seikkula (above) attests. A matter of working with the reasoning of the client without the necessity of making causal conjectures; or of privileging 'witness knowledge' rather than 'aboutness knowledge' (Shotter, 2012).

Bateson (1997) made a similar analysis of the heart of the 'psy' confusion when he noted that living things use energy from their own metabolism in their response to various stimuli, which is quite unlike causal processes in the physical world (where energy is transferred from one billiard ball to another)⁷. From this observation he defined 'mind' or a 'mental process' as a circuit where each part, using its own energy, can 'trigger' the next to respond. So if we are felling a tree, there is a circuit that includes the gash in the tree, the eye, the brain, the muscles, the axe, and the gash, which 'information' is flowing around. 'Mind' for Bateson, was immanent to this circuit (and not a transcendent entity watching it); and when we sit down for a break from our labour a different circuit or 'mind' comes into play.

He went on to ask where the blind man's 'self' begins⁸. At the handle of his cane? At the tip? Halfway up the cane?

Well, 'self' or 'mind' is not determined by anatomy experientially; our attention is flowing around a circuit that includes the cane and the street. In this way 'mind' is extended or 'distributed'. We find a similar idea in Heidegger's (1962) notion of 'Dasien'; most of the time we are so absorbed in our activities that we are not aware of any 'gap' between our self and the world. The car or hammer feels like part of me (until something goes wrong). For the Cartesians 'mind' was 'in here' (anatomically), and the world 'out there'; but in this newer philosophy of mind, 'mind' is both 'in here' and 'out there'. There is some speculation that Heidegger may have been influenced in his development of 'Dasein' by Zen Buddhism, for this is known in Zen as the doctrine of 'no mind' (Suzuki, 1949; Noë, 2009).

Now Wittgenstein, in his later philosophy (1958), also showed us that we can and often do experience this same sense of unity socially. A conversation can take on 'a life' of its own (Shotter, 2012). Our attunement with each other is such, that most of the time we are able to directly 'mind-read' each other, without having to infer how it is with each other via some sort of interpretive device or 'theory of mind' (Leudar & Costall, 2009)⁹. Wittgenstein wrote:

"We see emotion" – as opposed to what? – we do not see facial contortions and make the inference that he is feeling joy, grief, boredom. We describe the face immediately as sad, radiant, bored, even when we are unable to give any other description of the features. – Grief, one would like to say, is personified in the face. This is essential to what we call 'emotion' " (1980, §570).

Proponents of 'theory of mind', we might say, have viewed the glass as half-empty, stressing the times we have difficulty 'reading' the other, or when there is deception; but as Wittgenstein notes deception is a game learnt later in development. If grief didn't have certain characteristics, one couldn't learn to feign it. Many see the philosophy of Wittgenstein's later work as a form of therapy for overcoming our culturally induced sense of separation or alienation from each other and nature (Read &

Crary, 2000).

In this regard consider Wittgenstein's elucidations on perception, which have been developed further by Gibson (1979) and Noë (2009). The primary function of perception is not to obtain clear representations (pictures) of the world (as so long thought, and which Cartesian science is built upon), but to develop sensorimotor skills for the purpose of keeping track of our relationship with the world; or, more simply, to stay attuned with the world. Noë (2009) calls the Cartesian assumption "the grand illusion"; the idea that we are separate minds interpreting sense data and each other in order to navigate our way through life. Wittgensteinian scholars argue that the only people who need a 'theory of mind' to socially navigate (besides some mental health professionals) are those attracting a diagnosis of Aspergers, as they lack 'the instincts' the rest of us enjoy (Leudar & Costall, 2009). Further, these considerations have led to the argument that developmentally, the sensorimotor stage is not abandoned or overcome, as Piaget suggested, but is refined as language and perspective taking develop (Thelen, 2000).

As we are able to 'mind-read' in most situations, Wittgenstein saw an ethical demand in our intersubjectivity, especially with suffering: a "primitive reaction to tend, to treat, the part that hurts when someone else is in pain; and not merely when oneself is.... - a response of concern, sympathy, helping" (1967, §540). This same idea finds expression in the philosophy of Emmanuel Levinas (1998), where the 'face of Other' appeals to my goodness or responsibility, it invites my hospitality. This 'call of Other' is the basis of our humanity; all our thoughts and actions as humans stem from this 'call' (Gantt & Williams, 2002; Overgaard, 2007). This prioritises heteronomy over autonomy, and Levinas is eliciting a great deal of interest in current philosophy of ethics, as it has generated an uneasy tension with the ideals of liberation that drove the Enlightenment and our current economic games (Aasland, 2009). Both Levinas and Wittgenstein find strong attraction to Dostoevsky's character Father Zossima, who says in this regard: "everyone of us is responsible

for everyone else in every way, and I most of all" (Dostoevsky, 1958, p.339). Levinas calls his own philosophy an 'ethics first philosophy', on the basis that because of this heteronomy, ethics precedes ontology or epistemology ('know that').

As might well be imagined, these insights from philosophy have sparked a revolution of sorts in cognitive science, called Radical Embodied (or sometimes 'Extended' or 'Enactive') Cognition (REC) (Chemero, 2009; Clark, 2008; Gallagher, 2005). Rather than thinking of thinking as something going on in the head, REC views thinking as the subtle positioning and re-positioning of our bodies in the world (Harré & van Langenhove, 1999; Miles et al., 2010). Change blindness (losing attunement) is of more interest than illusion (not getting a clear picture) in this paradigm. In psychiatry, embodied cognition is leading to new insights into the nature of many of the 'disorders' dealt with there too; for example so-called 'schizophrenia' is seen as 'disembodiment' rather than a disturbance in 'theory of mind' (Fuchs & Schlimme, 2009). Similarly, 'autism', as the embodied cognitivist Gallagher (2005) argued, is not a ToM disturbance so much as sensorimotor one; and hence treatable (Porges, 2011; Drayson, 2009). With regards to psychotherapy, the values of counselling psychology are preferred over clinical psychology, as attunement to the client as they attune to the world is the primary function (Drury, 2013).

Putting ourselves out of business

With the resolution of the mind-body problem in light of these philosophical considerations and the development of Radical Embodied (extended) Cognition, the opportunity arises to cultivate a more selfless culture. With the recognition of our heteronomy, "I" finds more use as a pronoun rather than a noun; and 'relational mindfulness' becomes central to psychotherapy and cultural development (Bakhtin, 1981; Surrey, 2005; Lysack, 2008; Falb & Pargament, 2012). A pathway opens here to put mental health services out of business (Robbins, 2000).

If we are to realise Bateson's (1997)

dream of the necessary unity of mind and nature we need to dissolve the individualism that drives neoliberal capitalism (Aasland, 2009; Aldred, 2010). Foucault (1980, 1982) indicted the 'psy' disciplines for their role in the fabrication of the individual subject by the industrial culture's technology of power. However, Foucault's work on governmentality also showed that the 'psy' disciplines could play a central role in deconstructing the sociogenesis of the atomistic self-interested *homo economicus* (Ferro, 2013; Rose, 2007; Hook, 2007). This philosophy of self-interest has led to a situation where wealth accumulates into the hands of fewer, who in turn, attempt to store this wealth in loans to the growing poor, until the bubble bursts (Wikipedia, 2013). Rather than relying on an 'invisible hand' to protect public good, or turning to Marxism as a solution, Levinasian scholars argue that selfish *homo economicus* needs upsurping with at least *homo reciprocans*, or preferably, Levinas' "ethics first" that does not even require reciprocity (Aasland, 2009; Aldred, 2010; Ferro, 2013). Greed or selfishness is a mental health issue in need of urgent address; a more ethical way of being centralized (Dean, 1999). A growing number of psychologists have noted that the 'McDonaldization' of clinical psychology carry values of *homo economicus* that are alien and offensive to many in other cultures (Marsella, 2012; Prilleltensky, 2012)¹⁰.

An example of where psychology can be seen to be putting ourselves out of business can be found in Seikkula and colleagues work with psychosis or SMI (Aaltonen et al., 2011; Seikkula et al, 2011). Utilising Vygotsky's tool-and-result methodology, Seikkula's team begin their work in the home of a new client by holding 'Open Dialogue' meetings with the client and his/her social network. One can take the view that both the client and the social network have taken refuge in an exaggerated state of isolating monologue (Anderson, 2002), unable to engage each other (i.e. there is a "breakdown" in the network's "collective mind"). Reports by Seikkula and his colleagues indicate that both the members of the network and the client were initially quite frightened; however they are all soothed when

the deliberating atmosphere of Open Dialogue is facilitated, by allowing multiple viewpoints to be entertained. Re-engaging the network and client in dialogue is the aim of the therapy; and as the re-engagement occurs the psychosis abates. They have incredibly low rates of hospitalisation and if medication is needed, the preference is a brief spell of anxiolytics rather than anti-psychotics. Now that they have been doing this for over two decades, they are finding that within the social networks are veterans of previous Open Dialogue meetings. Thus the community is becoming knowledgeable about how to deal with psychosis, and they are in effect, putting themselves out of business.

Another possible avenue lies in Porges' (2011) polyvagal theory. With the resolution of the mind-body problem he provides us with perhaps the first biomarker of mental-physical health. Vagal tone (the variability in heart rate between in-breath and out-breath) serves as a biomarker for the balance between the sympathetic and parasympathetic nervous. Prolonged imbalance can lead to various health problems; and the social engagement system serves as a gateway to facilitating greater harmony. Therapists utilising Porges' polyvagal theory are stressing relational mindfulness in their therapy (e.g. Ogden & Fisher, 2014). Relational mindfulness can be contrasted with the individual mindfulness, which has been criticised as little more than another "coping mechanism for dealing with the stresses of modern life" (Cohen, 2010, p. 111), or "a technique for improving individuals' functioning within late capitalism" (Stanley, 2012, pp.632). That is to say, individual mindfulness can be seen as a tool in Vygotsky's 'tool-for-result' methodology; whereas relational mindfulness is an aspect of the 'tool-and-result' methodology that we saw in Seikkula's work.

Social work literature cites managerialism as the principle obstacle to the development of more ethical practices that may help us realise the unity of mind and nature (e.g. McLaughlin, 2005; Miller, 2008). 'Witness' conversations, where the therapist remains open to being changed him- or herself, need to take precedence over 'aboutness' conversations, where

the client is fitted to pre-existing schema (Shotter, 2012; Drury, 2013). We see this in Israel's child welfare services which have begun moving away from a pathology and risk focused orientation, to an empowerment focused orientation working around the client's definition of the problem (Strier & Binyam, 2013). Or in Arizona's Southwest Behavioral Health Service, which has introduced client self-rating measures to become a client-directed outcome-informed service (Bohanske & Franczak, 2010).

Conclusion

This paper has set out to show that due to psychology being largely taken over by a form of 'scientism' the discipline has been recruited to provide scientific legitimation for the individualism that drives an eco-destructive neoliberal capitalism. A number of philosophers have shown us numerous deep-seated confusions and problems in this 'scientism', such as that between 'cause' and 'reason'. These difficulties in our own reasoning finds expression in the massive amount of evidence now accumulated that our mental health services are an "abominable mess".

However despite this mess, a subaltern voice finds expression in pockets of clinical excellence where mental health services have outstanding results. When coupled with the insights of the philosophers and sociologists who have resolved the mind-body dilemma, we begin to see that the common factor in these therapies is of therapists attuning to their clients (reasoning) as they attune to the world. In this manner the necessary unity of mind and nature, which Bateson showed, can be realised.

Unfortunately neoliberalism has imposed managerialism upon our education, health, and welfare services, which in many places, making these developments difficult. However, we can find examples of alternate managerial systems that have allowed these more effective approaches to flourish. Such systems have the potential to reverse top-down control systems in favour of forms of governance where bureaucracies support practitioners to empower people to realise their health and potential. There is much onus on psychology as a discipline to further

these developments.

Footnotes

¹ It is noteworthy that many of these authors have had their careers negatively affected by their writings

² In Bevan & Hood's (2006) metaphor of performance indicators (or KPIs) as targets, client self-assessment is closer to the bulls-eye of the target and thus less susceptible to 'gaming'; whereas many current KPIs in use are quite peripheral to whether people are actually recovering. Related to this is the difficulty with totally relying on the MH Commission's definition of 'recovery' as "living well in the presence or absence of symptoms of mental difficulties"; for as Korman (1997) once jested, it allows us all too easily to emulate the tailor who adjusts the customer to the badly made suit, rather than cutting the suit to fit the man. Although primacy should be given to client self-assessment in therapy, we also need the 'hard' measure of 'symptom free', 'without medication', and 'in full-time work or study', such as we see in Seikkula's work to claim 'recovery' has occurred. In this paper I have preferred studies that backed up their claims from 'soft' measures with 'hard' measures, when discussing 'recovery' (or positive outcome). The original intent of the NZ MH Standard Measures and Recovery project was to include a functional measure, a substance abuse measure, and client self-assessment, as well as HoNOS; but presumably due to feasibility reasons these have not been implemented.

³ With procedure taking precedence over outcome 'knights' may well be mistaken with 'knaves'.

⁴ c.f. discussion in the British Journal of Psychiatry following Dolan & Doyle (2006).

⁵ The TV show 'In Treatment' also raises the intriguing question of whether keeping notes may impair therapy. If therapists are more intensely attuned to their clients will they remember better than those therapists who rely on their notes?

⁶ This of course does not prevent therapists from speculating with their clients about alternative possible ‘causes’ of their problems, such as Narrative therapists sometimes do, as it can sometimes be therapeutic to discover a ‘less toxic’ possible cause.

⁷ Bateson argued that misunderstanding this difference in energy use led to “the myth of power”. Keeney & Keeney (2012) provide recent comment on these muddles and how knowledge can get in the way of acting.

⁸ Freud’s pupil Paul Schilder was perhaps the first to use this example, probably as a result of his study of Husserl.

⁹ Thelen et al., 2001 offer an embodied mind solution to the ‘A not-B’ problem which is so central to ToM thinking.

¹⁰ It is noteworthy that Atkinson et al. (2007) claims it was its commitment to multiculturalism, and not its base in humanism or phenomenology that saved counselling psychology from being absorbed by clinical psychology.

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