CBT

VALUES AND ETHICS

DAVID KINGDON | NICK MAGUIRE
DZINTRA STALMEISTERS | MICHAEL TOWNEND

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GENERAL PRINCIPLES OF VALUES AND ETHICS

Learning outcomes

After reading this chapter and completing the activities at the end of it, you should be able to:

1. Be aware of the range of cognitive behavioural therapies that have developed.
2. Understand why an appreciation of general principles of ethics matters.
3. Know what types of ethical theories are relevant.
4. Realise the importance of human rights, ethical and legal frameworks.
5. Know the sources of value statements for mental health care that can help.
6. Clarify the specific principles that relate to psychological treatment.
7. Use the sources for ethics particularly relevant to CBT.

We are going to begin by providing a broad description of cognitive behavioural therapy and then describe some broad ethical principles relevant to using it.

Cognitive behaviour therapy

Since Freud developed theories of the ways in which one's internal world may govern behaviours, a wide range of therapies have developed. Evidence to support the effectiveness of psychological therapies has followed – more for some than for others. This empirical approach formed part of the behavioural work of Thorndike (1905), Watson (1913) and later Skinner (1938, 1971), and was later operationalised as

a formal psychological therapy by Wolpe (1968) and Marks (1987). Cognitive aspects of psychological therapies first appeared in Kelly's (1955) personal construct theories and then Ellis's rational emotive behaviour therapy (1962) and Beck's cognitive behaviour therapy (1963). Behavioural theories have proved robust over a century of experimental investigation, with cognitive processing research being comparatively younger with 30 to 40 years of work.

There are, very broadly, three schools of psychological therapy based on distinct theories of pathology and change. Psychoanalytic and psychodynamic therapies were until perhaps the mid-1980s dominant in the field of talking therapies. However, a lack of empirical validation of theory and effectiveness, with a growing evidence base for both cognitive and behavioural therapies, led to a significant shift, culminating in the government-sponsored Improving Access to Psychological Therapies programme (IAPT) making CBT the main model. More recently, evidence has developed for related therapies, including brief interpersonal therapy (Klerman and Weissman, 1994) and mentalisation-based therapy (Bateman and Fonagy, 2012).

There are now around fifty or more interventions based on the expression of the relationship between thoughts, feelings and behaviours. The interventions make use of techniques which enable a number of change processes, particularly important among them is 'metacognition' (the ability to reflect on one's own thoughts and internal world) and cognitive/behavioural habituation. Most of these therapies are based on theories that have received empirical attention to demonstrate their validity. These therapies fall into two basic groups, sometimes referred to as 'second' and 'third wave' cognitive therapies, the first wave being therapies based on behavioural principles. The different forms of CBT often have different theoretical foci, but overlap in significant ways. Below is a brief consideration of the main families of cognitive and behavioural therapies, which arguably have coherent theories and effectiveness evidence bases.

Families of cognitive and behavioural therapies

The most widely used approaches were developed by the 'father' of CBT, Aaron Beck, who first published a fully formulated treatment approach for anxiety and depression in 1979 (Beck et al., 1979). The theory proposes that the negative content of thoughts is important, originally expressed as thinking errors. It is these that lead to and maintain distress and maladaptive safety behaviours, which in turn maintain the thought system. Cognitive processing is acknowledged in terms of distortions, and it is theorised that problematic ways of thinking due to fundamental (core) beliefs and 'rules for living' formed in interaction with childhood experience then lead to 'safety behaviours' that enable

the avoidance of distress. Therapeutic interventions involve identifying problematic ways of thinking in terms of content, and testing them and emotion intensity using behavioural experiments. It may be delivered in individual and group formats.

Schema-focused cognitive therapy (Young et al., 2003) was developed to treat the complex interpersonal issues inherent within personality disorder. Young et al. identified 18 fundamental 'schema' from patient records, i.e. clusters of beliefs about the self and others that drive perceptions and maladaptive behaviours. The theory posits different 'modes' of operating (behavioural repertoire subsets), to which people move, depending on contextual factors, and that there are three broad ways of attempting to cope with distress: schema avoidance, overcompensation and surrender.

Dialectical Behaviour Therapy (DBT; see Linehan, 1993) focuses on reducing maladaptive behaviours (particularly self-harming behaviours) and increasing functioning for people with complex trauma issues. The premise is that clients have not yet acquired certain skills, e.g. managing emotions, establishing and maintaining relationships (perhaps due to attachment disruption and/or inconsistent, punishing or neglectful parenting). Emotion dysregulation is a key issue and interventions develop skills to manage anger and anxiety. The biosocial model theorises that the set of symptoms termed 'personality disorder' stem from a combination of an early invalidating environment, together with a biological predisposition to high arousal. The therapeutic relationship is an intrinsic aspect of DBT treatment as a model of a healthy relationship and also to reinforce behaviours that are less harmful to the individual. 'Mindfulness' techniques are used to enable clients to notice the negative judgements that they make about themselves and others.

Acceptance and Commitment Therapy (AaCT; see Hayes et al., 1999) is based on an empirical theory, Relational Frame Theory (RFT), which associates language (internal dialogue) with distressing experience. The useful concept of 'cognitive fusion' is described, i.e. that our emotional experience becomes 'fused' with the words we use to describe it. Treatment makes use of techniques to enable the individual to accept difficult life events and defuse from troubling experience. This may be enabled by experiential 'defusion' from meaning of words and concepts. Articulation of an individual's values is important, which may enable the individual to be clear about behaviours in which they engage that are in the service of those values.

Mindfulness-Based Cognitive Therapy (e.g. Segal et al., 2012) has an evidence base in treating recurrent and severe depression. The practice of mindfulness (purposefully paying attention to experience, including thoughts) has been found to be particularly useful in reducing the intensity of depression experienced, and the lengths and frequency of

depressive episodes. The therapy makes use of theoretical findings, indicating that negative moods can increase the likelihood of negative images and thoughts, thereby exacerbating the depressed mood.

Values and ethics

So, that describes CBT. Now we will move on to discuss values and ethics. You may ask why you need to know about general principles of values and ethics? It is quite likely that in your day-to-day practice, these can all seem to be a bit distant and irrelevant. But, you may meet a problem that we have not covered or a combination of issues that seem to need apparently conflicting approaches. You may need to explain the reasons behind your chosen approach to a client or trainee. In these circumstances, you can sometimes find it very helpful to be able to speak from first principles – if you can remember them. We will keep it simple for that reason and, by the end of the chapter, we hope that you might even find it interesting – we have, and have learnt a lot in the process.

Two distinct types of rights are defined by philosophers: natural and legal rights. Natural rights are viewed as more basic 'elemental' and therefore not related to laws, culture or beliefs but fundamental and universal. Legal rights are those which come from specific legal systems derived from individual cultural norms and expectations and so can vary between countries. However, there are also legal rights which transcend national systems: the Universal Declaration of Human Rights is the most prominent of these. In Europe, the Council of Europe also has considerable influence. Each has enshrined natural rights into international law, with the highest priority being given to the right to life and to liberty. There are also specific provisions for people with mental health problems, e.g. in the Council of Europe Committee of Ministers Recommendation on Human Rights and Psychiatry (2004: 11; Kingdon, Jones and Lönnqvist, 2004).

There is a history to this: John Locke (1841) held life, liberty and property to be primary considerations in describing rights:

- Life: Everyone is entitled to live once they have been created.
- Liberty: Everyone is entitled to do anything they want to as long as it does not conflict with the first right. (You might also think that there is a trade-off with other people's rights, and not just of their right to live, but we'll come to that later.)
- Property (or 'Estate'): Everyone is entitled to own all they create or gain through gift or trade, so long as it does not conflict with the first two rights.

However, property has been deemed in some frameworks to be subordinate to 'pursuit of happiness'. In the 1776 United States Declaration of Independence, these rights were famously condensed to:

> We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights …

The signers of the Declaration of Independence deemed it a 'self-evident truth' that all men are 'endowed by their Creator with certain unalienable rights'. 'Unalienable' means 'incontrovertible' – or, if that doesn't help explain it, 'absolute rights'. However, it may not matter because Rousseau (1920) believed that the existence of unalienable rights, whatever they are, is unnecessary for the existence of a constitution or a set of laws and rights. His idea was of a 'social contract', which is the most widely recognised alternative to unalienable rights. The social contract describes the agreement between members of a country to live within a shared system of laws and that rights and responsibilities are derived from a consensual, agreed, contract between the government and the people. Specific actions of government are the result of the decisions made by members acting in their joint collective capacity. Government is instituted to make laws that protect the three natural rights mentioned previously, i.e. to life, liberty and property. However, if a government does not properly protect these rights, the populous, the people, has the right to overthrow it.

Hutcheson, on this theme, also placed clear limits on the notion of unalienable rights, declaring that: 'there can be no Right, or Limitation of Right, inconsistent with, or opposite to the greatest public Good'. He elaborated on this idea of unalienable rights in *A System of Moral Philosophy* (Hutcheson, 1755), based on the principle of the liberty of conscience. This had come about because of the Reformation of the Church which had bought to prominence the idea that there were further rights that were important and acting according to your conscience was one of these rights.

This is getting nearer to, but does complicate, the discussion about rights as it relates to professional practice. This idea meant that you could not give up the capacity for private judgement, e.g. about religious questions, regardless of any external contracts or oaths to religious or secular authorities, so that right is also, here we go again, 'unalienable' according to Hutcheson (1755):

> Thus no man can really change his sentiments, judgments, and inward affections, at the pleasure of another; nor can it tend to any good to make him profess what is contrary to his heart. The right of private judgment is therefore unalienable. (Hutcheson, 1755: 261–2)

In contrast, a thing, say, a piece of property, can, in fact, be transferred from one person to another. According to Hegel, the same would not apply to those aspects that make one a person:

> The right to what is in essence inalienable is imprescriptible, since the act whereby I take possession of my personality, of my substantive essence, and make myself a responsible being, capable of possessing rights and with a moral and religious life, takes away from these characteristics of mine just that externality which alone made them capable of passing into the possession of someone else. When I have thus annulled their externality, I cannot lose them through lapse of time or from any other reason drawn from my prior consent or willingness to alienate them. (Hegel, 1967: 66)

In discussion of social contract theory, 'inalienable rights' were said to be those rights that could not be surrendered by citizens to the sovereign. Such rights were thought to be *natural rights*, independent of positive law. Some social contract theorists reasoned, however, that in the natural state, only the strongest could benefit from their rights. Thus, people form an implicit social contract, giving up their natural rights to the governing authority to protect the people from abuse, and living under the legal rights of that authority.

As no people can lawfully surrender their religious liberty by giving up their right of judging for themselves in religion, or by allowing any human beings to prescribe to them what faith they shall embrace, or what mode of worship they shall practise, then neither can any civil societies lawfully surrender their civil liberty by giving up to any external body their power of legislating for themselves and disposing of their property. In other words, no group of people can give up their right to choose a religion – or not to choose one – or set laws for them or dispose of their own property.

The 1948 Universal Declaration of Human Rights asserts that rights are inalienable:

> recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

The Council of Europe was established in 1949 after the Second World War to promote human rights, democracy and the rule of law in its member states and essentially be a barrier against further devastating conflicts. It includes the European Convention on Human Rights 1950, which has been incorporated into UK law by way of the Human Rights Act 1998. The European Court on Human Rights has jurisdiction over UK law and appeal to it is possible, especially for human rights issues.

The Committee against Torture is a monitoring body which includes oversight of mental hospitals and regularly visits countries to inspect them. It does not have the resources to inspect all hospitals but does have the right to do so. The Council of Ministers of the Council of Europe issued a recommendation on psychiatry and human rights in 2004 and this has implications for mental health services. It includes reference to the importance of professional standards and regulatory bodies (referred to later) and also an oversight commission in each country. This was the Mental Health Act Commission in the UK but this function now forms part of the remit of the Care Quality Commission.

International documents establishing legal rights

The Magna Carta (1215, England) required the King of England to renounce certain rights and respect certain legal procedures, and to accept that the will of the King could be bound by law.

The Declaration of Arbroath (1320, Scotland) established the right of the people to choose a head of state (see Popular Sovereignty).

The Bill of Rights (1689, England) declared that Englishmen, as embodied by Parliament, possess certain civil and political rights.

The Claim of Right (1689, Scotland) was one of the key documents of Scottish constitutional law.

Virginia Declaration of Rights (1776) by George Mason declared the inherent natural rights and separation of powers.

United States Declaration of Independence (1776) succinctly defined the rights of man as including, but not limited to, 'Life, liberty, and the pursuit of happiness', which later influenced 'liberté, égalité, fraternité' (liberty, equality, fraternity) in France.

The phrase can also be found in Chapter III, Article 13 of the 1947 Constitution of Japan.

Also, Article 3 of the Universal Declaration of Human Rights reads: 'Everyone has the right to life, liberty and security of person'.

The Declaration of the Rights of Man and of the Citizen (1789, France) was one of the fundamental documents of the French Revolution, defining a set of individual rights and collective rights of the people.

The Universal Declaration of Human Rights (1948) is a comprehensive set of standards by which governments, organisations and individuals would measure their behaviour towards each other. It declares that the

'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world …'.

The European Convention on Human Rights (1950, Europe) was adopted under the auspices of the Council of Europe to protect human rights and fundamental freedoms.

The International Covenant on Civil and Political Rights (1966) is a follow-up to the Universal Declaration of Human Rights, concerning civil and political rights.

The International Covenant on Economic, Social and Cultural Rights (1966) is another follow-up to the Universal Declaration of Human Rights, concerning economic, social and cultural rights.

The Charter of Fundamental Rights of the European Union (2000) is one of the most recent legal instruments concerning human rights.

Rights in relation to acts on the person are important in mental health settings as these affect consideration of what level of intrusion and the circumstances involved and sanctioned is appropriate in physical but also psychological terms. This protects therapists in circumstances where they are asking about personal issues and provides the protections and rights that the client has.

At an extreme level, the libertarian non-aggression principle is relevant as it holds that only the initiation of force is prohibited; defensive, restitutive or even retaliatory force is not. Clearly, physical coercion will not be appropriate in therapeutic encounters. However, as effective interventions are developed in circumstances where patients are severely unwell, psychiatrists, nurses and psychologists can be acting, at least partially, as 'therapists' with people who lack insight into a need for treatment, and will be involved in situations where force is used, e.g. to administer medication and detain people in hospital. It is therefore important to be aware of the principles involved where this is occurring. Even if physical coercion is not likely to feature in their practice circumstances, all therapists need to be aware of the potential for psychological coercion and similar principles apply.

The provisions of the Helsinki Agreement, again established after the Second World War, govern specific issues regarding research. The World Medical Association (WMA) developed the Declaration of Helsinki (1913) as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. It forms the foundation for the ethical conduct of

research and, so, is relevant to any research activity involving human beings and hence underpins Research Ethics Committees.

Safeguarding of clients is now receiving much greater attention than previously due to, sadly, numerous occasions where rights of vulnerable people have been seriously infringed by people caring for them, including therapists, and others who have been in a position of power over them. Social and health care helps people with care and support needs to live full lives, free from abuse and neglect. This includes preventing abuse, minimising risk without taking control away from individuals, and responding proportionately if abuse or neglect has occurred. Health services, including therapists and mental health practitioners, local authorities, other care providers, housing providers and criminal justice agencies, are all important safeguarding partners who collaborate to protect clients whilst also empowering them (see Chapter 2).

The Care Act 2014 in England introduced new safeguarding duties for local authorities, including leading a multi-agency local adult safeguarding system, making or causing enquiries to be made where there is a safeguarding concern, hosting safeguarding adults boards, carrying out safeguarding adults reviews and arranging for the provision of independent advocates. Within health organisations, safeguarding processes are, or have been, developed to make sure that where there are concerns about vulnerability, neglect or abuse, there is a robust route to see that action is taken to remedy or protect the individual.

Empowerment and safeguarding are amongst the key sources of values described for mental health practitioners. Ten Essential Shared Capabilities (Hope, 2004) have been described, defining service user rights and responsibilities, values-based practice and recovery principles.

Ten Essential Shared Capabilities

1. Working in Partnership
2. Respecting Diversity
3. Practising Ethically
4. Challenging Inequality
5. Promoting Recovery
6. Identifying People's Needs and Strengths
7. Providing Service User Centred Care
8. Making a Difference
9. Promoting Safety and Positive Risk Management
10. Personal Development and Learning

(Hope, 2004)

Cognitive behaviour therapy: collective values and personal values

The values that are embedded in psychotherapy, such as anti-discriminatory practice, empowerment of clients, respect of diversity, have consistency with these legal rights as expressed by the Universal Declaration of Human Rights (1948). However, it is worth considering to what extent the CBT theoretical model fits with the Human Rights Act's notion of justice and anti-oppressive values, and also with the values depicted in the Ten Essential Shared Capabilities (Hope, 2004), chiefly challenging inequality. There is no argument that, as therapists, we endeavour to act in accordance with such worthy values, however, it can be beneficial for all to sometimes question the theoretical model that is employed. Within CBT, whilst importance is placed on the client and therapist working together to develop more helpful thinking styles and behaviour, the 'problem' is predominantly located at the level of the client. The CBT theoretical model emphasises the interaction of cognitions, physiology, emotions and behaviours within a context. However, given that structural oppression and inequality exist in society (Lago, 2006), is the role of the environment sufficiently developed in the model? Is structural oppression that may be relevant to the client adequately taken into account? Does it need to be? These are perhaps the sorts of questions that CB therapists need to reflect on to ensure that they are not unwittingly perpetuating values or standards of behaviour that they have little regard for, in this case, inequality and oppression.

This said, therapists' values are influenced by the professional code of practice and ethics that the therapist adheres to. The British Association for Behavioural and Cognitive Psychotherapies (BABCP) code of Standards of Conduct, Performance and Ethics, like other codes of practice, not only communicates the collective values of the profession it represents (Francis and Dugger, 2014), but also shapes values. Although, the BABCP's code does not make a clear statement about the values that underpin it, like, for instance, the Australian Code of Ethics (APS, 2007), which names the underpinning values as:

- Respect for the rights and dignity of people and peoples
- Propriety
- Integrity

The BABCP's values are, nevertheless, evident. It is apparent from reading the document that the values that are significant within the BABCP code relate to:

- Honesty and integrity
- Respect for the dignity of others
- Co-operation
- Responsibility and accountability
- Protection of service users
- Effectiveness

The values held within the BABCP code of Standards of Conduct, Performance and Ethics are unsurprisingly consistent with the inherent values of the CBT theoretical model that accentuates working collaboratively, with respect for the client's subjective meaning and safety, while employing empirically informed techniques. Whilst these values inform our practice, we have to remember also that, in the socialisation process, values from our personal history, private life and culture may also influence our practice. It is not improbable, therefore, that the values that the therapist holds might at times be challenged within the therapeutic context. Tension could be experienced in relation to the differing values held by the client, or even with those endorsed by the employing agency, particularly if the employer's values are firmly linked to commercial priorities (Shillito-Clarke, 2003). Although therapists recognise the importance of not dismissing the client's values (Barnes and Murdin, 2001), it remains possible that the therapist's personal values may unintentionally enter the therapy room, particularly when working with vulnerable clients. The therapist's response to the client's disclosures, either verbally or via non-verbal communication, may reveal their conflicting personal values, and hence disempower or confuse the client.

Just as it is important to question the values underpinning the CBT model, so is it of course beneficial for therapists to reflect on their own value system. For instance, they may question what their current values are and how they have changed. Upon reflection, it becomes possible to prioritise which values hold greater personal significance and how they are congruent with those of the profession. What is more, is that it is suggested that reflecting on values can facilitate deeper self-knowledge and develop ethical thinking (Ellis, 2015).

Ethical theories

Ethics is concerned with conduct. It questions the rights and wrongs of behaviour, and therefore pervades every aspect of our life. Within the health care profession, the ethical theories of Deontology, Utilitarianism and Virtue Ethics are evident. Although they can be somewhat aspirational in nature, these theories help in the decision-making process of

which action to follow. While the theories may lead to the same action, the reasoning behind them will differ. There are a range of perspectives within each theory, however having an understanding of the basic theories will enable the therapist to reflect upon the values that underpin them, and identify which are congruent with their own values. We will briefly look at these theories now as an overview, but in-depth reading is recommended.

Deontology

Deontology, derived from the work of Immanuel Kant (1724–1804), is concern with 'duty': a duty to certain principles or rules. It utilises reasoning to create rules and gives prominence to the agent's intention behind an act (Playford et al., 2015). It does not, however, focus on consequences. Kant's Categorical Imperative states: 'Act only according to the maxim by which you can at the same time follow will that it should become a universal law' (cited in Van Staveren, 2007: 23). This fundamental rule is associated with a number of underlying principles, which include the Principle of Universalisability and the Principle of Humanity.

The Principle of Universalisability suggests that a moral rule for living is one that can be applied to anyone, all of the time. This, arguably, could be problematic, given the diversity of society and the range of value systems that are evident. Nevertheless, from this perspective, it is deemed that some actions are intrinsically good and others intrinsically bad. It suggests that we have a duty to do what is intrinsically good, such as telling the truth, and avoid what is intrinsically bad, such as telling lies. It is not too difficult, though, to imagine that following such a rule could lead to harm. It might be difficult to follow this rule if, for instance, someone was at risk of harm from a perpetrator, and to tell the truth might endanger them. Even though it may be less challenging to understand how some action or inactions, for example refraining from killing someone may be sensible and perceived as intrinsically good, do such rules translate to all situations? Consider life-threatening situations.

Act Deontology, a branch of Deontology, in some ways moderates traditional Rule Deontology by formulating rules that take into consideration the situation. If we look at the Principle of Universalisability and the action of keeping confidentiality within the therapeutic context, a maxim or principle from an Act Deontologist perspective might be: 'Keep confidentiality unless someone will suffer serious harm'. The intention behind keeping confidentiality within the therapeutic situation is based on the need for trust. If therapists were to breach

confidentiality with no regard for their clients, then trust or fidelity would have no meaning in therapy.

Deontological principles can be observed in ethical codes. A list of obligations for therapists to adhere to, for instance, appear in the BABCP's code under the heading: 'Your Duties as a Member of the BABCP' (p. 3). The duty, for example, 'You must act in the best interest of your client', is a universal principle for all therapists to follow. Moreover, duties that are consistent with the Principle of Humanity which communicates the value of equality and justice, are also communicated in ethical codes. By example, the APS Code of Ethics (2007) states under the principle of Justice, 'Psychologists assist their clients to address unfair discrimination or prejudice that is directed against their client' (A.1.3). The obligation to treat others with respect principally draws attention to the need to treat people as an end in themselves, and not as a means to an end. In other words, not to use or manipulate people to fulfil our needs. So, again, if we look at this principle in relation to CBT, it could be argued that its emphasis on collaboration helps to negate treating people as a means. However, when we look at the same principle in relation to certain procedures, treating clients as an end in themselves might be less discernible. From a Deontological perspective, collecting measures each week without fail from clients in order to demonstrate the effectiveness of a service could be construed as treating people as a means to an end.

Although Deontology employs reason and reflection to discover which principle or rule should be followed, determining the appropriate rule or the weightier duty can be problematic. This can be particularly challenging in the therapeutic situation where there can be a number of competing duties.

Utilitarianism

In contrast to Deontology, Utilitarianism, also known as Consequentialism, relates moral actions with outcomes. Carefully assessing the consequence of actions are fundamental to this theory. Utilitarianism was derived from the work of Jeremy Bentham (1748–1832) and of John Stuart Mill (1806–73). It proposes that an action is right if it produces the best outcome for the greatest number, or, as Mill advocated, 'the greatest happiness for the greatest number' (cited in Playford et al., 2015). So, if we consider the therapeutic setting again, and the example above of collecting data from each client after every session to demonstrate the effectiveness of a service, it could be argued from this perspective to be a good thing. If the data demonstrates that the service is effective, then, as a consequence, the service remains available to benefit many people.

Even if the data reveals that the service is not effective, then funding could be redirected to a more useful service, again to the greater good of many people. (Assuming, of course, that the tools employed measure what they are supposed to measure.) It would seem that collecting the data potentially benefits many, and outweighs the inconvenience that the client and therapist may experience.

Similar to Deontology, Utilitarianism can be separated into Rule and Act. Briefly, the former, Rule Utilitarianism, advocates that rules for moral actions can be derived at by calculating outcomes, the rules can then be generalised to other situations to produce good outcomes. Although Act Utilitarianism also recognises the need to calculate the best outcomes, it proposes that to derive the best outcome necessitates a calculation of consequences in each situation. Although it might appear to be a straightforward approach simply calculating the best outcome for the greatest number, it can be problematical in assessing or predicting outcomes. Short-term consequences may be very different to long-term ones. Moreover, maximising benefits for the greatest number could result in the minority being overlooked, thus undermining the values of justice and equality.

Virtue Ethics

The ethical theories discussed so far have been concerned with formulating and following rules. However, Virtue Ethics, originating from the work of Aristotle (384–322 BC), rather than being guided by principles and rules, focuses its attention on the qualities or traits of the moral agent. The moral agent currently under discussion is the therapist. Characteristics or virtues, such as kindness, patience, honesty, having integrity, are valued. Consideration of how someone with such virtuous characteristics may behave in a given situation, guides action. A virtuous agent is naturally inclined to do good (Dalal, 2014), and, according to Meara et al. (1996), they possess vision and discernment and will therefore behave morally. Although it is 'person-centred' in nature as the focus is on the virtuous agent (Begley, 2005), it also recognises the meaning of significant relationships, social relations and context as affecting decisions and actions (Shillito-Clarke, 2003).

Cultivating good habits, such as integrity and respect for others, and hence developing the self, is consistent with many ethical codes of practice, and are observed within the BABCP's ethical code and the APS Code of Ethics. However, it is not clear how being a virtuous agent enables objective decision-making. Indeed, it is questionable if a good person with good motives always produces the best or right outcome.

Moreover, it is necessary to be able to justify actions, particular when faced with an ethical dilemma. Virtue Ethics does not provide a guide to decision-making. Nonetheless, the virtuous qualities advocated by Virtue Ethics are valued within the therapeutic context, and are certainly sought when recruiting CB therapists (BABCP, Knowledge, Skills and Attitudes (KSA)).

Activities

- Consider what values you hold as important. How do they fit with being a CB therapist?
- How are measures and targets used in your organisation? Does this fit with a Deontological or an Utilitarianism approach?
- Reflect on the values that are predominant in your current employment. How congruent are they with your values?
- What would you do if you felt that working in your client's best interest conflicted with your agency's policies? How would you resolve this dilemma? Do the ethical principles compete? What are your responsibilities in this situation?