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ARTICLE

Systemic thinking and values-based practice

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SUMMARY

Values-based practice is a new approach to working with complex and conflicting values in mental health practice. Theoretically, it argues that many clinical and ethical dilemmas in psychiatry arise because of the different value perspectives taken by the players involved. By exploring the differences in value systems 'held' by each player, it may be possible to come to a richer consensus that can incorporate both similarities and differences. In particular, values-based practice suggests that, traditionally, the value perspective of the patient is often either not considered or is ignored, and that by giving it voice, clinical practice will become more patient-centred. In this article, I will compare values-based practice with other types of systemic thinking in mental healthcare and I will discuss some areas of clinical practice where values-based practice may be difficult to apply.

DECLARATION OF INTEREST

None.

> Values are those deeper illuminations in whose light justice and injustice, good and evil, means and ends, are seen in fearful sharpness of outline.
>
> (Jacob Bronowski 1956: p. 73)

What are values and why should psychiatrists take them seriously? Fulford and colleagues (Fulford 1989; Woodbridge 2004) suggest that looking at the different values that mental healthcare professionals and patients bring to their experience in the clinical arena can help:

- to make clinical care more patient-centred
- to address difficult conceptual issues such as diagnosis
- discussion of difficult ethical dilemmas in clinical practice, such as involuntary treatment.

The theory behind values-based practice suggests that fact-based and values-based reasoning are both important for good-quality clinical decision-making. All medical practice is a value-laden process, from assessment to discharge (Fulford 1989), but clinicians are not always aware of how their values influence their decisions and communications. Fulford draws on the analytical and linguistic philosophy of J. L. Austin to suggest that careful attention to the language that healthcare professionals use is one way of raising awareness of values.

So far, Fulford and colleagues have sought to introduce values-based practice into community mental health practice and into child psychiatry. The feedback from both service users and professionals has been good and the National Institute for Mental Health in England (NIMHE) has developed a workbook for values-based practice in mental healthcare (Woodbridge 2004). Policy developers support it as being both patient-centred and respectful of diversity (National Institute for Mental Health in England 2004). In this article, I want to show how values-based practice compares with other systemic ways of thinking in mental health practice and present some clinical domains that are challenging to such ways of thinking.

What is systemic thinking?

Values-based practice can be described as a systemic approach to clinical practice. A systemic approach can be contrasted with an individualistic or dyadic approach to healthcare in a number of ways. I will describe these below, using the perhaps old-fashioned language of 'patients' and 'doctors'. I use 'doctor' simply because that is my perspective and experience, but the meaning can be applied to anyone in the position of professional healer or carer. I preferentially use the term 'patient' because, although people may elect to use services, they do not elect to become ill and that sense of dependence and vulnerability that is inherent in the word 'patient' is crucial to understanding mental healthcare relationships.

The dyadic approach

In dyadic healthcare relationships, there is no relevant experience outside the consulting space. The patient brings a problem, which the doctor considers thoughtfully. The therapeutic focus is on the problem itself. Removing or ameliorating the problem is the doctor's task; the doctor takes action to do this and with that action the relationship ends. This type of approach is traditional in medicine and finds its clearest expression in surgery, or any other event where there is a discrete injury

or disease process. As an approach, the dyadic relationship works well for problems that do not undermine people's personal identities; it also emphasises the role of the doctor as one who takes action and the patient as largely passive.

Systemic thinking

In contrast, a systemic approach assumes that the patient exists within a number of social systems or groups and has different roles in each of them. Although 'the problem' has a clinical aspect, it also has meanings for the patient that are outside the doctor's experience. To really understand what 'the problem' is, the doctor has to consider all the patient's different social identities (parent, partner, lover, worker, friend) and understand the impact of 'the problem' across these domains.

Furthermore, the doctor needs to appreciate that in becoming a patient, an individual is now engaging in a new social system; both patient and doctor are engaged in what one might even call, as Wittgenstein (1953) suggested, a new language game. The doctor herself understands that she too is part of a system of roles within her own life, both personal and professional: in particular, she may have multiple roles within a complex healthcare organisation, such as a hospital or trust service. To deal with 'the problem', both she and the patient must find a way of negotiating what is best for the patient from the patient's point of view and what is best from the doctor's point of view. Engaging in treatment will become a mutual task for doctor and patient in which both take action.

Systemic approaches to general healthcare

The benefits of a systemic approach to therapeutic relationships emerged first in relation to chronic illnesses and other disorders that fundamentally alter people's personal identity and social experience. If you break your leg, you do not remain forever someone with a fractured femur. However, if you develop rheumatoid arthritis, the illness becomes part of your everyday experience and to some extent alters your previous identity. Different people deal with this in different ways: some ignore their disorders, some make them the focus of their existence and some want to be people who 'live with' a disorder. The point here is not that there is a right way, rather that the disorder forces the patient to consider a change of social role and identities (Kleinman 1988; Toombs 1992). A systemic approach by the doctor provides a space for the patient to consider this process and explore it, with the doctor as expert companion.

A systemic approach has become more widespread in those aspects of medicine where care is more important (or possible) than cure: physical disability, chronic diseases and palliative care. However, to some extent it has still been seen as being delivered by nurses and therapists allied to medicine, rather than being part of the good medical therapeutic technique of doctors. Of course, there have always been noble exceptions to this and 'holistic' medical practitioners are familiar with systemic approaches to treatment. General practice is also well-nigh impossible to carry out effectively without a systemic approach.

Systemic approaches to mental illness

Damaged identity

The systemic approach has been of particular value to psychiatric practice for a number of reasons. First, damaged identity is crucial to mental illness and its manifestations. Most, if not all, mental disorders damage personal identity to some degree and impair the capacity for autonomous function. Keeping an integrated sense of self across all domains is the job of our personalities and it is often at the level of personality function and identity that clinical problems first emerge. Thus, it is very common for a patient to complain, 'I am not myself', and even more common for others to bring the patient saying, 'She is not herself'. It may be difficult to know what to make of these complaints unless one has a sense of the different social systems in which the patient lives.

If the patient has a severe mental illness, then their personal identity is fundamentally altered, sometimes permanently. This has an enormous impact on the people around them, which in turn affects the patient (Glover 2003). The expressed emotion (EE) literature relating to schizophrenia makes it clear that all of the patient's relationships are part of the therapeutic process, not just the relationship with the doctor. Even if the patient recovers, the stigma of a psychiatric illness persists, as has been discussed in the pages of this journal (Byrne 2000); readers will recall Goffman's (1963) association of stigma with 'spoiled identity'.

Social impact

Second, many aspects of psychiatric disorders first impinge on the social realm. It may only be in one area of relationships that the problems first emerge; and the degree to which they spread to other domains, or are confined to only one, will tell the psychiatrist a great deal about the problem.

This is perhaps most clear in the case of non-psychotic psychiatric disorders, where the patient's distress is manifested in different ways through their relationships with other people that construct their identity.

This particularly applies to any psychiatric disorder that affects children and young people. Within child psychiatric services, systemic approaches to therapy have been developed that look at the role of the child in the family system and try to understand how 'the problem' affects the family system, for good or ill (Bateson 1973). Many eating disorder services take a systemic family approach to treatment and also seek to understand how the patient feels about 'being' someone with an eating disorder, rather than 'having' an eating disorder (Tan 2006).

Perspective and narrative

Bracken & Thomas (2001) have argued that all psychiatric practice needs to locate the patient and their problems within a social and cultural context, and that healthcare professionals need also to be able to self-reflect on their own context to make sense of patients' perspectives on their problems. This fits in with a narrative model of clinical encounters in psychiatry, where the psychiatrist takes seriously the patient's own conscious narrative, but may also try to explore the less conscious aspects of the patient's story (Holmes 1998). The point about a narrative is that it connects different aspects of experience by a network of representations of self and others, which 'guides action and enables social relationships'. The 'voice' of the patient mirrors the perspectival approach of values-based practice, where the service user's point of view is at the centre of policy and practice.

The values-based practice approach is explicitly linked with other models of care such as the narrative model mentioned above and patient-centred care. By extension, there are links between patient-centred care and person-centred care, as described by psychotherapists such as Carl Rogers. In this approach, the patient's own account is more important than a formal diagnosis.

BOX 1 Case example: taking the non-problem seriously

Valerie presents to her general practitioner complaining of depression and anxiety following the break-up of her marriage. He thinks she may benefit from counselling and support from Heather, the community psychiatric nurse linked to his practice. Heather notes that Valerie gives a history of having experienced violence during her marriage and wonders if she has post-traumatic stress disorder. She refers Valerie to Margot, a psychologist who runs a community group for women with depression which uses both educational and cognitive–behavioural therapy techniques. Valerie attends the group regularly. After 6 months, several group members express their wish to leave the group. Margot explores the reasons with everyone present and is surprised to find that the majority of the group find Valerie critical and contemptuous of their distress. No one supports Valerie, who bursts into tears, saying 'You are all mean to me, just like my husband'.

Q1 What problem did the general practitioner see?

Q2 What problem did Heather not see?

Q3 How might Valerie define her problem?

Q4 Is there a non-problem that Valerie cannot see, but others can?

Psychodynamic psychiatry and systemic theory

Psychodynamic practice is essentially systemic and in this sense resembles values-based practice. All theories of dynamic psychotherapy assume that each person is the sum of their relationships, past and present. Group analytic theory, in particular, emphasises the social construction of personal identity, and therefore to some extent the social construction of 'illness' or at least the 'symptoms' of illness. For example, in relation to assessing a new problem, a dynamic approach not only considers the patient's account, but also wonders what stimulated the referral for assessment and, by extension, whose anxiety is driving the referral. Who exactly is it that is most worried about the patient, and why?

Defence mechanisms

Dynamic theories of psychological life and growth suggest that people use a variety of psychological defences to manage stressful experiences during a life course. These defences become part of the person's make-up or identity. People with mental distress, or with generally poor social functioning, tend to use immature and maladaptive defences for too long and in inflexible ways (Vaillant 1995). Even in cases of severe mental illness, some of the symptoms can be seen as extreme versions of defences against the subjective mental distress of disorders such as schizophrenia.

The defence often manifests itself as a symptom. Michael Balint (1957) noted how various types of psychological distress might often be manifested as symptoms of physical illness. The defence may then become a problem in its own right; it is often only when treatment starts that one gets a sense of the 'non-problem' (Garland 1982), as exemplified in the fictitious example in Box 1. As Holmes (1998) suggests, the 'symptom' is only a fragment of a much bigger narrative of the personal experience of the patient and it is this that the psychodynamic practitioner explores.

Team-working

Such an approach is vital for effective multi-disciplinary team-working, particularly in general psychiatric practice. For example, many patients may be first brought to services involuntarily. This is an important action, often carried out in states of high anxiety; there is ample evidence that patients

Advances in psychiatric treatment (2009), vol. 15, 470–478 doi: 10.1192/apt.bp.107.004549

do not like it, and professionals often disagree about whether it is indicated. A psychodynamic approach directs that all the anxieties that lead to such action need to be understood from the different perspectives of the people involved. What are the patient's anxieties, if any, and are they in any way the same as the referrer's, the carer's or both? Does the community psychiatric nurse have the same anxieties as the general practitioner? Do they see the patient in the same way, and if not, why not?

Psychodynamically, differences of opinion between professionals are seen as reflecting different relationships with the patient and different aspects of the patient's problems. Discussion of these different perspectives and anxieties is both essential to team-working and beneficial to the therapeutic process. Hence, psychodynamic practice, like values-based practice, requires good communication skills, particularly in groups, to facilitate discussions in which dissent can be heard and anxieties explored.

Psychodynamic practice and values-based practice

There are a number of other ways in which psychodynamic practice resembles values-based practice. Both approaches are 'patient-centred', i.e. both assume that the patient's identity and experience are the principal focus of therapy and clinical engagement. The patient's perspective has to be explored and accepted as valid for them; only then can it meaningfully be compared and contrasted with others' views, including that of the therapist. As one famous psychodynamic practitioner said, it is an approach in which the doctor says, 'Tell me what I don't know about you', rather than 'Let me tell you about you' (Bowlby 1988).

A multidisciplinary approach

Both values-based practice and psychodynamic practice assume that different people in the patient's personal system will hold different aspects of knowledge about the patient's problems. Thus, best-quality therapeutic decision-making about the patient must involve all those involved in the care of the patient. Practice must be multidisciplinary because this ensures that no vital aspect of information about the patient is lost (Surowiecki 2004).

The relevance of language

Psychodynamic practice, like values-based practice, assumes that many people are unaware of feelings and thoughts that they have about a person or a situation, particularly fearful thoughts and feelings. Careful attention to the language people use and the ways they speak can raise awareness of not only what people value, but the extent to which what they value reflects what they fear to lose. The narrative meaning of a sentence can be altered just by the way that one word is emphasised (Box 2); psychodynamic and values-based practitioners are alert to such apparently small aspects of language use.

BOX 2 Taking language seriously: the importance of deictic stress

'I wouldn't kill anyone' (no emphasis, no meaning)

But attention to different emphases reveals different and important meanings:

1 '*I* wouldn't kill anyone' (I am not that sort of person)
2 'I *wouldn't* kill anyone' (I don't do that sort of thing)
3 'I wouldn't *kill* anyone' (although I might get very cross with them)
4 'I wouldn't kill *anyone*' (just people who annoy me, such as you).

Theories and techniques

Psychodynamic practice draws on a range of knowledge bases (biological, psychological and social) and responds to advances in empirical knowledge; theory is modified by new information, which in turn alters practice. For example, psychodynamic practice prefers to see the different 'schools' of psychological theory as different techniques, which may be indicated for different types of problem. Cognitive techniques are clearly indicated for people with highly dysregulated mood states, where more thinking about feeling is needed; reflective techniques are indicated for patients who have difficulty in expressing feelings, or dismiss their importance.

The importance of feelings

An important principle of values-based practice is that we tend to notice values only when there is a problem. Similarly, psychodynamic practice argues that we notice feelings only when there is a problem, either because the feelings are negative and therefore scary, or because they lead to conflict with other important people in our system. The overlap with values-based practice is essential because feelings and values are linked experiences: we have feelings about that which we value and a person's values may say a great deal about how they feel and think about themselves or others. Placing a value on something requires discernment: a

process of judgement and reflection on feelings aroused by an experience or object. Hobson (1988: p. 90) describes values thus:

> Choice, will, directedness are characteristics of feeling… it is a *valuing* [process]… *Feeling imparts value* to experiences and involves a choice… or a judgement. [emphasis added]

Reflection

There is one final way in which psychodynamic theory and practice overlap with values-based practice, and that is in the area of reflection. Bracken & Thomas (2001), when arguing for a postmodern psychiatry, ask that there be a self-reflective aspect to professional thinking, which poses questions such as, 'What if I don't know all the answers?' or 'What if there is more than one right answer, and the patient has at least one of these?' Psychodynamic practitioners are familiar with this type of uncertainty and complexity and assume that it is part of the work of getting to know a person well. They also assume that in this process they will have thoughts, feelings, beliefs and attitudes about the patient that are meaningful to the therapeutic process. This is sometimes called countertransference and psychodynamic practitioners are required to self-reflect on this experience in the process of supervision to ensure that they are not missing some vital aspect of the patient's identity and experience.

Values-based practice emphasises the role of reflection on, and discussion of, the different value perspectives of different agents involved in a patient's care, by all those agents. A narrative psychodynamic approach will also suggest that each 'voice' may be saying something important about the patient's experience. This is particularly true when working with people with personality disorders, whose inner sense of self is fragmented and where their point of view may change from day to day. A group dynamic perspective also has an inherent values-based practice approach because it assumes that each voice has equal importance and that it is clinically unwise to ignore dissenting voices.

Problems for systemic thinking and values-based practice

The patient's values

Both values-based practice and psychodynamic practice put the patient's perspective and values at the heart of service delivery. There is an understanding that even if the patient's value system seems odd to others, there will be respect for that perspective and an audience for it.

Conflicting values

There are problems with this approach when a patient's personal value system seems to include beliefs about others that are (as the US Constitution so nicely puts it) 'cruel and unusual'. If a patient sees others as contemptible, worthless, there to be exploited or a source of threat, how can these values be respected? If a patient's values lead him to act in ways that threaten to damage others, how can the psychiatrist honestly say to him that they respect his point of view? Even if the psychiatrist gives him room by saying, 'Well, you can feel that way, but you can't act that way', still at some level they are not accepting his values or perspective as different but equal. They want him to change his world view to fit in with theirs and this does not fit with either values-based practice or psychodynamic practice.

Do values come first?

The values-based practice approach would argue that the process of discussion between patients and professionals, and between professionals, is crucial here. It is perfectly possible to discuss these tensions with patients in a transparent, reflective and respectful manner, and teams who work with violent or forensic patients have to develop the skills to do this. But it is not clear how this will resolve the question of whether it is bordering on the deceptive for mental healthcare professionals to say that they will make 'the values of the service user/client… the starting point and key determinant for all actions' (National Institute for Mental Health in England 2004: p. 10) when working with patients who behave antisocially (a problem not confined to forensic practice). Actually, it might be argued that, when working with patients who break the law, mental healthcare professionals are not so much interested in whether the patients feel better, but whether they behave better (Adshead 2000).

Society's values

As a doctor, the fundamental role of the psychiatrist is to care for patients who have mental disorders. In this sense, psychiatry is influenced by the values of the medical profession as a whole. However, the practice of psychiatry is also influenced and directed by the society in which it is practised. Values and ethical views may be influenced by both internal and external factors such as government policy, laws, attitudes, economic wealth and the knowledge base at the time.

The difficulties of risk avoidance

The current dominant value applied to most Western psychiatric practice is the avoidance of the risk of harm: the need to anticipate and prevent

Advances in psychiatric treatment (2009), vol. 15, 470–478 doi: 10.1192/apt.bp.107.004549

all possible harm and the need to punish those who fail to do this, as a warning to others and to drive professionals to greater efforts to prevent harm from occurring. There are many different theories about why this zeitgeist has arisen and it may have had some spin-off benefits in some social systems. However, in psychiatry, this social value set has led to patients with psychiatric disorders once again being principally seen as a source of unpredictable threat to others, rather than as people with illnesses and disabilities who need help. By extension, psychiatric services are expected to anticipate and prevent patients doing harm to others, while respecting patient autonomy and attempting to deliver 'user-led services'.

Perceptions of the psychiatrist's role

For example, at the time of writing, there appears to be a strong social feeling in the UK (as evidenced by media reports, legal judgments, parliamentary debates and governmental guidance) that it is the duty of psychiatrists to prevent any patient from acting in ways that might harm the public. The value of psychiatry then, from the social point of view, is as a defender of public safety and controller of dangerous people. Some psychiatrists may agree that this value is part of their professional moral identity or they may agree that it is a part, but only to a certain degree and with certain caveats and limits. Some psychiatrists will feel that the value of psychiatry lies in its care of sick and disabled people, and that it is this that gives psychiatrists their moral identity. The point here is that there is a debate and discussion to be had, that there may be a clash of values between the social group and the professional group, and that to move forward is to be engaged in a reflective process of discussion and action.

Risk assessment and confidentiality

It seems hard to reconcile risk assessment and management with the values-based practice approach quoted above. This is particularly true since risk assessment is carried out on patients without their consent. Many trusts require risk assessment forms to be completed by professionals without any discussion with the patient about the outcome or the use to which the information will be put. Confidentiality is assured, and the patient may be told that no information about them can be disclosed to anyone else without their express consent, but if someone, anyone, perceives the patient to present any sort of risk, then the anxiety about this usually means that information about the patient is shared with others, again without the consent of the patient.

Of course, there are policies that are meant to protect patient information; only details relevant to the risk should be shared and this should be purely on a need-to-know basis. But the point about systemic thinking in the domain of risk assessment and management is that all voices need to be heard and respected, not just the patient's. In a multidisciplinary team, each person may feel that they have a good claim to other people's specialist knowledge about the patient as part of the process of providing care, even if the patient refuses to give consent to that disclosure. Professionals in a team may play risk as a professional trump card: their need to have access to patient information is necessary for risk management. This issue arises particularly in multi-agency public protection panels, where the values of society (risk and harm prevention) trump the values of values-based practice.

The counter-argument here is that values-based practice is a process whereby values provide a framework for ethical principles, and presumably also for understanding how those principles come into conflict. A values-based practice approach allows for a fuller and more complex discussion about how conflict between ethical principles can be resolved. It would also argue for a positive risk-taking, which balances the need for patient recovery with the value of safety. What is not explicitly addressed is how to include reflection on possibly unconscious negative feelings.

Professional values of psychiatry

The third problem for systemic approaches such as values-based practice is linked with the point above. How do psychiatrists incorporate both the professional values of psychiatry and the personal values of practitioners? Where do psychiatrists get their values from and how do these fit into their professional identity?

To be a professional is to acquire a body of knowledge that is used for the benefit of others and to use that knowledge with judgement and discernment (Fish 1998). There is still room for debate about how personal and professional value systems overlap in psychiatry. Sarkar (2004) calls this the 'who-ness and what-ness' of professional practice and describes the complexities of keeping these separate in psychiatric practice, with particular references to professional boundary violations.

The psychiatrist's character

There is a particularly problematic aspect to psychiatry because, unlike other branches of medicine, character and practice are inextricably

entwined. In theory, a surgeon could be an excellent practitioner but a non-virtuous person – this lack of virtue would not affect his skill as a surgeon. In psychiatry, however, it seems much more likely that the sort of person you are profoundly affects how you practise as a psychiatrist. If true, this raises complicated questions about selection for training, teaching, appraisal and discipline. It also raises questions about justice: could it ever be fair to exclude someone from being a psychiatrist on the basis of some individual psychological quality? Who will decide what virtues make a 'good' psychiatrist? And what about the value of flawed individuals?

The Ten Essential Shared Capabilities (National Institute for Mental Health in England 2004) refers to the importance of balancing values. This is important in the training of psychiatrists in the nature and scope of their professional role. It is also important when thinking about poorly performing doctors and those who breach professional boundaries. Values-based practice may be a useful way to think about vocational rehabilitation for such professionals.

The value of psychodynamic skills

The role of psychiatry in delivering care to patients has been discussed under the rubric of 'new ways of working' (Department of Health 2005). There is real danger that only other professions will be able to offer the systemic therapeutic approach that once used to be a role of psychiatrists. A generation ago, every psychiatrist was familiar with the principles of psychodynamic practice and used them to manage difficult patients and help teams of professionals to deliver a service. An unfortunate side-effect of psychiatry as 'mental health science' has meant that psychiatrists stopped learning the psychodynamic skills that made them helpful and effective. It is hoped that a competence-based curriculum and training programme for future trainees (www.rcpsych.ac.uk/training/curriculum/curriculum2009.aspx) will amend this oversight (Mitchison 2007; Mizen 2007). In the meantime, psychiatrists need to develop listening and communication skills (essential to both psychodynamic and values-based practice) to retain and integrate their medical role in mental healthcare.

A further issue is whether psychiatrists should concentrate less on curing mental illness and focus more on promoting mental health. Seligman (2002), arguably a leading expert in the origins and treatment of depression, argues that the promotion of happiness should be the main value of psychiatric and psychological practice. On the other hand, happiness may be so unusual as to count as a disorder itself (Benthall 1992). Furthermore, there is reason to think that social factors contribute as much to happiness as do individual characteristics (Oswald 1997) and psychiatry may not be able to influence these factors.

Conclusions

Values-based practice is an important conceptual framework not only for looking at ethical decision-making, but also for helping to develop a professional identity for psychiatrists. There is a strong public wish that doctors commit themselves to certain values and principles as part of the relationship of trust that patients have to negotiate with them. How might psychiatrists establish a set of values that provides a professional moral identity in psychiatry?

Defining good practice

In the UK, the General Medical Council (2006) has devised a list of the duties expected of a doctor as a way of defining medical moral identity. All the medical subspecialties are expected to draw up their own version of *Good Medical Practice*, and the Royal College of Psychiatrists now has *Good Psychiatric Practice* (Royal College of Psychiatrists 2009). This is meant to provide guidance and information about the values of the profession; to spell out a psychiatrist's moral identity. Unlike the other English-speaking professional psychiatric groups, the College does not have a specific code of ethics (Sarkar 2003).

It could be argued that a list of virtuous attitudes and behaviours may end up looking like an ethical 'wish list', which does not do justice to the complexity of the decisions that have to be made, or the diversity of the different groups involved. It may even be undesirable to have a code of ethics or professional oath to give values identity because they can be misinterpreted as a set of quasi-legal rules, or give the impression that the right answer to a problem is 'out there' on a list, rather than in the mind of the professional.

Reflect and respect

Having a statement of values for psychiatry, or a code of ethics, would need to include some sense of action, of process. As suggested by values-based practice, a key value skill for psychiatry might be 'reflection' or the capacity to reflect; of taking time to think about the different ethical positions involved in any dilemma. It could also begin and end with the concept of 'respect' (as a verb). To respect something or someone is to be 'mindful' of them: to care about their experience as much as your own. Many patients (both psychiatric

Advances in psychiatric treatment (2009), vol. 15, 470–478 doi: 10.1192/apt.bp.107.004549

and non-psychiatric alike) describe experiences of 'disrespect', where they felt as though they had disappeared from the mind of the doctor altogether and that their views and feelings did not matter. It may well be that their feelings and views do not reflect the best solution to a dilemma, but the point is that they are considered and taken notice of.

A way forward

The College could have a code of ethics, which would set out some key values in psychiatry, which could then be the conceptual underpinning for ethical reasoning and principles of action, much as its American and Australian counterparts do (American Psychiatric Association 1989; Steinberg 2000). There might then be differences in interpretation of values and principles and these differences themselves would need to be the subject of reflection and discussion. The College's Ethics Sub-Committee could be a useful space for exploring different sets of values and principles, and for protecting dissent and diversity.

Perhaps it is not so much 'values' that psychiatrists should look at, but the process of 'valuing' in their practice – how they discern and make judgements about their emotional responses to their work. All doctors have powerful emotional responses to their professional work with patients, some positive and some negative. Thinking about the process of working may give psychiatrists a better handle on what values are important to which groups of people involved in any of the multiple and various ethical dilemmas that they face in psychiatry.

An ongoing process

Values-based practice emphasises that making and maintaining a moral identity in healthcare is a process, not an achievement. The values of mental healthcare require constant reassessment and reflection, not least because knowledge about mental disorders and distress is changing all the time. The values of the society may change and force psychiatrists to reflect on their relationship with the social group of which the profession is a member. The values of the patient may be overlooked or come into conflict with those of others. Systemic approaches such as values-based practice can help mental healthcare professionals to keep all these values in mind.

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MCQ answers

1	2	3	4	5
a f	a f	a f	a f	a f
b f	b f	b t	b f	b f
c t	c t	c f	c f	c f
d f	d f	d f	d t	d f
e f	e f	e f	e f	e t

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MCQs

1 Values:
- a are always shared between members of teams
- b are always clearly expressed
- c may be difficult to articulate
- d are usually overlooked when they clash
- e involve numerical judgements.

2 Systemic ways of working:
- a are common in medical practice
- b are unusual in the care of chronic conditions
- c may be helpful when the patient's personal identity is changed by their illness
- d exclude the patient's different social identities
- e should be used in every branch of medical practice.

3 Clashes of value:
- a are best resolved by legal action
- b are best resolved by discussion of perspectives
- c are always resolvable
- d rarely arise when people are anxious
- e are evidence of mental illness in the patient.

4 Values-based practice and psychodynamic practice have the following in common:
- a attention to the patient's speech
- b use of psychoanalytic ideas about the unconscious
- c may be practised only by specialist therapists
- d require attention to facts and values
- e require extensive (and expensive) training.

5 Values in psychiatry:
- a are based on General Medical Council guidance
- b are well articulated in professional guidance
- c are unaffected by social contexts
- d play no part in professionalism
- e need to be addressed as part of continuing professional development.

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