

Why has Research on Mental Health Always Been a Low Priority in New Zealand (and Elsewhere)?

Robert Miller

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Know then they self; presume not God to scan
The proper study of mankind is man.
Placed on this isthmus of a middle state,
A being darkly wise, and rudely great:
With too much knowledge for the sceptic side,
With too much weakness for the stoic's pride,
He hangs between; in doubt to act, or rest;
In doubt to deem himself a God, or beast;
In doubt his mind or body to prefer;
Born but to die, and reas'ning but to err;
Alike in ignorance, his reason such,
Whether he thinks too little, or too much;
Chaos of thought and passion, all confus'd;
Still by himself, abus'd or disabus'd;
Created half to rise and half to fall;
Great lord of all things, yet a prey to all,
Sole judge of truth, in endless error hurl'd;
The glory, jest and riddle of the world.

Alexander Pope (part of *Essay on Man*, 1734)

1. Introduction:

In 1989, when I first went to one of the Winter Workshops on Schizophrenia (at Badgastein, Austria), I received a comment from Henry Nasrallah, a rising researcher in this area, founder of the then new journal *Schizophrenia Research*, that New Zealand had made little contribution to research on schizophrenia. Since then, little has changed; but to put this in context, many of the countries where much bigger research effort has been devoted to the disorder called schizophrenia, do not appear to have benefited much from the research in their mental health services. Worldwide, research on schizophrenia is remarkable for its lack of tangible success, a point I made in a lecture when my book *A Neurodynamic Theory of Schizophrenia and Related Disorders*¹ was launched in 2008.

When the suggestion arose recently that I address the question, ‘Why has Research on Mental Health Always Been Low Priority in New Zealand?’ I mentioned this to a friend, and very experienced psychiatrist. He raised his eyebrows, and said: ‘Where do you start?’ The exasperation in that answer might account for the diversity of areas touched on in this essay. There are *many* reasons why serious scientific and research effort on mental disorders has lagged behind research efforts in other areas of medicine, or has not been translated into improved mental health care. An obvious one is that it is a more difficult area philosophically, conceptually, as well as in practical terms than most other areas of medicine. In paragraphs below I refer to this; but the main issue I address is that neglect of mental health research goes beyond its inherent difficulty: This area has been *actively avoided*, with few researchers in psychiatry really able to claim that they are part of the broad sweep of progress in the natural sciences and scientific medicine. There are many reasons for this, some very old, many quite international in their reach, as well as some contemporary trends, and a few as special aspects of the New Zealand and Australian experience. Some of the reasons are specific to mental health care and research, others to health care and research more generally, and others reach widely to assumptions on which many facets of today’s societies are constructed. Since the problems I address are as much those of *translating* research into practice as of research priorities in themselves, and in this sense are by no means confined to New Zealand, this essay addresses both areas.

I start by quoting Francis Bacon, the first to write on - indeed to define - the basic method of the natural sciences:

¹ See: *A Neurodynamic theory of Schizophrenia: Introduction*. Lecture given 5th February 2008, at the Winter Workshop on Schizophrenia and Bipolar Disorders, Montreux, (www.robertmiller-octspan.co.nz)

If the notions themselves – which is the root of the matter – are confused and over-hastily abstracted from the facts, there can be no firmness in the supra-structure.²

Since 2008, I have become increasingly aware of the force of his point. Without exaggerating much, psychiatry and mental health care generally are characterised by *profound conceptual confusion*. In psychiatry itself this applies to most of its diagnostic categories, which were never established by proper scientific reasoning. I include ‘schizophrenia’ here: I see no reason to reject the scientific reasoning I developed in my book on schizophrenia, but I now see this as explanations for a cluster of symptoms, rather than of a specific disorder. However, the confusion gets worse the more one distances oneself from the reality of mental disorders as seen by the best front-line clinicians and most intelligent service user activists. To be specific I refer to other professions with their own agendas and styles of discourse, but which sometimes have to deal with mental disorders. Sadly, those other professions exert decisive influence on how psychiatry is practiced, and how research is conducted, introducing aspects of their own style where it is inappropriate. In Bacon’s terms, overall there is ‘no firmness in the supra-structure’. In present context, that statement refers most directly to mental health services, and research endeavours supposed to underpin such services. In addition, conflicts and contradictions have arisen between thinking in these areas, and those developed in other professions. They involve many concepts, but focus most profoundly on one which most scientists definitely think to be in the ‘too hard’ basket – that of *personhood*. Obviously this concept is involved in many areas of life other than psychiatry, some of them much older than psychiatry. As a result, this essay moves between a number of different fields, and starts way back in history. I refer to conflicts between different traditions which have hitherto been kept apart; yet that cannot continue: It is all coming to a head in the near future.

2. History

(a) Models of Human Nature

According to Bertrand Russell³, two thousand five hundred years ago, Pythagoras developed the notion of formal reasoning, a distinctive part of Western culture ever since. For him, facility in reasoning (rationality) was not a natural human endowment – it was superhuman, a gift from the gods. So ‘reason’ was separated from mundane human faculties and concerns. A

² Francis Bacon (1620/1889): *Novum Organum*. Clarendon Press, Oxford, edited by Thomas Fowler.

³ Russell, B. (1945) *History of Western Philosophy*. George Allen and Unwin Ltd.

few centuries later, Plato continued this dualism: Rationalism was important, but as an ideal, not as the norm. The Roman world developed the philosophy of law, and a key figure was Marcus Tullius Cicero (106-43 BCE). For him, one of the origins of laws was ‘the intelligence and reason of the prudent men’. Clearly only a minority were held to be ‘prudent’. However, in his later writing, reason was no longer a prerogative of the prudent and wise. Imperceptibly, rationality, at least in legal systems, became a basic assumption *as the norm for humankind*⁴. Much later, at least in English tradition, an assumption underpinning legal systems was that of the ‘*reasonable person*’ (not quite the same tradition as the ‘rational man’, but related to it). The shift from rationality as the prerogative of the few to the accepted norm for humanity may be related to the fact that in classical Rome, as often today, those who access the law are those with status, wealth and especially, education.

However, rationality is by no means a natural faculty for human beings. The *natural* faculty, built into the very tissue and function of our cerebral cortex is *association* (*inductive* rather than *deductive* inference), a faculty shared with all mammalian species. If we *do* acquire a capacity for deductive reasoning it is through education, example, and continued practice. There are cultural differences in this, and there may also be personality traits which enable the faculty to develop more strongly in some people than in others. In no way is it a universal human attribute.

Fast forward to the Christian era and St. Augustine of Hippo. Augustine still maintained the primacy of reason, but was acutely aware that the human soul was a perpetual battleground between rationality and passions; that it is ‘characteristically human to find oneself out of one’s own control – gripped by illicit passion’, against which ‘the philosopher’s appeal to our voluntary powers seems feeble and shallow’⁵. As a result, at least in Western culture, there has been a split ever since between reason and emotion (‘Chaos of thought and passion all confus’d’, as Alexander Pope put it in his ‘Essay on Man’). Over the centuries since Augustine, the Christian doctrine of the indivisible eternal soul has also been a continuing theme, an expression of underlying mind-brain dualism pervading western culture (whatever we *say* in denial of this). René Descartes, although anti-clerical, continued the rationalism and dualism. For Isaac Newton, the ‘soul’ was also indivisible⁶,

⁴ Beland, FP 2010, [Some Remarks on the Notion of ‘Natural Law’ in Cicero’s Laws](http://faculty.isi.org/blog/post/view/id/534/).

<http://faculty.isi.org/blog/post/view/id/534/>

⁵ Michael Rosen (2004) *Against rationalism*.

Scholar.harvard.edu/files/michaelrosen/files/against_rationalism.pdf

⁶ In the last edition of Newton’s *Principia*, published a year before he died in 1727, he writes as follows: ‘Every sentient soul, at different times and in different organs of senses and motions, is the same indivisible

but *not* eternal. He denied personal immortality. Personhood, *was* thus somehow ‘in the divine world’, but not entirely so: As a strict monotheist, he could not countenance *any* spiritual entity competing with the omnipotent deity. In short – despite the supreme scientist that he was - he could not incorporate human nature into *scientific* reasoning of his natural philosophy.

Since then, Western concepts of human nature derive from classical philosophy, and early Christian theology. No-one has defined human nature in detail in term of concepts from the natural sciences; few have made the attempt. Rationality has been, and still is, assumed widely to be a defining feature for human beings. Carl Linnaeus, taxonomist from the century after Newton, named our species *Homo sapiens*, presumably basing the adjective *sapiens* (‘wise’), on current ideas of rationality as a defining human feature. Yeah, right!; a hint of triumphalism perhaps? Wouldn’t *Homo vana* have been more apt? In the same century, as economics developed with Adam Smith at its origin, ‘rational choice’ was a basic premise, based on the idea that humans beings are intrinsically rational. This assumption has however been widely criticised, not least by Friederich Hayek. Economic ideologies are of course highly relevant to the way research priorities are decided.

There is however an alternative tradition in Western philosophy, albeit a minor one. In Holland, Newton’s contemporary, Baruch Spinoza, another of the great rationalist philosophers of the seventeenth century, developed a view of human nature very different from the mainstream. Whereas Newton held that God and Nature were quite separate entities (as were presumably Mind and Brain), Spinoza advocated that God and Nature (or in microcosm, Mind and Brain), were utterly different, yet nevertheless inseparable aspects of a single entity (as are the two faces of a coin). This was a radical break with mainstream tradition in all Judeo-Christian religions, akin to Eastern philosophy. Spinoza’s *Ethics* was a major statement of the philosophy which is often now called ‘psychophysical parallelism’.

In the nineteenth century Germanic world, this line was developed further. Gustav Fechner, pioneer of psychophysics (the most rigorous branch of psychology today) was a through advocate of psychophysical parallelism, and influenced a number of other scientists at the time, whose work spanned both physical and psychological sciences (especially in sensory physiology

person. There are parts that are successive in duration and coexistent in space, but neither of these exist in the person of man or in his thinking principle, and much less in the thinking substance of God. Every man in so far as he is a thing that has senses, is one and the same man throughout his lifetime in each and every organ or his senses. God is one and the same God always and everywhere.’ Newton, I (1727) *The Principia: Mathematical Principles of Natural Philosophy*. (trans: Bernard Cohen and Anne Whitman) Berkeley, University of California Press.

and psychology). Herman von Helmholtz was one such; but most important in our context was Ernst Mach. His philosophy allowed him to make statements about human personhood which had a much stronger claim to be truly scientific than anything written hitherto. No longer was the Ego (or soul) a mysterious indivisible unchanging metaphysical entity (implied by much of our language, culture and history, to say nothing of legal systems). For Mach it *was* actually a complex dynamic, ever-developing structure. In psychiatry, a neglected pioneer was Carl Wernicke, known to English speakers as a pioneer neurologist, although his writings on psychiatry may eventually prove to be more important⁷. He fully accepted Mach's view of personhood⁸: Most impressively, he builds a convincing theory, based on neuroscience available at the time, of how each person constructs for him/herself – and continually reconstructs – their own picture of personal identity. Other scholars (in France, Pierre Janet, Wernicke's contemporary; in the USA J. Royce, JM Baldwin and George Herbert Mead), have continued scientific/philosophical exploration of the concept of self-hood; and my former doctoral student Kate L. Ball made a significant addition to the topic in her thesis of 2010. Wernicke's theory of personhood can now be developed in more detail based on neuroscience advances in the last generation - but now is not the time to explore this.

Let me summarise the current conceptual confusion with an example. In 1979, a major report sponsored by NIMH, on medical ethics for research on human participants was published (the 'Belmont Report'). A background paper by Engelhardt⁹ dwelt on the principle of 'autonomy' as a foundation for medical ethics. As a major point the author separates human behaviour which is determined by *reasons*, from that determined by *causes*. He writes:

'Morality presupposes that individuals are worthy of blame or praise because they can freely choose between different lines of conduct. If that is not the case, then we are simply caused to engage in particular behavior and to call certain behavior moral or immoral,

⁷ In the last year, together with John Dennison from Otago, we have produced the first edited English translation of Wernicke's *Grundriss der Psychiatrie*. Sadly, Wernicke died from injuries sustained in a bicycling accident in 1905, while he was finalized the edition of *Grundriss* upon which we have worked. As a result, the shape of psychiatry has been determined for the past century by his contemporaries, Emil Kraepelin and Carl Jaspers. Those who know of Wernicke's writings on psychiatry believe that development of the discipline would have been very different had he lived to complete his life's work. The translation and our Editorial Commentary is in press as of February 2015, with Springer Verlag.

⁸ Although we have been unable to find evidence of direct contact between Mach and Wernicke.

⁹ Engelhardt, H.T. (1979) Basic Ethical Principles in the Conduct of Biomedical and Behavioral Research Involving Human Subjects, *Belmont Report, NIMH, Appendix, Vol I, chapter 8*.

and there is no possibility to mean anything by 'right' or 'wrong' other than that one is caused to call some things right or wrong. In that case, any serious talk of ethical principles must cease.'

The author makes a distinction between persons who *are* free, and therefore are 'moral agents', and those who are not, whose behaviour is *caused* rather than based on reasoning (such as 'very young children, or many of the very senile, mentally ill, or mentally retarded', and presumably other mammals). One must ask whether it makes sense to make such a sharp distinction between different classes of person. *Scientific sense?* Not to me; I am at ease with the notion that I am a member of a species whose cerebral mechanisms and emotional life are in many ways similar to those of other mammalian species; and that in any case my thoughts and emotions, and related processes in animals are the bi-product of a physical mechanism. *Philosophical or legal sense?* Obviously so, for some. The general public, of course, remain utterly confused; and we see their confusion often in daily events: Just like Engelhardt, but in a non-academic way, a person may at one time use one model of human nature, and then, when they encounter some inexplicable human behaviour, they may switch to the other. It is not clear what principles govern the switch other than 'gut feelings'. Likewise on personhood, most of today's scientists, including medical scientists and neuroscientists, remain in a muddle.

(b) Models of mental disorder

How does this play out with respect to models of mental disorder: Before the French revolution of 1789, there were many barbarities - persecution of witches by the Church, private madhouses - as is still the case in many parts of the world today. Occasionally enlightened practitioners sought to make sense of puzzling, sometimes frightening human phenomena. In the eighteenth century, the so-called Age of Reason, especially in France, when rationality came to be given a universal, quasi-scientific definition, mental disorder was seen as a deficit in the supposed natural human rational faculty¹⁰; and the sharp separation between 'rational' and 'mad' people was reinforced by confinement of the latter in asylums.

After 1789, scientific study began along different lines: The early French psychiatrist researchers saw their task as essentially descriptive. Only later were there attempts to systematise and classify mental disorders. By the 1890s, with Germany and Vienna as well as Paris now major players in psychiatry research, there were struggles over the concept of diagnosis, and

¹⁰ The same assumption can be found in late nineteenth century in writings of Wernicke, which led to difficulties in some of his interpretations of what he saw in his clinics.

over specific diagnoses in psychiatry, with several forces interacting. Medical traditions, especially those of academic neurology, hoped to establish a system of classification of mental disorders, and therefore of diagnoses to be used as generic classes, based on known causes in identified structures, as elsewhere in medicine. In contrast, an emerging dynamic tradition¹¹, incorporated reluctantly and only partially into mainstream psychiatry, focused on the individual, and on events in his or her life, and on individual analysis. Therapy was person- rather than diagnosis-centred.

Carl Wernicke practised psychiatry in the midst of this turmoil. He was a gifted clinician and acute observer of what he encountered, always trying to understand what he saw, on the basis of what he knew about the brain. On scientific and clinical grounds he was sceptical of many categories put forward at this time; and much of his shrewd clinical analyses were highly individualised, starting from symptoms, not diagnoses. He did not reject the possibility of valid diagnostic categories in principle, and for some clinical entities he insisted 'You have to get the diagnosis right'; and some of those entities were diagnoses he had formulated himself. He was generous to professional rivals, with one exception, Emil Kraepelin, who in the 1896 edition of his textbook formulated the concept of *Dementia praecox* ('Early dementia') forerunner of the concept of schizophrenia. Wernicke's scorn for Kraepelin is quite palpable.

Kraepelin was far less able as a scientist than Wernicke, bureaucratic in style, wanting clear categorical diagnoses. He wanted for psychiatry to be a stand-alone discipline, in contrast to Wernicke's holistic *neuropsychiatry*. His criteria for defining *Dementia praecox* were partly symptom clusters, partly long-term outcome (especially whether a patient recovered such that they could leave his asylum). Thus criteria for classification combined those needed by clinician-scientists, with those for an institutional administrator. Wernicke kept separate the two purposes for classification; but, because of Wernicke's premature death, Kraepelin's style prevailed.

Quite apart from confusion on principles for typology – whether medical or administrative in style, or highly individualised as in dynamic psychiatry - the general confusion about personhood still pervades the discipline of psychiatry. A few examples suffice to make the point. A book by Paul Calloway published in 1993 (from the Psychiatry Department at Cambridge university), compared two very different traditions of psychiatric

¹¹ Ellenberger,H (1970) *Discovery of the unconscious: The history and evolution of dynamic psychiatry*. Basic Books

thought, that in the West, and that in Russia/Soviet Union¹². I quote a paragraph, actually about Western psychiatry:

In forensic psychiatry, a label can make the difference between prison or hospital, even death or hospital. There are less dramatic consequences, for instance those arising as a result of the familiar old debate, conducted on psychiatric wards all over the world, about certain difficult patients, especially those who are being 'manipulative', violent, or who repeatedly indulge in self-harming behaviour, as to whether or not they are mentally ill as opposed to having a personality disorder.

In Engelhardt's terms the former would be 'caused behaviour' the latter 'behaviour with a moral element', based on assumptions of 'autonomy' and 'rationality'. Calloway continues:

The practical consequences are that the difficult patient who keeps his illness label is allowed to stay on the ward, whereas if he acquires a personality disorder, he may be discharged. The personality disorder label is usually favoured by the nurses who have to bear the brunt of difficult behaviour. Doctors, on the other hand, who might have to bear responsibility for what the person does when discharged (whatever the label) tend to favour the mental illness label. The way in which the diagnoses change is often arbitrary, resting more on some aberrant behaviour than any change in actual psychopathology.

Confusion is specially intense around one diagnosis, the ever-controversial clinical entity once called 'multiple personality', renamed in DSM-IV as 'Dissociative Identity Disorder'. The concept is quite old, but in the late nineteenth century was explored carefully in a few cases by Pierre Janet. Something related to this was accepted by Wernicke. After that, for nearly a century, the diagnosis was neglected in Western psychiatry, having been largely replaced by 'schizophrenia' (which, it should be said, is a very different clinical entity, however it is described). The concept came back into

¹² Apart from accusations of ethical malpractice related to dissidents in the Soviet Union (on which the author has many interesting comments to make), it is clear that Russian concepts of mental illness (which predate the Soviet era) are in many ways similar to those of Carl Wernicke. I do not know how the similarities arose; but Wernicke did work in Breslau, currently Wroclaw, in what is now Western Poland, and his manner of thought may have been distinctly Slavic. In those days, there was rich flow of scholarly ideas and personnel between the Germanic and the Slavic worlds. Today's frontier hardly existed.

fashion in DSM-III, but has remained highly controversial and polarising. For myself, I have no clinical experience on which to base an opinion; but, as a brain theoretician, it is a plausible way in which some individuals with a particular intrinsic personality type built into their brains, and exposed to certain types of psychic trauma, especially in infants at the age when personal identity is forming, may reconfigure their sense of personal identity. I find nothing difficult in principle about the diagnosis. I believe the controversy is not really about clinical facts: It is in reality a philosophical confusion about concepts of personhood, although clinicians' anxieties over the diagnosis may show up in quite different ways.

In a wider setting the same confusion lies at the heart of modern DSM. In the introduction to DSM-IV, we read: 'a common misconception is that classification of mental disorders classifies people, when actually what are being classified are disorders that people have'. This statement is used to justify preference for usages such as 'a person with schizophrenia' rather than 'a schizophrenic'¹³. However, it also seems to say that mental illness is *imposed on the person*, rather than being an imbalance of the internal factors which *go to make up a person*. What no-one in the committees that put together DSM-IV dared admit was that mental disorders *are* disorders of personhood itself. In the USA, land of the free, the line that was taken allowed mental disorders to be defined without upsetting the sacred virtue of personal autonomy; after all, once this virtue is challenged for persons with mental disorders, it would soon apply to most people, given that prevalence of at least one DSM diagnosis is now extremely high¹⁴.

In *research* on human mental disorders, confusion about personhood is compounded, because, on the one hand, a research study might be based on notions from natural sciences on the lawful behaviour of physical systems making up the brain, and, at the same time, researchers have to wrestle with ethics application in which concepts such as 'autonomy' and 'rationality' are held up as human norms and foundation stones for medical ethics, whose philosophical roots having nothing to do with the natural sciences.

¹³ With regard to the choice between word usages like 'a person with schizophrenia' as opposed to 'a schizophrenic', I, like the authors of DSMIII/IV, prefers the former usage. However, the reasoning for this preference is different: It is not based on a presumption about whether the illness is *imposed upon* the person, rather than being *part of* the person. Instead this preference is adopted because the former usage is of greater therapeutic benefit to patients: The best way to encourage the integration of a person, whether sick or healthy, is to treat them as an integrity, and help them to develop such integrity as they are capable of. The former usage encourages patients suffering from schizophrenia to reintegrate their personality as far as they can; the latter tends to dismiss a patient as permanently 'invalid' as a person.

¹⁴ The *National Comorbidity Survey* in USA, published in 2005, based on surveys carried out between 2001 and 2003, give prevalence of 29%, (12-month) and 48% (lifetime), for at least one mental disorder.

3. Administrative style

Let us go back to history again, namely to the birth of the ‘social sciences’ (so-called), and their implementation in social policies.

When Isaac Newton published his *Principia* in 1687, amongst other things, he proposed new ways to define key concepts (especially mass and force) which would support and be supported by precise mathematical (and quantitative) reasoning, which gave an exact description of experimental data on planetary motion. In the next century (*Age of Reason*), a debased version of Newtonian science started to appear in social fields. When the first statistics on age-related life expectancy became available, data seemed to fit nice mathematical equations. People said ‘Aha - it’s good quantitative science like Newton’s.’ Not only did this start the Life Insurance Industry; in a broader scheme of things, it started what we now call ‘social science’ and ‘science-based social policy’. From that time there has been a steady stream of public policies based on so-called scientific analysis of society and history (Marx’s being one of the more influential, but by no means the only one). The flaw was that, in adopting Newton’s method, it *was* quantitative, but never established the validity of many of the concepts around data collection and reasoning were based with anything like the precision of the concepts in Newton’s system.

Over the centuries, another element crept in. More and more notice was taken of *correlations* between different data sets, initially for correlates of suicide statistics, but extending far beyond this, as more and more facets of social life came to be charted statistically. With these developments came increasingly sophisticated methods of statistical analysis. Although the idea of causation (which is hard to define) is conceptually different from that of correlation, the abundance of data on correlations in academic and policy literature gradually persuaded many people (despite their explicit denial) to assume that correlation indicated causation. The history of this insidious shift is described in detail in a recent monograph¹⁵. In academic literature, the flaw is usually recognised, so discussion sections of research papers usually explore alternative ways in which an observed correlation could come about, short of direct causation. In areas of social and economic policy, where persuading a naïve populace is often higher priority than presenting a fair and balanced view of the truth, this flaw has been adopted most widely and dangerously. The style often seems to be an inappropriate attempt to mimic methods of the hard sciences to give it the aura of universal validity.

¹⁵ Hacking, I (1990). *The Taming of Chance*. Cambridge University Press

The latest manifestation of this long history is what is known as the ‘managerial revolution’, separating administrators from those administered. This gave the former more power than previously, when they had been members of teams expected to be in two-way dialogue with those at the front-line, rather than agents of control. Most recently, this is compounded by the trend to combine the predictive powers of several data sets which each have correlations with an outcome, supposedly producing stronger, more determinative predictions. As the range of datasets increases (‘Big Data’) it is claimed that this might even help to identify individuals. We now know of strategies based on ‘profiling’, to screen, for instance, for possible terrorists in aircraft passenger lists. In areas of social policy, such strategies may have decisive impact on *individuals*; yet, in principle, aggregate data never give data about individuals, however the data sets are manipulated and combined.

Alongside the managerial revolution is the dogma of market rectitude. If there is no real market – and this often applies in social services and mental health care – it may be necessary to set up structures *as if* there were one. So, there may be mandatory targets based on performance indicators, which are published to bring about competition between agencies with different, but complementary agendas, different inherent problems, and intrinsic strengths; and *contestability* becomes the buzz-word. This means, *inter alia*, that social services, especially those in the mental health area are forced to compete for funds, when their respective functions are natural complements to each other, and between whom collaboration rather than competition should be fostered. *Many* different functions need to collaborate. This applies more widely: Economic and social agendas of any government need to be going in the same direction, albeit with different detailed agendas. Is it so? Not often, I suspect. I ask if our economists have gone mad; and I am not the only one to do so¹⁶.

Apart from funding models, we have had for twenty years the dogma of ‘evidence-based medicine’. The origin, as far as I can discern, was to limit untrammelled personal authority of clinicians in making decisions, and the ethical pitfalls to which this leads. However true science is not concerned solely with evidence, but also with reasoning (as Francis Bacon realised in 1620, after 2000 years of haggling between empiricists and rationalists). Moreover, collecting evidence is pointless unless it is based on sound concepts, a point to which little thought is devoted. There is, in any case, a better way to prevent unethical and authoritarian decision-making by

¹⁶ Reinhart, CM, Rogoff, KS (2009) *The time is different: Eight centuries of financial folly*. Princeton University Press

powerful medical consultants: to set up robust systems of transparency, which might mean accepting oversight as a normal routine by independent, experienced well-informed inspectors to check clinical practice. Such transparency is after all, a regular part of clinical training, and is recommended in some areas of medical and surgical practice. However, too often the way ‘evidence’ is to be collected is dictated not by the clinicians or service users – those who know most about basic realities of mental health care - but by administrators, who are some way removed from the front line (though of course, not from its financial aspects). Is the right evidence being collected? Again problems arise from conceptual confusion, incompatible concepts adopted by different agencies, and policies used to exercise power, without accountability of truly democratic style. It is ironic that the policy of ‘evidence based medicine’ was supposed to prevent exactly this.

I am by no means the first to point out dangers in the historical trend in social science and policy administration. A line of scholarship argues that excesses of ‘rationalism’ (*sic*) in social areas, growing since the eighteenth century, led step-by-step to Thomas Malthus’ ideas on population, ‘reforms’ of the 1834 British government which led to the workhouses, later to notions of eugenics, and then to totalitarianism, the actual implementation of eugenic policies, and the holocaust^{17,18}. Today’s administrators beware!

In research areas, particularly for mental health research, current funding models and the dogma of ‘evidence based medicine’ combine to produce frank absurdity. Of course, as explained above, there is profound uncertainty about the validity of basic concepts of mental disorder, and the scientific status and validity of the very concept of ‘mental illness’ (as opposed to some alternative). Such issues cannot be resolved by adding to the pile of empirical data collected around existing flawed concepts. It needs intensive scrutiny and meticulous scholarship by real theoreticians in the area – and it is such a large task that it probably needs to be a large team effort. However, methods of funding research - for instance by the HRC, when last I was involved - set experimenters and theoreticians in competition against each other, according to prevailing concepts of contestability. Of course I got nowhere. When I write like this, I tend to be misunderstood, as though I want to replace experiment with theory; likewise Francis Bacon himself is often misunderstood in a converse way, as though he advocated empiricism to the exclusion of rationalism. My point is actually the same as Bacon’s – that experiment and theory complement each other as inseparable parts of a single whole, albeit conducted by different people with different skills. To put it

¹⁷ Max Horkheimer, Theodor Adorno, (1947/2015) *Dialectic of Enlightenment*. Stanford University press.

¹⁸ Robert Miller: *A Brief Introduction to the Anti-Darwinian Heresy*. www.robertmiller-octspan.co.nz

bluntly: *Experiment without theory, and theory without experiment, are equally stupid; like clapping with one hand.* This synergy was crucial in the birth of the natural sciences 400 years ago, and has always been essential to the most rigorous scientific discipline – natural philosophy, which became physics, almost always led by scientists with different yet complementary skills and mindsets, specialising in one or other area. This synergy has never been strong in biomedicine, but is now desperately needed, especially in efforts to understand mental disorders¹⁹.

4. Political Battlegrounds

A variety of forces are in play in the mental health area, which come into conflict in several battlegrounds. Many of these were already present in the time of Wernicke and Kraepelin, and continue to this day. Wernicke started work as an academic neurologist; but by the time he practised in psychiatry, his ideas were more nuanced, and dynamic psychiatry was also making claims to be included within the mental health professions. In his practise, he tried to fit clinical realities into concepts of the medicine in which he had been trained; but this was only partly successful, and one has the sense in his *Grundriss der Psychiatrie*, that it was a struggle. After his death, some students in his class, notably Kurt Goldstein, did break free from the medical model, founding schools of psychiatry with different bases. All this debate is now returning to centre stage, with growth of consumer activism.

Apart from the medical conceptualization of mental disorders, Wernicke was a gifted clinician; flexibility in the consulting room must have been vital in developing clinical, therapeutic relationships, as was independence in his practice. These are traditions long held to be vital in clinical medicine. Wernicke's style of individual analyses had some similarity to the emerging dynamic psychiatry, although quite different in its concepts. However, in addition to academic neurology and its medical style, and dynamic psychiatry with its individualised analysis and therapy, the third force came from leaders working in asylums who were most aware of administrative needs: They knew of the huge numbers needing care in asylums, and so they needed to be able to take defensible decisions quickly²⁰, when large numbers had to be 'diagnosed', whether or not this was scientifically or clinically valid. In many

¹⁹ Robert Miller (2014) Validating concepts of mental disorder: Precedents from the history of science. *Biological Cybernetics*, 108, 689-699.

²⁰ Later, the pressure to have systems for quick decision-making about mental health on large numbers of people arose in a military context, both for screening recruits, and for dealing with casualties. The history of the relation between psychiatry and the military is an important one, and military requirements have cast a long shadow over, have distorted, and arguably still continue to distort psychiatric practice.

countries, especially the USA, administrators' style for psychiatry prevails to this day: As many people have commented, DSM-III and later editions of DSM are administrators' documents for classifying mental disorders, but now no longer for administration of *asylums*, but, in the US health system, to make defensible decisions over health billing, insurance claims, medico-legal matters etc.

In May 2013 the American Psychiatric Association launched the latest edition of DSM – DSM 5. Two weeks before this, NIMH, the largest funder of mental health research world wide, threw down the gauntlet, by publicly stating that NIMH would no longer accept DSM categories in the research it funded. Instead they hoped to develop what they call the Research Domain Criteria, based not on consensus amongst clinicians, but on neuroscience evidence – and possibly (but we must wait!) on proper scientific reasoning. The aim - and it would be a huge achievement were it to be successful - might be to establish a set of concepts of mental disorders which (in Bacon's words) were *not* 'confus'd and over-hastily abstracted from the facts'. The person at NIMH leading this bold program is Bruce Cuthbert, with whom I have exchanged messages. In late March 2015, he will appear as a keynote speaker at the congress of the European Psychiatric Association in Vienna.

There is now a fourth player in the struggle to make psychiatric practice more attuned to patients' needs: Activism by consumers/service users' groups and their spokespersons. Such groups are diverse. Usually, as can be expected, they have first hand, and often very bitter grass-roots experience of mental disorders, and treatments offered in mainstream psychiatry, and they often talk eloquently about this. They may have challenging words for the various professions involved in mental health care, especially psychiatrists, and their words need to be given careful attention. The groups themselves may not be democratic in style – a criticism easily levelled at the whole mental health scene. Understandably, members of such groups often lack key aspects of technical expertise; but they do have expertise borne of lived experience. Most service users know there is something wrong with the 'aggregate data' approach to mental health management, but have no power to change this – although they may say to their physician: 'I want you to treat *me*, not the aggregate statistics!'

At their best, service-user-led groups and their leaders have thoughtful well-formulated alternative ways to conceptualise mental disorders, which deserve detailed respectful discussion across the various frontiers in mental health. From the best of service-user advocates, one often hears a challenge to the very concept of mental *illness*, modelled, as it is, on illnesses in general medicine. This is a complex topic, with much to be said on both sides of the argument. The gist of the case often put forward by such advocates is that

‘mental *illness*’ is the wrong concept. Rather than an illness being defined, as elsewhere in medicine, as specific, objective disorders in a specific body system or anatomical structure, they prefer more holistic and subjective conceptualisation, perhaps the loss of an individual’s subjective ‘sense of personal wholeness’. This does not have to be anti-scientific, nor need it overturn past research, whether biological, psychological or social; and, while greater emphasis may be placed on therapeutic personal interactions, it need not object in principle to biological treatment. It is not *anti*-medical, but rather views mental disorders in a larger frame, including medical models along with others.

Without drawing too close parallels with the darker side of the history of administrative dominance of clinical research and medical practice, today’s administrative style creates clashes with the various other players in the mental health scene. For clinicians, flexibility in the clinical relationship, and therefore independence in consulting room practice is an important and long-established tradition. Today, many clinicians feel excessively constrained by administrative control, with whose policies they can hardly agree. As a result the clinicians may find diverse ways to ‘bend’ or ‘adapt’ policy guidelines and protocols to achieve their own ends, while appearing to fulfil policy guidelines. This is subterfuge, by no means ‘straight dealing’. Researchers into mental disorders, may have been constrained by the need to base their research around official diagnostic categories, however flawed they are, and devoid of validation by scientific reasoning. They too adjust what they do to fit concepts imposed from above, neglecting their own intelligence. Service users know that diagnoses, products of administrative dominance, often do not deliver the best treatment. Clinicians, if they are honest, also know this; so, treatment is very empirical – ‘what works’; and formal diagnosis then becomes a sort of ‘academic add-on’. This may change as the NIMH program gets under way.

To sum up, today we see a variety of forces at play in mental health politics: We see a rationalist model of human nature, defined most strongly in legal professions used vicariously to define mental illness; the traditional approach of general medicine, vying with the more relational approach to therapy coming from dynamic psychiatry. We see impersonal styles often implied by administrators’ needs, clashing with the flexibility needed in the consulting room by gifted clinicians; and this also clashes with the insistence of service-user activists that they be given greater individual attention as persons, rather than just as cases of a particular diagnosis, with no other distinguishing features. Occasionally, and to date only partially, we see hints of a view of human nature based on advances in neuroscience, a style where much can still be learned from Carl Wernicke 120 years ago. In terms of the

lack of conceptual clarity - the main theme of this essay - the issues are fundamental. As already described we have clashing models of human nature; rival models of what mental disorder (or mental 'illness') might be; and spinning off from that, interminable debates about the validity of specific diagnoses; and hierarchical styles of modern management which are incompatible with older styles based on partnership.

However, a real challenge, perhaps the greatest *political* challenge, is to find a style of interaction between the different players which can enable respectful democratic discussion between protagonists who start from basic assumptions which appear to be quite different. Just what, if anything, the different players have in common is not clear. If agreement could be reached on that, it might define a process for reintegration amongst the players.

5. Features unique to antipodes

All the problems addressed above combine with some unique aspects of the antipodean experience. The first is the deep-rooted *pragmatism* in the dominant cultures in New Zealand and Australia. Pragmatic success in creating a way of life was a primary virtue, as new societies and nation states were built *de novo*, by a deliberate strategy of colonization from Britain and elsewhere. Science and technology of the day were used and developed to fit the local scene as means to this end, but the intense philosophical struggles of past centuries which led to birth of the natural sciences were taken for granted. So were the political struggles which led to notions of democracy and its processes, and more recent emergence of concepts of human rights. This has led to a populace which is not adept at examining in dispassionate and rigorous fashion hard intellectual issues on which their own societies are founded. As a result, today, influential people aspiring to political power, can absorb radical ideas when travelling overseas, work them up to easy slogans, which are rolled out at election time; and the voting public falls for them, with neither time nor analytic skills to mount a challenge. In the mental health area, this means that there has been little deep analytic thought of the complex issues discussed above.

In addition, a tradition handed down from the earliest days of settlement emphasises *physical strength and endurance*. These were prized virtues, reflected today in our obsessive worship of sporting prowess, and success on the sports field. Along with these, *individualism* and *personal autonomy* were of prime importance (characteristics found even more strongly in the USA). In the earliest days, where survival itself was the real issue, concerns about mental health were hardly a high priority. Disability or mental weakness of any kind was not so much a health problem, but moral failure, as graphically portrayed by Samuel Butler, an early visitor to New Zealand, in his fantasy-

novel *Erewhon*. Mental disorders ran counter to prevailing attitudes not only in terms of the conceptual confusion they provoke, but also in terms of the implicit failure to meet up to the challenges of building a new society; and these attitudes are still prevail today.

The third attitude which compounds this is the widely-believed fiction that New Zealand is a ‘classless society’. Deep-rooted *anti-intellectualism* developed from this: Higher education, and interest in exploring ideas is widely seen as a reflection of elitist, upper-class values. Again this makes it hard to devote serious intellectual effort to analysis of the complex concepts of mental disorders. Prevailing attitudes may be summed up as appeals to ‘common sense’ and simple solutions (actually simplistic ones). However, mental health and the problems arising from mental disorders *are* complex, never solved in simplistic ways. As H.L. Mencken – wit and journalist of a former generation from the USA - said ‘To every complex problem, there is a solution which is simple, neat, and *wrong!*’ In mental health care and research we encounter results of that aphorism every day.

There are major compensatory strengths to be found in New Zealand, which might be developed as part of the solution to problems I address. New Zealanders are notable for their energy, willingness to try new methods (if not always fundamentally new *ideas*). In founding a new country, many new arrivals were escaping from difficult situations in their original country, and wanted to create something better here; and there is thus a tradition of bringing in progressive social reforms well ahead of most other countries. At their best New Zealanders *are* able to cross social barriers with ease, which in other countries are insurmountable; and because New Zealanders have to travel around the world, there is a quite cosmopolitan culture in many strands of New Zealand society. In addition, since the population is small, individual persons are more important; the tendency to revert to impersonal styles of administration is thus, to a degree, mitigated: New Zealanders often do have the ‘personal touch’ missing in more populous countries. Most important is the contribution coming from the holistic world view of Maori, which at its best, is a leavening influence on many of the more simplistic notions we inherit, or have developed here in Aotearoa in the Pakeha world. In addition, the necessity, from earliest days, to negotiate with Maori, a culture whose world view is profoundly different from that brought here from the northern hemisphere, does engender a political culture whose most striking feature may be its adaptability.

6. Attitudes to psychiatry to which this has led

The human species, from the point of view of taxonomy, is a member of the class *mammalia*. We share with mammals most of our repertoire of

emotional instincts, including fear: As mammals, we fear what is unfamiliar or novel, and we run away from what we fear. In a human context, that means we fear, and avoid situations we cannot understand. The deeper and more fundamental our lack of understanding, the more intense our fear and the more powerful our instinctive avoidance. If we see or hear images that remind us of what we do not understand those also becomes sources of fear and trigger our avoidance reactions, which reactions can thus progressively expand. As a result, any reminders of our fragility, vulnerability, and lack of personal wholeness, generate such fear and instinctive avoidance. As already discussed, mental illness (or whatever we call it) reminds us of profound issues, referring in part to *our own* sense of personal identity, and how we should relate to other people, which few can analyse at a level deep enough to resolve our sense of confusion. The fear and avoidance to which this leads are powerful motivating forces, especially for those with no direct experience of mental disorders. We fear what we do not understand, and therefore avoid going near it. Hardly an intelligent strategy.

In the context of research on mental disorders, better understanding is hardly likely to come from adding to the pile of empirical evidence already available, which in contemporary context, is usually collected with quite different purposes in mind, and in any case based on concepts which may be flawed. What is needed is serious attention to the *theory* from which true understanding should come, which mainly means intelligent assimilation and integration of what is already known. However, in a research environment dominated by empiricism (that is, ‘evidence’ to the exclusion of ‘reasoning’), and in a society which in a broader sense is often afraid of new ideas, this is hardly likely to happen.

What *does* happen is that behaviours appear which are irrelevant to the immediate issues, which ethologists might call ‘displacement activity’²¹; and they are equivalent to patterns of human behaviour which might be called ‘neurotic’ when people are overwhelmed by conflicting emotional demands, leading to incompatible motivational drivers of behaviour. Amongst the lay public we have of course age-old stigmatization of those who do not fit into a social group, an instinctive emotional reaction essentially the same as one might find in any species of social mammals. Quite apart from the explicit discrimination and exclusion to which this leads, and the fact that those who are targeted have few to advocate for them, they may become so demoralised that cannot be effective advocates for their own interests. More subtle, are the

²¹ This term was first used by Nikolaas Tinbergen and Adriaan Kortlandt, in 1940. In 1973 Tinbergen, an ornithologist, was one of the trio to be awarded the Nobel Prize in Physiology and Medicine, for work on animal behaviour, highly relevant to psychiatry.

comments of those who claim they are trying to help, but with phrases which are unhelpful. These may be of the form ‘Pull your socks up’ – when severe depression has, as an important, perhaps defining feature, the *inability* to take any decisions. We might hear ‘just try to be yourself’, as if a person who faces combined assaults of psychotic breakdown, and unsympathetic, if not brutal care in mental health service, has a clear idea of who he/she is. It might be ‘what is needed is a common sense approach’, as if phenomena of severe mental disorder fit into the layperson’s view of common sense. At its worst people conjure up images of mentally ill people as intrinsically violent, far beyond any statistical evidence to support their case. This is mainly a dark fantasy to give tangible reality to a projection which is otherwise a quite undefinable fear, whose roots lie in an utterly different realm – fear arising because of lack of understanding on matters which touch us very personally. (Interestingly, in Wernicke’s day, it was epilepsy which was targeted in this way. The term ‘schizophrenia’ had not yet been coined.)

Professionals do their displacement activities in more subtle ways, their instinctive capacities for covering their tracks being more finely honed to fit perceived social mores. Medical practitioners outside psychiatry may scorn the lack of rigour of the psychiatric professions, their diagnoses, and their treatments. This plays out politically in that mental health professions recruit few of the best graduates, and are perennially underfunded compared to other specialties. Amongst biomedical researchers in other areas of medicine we see the same scorn and neglect; but do those critics ever give serious thought to the immense intellectual problems of making the discipline more robust? Not likely: They prefer to take easy pot-shots from the sidelines, without trying to resolve hard theoretical issues. They, and their professional organizations thus become part of the wider social distancing from anything to do with mental illness: Patients, and mental health professionals alike become targets for stigmatisation.

Researchers actually working to understand mental disorders may know at some half-conscious level that there is something wrong in terms of fundamental concepts, but cannot say exactly what. However, because of the way mental disorders are publicly defined, and the need for ‘evidence’ rather than ‘understanding’, they usually adopt terms of popular discourse, rather than devote their energy to resolving underlying theoretical conundrums.

The displacement activity to which I refer is also found amongst many health administrators. In recent years, they may have been recruited from right outside the health area, with no direct experience in health, the essential interactions in clinical care (especially in mental health), or in medical ethics. They may have been led to believe that good mental health care is a no more than a logical sequence from diagnosis to formulation to treatment (over-

emphasising medication perhaps, and neglecting any role for therapeutic relationships). They may bring to the job prejudices common in the general populace, especially confusion about personhood. For administrators charged with making big decisions, involving large sums of money, their conceptual confusion is unlikely to appear on the surface; but what may emerge is a style of deliberate depersonalising of big issues, which yet touch many individuals in powerful personal ways. They may limit attention to aggregate statistical data avoiding personal engagement, and generally distancing themselves from front-line realities, sometimes deliberately, by setting up procedures which ensure 'plausible deniability'. What is worst, is to meet administrators who on the surface appear willing to engage with critics at a personal level, with a show of open dialogue; but once it becomes clear that criticisms are potent enough for their position to become vulnerable or require significant change, the shutters go down. The reality of their power comes to the fore. At this stage there may be a sense of betrayal.

7. What is needed now

The scenario I have described might be captured best by a line from Shakespeare's *Macbeth* – his darkest drama: 'Confusion now hath made his masterpiece'. Fear leading to avoidance is not intelligent; nor is it scientific; yet some topics for research *do* trigger fear, confusion, and such instinctive reactions, especially in the area of mental disorders. The answer: We *do* need to try to understand what we fear, to approach rather than avoid, learning carefully and cautiously all the time along the way - but still approaching not running away. Surely, that is the attitude of a good scientist and researcher, as it is of a good health practitioner. Most of what I have to say here is about style, rather than details of process or specific policies.

First, if research into mental health and serious mental disorders, is to gain any standing, a culture of trust and collaboration must be built between the various players. Notably trust must be established between researchers, administrators, and the more articulate and thoughtful amongst service users. Where to start? I suggest a series of forums where diverse stakeholders meet to discuss philosophies, aims and background assumptions for research, without hierarchy of status, profession, or rank. Increased transparency is needed, about purposes of research in mental disorders, with freer discussion not just of specific projects, but about fundamental purposes of research in psychiatry/mental health as a whole. This is important, because an ever-present danger in psychiatry is that governments want to use it for purposes alien to that of any caring profession; and this also applies in the research field. Transparency is the best safeguard here.

The dialogue should be candid, straightforward and respectful. Such ‘straight talking’ means that, if we are uncertain about something factual, or if we lack understanding of it, we can freely admit our ignorance, and lack of understanding, even if it is about fundamental matters, seeking clarification from others involved. Here I quote a founder of the natural science tradition itself, Galileo Galilei, who refers to the evasive language ‘. . .employed by some philosophers as a cloak for the correct reply which would be “I do not know”’. That reply is as much more tolerable than the others as candid honesty is more beautiful than deceitful duplicity²². It is appropriate to quote from such an old source here, because the state of knowledge (or ignorance) in psychiatry today is similar to that for physical sciences at the time when Galileo was writing – a little knowledge, a little understanding perhaps, but mainly confusion.

There are many fundamental topics for discussion, if the great diversity of stakeholders could join in such open dialogue. If service users were to be part of the process, and had powers at the time of decision-making similar to other members of the discussion, an issue would inevitably arise of getting the correct balance between long-term goals (often uppermost in minds of researchers) and short-term ones (on which service users are likely to place their emphasis). In arguing that long-term goals be part of the mix, another issue would arise, mentioned already here, the rebalancing between empirical research and theory. Without the *latter*, no progress can be made on the hardest problem, discovery of the most valid concepts for mental health research and practice. Without the *former*, there can of course be no tests of the value of newly-formulated concepts.

The focus of this article is mental health *research*, not regular *practice* in mental health care (although it often refers to the latter). In regular practice a call for transparency may be a bigger challenge than in the research area, because it may mean that clinicians have to admit mistakes they have made which had substantial adverse consequences. This possibility is more likely and more stressful than in research; yet, even in clinical practice, merits of transparency have a long tradition: Transparent audit of health practice probably started with Theodor Bilroth, gastro-intestinal surgeon in Vienna in the late nineteenth century. Despite his being at one point the target of strong public vilification when a patient died on the operating table during a pioneering new operation, it was *he* who insisted on publication of all results, with the result that surgical safety and expertise steadily improved. Carl

²² Dava Sobel (1999) *Galileo's Daughter: A Historical Memoir of Science, Faith, and Love*. Walker and Company.

Wernicke was also not afraid to admit his mistakes, at least to his very advanced class of trainee psychiatrists. Note that calls for transparency were not enforced by administrators, but came from practitioners, as the best way to safeguard their own practice.

Opening up the research agendas, with increased transparency may be needed over a broad area of research; but in view of historical shortcomings, and dark corners in the mental health area, it is needed more there than elsewhere. A specific area where improvements could be made is to abolish or greatly reduce the anonymity of peer review both of research papers, and, with differences in detail, in applications for research funding. I have written elsewhere on the rationale for this²³.

When I started to write this piece, I did not realise how big the issues raised would be. I now realise that huge forces will oppose my conclusions. Philosophically, rival concepts of personhood may be most intractable. The model of personhood, which Wernicke developed based on neuroscience of his day, and which can, in my view, be formulated now with much stronger reasoning, is bound to arouse opposition from powerful religious bodies, as well as from legal professions (especially in the USA). Our political masters with oversight over mental health professions might not like it either, since they need to respond to (and to some extent are bound by) public opinion, which hardly grasps a scientific perspective of personhood. Any shift from a strictly medical concept of mental disorder (or *illness* as some would prefer), is likely to be ahead of its time for many of today's psychiatric practitioners. Apart from that, if the several parts of the mental health services are to work together as partners in a complex whole, and if research activities in different centres are to be seen as partners in this larger scene, rather than competing stand-alone 'businesses', opposition may be expected from those committed to current funding models, especially from some who claim, against all the evidence, that systems based on this fit concepts of economic rationality.

Is this all soluble? I do not know; but I ask a pertinent question about process: What could be an appropriate process for reaching consensus when even the most fundamental assumptions are not shared between protagonists, and when there is scant evidence of *any* common ground? If this is *not* soluble, the last acid couplet of Pope's poem in his *Essay on Man*, seems appropriate, as much for the discipline of psychiatry as for humankind itself:

‘Sole judge of truth; in endless error hurled:
The glory, jest and riddle of the world’.

²³ Robert Miller (2013) *Anonymity of peer review*. www.robertmiller.octspan.org.nz