FROM 'BAD' SCIENCE

MARTIN SEAGER OFFERS AN ALTERNATIVE TO THE PREVAILING SCIENTIFIC CULTURE OF TALKING THERAPIES: A PSYCHOLOGICALLY MINDED FRAMEWORK THAT DEMONSTRATES THE TRUE VALUE OF COUNSELLING

This article is based upon a keynote presentation that I gave at the BACP Practitioners' Conferences in London and Leeds earlier this year. I argue that the whole world of counselling and talking therapies, whilst now superficially acknowledged at a political level, is also powerfully marginalised by a prevailing scientific framework and vocabulary that disqualifies the mind and subjectivity in relation to the material and objective. In such a split and 'mind-blind' scientific culture, we end up with 'bad' science that depersonalises and medicalises the very things in life that are most personal, including our compassion as human beings. I then explore the implications of this in terms of damage and toxicity within existing mental health science and service cultures, and offer an alternative psychologically minded framework that demonstrates the true value of counselling and provides a more positive vision for mental health services in the future.

TO GOOD MENTAL HEALTH

MIND-BLINDNESS* IN TRADITIONAL WESTERN SCIENCE

In traditional Western science at least (from the age of reason and enlightenment in the late 17th century onwards), the mind and subjectivity are assumed to represent a bias that should be factored out of our calculations about what is *really* going on 'objectively' in the universe. This false epistemological assumption makes for 'bad' science as a whole, but particularly when we try to make the human mind itself the object of our scientific study. This means that in the world of mental health, the brain is inevitably privileged over the mind and the 'medical' is privileged over the 'psychological' and 'interpersonal'. This is so much deeper than a medical model. After all, a model would be constantly tested and challenged, not taken as fact.

The concept of mind is therefore only given credibility as something at best synonymous with the brain, whilst psychological data are seen as 'soft' and only biological data as 'hard'. Within this scientific framework it is assumed that we can somehow observe nature from the outside, as if our observing minds were not part of the picture. This 'mind-blind' position ignores the fact that all observations are inevitably subjective and so subjectivity is in reality the gateway to all science and understanding. Objectivity can only be the search for patterns in subjectivity.

There is some hope in the fact that quantum physicists are beginning to recognise the problems with this mind-matter split. As long ago as 1975, for example, Fritjof Capra, in *The Tao of Physics*[1], stated: 'Quantum theory thus reveals a basic oneness of the universe. It shows that we cannot decompose the world into independently existing smallest units. As we penetrate into matter, nature does not show us any isolated 'building blocks', but rather appears as a complicated web of relations between the various parts of the whole.' Capra goes on to say: 'These relations always include the observer in an essential way. The human observer constitutes the final link in the chain of observational processes, and the properties of any atomic object can be understood only in terms of the object's interaction with the observer.'

However, because this integrative and interactional position is not yet mainstream in Western science and the mind remains disqualified or relegated, psychological science and, with it, counselling approaches based upon empathic connections between minds, are seen as at best an art, not as part of true science.

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THE TOXIC IMPACT OF MIND-BLINDNESS ON MENTAL HEALTH SCIENCE AND SERVICE CULTURE

Because hard science has become split off from art and religion when trying to understand the human condition as part of the natural universe, this means that mental health science, inevitably, has become obsessed with finding answers to the emotional life of humankind in the physical brain. This has been referred to by Raymond Tallis as 'neuro-mania'[2]. Of course, if this approach to mental health science were valid, then a love poem would probably look like the following:

The empirical love song of Alfred E Prefab
An affectional bond has been detected,
A skin response has been affected,
Neurotransmitters are activated,
And positive affect correlated.

The cortex has been stimulated,
And dopamine invigorated,
What else is there now to be stated?
'Empirical love' is validated!

Hopefully you laughed when you read this poem. If so, you did so because you recognised that the vision of humanity contained in this poem is hopelessly depersonalised and inadequate. Indeed, if this vision were correct, you could not have laughed and I would probably have never written the poem in the first place.

However, more seriously, this is the prevailing view that contemporary science takes of our mental health and this, therefore, leads to the following depersonalising distortions:

1 People are seen as having 'objective' mental health conditions, rooted in biological vulnerabilities, that can only seriously be treated by 'objective' interventions.

2 Research, service design and policy in mental health become organised entirely around the notion of mental health conditions in the brain rather than human relationships.

3 Rich interactional life experience is reduced to vague mechanistic notions of 'stress' or 'support'.

4 The whole of human personality development over a lengthy childhood is reduced at best to a paragraph of 'history' in a clinical file.

5 Talking and relating is seen, at best, only as an *alternative* to chemical treatments.

6 Relationships and attachments between people are disqualified and overlooked, both in terms of the causation of mental health problems and also in terms of care delivery.

7 Talking therapies only get measured or funded as if they were like drugs.

8 The psychological impact of psychiatrists upon their patients (for better or worse) is never measured at all.

9 The subjective views of all, including the patients and their relatives, are regarded as secondary to the authoritative view of the diagnosing clinical practitioner.

10 The human system ('professional family') in which healthcare is delivered, for both staff and clients, is almost completely ignored.

The simplest way I can illustrate the horrors of this gross depersonalisation of human emotional life is to think of the example of William Beech, the eight-year-old boy in the wonderful novel, *Goodnight Mr Tom*, by Michelle Magorian[3]. In this story, set during World War II, William, an evacuee from London, gradually comes to find a place in the heart of a gruff older man (Mr Tom) who lives alone in a country cottage and has been forced to take him in. William also gradually comes to trust Mr Tom and to become attached to him. For William, Mr Tom becomes the father he never had and also the caring parent who begins to repair the damage done by an emotionally unstable and abusive mother. For Mr Tom, his bond with William begins to heal some of the grief of losing his own wife and young son. The story traces their growing bond and, for both of them, a new family is created where before there was only hurt, loneliness and emptiness.

There is a crucial point in the story, after William's mother's suicide, where the authorities step in and William is expected to be taken into 'care'; back in London to receive 'proper treatment'. As readers of the story who have identified with both William and Tom, we are all horrified by this prospect and can easily understand that the best thing for the mental health of both of them is to be allowed to continue to live together as father and son. However, we are also being shown that, in accordance with society's medicalised view of mental health, William Beech should have the proper *treatment* for his *condition*, which Mr Tom is assumed to be unqualified to provide. Thankfully, Tom is allowed to adopt William and, by the end of the story, William movingly thinks of Tom as 'dad'.

This story, like so many other great works of fiction, shows how we can all understand that age-old human relationships are the basis of our mental health, and yet contemporary science is still, to this day, closer to the detached and medicalised position taken by the authorities in Magorian's story. We are, as mental health professionals, still under great pressure (often through funding controls) to collude, at least outwardly, with this false and depersonalised culture.

A POSITIVE ALTERNATIVE: PSYCHOLOGICAL MINDEDNESS – PUTTING MIND INTO MENTAL HEALTH SCIENCE

It seems strange that we should have to argue at all about the reality and validity of mind within science, especially the science of what we are calling mental health. For me, therefore, it helps to view mind as a dimension of the universe, like time and space. No-one would seriously argue that time or space did not exist. Though they cannot be touched, they are dimensions whose existence can be inferred from all our observations. They are concepts that make sense of and give coherence to all our observations. The same is true for mind. Like time and space, no observation would make sense without it. Without mind, there could be no meaning, no interpretation, no ambiguity, no curiosity, no language, no theorising, no creative imagination, no data, and certainly no science. Without mind, Newton's apple might still have fallen, but he would not have been curious about what it meant.

A psychologically minded approach, on the other hand, would automatically necessitate the following transformations, placing mind and relationship at the centre, rather than at the periphery, of our mental health science and our services:

1 A recognition that relationship is key to all human wellbeing and involves 'mind to mind' empathic connections between human beings from the first infant attachment onwards and from the cradle to the grave.

2 Recognising that those with the most serious mental health problems will have suffered emotional damage arising from the most serious violations of relationship (through abuse, neglect and trauma) during their developmental years.

3 Switching the emphasis, therefore, from treating mental conditions (stigmatising) to healing emotional damage and meeting the universal psychological needs of the human condition (normative and positive) and recognising that the potential value of psychiatric drugs is as emotional regulators not as treatments for mental illnesses[4].

4 Honouring these ancient and universal psychological needs of the human condition based on the overwhelming evidence, not just in the therapy literature, but in all human culture and art forms (including novels, plays, poems, song lyrics, operas, films and TV dramas and comedies).

5 Having a positive definition of these needs. One attempt at such a definition comes within the 'human givens' approach[5]. My own definition comes originally from a paper I wrote with colleagues[6] for the then Health Secretary. At that time we described five core needs: (a) to be loved (b) to be heard (c) to belong (d) to achieve and (e) to believe. Since that time, I have considered adding five more: (f) to worship (g) to procreate and create (h) to sing, dance and make music (i) to laugh, celebrate and rejoice (j) to mourn, grieve and express sorrow.

6 Accepting the overwhelming evidence from psychotherapy outcome studies[7,8] and elsewhere that relationship is the 'baby, not the bathwater' in all forms of therapy and intervention in the mental health of fellow human beings – it is truer to say that different therapy techniques, brands and models are a vehicle for relationships rather than vice-versa – the therapist is the cure, not the therapy brand.

7 Recognising that Sigmund Freud's reference to a 'love cure'[9] and Carl Rogers' conclusions about 'empathy, warmth and genuineness'[10,11] relate to universal aspects of relationship that are essential for therapeutic change and development, regardless of the therapy brand or model (including psychiatric).

8 Designing services to promote consistent relationships and attachments ('psychological safety') between those in need and those providing care[12,13].

9 Reworking Abraham Maslow's famous hierarchy[14] to recognise that psychological and spiritual needs are ultimately even more crucial to human beings than a mere physical existence; otherwise it would be impossible to explain why most suicide and self-sacrifice is by people whose physical needs are met: 'Man shall not live by bread alone' (Matthew 4:4).

10 Designing services to care for the caregivers too, recognising that the human qualities and the environmental conditions needed to provide care and compassion also need to be maintained and nurtured through relationships.

COMPASSION: FROM MIND-BLINDNESS TO PSYCHOLOGICAL MINDEDNESS

Within a mind-blind scientific culture, even human compassion can get reduced to a neurological structure ('mirror neurons') or to a mere skill or tick box competence that can be taught from a structured course. Psychologically, however, it is indisputable that compassion is a live, relational, dynamic and interpersonal phenomenon that cannot exist in a vacuum. It is, like everything else in the universe, context dependent. To be created in the human personality, compassion must first of all be experienced through one or more empathic relationships, preferably from the first attachment onwards. The developing infant can only develop an authentic and healthy state of mind and identity if his or her own feelings are accurately tuned in with and mirrored by an adult caregiver. Research into 'mentalisation'[15] has helped to explain this process and has helped to integrate developmental psychology with psychoanalytic theory, which has rightly highlighted the importance of identification in human relationships from the cradle to the grave. Empathy always involves identification, the mental capacity to connect with another human being by imagining what it feels like to be in their place. The developing infant needs to be identified with accurately to grow healthily. All forms of psychological therapy are, in essence, nothing other than an attempt to correct any earlier damage through healthier identification. As human beings in all cultures, we also constantly use stories from childhood onwards as our way of maintaining links to each other through identification. To this extent, therefore, whilst recognising the value of *self-actualisation* as a driving force in human wellbeing, there is a need also to remember the equally powerful drive to *connect with and relate to others through identification*.

CARING FOR CARERS

This means that those seeking care of any kind need to have access to at least one other human being who is in a state of mind to identify with their situation. Without identification, there can be no real compassion. And yet, because of our mind-blind culture, there has been almost no attention paid to the relational conditions (particularly being identified with by the organisation as a surrogate parent) that enable professionals and other carers to remain in a receptive state of mind where they can retain the energy to continue caring for and identifying with others. Society is quick to blame individuals for a lack of compassion when, in reality, people who choose caring roles are likely to be on average more compassionate than those who do not.

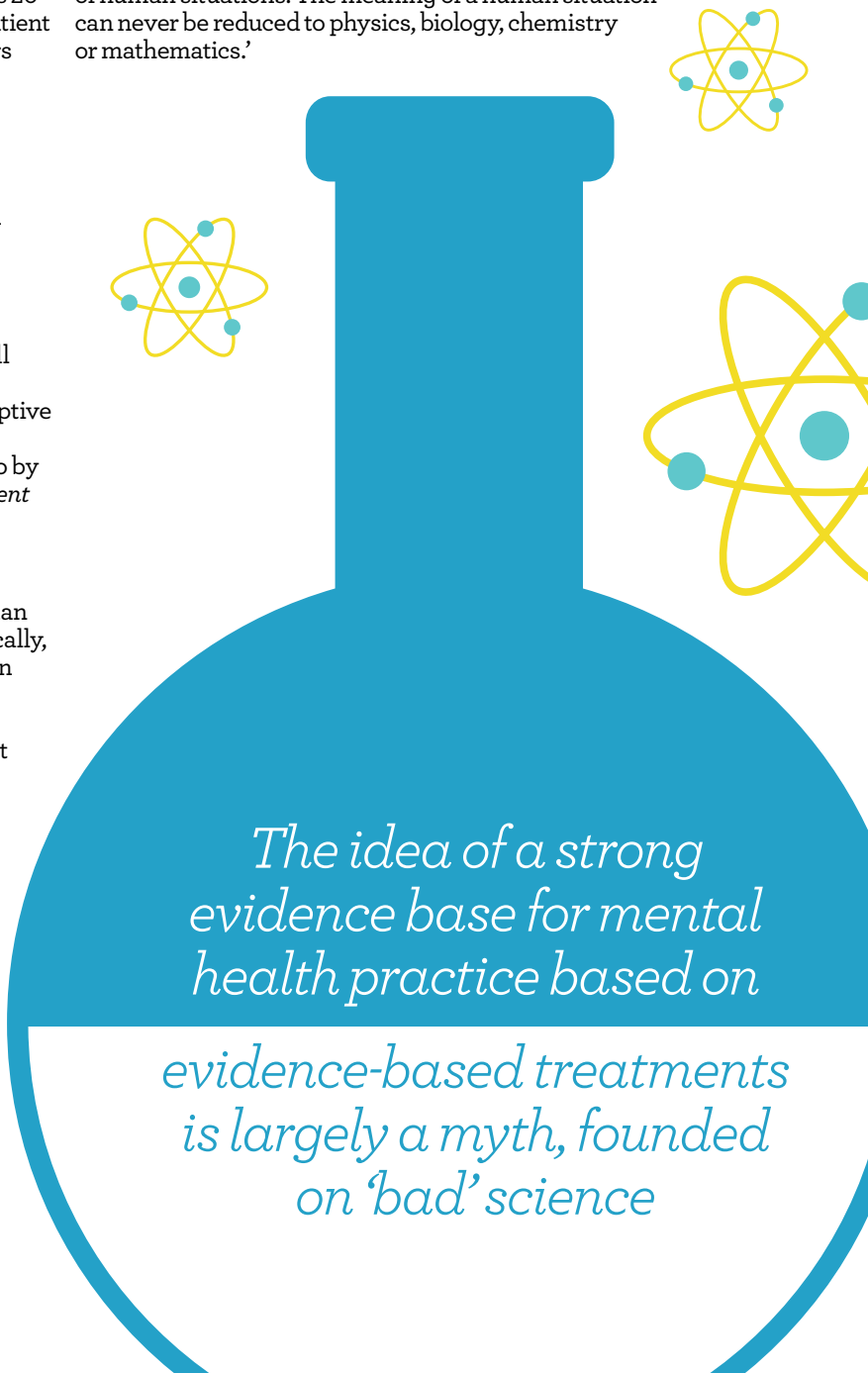
In a recent paper, *Who cares for the carers? Keeping compassion alive in care systems, cultures and environments: a psychologically minded approach*[16], I explain that professional caregivers, however well trained and compassionate they might be, have only a finite amount of energy for such emotionally demanding work, and that many environmental factors can hinder or help the receptivity of their state of mind. In other words, compassionate care depends upon not just an interaction between a caregiver (A) and a client (B), but also upon the context in which the care is provided (C). I use the simple example of an overburdened single parent, who loves their children but has no back-up. I also refer to the example of a GP seeing, perhaps, their 21st patient of the day. In such circumstances, it should be obvious that the emotional and physical impact of seeing the previous 20 patients will impact on the receptivity of the GP to patient number 21. The same applies to nurses, social workers and to all professional and non-professional carers. And yet, whilst there is some acknowledgement of these issues in the familiar concepts of 'burnout' and 'compassion fatigue'[17] there has been very little awareness of, or research into, the psychological conditions that would enable the emotional attention and energy of carers to be refreshed so that they can continue to give of their best and also maintain satisfaction in their important work. This is a safety issue, no less serious than that of working hours for airline pilots and '...has almost nothing to do with skill or moral goodness and almost everything to do with staff being emotionally supported to maintain a receptive state of mind'[16]. This is, therefore, a failure of culture rather than of individuals, and this is highlighted also by Ballatt and Campling in their excellent book, *Intelligent Kindness: reforming the culture of healthcare*[18].

A LANGUAGE OF COMPASSION

If compassion involves identification with other human beings, then a more scientific language for it is, ironically, poetry, which is deliberately personalised, rather than traditional scientific language, which is deliberately depersonalised. Let us look now at an extract from another poem, which I think will have a very different impact on you from the one featured earlier. This poem, called *Nursing the Nation*, was delivered by Molly Case, a student nurse, to the Royal College of Nursing (RCN) Congress 2013 as her response to the bad publicity the nursing profession had been receiving:

One lady passing had no relatives to stay,
We sang her to sleep, let angels carry her away.
Were you there that day when we held her hand?
Told her nothing would harm her, that there was a higher plan?
Saw her face as she remembered a face she once held?
Saw her breath in the room as she finally exhaled?

In *Who Cares for the Carers*[16] (mentioned above), I comment on this poem in the following self-explanatory terms: 'By reading this poem it is impossible for the empathic mind not to feel compassion for this lady in her last moments of life and appreciation for the value of nursing care at its best in honouring the sanctity of human life. This poem enables the reader or listener to identify with this situation in a way that would not be possible if the same situation was described in the language of traditional Western science, which is deliberately depersonalised.' I go on to state: 'Poetry is, therefore, in many ways a better method for achieving a true description of human compassion than traditional Western science. Poetry and art generally invite us to identify with other human beings and the meanings of human situations. The meaning of a human situation can never be reduced to physics, biology, chemistry or mathematics.'



CONCLUSIONS

— Ever since the age of enlightenment and reason, in the West, at least, mind has been split from matter, and art from science. This split into domains of hard and soft data has created the potential for 'bad' science, particularly when trying to study the mind itself.

— The idea of a strong evidence base for mental health practice based on evidence-based treatments for specific mental conditions is largely a myth, founded on 'bad science' that, in truth, depersonalises and objectifies phenomena that are quintessentially interpersonal, dynamic and contextual.

— Comparing talking approaches to chemical approaches for mental health problems is equally 'bad' science, but if comparisons are truly to be made, talking and relating is always the biggest part of what works in helping fellow human beings with their mental health.

— There are universal psychological factors, particularly attachment and empathy (love), which are always involved in therapeutic success and human development of any kind.

— Where traditional psychiatry is helpful, this is often partly because psychological needs of patients are also being met. However, because of 'mind-blindness', the personal qualities and the psychological impact of psychiatrists, for better or worse, never get measured.

— It is much better, both in scientific and in humanitarian terms, to think of all people, like William Beech in *Goodnight Mr Tom*, as having universal psychological needs that need to be met rather than mental conditions that need to be treated. The only relevant condition is, in fact, the human condition.

— If we as a society want people with mental health problems to be optimally cared for, then we have a duty to care also for those providing the care. Without the right back-up and working environments, our doctors, nurses, social workers, counsellors/ psychotherapists and other carers will not, despite all their training, professionalism and compassion, be able to maintain the receptive state of mind that is essential for their work. This will only lead in the longer term to poorer care, more complaints, burnout, sickness, absence, and even in extreme cases, suicide[19].

THE WAY FORWARD

Changing and challenging 'mind-blindness' in science, particularly mental health science, can only be a matter of evolution not revolution, and ripples will spread from many sources and at many levels, including the following:

Research

There is a need, for example, to factor analyse our art, music, literature and drama to demonstrate the universal psychological themes in the human condition, to help us move away from thinking about 'mental conditions'. It would also be vital to research and publish the evidence on what nurtures and what kills compassion in human environments. This isn't rocket science and is more about asking the right questions than the complexity of answering them. Many of the answers are already there, not just in existing scientific writings, but also in everyday life and in the world of art, drama and literature and even universal religious practices, if we only look for them[16].

Media

The quickest and most powerful way to change public attitudes is through the media and it is public attitudes, in the end, that have the greatest impact on creating change in public policy and practice. There is consequently a need for more psychologically minded conversations about mental health in the media that challenge existing prejudice and that create hope for people that mental health is a natural part of all our lives, not a series of conditions.

Political level

Politics, like anything else, works on contacts, relationships and beliefs. Politicians are influenced by the prevailing dogma within society, by the media, and by the individuals that they relate to on an everyday basis. There is a need to put the overwhelming evidence supporting the need for a major culture change before the right politicians. To be most effective, this evidence needs to be integrated from the widest variety of sources and to be supported by the widest number of stakeholder groups within our society. In this respect, it would help if the various psychological professional bodies such as the BPS, BACP, BCP and the UKCP could give up brand warfare and come together with one voice.

Educational level
Conferences, books, articles, teaching and training events can exert a 'drip, drip' effect and contribute to culture change. This article itself is based upon a conference presentation and it is hoped that these ideas will resonate as widely as possible and strengthen any ripples that you, as readers, can make within your own circle of relationships.

Institutional level
A truly compassionate culture can only originate from those at the top of any institution where we are expecting these qualities to be found. This means that influencing organisational leaders and managers is vital, for it is they who have the most power to detoxify or pollute the culture in which care providers are working. Like families, organisations can, of course, be healthy or dysfunctional. Managers, like the caregivers of children, can tune into the needs of their employees or fail to do so. Anything that helps them to do so will therefore promote the health of the whole system.

Team level
People with caring roles usually or often work in teams, which become like small family units. Anything, formal or informal, that helps a team to connect better as a group and that supports individual members in processing the emotional impact of care work, will enable the team as a whole to stay more psychologically receptive to the needs of its clients.

Personal level
There is currently a fashion for promoting resilience and self-care at the individual and personal level amongst health and care professionals and this can potentially be very valuable. However, equally, there is a danger that such approaches in isolation could collude with unsupportive and even toxic organisational cultures and working environments. After all, asking a single parent with no back-up to practise self-care and resilience would be unhelpful and even damaging. We must be careful not to impose the same psychological naivety upon our healthcare professionals. ■

* Extending Simon Baron-Cohen's (1995) concept relating to autism[20]

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READER RESPONSE

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