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A competency mechanism

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Abstract

A critical review is offered of the dominant "competency mechanisms" recommended by the "psy" professions for professional development and public assurance. Although the New Zealand Association of Counsellors has voted against registration under the Health Practitioners Competence Assurance Act (2003), it has advanced "competency mechanisms" similar to those developed by some of the registered professions. These mechanisms are a form of "panopticism," which has been subject to severe criticism by Foucault and other scholars. A review of the evidence shows that neither licensing nor panopticonian self-examination protects the public as intended. An alternative mechanism of routine outcome monitoring is therefore suggested that makes practitioners more directly accountable to their clients, rather than to a third party. This not only positions counselling more favourably, both economically and politically, but also resonates better with the emerging 4E cognition paradigm, which promises to be ecologically more sound.

Keywords: panopticism, professional regulation, competence, outcome monitoring, 4E cognition, whanaungatanga

This article reviews current trends within the literature pertaining to the regulation of health professionals, with a primary focus on competence assurance. The New Zealand Health Practitioners Competence Assurance Act (2003) calls for "mechanisms to ensure that health professionals are competent and fit to practise" (s3(1)). Criticising the mechanism developed by many health professions, including the New Zealand Association of Counsellors (NZAC), of some form of regular self-examination (known as "panopticism"), this article argues that public safety and assurance can be better achieved by transparent routine outcome monitoring. It will also show the emergence of a new paradigm in philosophy, politics, and cognitive science that suggests a sea

change in how competency assurance might be achieved. The paper urges professional associations such as NZAC to adopt this change.

Historical context

Since the 1950s, union membership has been declining, with a shift from production to service industries accompanied by a growth in occupational regulation (Kleiner & Krueger, 2010). This has occurred against a backdrop of an accelerating institutional production of individualism, well-identified by Foucault in his early work (e.g. 1980). Bauman (2007) has described our rapidly changing post-industrial society as "liquid modernity," for the neoliberal agenda has accelerated the individualising process by casting everyone as an entrepreneur, which in turn speeds up the market. As Foucault (2008) foresaw, increases in entrepreneurship or profit-driven market competition result in increased frictions, and this requires more judges to regulate the frictions.[1] Thus, risk management regulations have arisen to deal with these growing uncertainties (Beck, 1999; Power, 2007).

Occupational regulation, as an aspect of this, has increasingly shifted from minimally restrictive forms of peer membership to highly restrictive forms of licensing (or registration) where, in the "psy" disciplines, titles and scopes of practice are prescribed and monitored in some manner (Macleod & McSherry, 2007). Across the board, "[o]ccupational licensing has been among the fastest growing labor market institutions in the United States since World War II" (Kleiner, 2015, p. 2).

This increasingly restrictive approach to occupational regulation would see neither Bill Gates nor Steve Jobs eligible for licensing as executives, as neither graduated from a university. On the basis of his education, Jay Haley, a founder of family therapy and the journal *Family Process*, would not be eligible for registration (or licensing) in any of the "psy" professions today, and might struggle to gain membership in NZAC. Research examining the relationship between therapeutic effectiveness and outcome that considers a variety of practitioner variables—including professional development, years of experience, and qualifications—shows there is no relationship (Chow et al., 2015; Malouff, 2012). However, despite a lack of empirical evidence, regulators continue to insist that competency assurance processes involving practitioner accountability for mandatory continuing education make them more effective and less likely to be harmful.

The claim that they will be less harmful stems from neoliberal risk management procedures, for as Power (1999, 2007) demonstrates, practitioners are increasingly

being judged on their adherence to a set of risk management rules. For example, a Royal College of Psychiatrists survey showed that most recommended "risk assessment" forms were seen as useless by psychiatrists, and primarily a form of defence "to protect the organisation" (Szmukler & Rose, 2013, p. 128). In Power's (2007) analysis, professional focus on clinical outcomes is being marginalised in favour of following defensible process, and with this acceleration of managerialism we are now witnessing a further shift from first-order risk (the safety of the client and others) to second-order risk, the reputational risk to the organisation or profession ("have they followed correct procedures?"). In medicine, this was seen in the increased funding to efficacy research, based on this risk management notion that accountability should shift to a practitioner's adherence to empirically supported procedures (Chiappelli, Brant, & Cajulis, 2012).

However, although practitioner variables can be eliminated to a large degree in some physical health domains, the person of the therapist turns out to be the most important variable in mental health (Wampold & Imel, 2015). Indeed, mandating a specific treatment in mental health may do harm. Nevertheless, best-practice guideline committees threaten to excommunicate practitioners who fail to utilise empirically supported treatments (Cooper, 2011; Prescott, 2013).

Further assaults on effectiveness in the name of efficacy (i.e., "best practice" procedures claims) came with the development of "core competencies." The US Institute of Medicine (Greiner & Knebel, 2003) recommended five core competencies that all 21st-century health practitioners should be educated in as the "key skills" of the workforce. Various professional health institutions changed the number of core competencies (for example, the New Zealand Psychologists Board has nine), and these became the values against which health professionals began to be monitored and were required to self-monitor.

Although the US Institute of Medicine claimed that the "application of the competencies is not intended to be pejorative" (Greiner & Knebel, 2003, p. 49), practitioners might not share that view. Consistent with the paucity of evidence that such surveillance improves performance, it is noteworthy that wide variations in costs, quality, and effectiveness continue despite these efforts (Leifer, 2014; Yong, Saunders, & Olsen, 2010). Increasingly there are claims that it will take transparency of outcomes (of both practitioners and clinics/hospitals) and costs to bring about real quality improvement in healthcare (Henke, Kelsey, & Whately, 2011; Lamb, Smith, Weeks, & Queram, 2013). However, disclosing outcome variances has not been well received by some in the health field (Henke et al., 2011; Yong et al., 2010).

Many aspects of this history have been highlighted by other authors in this journal over the past decades (Cornforth, 2006; Crocket, 2013, 2014; McAlpine, 2011; Miller, 1994; Tudor, 2013). However, much of that conversation has been on the merits of state regulation versus self-regulation (via the professional association), without consideration that if the same mechanism is utilised, the difference might be moot. More recently, this conversation has begun to stress the importance of linking outcome monitoring to quality assurance (Crocket, 2013; Manthei, 2015), which fits well with the central argument of this paper: a need to move from process-based accountability to outcome-based accountability.

A protection racket?

Tudor (2016) argues that overprotectiveness by the "Nanny state," such as we see in the state regulation of the psychotherapies, is an example of Eric Berne's "protection racket."[2] As early as 1974, Pfeffer concluded that occupational regulation in this form is not shown by empirical evidence to be in the interests of the consumers or the general public. Although we are led to believe that public outcries such as the Cartwright Inquiry or the Lake Alice adolescent unit scandal have driven the move to greater regulation, globally the initiative has more frequently come from within the professions themselves (Kleiner, 2006). Carl Rogers (1973) long ago noted that "tight professional standards do not, to more than a minimal degree, shut out the exploiters and the charlatans" (p. 383). Even Adam Smith (1776/2009) saw such endeavours as little more than a protection racket that claimed to protect the public but actually benefitted the guild. He said it was "impertinent" and "oppressive" for the lawmaker to "encroach upon the just liberty" of the workman and his [*sic*] employer to decide whom the employer employs, and that crafts lengthen the apprenticeship to ensure higher earnings (p. 91). Whether or not state regulators or professional guilds determine the length of the "apprenticeship" and the "core competencies" makes little difference to this argument about the effectiveness of the service the public receives.

Adam Smith (1776/2009) had seen that medieval guilds were able to limit the number of individuals working in their industry and thus drive up prices, and all evidence shows that exactly the same is occurring with this resurgence of occupational guilds. The economist Milton Friedman noted the same with regard to the earliest licensed health practitioners (Friedman & Kuznets, 1945). He showed that doctors, who had been able to restrict the number of practitioners, had been able to drive up their incomes in the early part of the 20th century, in comparison to dentists, who had not restricted their numbers.

Kleiner (2015) has demonstrated that the price of services increased by at least 15% in the US through such restrictions, thus adding to the wealth disparity problem, which in turn is generating a lot of the social ills we are being called upon to address (Wilkinson & Pickett, 2009). Wealth disparity was at its lowest during the manufacturing era, as unions forced the sharing of profits. Kleiner and Krueger (2010) also identified the expansion of occupational regulation as a contributor to the neoliberal growth in wealth disparity. There is no compelling reason why it may be any different here in Aotearoa. The NZAC Code of Ethics (2016) calls upon us to "promote social justice" (5.2h), so it is difficult to see how we can justify succumbing to the current dominant discourse on regulation.

Kleiner (2006) also argued that if more regulated professionals were making fewer mistakes because of ongoing competence programmes, their indemnity insurance would be lower. But there was no evidence that this was the case in any profession. Indeed, Kleiner found little in the way of evidence that the public is better protected by the greater regulation of numerous professions, including mandatory ongoing education requirements. Tudor (2011, p. 157) stated that there "are some eleven books (and many more papers) that have rebutted this assumption" that the recipients of "psy" services are better protected by licensing and regulation. Critics of licensing (e.g., Postle & House, 2009; Tudor, 2013) claim that those high-profile public scandals, such as the Cartwright Inquiry, are better dealt with through other legislative bodies such as the Human Rights Review Tribunal or the Health and Disability Commissioner, as they are usually system failures rather than individual practitioner failures. Many of these scandals could have been avoided through the transparency of practitioner and clinic outcomes (Henke et al., 2011; Lamb et al., 2013). Instead, there is this preoccupation with process regulation, which Power (1999, 2007), like many systems theorists, has argued is just another expression of the neoliberal agenda of greater individualisation and "responsibilization." Rather than recognising them by their fruits (Matthew 7:16), system failures are masked by undue attention to their processes.

Moving beyond panopticism

A significant reason for this flaw in our thinking, which causes us to focus on process rather than outcome, can be attributed to Cartesianism: the idea that we have a separate mind standing apart from life controlling it. For Foucault (1977), this way of thinking led to a sophisticated form of governance that he called "panopticism." The early 18th-century English architect and politician Jeremy Bentham designed a prison where the guard tower was such that the guards could look into the cell of each

prisoner, but the prisoners could not observe the guards. Bentham argued that since the prisoners never knew when they might be under surveillance, they would regulate themselves, and he considered this to be generalisable as the perfect metaphor for the governance of the whole population.

Power (1999) claims that just such a governance process became a reality by late in the 19th century, as the management class entered the factories and used forms of panopticism to regulate deviations from the most economic behavioural norms. Foucault viewed this mechanism as having been so successful that it had created a self-surveilling society of "fabricated" docile subjects, monitoring ourselves for deviation from "normalizing judgements." These judgements are distributed in everyday conversation and institutional practices.

Some may question why Foucault (1980) called panopticism "diabolical" (p. 156); after all, self-monitoring in the acquisition of most skills appears to be the usual process. Indeed, in the (Wittgenstein-inspired) five-stage model of skill acquisition developed by the Dreyfus brothers (1980, 1986), the initial stages involve the learner engaging in self-monitoring (or teacher-monitoring) activities with constant referral to the rules. However, as expertise develops, the rules are not internalised or increasingly abstracted, as the earlier cognitivist paradigm of learning would have it, but replaced by perceptions (recognitions) of patterns to which the expert immediately reacts. When we come to a fork in the road, we increasingly look for signs in the world (perceptions) for how to go on, rather than to our maps. Working memory is no longer needed (Feltovich, Prietula, & Ericsson, 2006). In other words, we no longer rely on or need conceptual or intellectual ("know that") knowledge to perform some task, but instead trust our intuition or performance ("know how") knowledge. The Dreyfus brothers (1986) demonstrated this by having a chess grandmaster playing multiple games (successfully) while adding numbers aloud, or in popular (*Star Wars*) parlance, "Trust the force, Luke." Foucault (1977) called panopticism a "cruel ingenious cage" (p. 383) because it traps us in a position of permanent self-monitoring, a neurosis if you like.

The idea that Cartesianism has led to a widespread neurosis in Western culture where we are constantly monitoring ourselves, or have fabricated a "mind" or "self" to do this, is neither new nor unique to Foucault. Among the multitude of writers who have explored this are Nietzsche (1887/1967), Merleau-Ponty (1945/1996), Wittgenstein (1958), Burrow (1968), Bowen (1978), Bakhtin (1986), Varela and colleagues (1991), Levinas (1998), Noë (2009), and Shotter (2016), to name but a few. These writers have noted a permanent and chronic division within ourselves, and this is being reinforced

by institutionalised practices that demand we self-monitor. Bourdieu (2000) would have us see that there is a misrecognition of our collective condition, for when we obtain mastery of something there is no longer a sense of self in the performance. As the Dreyfus brothers (1980) noted with expert pilots: "rather than being aware they are flying an airplane, they have the experience they are flying" (p. 12). The car feels like part of me (I feel *my* wheels on the road) when I'm driving (Heidegger, 1962).

Bakhtin (1986), Bowen (1978), Levinas (1998), Merleau-Ponty (1945/1996), Shotter (2016), and Wittgenstein (1958) have all proposed, in their own ways, the existence of a primary intersubjectivity between us, or between us and the world. They claim we have an innate disposition to bodily collaborate with each other, present from birth. We don't infer someone is in pain; we usually see it immediately (Overgaard, 2007). We don't empathise and then react, as the simulation Theory of Mind would have it, but react immediately with concern on seeing pain in another (Leudar & Costall, 2009). The neurology of this is now studied as second-person neuroscience (Schilbach et al., 2013); the mirror neurons are more active when we are engaged in a complementary dance of interaction than when we are just mimicking each other (Newman-Norlund, van Schie, van Zuijlen, & Bekkering, 2007).

However, when we develop what Merleau-Ponty called our secondary intersubjectivity, our relationships become mediated through our symbols or intellect (Daly, 2014). When we develop this ego or chronic self-monitoring, we become less relationally responsive and have to conduct our therapy through assessments and treatment plans, as there is no intuitive collaborative reciprocating "dance" with each other. The parent is puzzled when the infant comes back from "time out" and hits Grandma again; the child is learning that it has the power to hurt, but the parent just sees "good" or "bad," "right" or "wrong." If trusted, and Grandma shows she's hurt, the infant will stop hitting as he recognises Grandma's pain or withdrawal of coordination, for there is an innate ethic to coordinate (Burrow, 1968; Levinas, 1998). Instead, in secondary intersubjectivity, the infant is being taught to monitor itself, and its parents, for indications of right or wrong behaviour, and begins to develop an over-individuated self in his desire to be a "good boy." For Levinas (1998), ethics is an innate response from within (which is obvious when we see a hurt child lying on the road), but morality involves rules imposed from without.

Western culture rationalised this loss of primary intersubjectivity when Hobbes (1651/1996) declared that the state of nature consists of a "war of every man against every man" (p. 88). Locke and Rousseau declared we begin as blank slates (i.e.

no "primary intersubjectivity"), dissociated from each other and in need of an agreement or contract to hold us together. Such social contract theories claim that we have consented, either explicitly or tacitly, to surrender some freedoms in exchange for "a society of security" (Foucault, 2007, p. 11). But such contracts are the very thing keeping this social neurosis alive, for they are premised on the assumption of our being separate.

As Tudor (2011) has noted, most indigenous traditions begin with our unity with each other, our innate sociality. In Māoridom we call this "whanaungatanga," our "us-ness" or "we-ness" if you like. It is *ubuntu* in Zulu, and in Korean "*shimcheong* means to become one in flesh and spirit" (Choi, Han, & Kim, 2007, p. 323). From the perspective of the Dreyfus' (1980) skill acquisition model, we might say that there was a stage of awkwardness as we learnt some particular social skill, but once mastered we should have returned to a state of unity, harmony, or resonance with others. However, due to the constant self-judgement of panopticism, we have become locked into a state of awkwardness. The social and ecological consequences are obviously now disastrous. Thus, panopticism is "diabolical" for it works against the generation of relationally responsive therapists (and people).

Competence and expertise

Are competence and expertise the same? Certainly, the skill acquisition model of the Dreyfus brothers indicates that mastery means achieving that state of "seamless" performance where the pilot is flying, and not the plane. The tool has become an extension of the master. Similarly, Polanyi (1974) saw competence defined by tacit rather than explicit knowledge, and that, like asking the millipede how it moved its 73rd leg, too much scrutiny destroys the skill (pp. 18–19). In the same vein, Wittgenstein attempted to show us that such "virtues" (skills) show themselves, or are revealed in performance, far more than anything we can say about them (Moyal-Sharrock, 2016). According to Alan Watts (1977), Taoists see the highest form of competence as a virtue called *te*, where "power is exercised without the use of force" (p. 121). He illustrates this by way of Chuang-tsu's story of Prince Wen's cook, who has never needed to sharpen his knife in 19 years; 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. Prince Wen declares that from his cook he learns the way of life!

A further example is found in Aristotle's *Nichomachean Ethics*, where he suggests that heuristic devices such as *epistemes* (theoretical models, we might say today),

technes (rules or techniques), and *phronesi*s (practical wisdom, good judgement, or prudence) are used in the acquisition of a skill. But once the skill is learnt, these devices can be thrown away. It is in this respect that Keeney and colleagues (2012) call psychotherapy a "performative art." We are seeking a mechanism that enhances our skill to become sharp and seamless.

The Dreyfus model of skill acquisition contrasts sharply with the more traditional Western thinking of Plato, Kant, and Chomsky (among others) who argue that "expertise" is the abstracting and internalisation of increasingly sophisticated rules. Chomsky (e.g., 1979) sees tacit knowledge not as performance knowledge ("know how") but as implicit rules that we are following but maybe not aware of. The metaphor of the computer is usually used in this paradigm of cognitive science, called "cognitivism," which suggests there are rules in our programming, awaiting discovery. From this traditional way of thinking we can see how we were led to pursue *efficacy* (rules) instead of *effectiveness* (expert performance). *Cognitivism* became the model used by neoliberal risk managers in the development of ritualised procedures (an algorithm of rules to follow) as a way of redistributing responsibility and reducing the anxiety of blame.

British nurses have been identified as early adapters to this transformation (Lees, Meyer, & Rafferty, 2013). By having all nurses complete a set of procedural tasks for all patients on a ward, and fewer by one nurse for one patient, the nurse–patient relationship was transformed—a paint-by-numbers approach. This drove research in health practice towards *efficacy* rather than *effectiveness*, which meant that accountability was assessed by the practitioner's adherence to "empirically supported procedures" or "best-practice guidelines" such as those issued by the UK National Institute for Health and Care Excellence (NICE). Efficacy researchers wanted to eliminate the practitioner as a variable affecting outcome, and thus practitioners were deemed "competent" if they did it by the numbers. This no doubt had considerable appeal to some forms of factory management. However, as we have seen, in mental health the *person* of the therapist far exceeds any method (Duncan, Miller, Wampold, & Hubble, 2010; Wampold & Imel, 2015). As such, we are ethically bound to resist this vision of "competence," as the interests of the client are secondary to the safety of the organisation.

It is also not difficult to see how the unexamined assumptions of cognitivism may have led the educators in our profession towards efficacy thinking. If competence is defined as conforming to best-practice standards and staying up to date with the newest treatment models, then there is opportunity to expand educational services to

the profession. In a review of the outcome literature over the past 40 years, Scott Miller found that drop-out rates and numbers of clients getting better have not changed. He amusingly described this constant attendance at continuing education workshops as being like riding an exercise bike—working up a sweat but not getting anywhere (Thomas, 2014). To repeat, there is no evidence that continuing education improves effectiveness in mental health and addiction services, even if that claim can be made in some parts of mainstream medicine.

Fortunately, cognitivism has been superseded by the 4E-cognition paradigm in cognitive science (Menary, 2010; Noë, 2009; Varela, Thompson, & Rosh, 1991). The "E" stands for "enactive," "embedded," "embodied," and "extended," and represents the idea that as we have more nerves going *to* the senses than *from* them, we are using our senses like a blind man with his cane, to remain attuned to the task at hand. Like the Dreyfus learning model, when undertaking tasks that we've mastered, our attention (or "mind" if you like) flows around an extended circuit that includes objects in the world. In the now famous experiment, we are so at-one with counting the number of times the basketball players pass the ball that we don't notice the woman in the gorilla suit walk through them (Simons & Chabris, 1999). We are bodily embedded in the world—there's no Cartesian "self" standing apart from the activity—and most of the time (or the default position in this new paradigm is that) we are at one with the world. In therapy (and at other times in life), a conversation can take on a life of its own (Shotter, 2016). When competence is seen as mastery, it doesn't lie in knowing how we moved our 73rd leg; it lies in just moving it—effectively!

A mechanism for competence and its enhancement

The argument then is that the pathway to competence is through effectiveness. Over the past 15 years or so, 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 can lead to massive reductions in dropout rates as well as improved effectiveness rates for most counsellors (Duncan et al., 2010; Lambert, 2010). This evidence shows that services that utilise continuous feedback of client-reported outcomes (without clinician interpretation) can achieve levels of effectiveness that match or exceed those of clinical trials (Reese, Duncan, Bohanske, Owen, & Minami, 2014). Although a growing number of "psy" practitioners in Aotearoa have adopted these tools, the impression among many of the agencies is that a stronger network of agencies and practitioners is required to ensure such tools

benefit our community (Partnering for Outcomes Foundation Aotearoa, 2017). It is suggested that NZAC could provide that network.

As things stand it can be claimed that members of the public are being put at risk, as they are being led to believe by the efficacy research rhetoric that if practitioners are adhering to "best practice" guidelines, and engaging in professional development activities to learn these methods, they will be receiving the best help available. Now while an empirically supported treatment may have achieved an 80% recovery rate in clinical trials, most "real world" agencies are only achieving a 15% recovery rate on average (Drury, 2014). This is due to a variety of factors, including that there are few pure "~~depressives~~"[3] in the "real world," unlike the clients selected for clinical trials. Bohanske and Franczak (2010), who manage most of the mental health and substance abuse practitioners in Arizona, found that 80% of their practitioners showed remarkable improvements in their outcomes after routine outcome monitoring tools were introduced. As Sparks and colleagues (2011) commented, the use of these outcome management tools is in effect bringing clients to the front of the classroom as teachers of how to be more competent (effective) therapists. What we now term "professional development" activities move to a position secondary to this primary source of practitioner growth and improvement of practice.

As noted earlier, this is a shift from process-based accountability to outcome-based accountability; counsellors become more directly accountable to their clients. With growing emphasis on being transparent with the public (and referrers) regarding our outcomes, we are able to provide potential clients (and key stakeholders for that matter) 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). As Brown and Minami (2010) have argued, in a buyers' market, practitioners who offer outcome data have a better product to sell than those just offering "compliance" data.

During the past 15 years of the development of outcome accountability, statistical techniques and computer programs have evolved, so it is now possible to generate trajectories of change on a session-by-session basis with which comparisons can be made of similar clients' progress from large databases of client change scores. Agencies, or professional organisations for that matter, can develop new outcome measures "on the trot," so to speak, allowing greater flexibility in making comparisons or

dealing with specialist populations (Lambert et al., 2013). Through the use of what is called the Reliable Change Index (RCI) (Seidel & Miller, 2011), individual therapists can monitor not only their comparable effectiveness with colleagues, but also their own for different periods of the year or through their career; or they can compare their effectiveness on client variables such as gender, age, or a specialist population (Lambert, 2010).

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 clients complete the outcome monitoring forms, rather than the clinicians. Nonetheless, it is a necessary consideration. If outcome management were administered by NZAC, then a further check to the system would be to implement two- and five-year follow-ups of outcomes, as Seikkula and his team do in their work with psychosis (Seikkula et al., 2006). Although false advertising laws and our code of ethics would cover "falsified" results, this could be an aspect of our competency system.

Unlike current accountability systems, there would be no need to make outcome monitoring mandatory, only transparent. If professional bodies like NZAC were to encourage and disseminate outcome results, those who did not use outcome monitoring would stand out more clearly. Sparks and Duncan (2010) claim the research shows that outcome management raises the performance of the poorer performers, more than the better ones, giving all who use outcome management a market edge over those who do not. Thus, there is also an opportunity here for transparent outcome-monitoring practitioners to gain a better market position.

A possible future politics of counselling

Tudor (2011, 2013) argues that the proposition by some that we should adopt a form of professional regulation along the lines that other professions have chosen (i.e. registration and ongoing education) for fear of losing credibility can be considered not only a form of "group think" but also a form of professional and societal regression. As a result, he calls for a greater degree of differentiation of self to avoid being lulled into this position. But from the perspective presented here, increases in secondary intersubjectivity and reduction in primary intersubjectivity are not wisdom.

Our task is to move away from institutional mechanisms that "fabricate" (Foucault, 1977) over-individuated selves, as panopticism does, and embrace practices that bring our primary intersubjectivity, and the ethics associated with it, to the fore. Our primary

intersubjectivity is not something to be pathologised, as it might be in an over-individuated society. A recognition of this, as advocated by Bourdieu (2000), allows us to acknowledge our propensity to resonate with each other, and find ways of dealing with the risks of, say, conformity associated with being human.

In this vein, outcome measurement can be seen as having a conformity or preferred "group think" aspect when viewed as an expression of empowerment theory (Perkins & Zimmermann, 1995) and in what is being called the new "sharing economy" (Botsman & Rogers, 2010; Gansky, 2010). Empowerment politics has its roots in the civil rights movement of the 1960s, and found expression in the "psy" disciplines when Rappaport (1981) urged our professions to be "more a social movement than a profession." He argued that we needed to keep an eye on when we became part of the problem (e.g., by fostering societal dependence as professional numbers grow, and disempowering the community from its own native skills) and thus doing what we can "to enhance the possibilities for people to control their own lives" (p. 15). One aspect of our political task is, as Robbins (2000) once expressed it, to put "ourselves out of business."

Empowerment suggests a move from a position of being society's professional "expert parents," instructing our "wards," to collaborators in strengths-based conversations (Saleebey, 1996). Indeed, it was the strengths-based conference organisers that brought Barry Duncan, who with Miller developed the Outcome Rating Scale (ORS), to Aotearoa in 2007 as part of our introduction to client-rated outcome management (D. Wood, conference organiser, personal communication, 2016). In essence, this is because the ORS can be read as a strengths assessment by clients as much as it can be read as a deficit assessment.

Outcome monitoring also resonates with the growing "sharing economy" phenomena seen in Uber, Airbnb, and the like. Although such businesses are not without their own ethical problems (Schor, 2014), *Time* magazine claims the sharing economy will change the world (Walsh, 2011). When Adam Smith (1776/2009) advocated for free market principles, he was being guided by the Scottish moral philosopher Hutcheson (1725/2004), who argued that authenticity binds us together better than calculated self-interest. Some advocates of the "sharing economy" (or "digital matching" or "collaborative consumption") claim that "dotcommunism" might achieve greater wealth equality, when Lenin and Mao couldn't, by encouraging greater market authenticity (Botsman & Rogers, 2010; Gansky, 2013; Lansley, 2016; Schor & Fitzmaurice, 2015; Tanz, 1999).

Here in Aotearoa, we have seen the growth of the NoCowboys website, which has recently begun listing some health professionals (NoCowboys, 2016). It would be preferable, I suspect, for most counsellors to have such a register administered and monitored by the professional association. If the association were to administer a client-rated outcome monitoring service, numerous ethical and pragmatic issues would need to be resolved. Counsellors obtaining high recovery rates would no doubt want their outcomes to be known publicly, but any restrictions they may have placed on the choice of clients they saw would also need to be transparent. Other pertinent ethical and legal matters would need to be carefully considered.

Conclusion

The move to monitoring counsellors through some form of panopticism is not supported by empirical evidence, and represents the politics, philosophy, and cognitive style of a fading paradigm. A new paradigm is emerging in politics, economics, philosophy, and cognitive science that empowers community trust and our sense of a primary intersubjectivity ("whanaungatanga"). A central mechanism in the facilitation of this has been "digital matching"—feedback data on effectiveness. This article urges the adoption of this mechanism as the tool for ensuring professional competence and development.

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Notes

1. See Foucault, 2008, pp. 149ff, p. 175 for a discussion of frictions.
2. A term from American slang where Chicago gangsters sold phony insurance policies.
3. The word "~~depressives~~" is written in strikethrough to signal the word is "under erasure"; meaning that the word is undesirable, but a better term has yet to be found.

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