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Above all, do no harm:

Towards more ethical ways of being and acting in psychological formulation

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Summary: *Recent evidence seems to suggest mental health service users can be at risk of persistent harm as a result of psychological interventions. This article analyses ways of addressing harm by using the 'lenses' of four ethical theories to view psychological formulation.*

There are a number of ethical theories that could be used as 'lenses' through which practitioners can interpret their way of being and acting. These theories are: consequentialism, deontology, justice, and virtue ethics and are characterised as follows:

- Consequentialism focuses on reaching the best outcomes for *the greater good*. When used in relation to the promotion of psychological well-being, Layard (2005) has argued we "should seek the greatest happiness of everyone affected, each person's happiness counting equally" (p.115). However, consequentialism could still be used to argue that harm is tolerable if it maximises the well-being of a greater number of people when compared with other interventions (Conway & Gawronski, 2013)

- Deontology stresses the importance of individual autonomy and viewing people's humanity as an end in itself and is premised on doing duty to oneself and to others. Deontology theory has been used to assert that harm is immoral regardless of the results that transpire. In mental health care, a clinician could use this as the driving force for actions to ensure any forms of harm are minimised as much as possible for service users, carers and the general public. However, we could question whether the drive to eliminate virtually all possible harm resulting from psychological intervention is feasible and could even impose an unattainable standard to the clinician aspiring to achieve the aim.

- Ethical theories of justice have been used to propose egalitarian notions of everyone having equal inherent value and being able to access resources equitably (Geirsson

& Holmgren, 2000). However, clinicians can question how much evidence there is that their clients really do receive equal treatment and choice.

- Virtue ethics theory is used to expound the merits of developing one's own ethical codes and truly living a unique set of character traits exemplified by balance between two extremes of character defect or excess. It is illustrated by the Values- in-Action classification of character strengths identified by Peterson and Seligman (2004), including forgiveness, self-regulation, prudence, and humility.

We will deploy each of these ethical theories to examine the potential for harm in the application of 'formulation' in psychological and mental health practice.

The notion of harm being associated with an intervention intended to help is not novel (Illich, 1976) and yet the potential for harm occurring is an ongoing concern in mental health care. Alarmingly, a recent United Kingdom-wide study (Crawford, et al., 2016) of over 14,500 users of psychological interventions, found one in 20 persons reporting perceived persistent harm after participating in psychological treatment. In this study, harm was defined to the respondents as having had "lasting bad effects from the treatment" but this could be interpreted in a multitude of ways. Harm was more likely to be reported if a service user was from a Black and Ethnic Minority background or was Lesbian/Gay/Bisexual or Transgender. If service users were unaware about the type of therapy they had received, persistent harm was likely to be reported too; these findings have implications regarding service users being involved in understanding what treatment options are available and being able to fully participate in treatment. From a consequentialist ethical standpoint, citing the figure of one in 20 service users in this study being adversely affected by psychological therapies could be interpreted positively, since the bulk of all service users would have remained unharmed by psychological interventions. This trend could support the case for increasing access to psychological interventions to wider groups of service users. However, the deontological perspective would

view even a relatively small number of users being harmed by psychological interventions as a source of concern.

Psychological Formulation and its Ethical Dilemmas

Formulation has been defined as '…a core competency for clinical psychologists at all levels, starting with training, and in all aspects of their work' (p.5). The skill of formulating with service users and leading on formulation meetings in mental health teams has been adopted as core activities for clinical psychologists (DCP and BPS, 2011). 'Formulation' is common in the lexicon of mental health practitioners as they hypothesise and create meaning about service users' experiences. In psychotherapy, formulation is considered to be a core skill important in relationship-building and creating shared meaning between the therapist and client (Eells, 2010).

The formulation meeting in today's mental health practice is often led by clinical psychologists and includes other professionals involved in service user's care, but is less likely to include the service users and their families. This lack of a service user/carer perspective is a concern and ideally formulation should be conducted collaboratively (Moloney, 2013). However, even if a partnership-based approach is used, harms could still occur if service users and providers have different perceptions of issues being raised when defining psycho-social problems for the client and planning appropriate interventions. Assay and Lambert (1999) identified that approximately 60 per cent change arising from therapy could arise from the therapeutic relationship, client's expectations, and the model/technique being used. There is thus considerable potential for harm if: the therapeutic relationship is dysfunctional; the client's expectancies are unrealistic or self-defeating; and the application of the model or technique is not appropriate for the specific client.

Ethically, best practice approaches to formulation should include an emphasis on dynamic reflexive skills to raise awareness within the team of the psychosocial and environmental factors impacting on themselves as individuals and how this influences the service user relationship and care (Johnstone & Dallos, 2014). To reduce risk of harm and build a more collaborative approach, the psychologist could support the team to develop a depth of understanding about their own place in the social world (Schön, 1991).

However, merely undertaking critical reflection and reflexivity is not enough to address the potential for harm that service users could experience as a result of coming into contact with psychological assessment, formulation itself and care delivery. Reflexivity may feel like a safe place from which to presume an objective perspective is being adopted and it has been argued that 'reflexivity is sometimes even thought to be a solvent in which the abusive aspects of psychology can be dissolved' (Parker, 1999, p.30). Whilst critical reflection is necessary, it is not an ultimate safeguard against causing harm or perpetuating disadvantaging social processes. Challenging harmful practices and finding ways to effect systemic change should be essential elements of the clinical psychologist's role, along with considering whether the egalitarian ethical theory of justice outlined by Geirsson and Holmgren (2000) can be used to expose and challenge dominant discourses of power and social processes.

We would argue that it is incumbent on mental health professionals to maintain efforts to consider their own participation with social processes. This is one of the most challenging aspects of working in mental health, but essential in order to establish a more ethical way of being. Here we have emphasised 'being' as well as 'doing'. As a note of caution, it is risky to construe 'being' as passive or neutral. Being is active and has impact; it is not possible to step outside of society and to avoid participating in social processes (Kondrat, 2002) because even non-participation is a choice and has consequences. Hence, there is an ethical obligation to

regularly scrutinise involvement in the subtle and the everyday, as well as the extreme and extraordinary.

Towards a more ethical way of being and acting through the four ethical theories

Using the indicated ethical theories we will point to potential ways of addressing these dilemmas outlined above.

Consequentialism

From a consequentialist perspective (see Barker, 2011), there are several vital considerations when undertaking formulation including assessment of: present and future results of an act, the possible effects on various stakeholders of such an act, and the comparative merits and disadvantages of any decisions to make this weighing up of consequences even more complex. Recent research into formulation dynamics (Hartley, et al., 2016) with fifty staff members working on inpatient wards caring for those who have experienced psychosis showed that self-reported psychological mindedness (used in formulation) was likely to be degraded by higher levels of emotional exhaustion among staff. This finding seems to suggest that the consequences of needing to engage in a more psychologically minded way through formulation may be linked to adverse consequences for the mental health professional too.

Justice

The adoption of a justice ethic in formulation is similar to critical community psychology in adopting multi-level perspectives to a service user's life experiences and encounters with service provision. In formulation, this could be addressed by confronting macro level influences on service users' lives (e.g. collective stigma, legislation, social policies). Raising awareness of multi-level influences (Bergström & Dekker, 2014) on a service user's life to highlight oppression and injustice may be of benefit to some extent, but might also be disempowering. This complexity is illustrated in the work being carried out by the

Psychologists Against Austerity network to highlight macro-level challenges for service users and carers with the perils of austerity discourses being used as the basis for cuts to mental health services; for some service users and carers, resistance to this discourse may not help in the short-term and may effect a feeling of powerlessness and helplessness. By contrast, there might still be a sense of control and empowerment among those affected by austerity policies, if they are engaged in anti-austerity activism and advocacy. Although effective mental health practitioners may engage in critical reflection by developing an 'understanding of how the personal and structural levels of power interact' (Fook & Gardner, 2007, p.35), there remains the risk of awareness-raising as achieving little, unless conscientisation (i.e. awareness, followed by action, followed by further awareness and action) can also result (Kagan, et al., 2010).

Deontology

Just as formulation could be a forum for exposing and addressing harmful practices, there is also the issue of exposing traumas that a service user has experienced and thus run the risk of re-traumatisation (Gilmour, 2015). When service users and carers are engaging in formulation, we would suggest a deontological 'lens' is vital to a clinician's duty to check for the possibility of harms occurring for a client.

Virtue Ethics

In order to formulate collaboratively with service users using an open and balanced approach informed by virtue ethics, we suggest that the psychologist demonstrates action in self-awareness, paying equal attention to the impact of their own bio-psychosocial circumstances on the formulation and raising this with peers and service users and families for scrutiny. There needs to be active engagement in self-awareness, paying as much attention to one's own bio-psychosocial circumstances as when formulating about service users/carers' situations. This

could mean adopting a collaborative, co-produced method of undertaking formulation in a way that is reminiscent of 'Open Dialogue' (Seikkula, et al., 2011) – a standard model for recovery assessment, planning and intervention in psychosis care in Finnish Western Lapland. This approach could enable virtue ethics to be exercised via principles such as tolerance of uncertainty, psychological continuity, and flexible processes to treatment planning and provision. The principle of balance is even more crucial when considering self-care for those health professionals involved in the formulation process, as Hartley, et al. (2016) have shown.

We hope we have illustrated some of the crucial considerations for mental health professionals when considering the potential for harm in planning appropriate psychological interventions for service users but also in enabling there to be sufficient user/carer involvement so that risks of harm can be monitored and addressed. By analysing the dynamics of psychological formulation via the 'lenses' of four ethical theories, we have addressed key areas for being more ethical in being and acting – the deontological and consequentialist 'lenses' have stressed the need to reflect on 'acting' by adhering to one's professional duty and the results of one's actions when formulating. In a complementary way, ethical theories of justice and virtue ethics could exemplify ways of 'being' to create more open and compassionate approaches to providing care.

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