WORKING WITH VALUES IN CLINICAL PRACTICE

***Andrew West**, author of Being With and Saying Goodbye: cultivating therapeutic attitude in professional practice, examines (at times provocatively) the idea of values and how they might or might not link to a values-based practice*

Like magic spells, words and phrases capable of creating mood or sensation should be used with care, particularly by people in positions of responsibility. 'Values-based practice' would be a case in point. It has a nice ring to it and surely must be something that, as therapists, we should aspire to. It sounds as though it might be a handy antidote, alternative or accompaniment to 'evidence-based practice' – but what does it actually mean? If we can clarify this, we can then think about how much we are already practising in a values-based way, and how much we might want to strengthen and promote the approach.

Value is the importance that we ascribe to something, whether it is concrete, like my violin, or abstract, like friendship. Values are linked by a nexus of reference. I value my violin because I value music. I play music with my friends and value certain friendships because we share an interest in music. But I also value my violin for other reasons, and I have friends who do not play music. Friends, music and a violin represent independent as well as interdependent values to me.

We generally think of value as being positive and yet, if valuing something means that we want it in our lives, how do we talk about the things that we very much do not want in our lives? Do we think of these things as having negative value, or do we positively value their absence?

Although these alternatives appear to come to the same thing, they don't, and the question points to an ambiguity. We know that someone can be fascinated by – drawn towards – things that he believes himself to not-want. Why do we spend so much time talking about things that we dislike? Perhaps – among the things that I don't want – one is a life that is too bland or too radiantly blissful. I appear to value, positively, the existence of things whose proximity I would value negatively.

In becoming more opaque, this argument in fact exposes some clarity: first, that values are in some sort of hierarchy. Second, that values can conflict and compete. Third, that the concept of value, like that of 'good', brings with it its own dark side. Therapists might be relatively well equipped to understand some of the complexity and perversity of our value systems.

There are two further, very important observations. It is quite probably impossible to live value free, and values have a way of appearing to be invisible. Each of these later observations is a paradox. The paradox in the second statement lies in the idea of something being both visible and invisible at the same time. Someone behind a tree in a game of hide and seek is not invisible, except to the person who can't see her. Values are very good at playing hide and seek.

Unlike people, though, values have a way of disappearing when they are in plain sight, standing in the middle of the field. This constitutes their

For illustration purposes: posed by model

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main strategic weakness, and is something that someone working in a values-based way needs to grasp and overcome. The danger lies in the fact that the topical, shouted-about value (like what you wear to the party) can obliterate something more fundamental (like whether you go to the party at all). In the clinical world, so much noise may be made about whether the treatment is effective that we neglect to explore with the client what effect he actually requires.

That it is probably impossible to be value free may best be illustrated by resorting to the setting of mindfulness (or Zen) meditation. Imagine that I am teaching meditation and explain that, to be 'mindful', one has to be non-judgmental – in other words avoid ascribing value to things. The paradox lies in the *value* that I have placed on a valueless existence. This will be important when it comes to working in a values-based way because, not only must I be able to notice and value values (my own and others') but I must learn to hold them in awareness while ignoring them. I may well, for example, have ideological or political values that need to be placed on one side while I enable my client to achieve a goal of which I, personally, disapprove.

I have found that the thing to do with a paradox is simply to allow it: neither to run away, nor to become too fascinated. Paradox is, like Winnicott's potential space, best considered a place to play. It is like a child's truth that does not equate to the rational, concrete notion of truth held by the adult, but is not a lie either. We must nurture this potential, paradoxical space (neither here nor not here) in order for us to grow and create. That is, if we value growth and creativity we must also value this paradoxical space. If we are to be conversant with values, therefore, we need to be able to be aware of them in peripheral vision, ready to bring them into focus, but not to do so prematurely or following our own values-agenda (except the meta-agenda which is that we value values).

What is values-based practice?

Let me now turn to the context of child and adolescent mental health, and focus on the question of how I can make my practice values based.

A moment's reflection reveals that any practice entered into by choice, and in which choice is prevalent, is based upon values. The very concept of choice only makes sense if alternatives can be sorted according to some system of values. *The Dice Man*, written by George Cockcroft (aka Luke Rhinehart), is a thought-experiment into the potential consequences of placing an equal value on any given set of alternatives, and it is clear that this is not the way that most of us live and work. To say, then, that my practice is based upon values is a tautology. Whatever I do will be informed by – shaped by – based upon – values. Many of these values will be overt and consciously treasured and nurtured by me, both personally and through the requirements of my profession. Many others will be hidden and will exert their influence covertly. We are likely to be largely unaware of many of the values that inform the decisions we make in our practice.

If all practice is based upon values, then what is values-based practice?

Values-based practice, in order to mean anything at all, must mean *practice that knowingly incorporates the appreciation of values that have a bearing on the decisions we make in that practice*. I say 'have a bearing' because it is not only the values that inform our decisions, but also those that should, within the values-system that we inhabit, inform our practice. For example, we might be making a decision on the basis of the well-known ethical principles of beneficence and non-maleficence (helping the client and doing no harm) but we might have completely forgotten the principles of respect or fairness. On the other hand, to assume that a certain value *should* inform our practice would be to jump to a premature conclusion. The task is to bring into awareness the values and weigh them before making decisions. The result of giving too much weight – either knowingly or unwittingly – to a given value, at the expense of alternatives, is what we call bias.

The correct question, therefore, is: how do I become better at identifying values and the influence that they have, in order to make better-informed and less-biased decisions? An important thing to remember is that, although values may be stated, more often they have to be inferred from language and behaviour. In the setting of psychotherapy, because we are explicitly dealing with unconscious material, we have to be particularly sensitive to covert values, because the client may not be in a position to articulate them. If our client is a child, we know he has a further, developmental, reason for being unsure or inarticulate in relation to his values. We also know that his values, which are likely to be evolving, may not be the same as his parents'.

So the clinician must be aware of a wide range of possible values – and sufficiently broad training and CPD can support this awareness. People may have strong values in relation to (to list just a few): spirituality and religion, cultural minorities, disability, gender and sexuality, politics, individualism versus collectivism, materialism, and performance-related versus intrinsic self-worth. We do not have time to parse, order and weigh all the values that, manifestly and theoretically, have a role – at least, not in an explicit and methodical way. What I believe we have to do is to maintain awareness that we are likely to be doing this subliminally, and be open to the likelihood that our preconceptions will be wrong. We may, for example, assume that the young man brought up in a strictly religious family is looking forward to a more liberal future, but find that he is keen to grow up a good and devout believer. We need to be able to discuss values with our clients and provide a values-based account of our treatment decisions, particularly if we are to step off the beaten track of prescribed guidelines.

A personal example of value complexity

It can be useful to reflect on the values that we believe we hold in relation to our work. I value, for example, punctuality. I think it is important to start and finish appointments on time. In my case, I often don't achieve this, and I experience shame in relation to it. (Honesty is helpful – indeed essential – in this exercise.) I try to comfort myself by saying that I am not practising psychotherapy, but medicine (as a child and adolescent psychiatrist in the NHS), but I apologise profusely to my client and experience cognitive dissonance in the presence of this threadbare excuse. I add to it the fact that I am busy – but then this calls to mind family walks when I was a child and I completed almost the entire walk 10 paces behind the group while feeling 'left behind'. Why do I do everything 10 minutes late? Why not catch up and stay there? I decide that this must be because I value the here and now more than the there and then; the actual over the (to me) theoretical. But I have to realise that the client in the waiting room is real, actual, and here-and-now to themselves, along with the passing time. So I ought to be able to correct this. What reason could I have? Am I simply undisciplined? And at that point I think I have the key! I value my lack of discipline in some way. Perhaps this is an inexcusable misbehaviour, but I actually do believe that there may be a justification in my practice as a child and adolescent psychiatrist. I think that my ability to be fully present with my client in the here and now is essential to the rapport – my understanding of her predicament and her sensation of being understood and nevertheless tolerated (and therefore tolerable). Furthermore, my own lack of discipline, resultant guilt and implied fallibility bring me down to earth with my client. Finally (this is less lofty and more in the league of snake oil, though nonetheless powerful), perhaps the waiting client accepts – even welcomes – a degree of flustered lateness because it implies that there are demands on my time, that my assistance is valuable to others and therefore to him. The placebo effect (never to be shunned, in my view) may be boosted by this practice, which would be underhand if it were not so complexly and sincerely motivated.

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And, in case you are wondering, I do accept the possibility that I am simply someone in need of training in time management. I accept the validity of that argument, and the power that values of respect and courtesy hold. It is just that I think that my client needs a dishevelled fellow traveller more than they need a slick or obedient technician. Or, to put it another way, I'm likely to be more use to them as I am, trying my best in a complex world – an analysis that places a great deal of value on authenticity in human development and relatedness.

Applied to the work setting

Applying the idea now, not to our own personal practice but more broadly to the settings in which we work, it becomes clear that the complexity is in no way dimmed. The simplest scenario might be that of the individual clinician treating an individual adult in private practice. In that one-to-one, relatively independent situation, there are personal values of both clinician and client to be taken into account, each within its own values context. The client may have 'important others' to account for, a job to hold down and laws to obey, as well as their personal ambitions and emotional and material needs. Does she want to be rich, pain free or happy, for example? Does he value his independence but also his marriage? The clinician meanwhile is likely to have fairly near the top of her values hierarchy the furtherance of the client's agenda, but she also has her own life to lead, conscience to square, and personal and professional ethical codes. The orthopaedic surgeon would be likely to plate the fractured arm bones of the street fighter, but might not implant titanium knuckles.

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Extend this a little further. Now it is a child, rather than an adult, being treated in private practice. He is brought by a parent who pays for the treatment. The child's values, depending on his developmental stage, are likely to be more or less aligned to, or in opposition to, his parents' own. The parents will value something in their child. Is it our job to deliver *that*, or to explore the child's emerging values system? I remember a cartoon we pinned, with a good deal of (as it turned out naïve) smugness, to the notice board at work. Two parents were watching their child play games on the console, and one was saying to the other, 'He thinks he can get a job playing computer games!' Well, I have met that child now, in the older sister of a client, and she is doing very well as a games tester for a big software firm. An adult can struggle to relinquish her own values when it comes to her child, and it is for the therapist neither to force that process, nor to abandon it.

I have expanded elsewhere on the ethical complication of 'who pays the piper'.[1] In the National Health Service, the person paying the piper is a massive and dispersed 'nonentity' comprising the state, the taxpayer, the commissioner, the regulator etc. There are so many rules. Why do I adhere to them? Some of them I can wholeheartedly say align with my own personal and professional values, but others I have to admit I adhere to because I value my job.

It is easy to see that, in a state-funded service, with contracting resources, there are likely to be a particularly large number of strongly held values, which may conflict. Take the child who is restless and distracted at school. One could start by thinking of what various parties want. The headteacher may want good results for the school. The class teacher probably wants to serve the child's educational interests, but also wants a class that can concentrate so that he can maintain order and deliver the curriculum. The child's parents may want the child to get good GCSEs, and the parents of all the other children in the class may want the child to sit down and shut up so that their own child can learn and thrive. The Government wants to avoid negative publicity. The clinician wants to serve the child's best developmental interests, but also to manage a large caseload efficiently.

In the immediate clinical setting, some of these competing demands can be fairly easily neglected, but it is not as easy as one might imagine. When I complete an almost totally spurious 'risk assessment' after seeing a child, I am likely to be avoiding a negative assessment in the upcoming Care Quality Commission (CQC) inspection, more than providing an efficient and sensitive clinical service to the child. There was less interest in the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) prior to the ready availability of a cheap medical intervention for it; yet, in no time, it became difficult for a child psychiatrist to avoid making the diagnosis if the signs were there. We easily adopt values, without realising it, as a response to peer pressure, public approval or fear of sanction.

And so what then?

One has to be cautious, therefore, when powerful interests propose the delivery of a 'values-based service'. It sounds good. We should do it. But whose values? In the same way that evidence-based practice risks replacing individual and idiosyncratic treatment decisions with population-based decisions derived from results averaged across vast numbers of people, so might values-based practice risk the displacement of individual and family values with values imposed by the state, institutions or fashion.

A little while ago, the idea was floated of listing the values to which the service adheres and declaring it to be a values-based service. Bearing in mind what has been said above about values – principally that all decisions are based on values – it would be a facile statement of the obvious to say that any service or practice was values based. We have to take it as meaning something more along the lines of 'noting and eliciting relevant values, explicit and implicit, and collaboratively weighing them to inform decisions'.

Listing the most obvious, uncontroversial and explicit values on the service banner may be acceptable, so long as those values are not then allowed too much to dominate the therapeutic process. But even leaving all of that aside, a moment's reflection will reveal that those 'headline' values are likely to conflict with one another. 'We offer a timely, evidence-based service' – two values, rarely disputed. What if the treatment with the more solid and measurable empirical justification is only available after a longer wait? Did we take for granted 'effective', or 'safe'? Did we genuinely establish the treatment goals? Did we allow the goal to be 'to figure out a goal' if that was what it needed to be?

Of course, 'evidence based' is similarly inevitable, in a sense. That is, our decisions are inevitably based on a) the evidence of our senses (including senses that transmit complex cognitive constructs like 'empirically proven in randomised controlled trials') and b) our values. The evidence-based practice movement would have us restrict the notion of evidence to a very narrow category in the spectrum of what constitutes evidence. I would like it kept broad. In the same way, we need to make sure that when we say our practice is 'values based' we do not restrict the meaning of 'values' to one or two hackneyed examples.

If we can think in these broader terms, then, we can think of all practice being informed by both evidence and values. Evidence-based practice would then require the practitioner to maintain an up-to-date awareness of the full range of evidence (from both outside and inside of the room), values-based practice would require a similar facility with values, and then clinician and client would negotiate weightings and apply them in order to mutually achieve decisions about treatment. (This has been called, on the wagon-sides of another band, 'shared decision making'.)

Given the present target audience, I am expecting the reaction to be along the lines of, 'but that is what counselling and psychotherapy are!' and I would agree, provided that they are not too prescribed or pressured. The above argument is partly an appeal for the values of psychotherapy to be brought to greater prominence in all areas of healthcare. The trend, though, is currently in the other direction. For example, which values inform the decision to discharge everyone after six appointments? Or to produce a written care plan with signed consent at the end of the first appointment?

I shall make one more provocative observation on evidence-based practice before reverting to the politically acceptable stance that evidence and value are on an equal footing. This is that evidence-based practice has the currency that it presently enjoys because of the *value* that society, the media and academia currently place on the statistical manipulation of data drawn from large placebo-controlled, randomised, trials. In other words, all practice is primarily values based, and as part of that we value the contribution that evidence of certain kinds can make to our clinical decision making.

In working with our clients, we need to pay attention to both evidence and values, and we need to do this at the macro and the micro level in each case. In the area of evidence, we need to be aware that certain clinical problems may have been found to respond particularly well to specific treatment approaches, or that certain treatments have been demonstrated, by and large, to carry certain risks. That is the macro level and tends to be called evidence-based practice. I would want to draw attention to a different level of evidence, which for the sake of symmetry we might call the micro – the intuitions and experience of the clinician, and the detailed descriptions provided by the client or her parents. These, too, constitute evidence.

Similarly, when it comes to values, we need to adhere to gross societal values, not least because we are likely to share them. The principles of beneficence and non-maleficence would be two that are relatively easy to accept and adopt. That of fairness may be a little more challenging when we are in the presence of an individual client and we have an eye to the welfare of a population or catchment area.

But we need to be wary of societal, or organisational values getting out of hand. Whatever may be said about state-funded clinicians' rights to conscientious objection, I am certain that the individual clinician's conscience can become the last safeguard against institutionalised abuse of professionalism such as was seen, for example, in Nazi Germany or, more recently and therefore contentiously, in Guantanamo Bay.

On the micro level, though, we need to be able to elicit the child and the parent's values while taking account of and, if necessary, suppressing our own. I sometimes ask parents, 'If you had to choose either to know *why* your child has this problem, or to have the problem *go away*, which would you want?' This question helps parents to sort out their motives in pursuing a diagnosis (is it to do with establishing their own guilt or innocence, for example?) and enables them in discovering a superordinate value, which is their child's wellbeing.

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Further reading

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