Understanding Counselor Moral Distress:
Adlerian Assessment and Logotherapeutic Intervention

A Literature Review

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Abstract

Since 1984, moral distress has been a recognized mental, emotional, and physical risk to frontline nurses as they struggle to balance patient needs with the limitations of cost-containment and other intransigent barriers impacting contemporary medical practice. This project explores how Moral Distress affects mental health counselors as well. When a healthcare provider is prevented from delivering the type or level of care he or she believes a patient needs, both a psychological and a spiritual crisis ensues. The felt powerlessness of this situation intensifies inferiority feelings. Adler taught that feelings of inferiority precipitate a self-defeating drive for superiority as one struggles to preserve one’s self-ideal. Increasingly, for both medical and mental health providers embedded in vertically-oriented and cost-driven care systems, this is a battle that cannot be won. Over time, and with repeated exposure to this double-bind, counselors may experience a widening rift between themselves and their own self-ideal as a helper, patients, fellow helping professionals, and the wider community they have devoted themselves to serving. This project will (1) define moral distress and distinguish it from ethical dilemmas, (2) highlight its principle mental, emotional, physical, and spiritual effects by distinguishing it from burnout, compassion fatigue, and moral injury, (3) identify how moral distress uniquely affects mental health counselors, (4) propose a framework for assessing moral distress based upon Individual Psychology, and (5) propose a conceptual framework for intervention based upon Viktor Frankl’s Logotherapy.
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Introduction

In 1984 nursing professor and researcher, Andrew Jameton first used the term *Moral Distress* (MD) in his textbook on nursing ethics. Since then MD has been the subject of ongoing research in the nursing profession. Jameton states that “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). This concept has undergone evolution as the research has expanded and deepened not only in the field of nursing but also in other allied health care professions, providing increasing empirical evidence to support the efficacy of the term and the syndrome it describes.

In their position statement, the *American Association of Critical Care Nurses* (2008) concluded that MD occurs when “you know the ethically appropriate action to take, but are unable to act upon it” hence causing “you to act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity” (p.1). Epstein and Delgado (2010) summarized that MD “involves a threat to one’s moral integrity” (Epstein & Delgado, 2010, Historical Overview, para. 5). These researchers pointed out, as Jameton had before them, that MD can include internal causes (lack of confidence, fear of job loss, anxiety) or external causes (institutional policies, lack of support, poor communication) (Epstein & Delgado, 2010). This literature review will focus on external causes impacting MD assuming that those occur first, triggering internal struggles subsequently.

In their proposal for a theoretical model of MD, Barlem and Romos described MD as the feeling of powerlessness that follows the inability to act on something perceived as ethically
adequate (2015). Barlem and Romos elaborated on MD as a trigger by describing it as “a painful feeling or psychological imbalance resulting from recognizing an ethically correct action that cannot be performed because of hindrances such as lack of time, reluctant supervisors, or a power structure that may inhibit a moral, political, institutional or judicial action” (p. 608). The concept of MD has since broadened to include multiple dimensions for study and assessment. Researchers Rodney, Musto, and Vanderheide (2015) confirmed the findings of previous research which identified the psychological and moral dimensions of MD and went further in emphasizing two additional domains of assessment. Moreover, they pointed out that MD must also be understood as a somatic experience because “in attempting to gain a greater depth of understanding of the experience of moral distress, we must recognize that it begins as a felt experience in the body” (Rodney et al., 2015, p. 94). In addition, considering the findings of neuroscience, they propose that the actual stress caused by MD should be considered a relational trauma based on the definition of trauma as “an event that overwhelms the nervous system so that the individual cannot launch an effective response to the threat” (p. 95).

Because MD was initially identified in the nursing profession, the concept is closely tied to the ethical nature of the work environment. As Burston and Tuckett observed “site specific” contributory variables must be considered in the experience of MD such as “resourcing (like time and money), staffing, the nature of care being provided, and the general organizational structures (what we have termed the ‘world of work’)” (p. 316). The effects of repeated exposure to situations causing MD, Jameton later said, had a cumulative effect (1993) which he called reactive distress (1993). This condition was subsequently further developed by Epstein and Delgado (2010) as moral residue which they proposed is characterized by the “moral wound of having had to act against one’s values” the effect of which, they continue, “is long-lasting and
powerfully integrated into one’s thoughts and views of the self” (Epstein & Delgado, 2010, Moral Residue, para.1). Epstein and Delgado associate MD, and the accumulation of moral residue, with the *moral crescendo* which results from the “sheer repetitive nature of similar clinical situations evoking moral distress [which] adds a sense of futility, increasing the moral residue” that can be damaging to both oneself and one’s career (Epstein & Delgado, 2010, The Crescendo Effect: Cause for Concern, para. 3).

To date the most comprehensive review of the argument-based nursing literature on the concept of MD is that published by McCarthy and Gastmans (2015) in which they conclude that “Jameton’s distinction between standard ethical dilemmas and, as he puts it, ‘dilemmas of distress’ captures something significant about the moral terrain within which nurses work” (p. 150). Understanding the distinction between MD and ethical dilemmas, such as those that are typically encountered in the broader realm of clinical professional practice, is integral to the task of assessing MD and intervening with its potentially debilitating effects.

**Differences between Moral Distress and Ethical Dilemmas**

In the same text where Jameton initially coined the term *moral distress*, he provided a series of additional distinctions necessary to discuss it. And Jameton was clear that MD is not the same thing as a moral dilemma when he said that “moral dilemmas arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action” (p. 6). In their article distinguishing each from the other, Epstein and Delgado stated that in cases of a moral dilemma “one recognizes that a problem exists and that two or more ethically justifiable but mutually opposing actions can be taken” (Epstein & Delgado, 2010, The Phenomenon of Moral Distress, para.1). Len Sperry (2007a) offers a comprehensive definition of ethical dilemmas as “conflicts that arise when competing standards of right and wrong apply to a
specific situation in counseling practice” (p. 37). Dilemmas arise because of competing or conflicting ethical standards, conflicts between ethical and moral standards, a lack of ethical standards addressing complex situations, or due to factors preventing a clear application of an ethical standard (Sperry, p. 37).

While both MD and ethical dilemmas can and do occur in healthcare settings, and these professionals are subject to the challenges of both as an inevitable part of the work itself, the critical difference between them for the purposes of this discussion are twofold: (1) ethical dilemmas, by their very nature, still allow for the professional’s capacity to decide and act, and (2) unlike a situation causing MD, where the right thing to do is manifestly clear, the right thing to do in the case of ethical dilemmas is seldom so. The decision-making process in the case of ethical dilemmas, while always including the potential to be wrong, carries the emotional and psychological advantage of at least holding out to the decider a greater sense of agency in analyzing and choosing from among the options at his or her disposal (however ambiguous they may be). While the outcome is not likely to be “perfect”, it nevertheless remains possible for him or her to exercise judgement, and then act. By contrast, at each stage of the evolution of the concept of MD, one factor remains constant—the decider already knows what the right thing to do is, but cannot do it.

**Cultural Considerations**

Any healthcare professional suffering the effects of MD is facing a conflict of values. As mentioned earlier, workplaces form ethical cultures. In discussing the influence of organizational culture on the moral environment in which healthcare providers work, Musto, Rodney, and Vanderhiede (2015) described *moral climate* as “the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered” (p. 97).
Musto et al. proposed that morally habitable work environments are places “where internal and external constraints to moral agency are minimized, difference is embraced, and moral well-being is promoted through shared understandings of responsibility” (p. 97). Moral Distress occurs in the context of a diversity of institutional ethical cultures, creating challenges to the professional’s sense of integrity and self-efficacy. To this fact must be added the confounding variables associated with an increasingly culturally diverse society in which healthcare practice and delivery, in all of its forms, takes place.

Providers and patients from around the world are now either delivering or receiving care here in the United States, each bringing a unique moral orientation and worldview. Put simply, what is experienced as morally distressing for a professional from one cultural group may not be for a professional from another. This fact must be included in discussions concerning MD going forward.

In response to their concern that the 2005 Code of Ethics and Standards of Practice of the American Counseling Association (ACA) (2005), did not adequately reflect the shift toward an increasingly multicultural demographic. Frame and Williams (2005) called upon the ACA to revise the code to reflect this new reality. In doing so, these researchers proposed a revised model for ethical decision-making based upon a “universalist philosophy, an ethic of care” (p. 165).

In addressing this same question, Knapp and VanderCreek (2007) proposed a multicultural ethical decision-making model after drawing important distinctions between relativist and universalist approaches to ethics (p. 661). They proposed that psychologists making ethical decisions with clients from other cultures utilize a centrist position between the two: soft universalism, (Rosenstand, 1994, as cited in Knapp & VanderCreek, 2007), a position accepting
that “values can differ, but not too dramatically, and some behaviors would be considered to be out of bounds even if some individuals in some cultures engaged in them” (p. 661). Given these cultural considerations, coupled with the realities of a healthcare system already ethically compromised by the active ingredients for morally distressing situations, what new standards or guidelines can be utilized to ideally reflect a soft universalist approach to decision-making? Two documents are suggested, one from within the field of psychology, and the other from the United Nations (UN).

In their article describing the *Universal Declaration of Ethical Principles for Psychologists*, (see Appendix A) Gauthier, Pettifor, and Ferrero (2010) stated that “one of the goals of the *Universal Declaration* is to encourage the development of codes of ethics across the globe that provides ethical support and guidance for psychologists” (p. 180). The *Declaration*, they affirm, “provides a moral framework of universally acceptable ethical principles based on shared human values across cultures” (p. 180) (see Appendix A). Without such a document, and the international consensus upon which it is based, healthcare providers suffering from MD risk having no standards external to their organizational culture to which they can appeal for moral clarity when cross-cultural variables contribute to it. It is dubious at best to assume that any organization can, on its own, anticipate and provide guidance for the many complex morally distressing situations that may arise between professionals and patients from different cultures.

An earlier, but similarly intended, document was drafted by the UN in the aftermath of World War II which offers not only valuable historical perspective but places the question of trans-cultural morality in a global framework extending well beyond the confines of any particular profession. In 1948, A UN international committee drafted the *Universal Declaration of Human Rights* (see Appendix B), which was subsequently adopted to serve as a “common
standard of achievement for all peoples and all nations…” (Paul & Elder, 2003, p. 42). The Declaration contains thirty articles reiterating in various ways the rights and dignity of the human person as inviolable and unconditionally independent of any state or nation (see Appendix B). These same rights would, by extension, include those of both patients and professionals.

Both of these documents, composed at different historical times and in different social contexts, share a common desire to reframe discussions of morality and social responsibility in a global context. Both affirm the (1) unconditional worth and dignity of the individual independent of identification with any particular state or political system, (2) intrinsic entitlement of all human beings to the rights outlined in each document, and (3) possibility of a global consensus on core universal moral principles by which to discern and judge the ultimate rightness or wrongness of particular actions (whether those are taken by a government or a healthcare organization). It is only a short logical step from this premise to assert on the basis of these declarations that health care professionals, including professional counselors, should be free to exercise their healing work unencumbered by MD, or more to the point, preventable MD. This, of course, is an ideal and no helping profession currently knows that better than nursing. The research on MD in the nursing literature is robust, compelling, and increasingly moving MD into the forefront of discussions of professional well-being. This cannot be said of the counseling profession. A search of the literature does, however, merit a limited number of articles and studies of MD and its effects from several allied helping professions. These articles and studies can serve as a bridge between the solid foundation already established in nursing, to that of professional counseling.
Bridging the Research to Counselors

In their research study of nurses and physicians, Austin, Saylor, and Finlay (2016) investigated the effects of MD on their professional quality of life. While this study combined nurses and physicians, two differences between them provide insight into the effects of MD on physicians. Compared to physicians, the authors cited several previous studies confirming that nurses are generally at higher risk for MD. They highlighted the fact that nurses develop more direct bedside relationships with patients with an increased sense of direct responsibility for them as a result. However, nurses have less influence on the direction the care of their patients takes.

These researchers observed that despite these differences in status, power, and ability to influence within the system, there were significant similarities and correlations between physicians and nurses regarding the most morally distressing situations they confront, the top four of which were found to be (1) following a family’s wishes to continue life support when it is seen as no longer in the best interests of the patient, (2) initiating life-saving procedures when those are seen as only prolonging time of death, (3) seeing the quality of patient care suffer due to the lack of provider continuity, and (4) seeing patient care compromised by poor team communication. As these researchers concluded, these data confirmed that for both physicians and nurses the top morally distressing situations were related to providing what they saw as unnecessary life-support and initiating life-saving procedures that would only prolong time of death.

Of particular importance for this discussion is the finding that physicians and nurses experienced virtually the same situations as morally distressing despite what some might assume to be a significant power differential between their roles and status in the organizational hierarchy. Doctors, one might assume, could insulate themselves more readily from the frontline
daily pathos of suffering patients, or teams miscommunicating, and resources directly impacting patient care dwindling or being misappropriated. With those assumptions unsupported by the findings of this study, nurses and physicians roughly share exposure to the same morally distressing situations in the course of their work. Therefore, it is important to focus on the effects of MD among these professionals.

In her discussion of MD as it affects professionals in Physical Therapy (PT), Carpenter (2008) places her assessment in the larger context of the complexities of a changing health care environment. She effectively speaks for providers in virtually all branches of health care when she says that physical therapists must find a way to practice in a field which increasingly requires them to respond, “to a bewildering array of funding decisions, policies, and guidelines resulting from major and ongoing changes in health care system delivery and health institution reorganization” (p. 69). She adds that these decisions and changes “rarely involve frontline practitioners in decision making” (p. 69). It could be argued that this contextual variable plays a prominent role in the onset of MD for practitioners in many branches of health care. As with nurses, the unilateral nature of high-impact budgetary and practice decisions by senior management in these systems leaves frontline PTs with a challenging combination of immediate responsibility for patient well-being and the quality of care, with no opportunity to advocate for them at the policy level. Moral distress is also becoming more widely recognized and researched in those health care disciplines focused primarily on mental and behavioral health.

In their study of MD as it effects psychologists, Austin, Rachel, Leon, Bergman, and Lemermeyer (2005) reported on the unique aspects of MD as it is experienced by them. One study cited by the authors “found that psychologists, more than physicians, reported being influenced by their code and were less likely to report being influenced by family views,
religious background, and peer attitudes” (2005, p. 203). Unlike their colleagues in medicine, psychologists were found to be more Deontological in moral orientation, relying more on a commitment to duty than utility. Psychologists were found to be less relativistic and, as a result, more consistent in their ethical decision-making. A significant theme found by these same researchers among psychologists was “the tension of being responsible within and to an occupational community and to society as a whole, while accepting one’s moral choices as ultimately personal” (Austin, et al., 2005, p. 203). In their research on the causes of MD for psychiatrists, Austin, Kagan, Rankel, and Bergum (2008) found that they experienced MD because of having to be an “artificial person” -- a term originally used by the philosopher, Thomas Hobbes (1651), to describe what happens when someone must act in the name of someone else, instead of in their own name (p. 93). This occurs for psychiatrists as a problem intrinsic to their role both in medicine and society at large. Psychiatrists, these researchers found, “are placed in the situation of competing responsibilities as agents for their patients and for their society” (Austin, Kagan, et al., 2008, p. 93). The dilemma arises when “physicians are increasingly facing pressure to use clinical expertise for social purposes or on behalf of third parties” (Bloche, as cited in Austin, Kagan, et. al., 2008, p. 93). Psychiatrists, by virtue of their role, face the competing demands of serving their communities versus their patients. Like psychologists, these physicians working within the mental health system, appear subject to an ongoing form of MD which apart from any situation, is related to their public role and the expectations that come with it. This factor alone may leave them vulnerable to the “artificial person” dilemma Hobbes described, i.e., the demands of their role, and the organization defining it, may compel them to act against their own values.
Not all professions in health care share the same variables that contribute to MD. While there is currently no research specifically addressing the effects of MD for professional counselors; physicians, psychiatrists, psychologists, pharmacists, social workers, physical therapists, and health care managers, all conduct their work in the context of ongoing fiduciary relationships with patients, and these can partially serve as the scaffolding for a bridge between these allied professions and clinical counselors.

In their review of the development of a MD scale, Swedish research team Sporring, Hogl and Bengt Arnetz (2006), compared pharmacists to other health care professionals in clinical settings. The aim was two-fold. The first being to develop and norm an assessment scale to measure MD in most medical settings. Secondly, to isolate any sources of MD that might be unique to pharmacists. At the conclusion of their study the authors produced a MD scale requiring further validation, but also providing two important findings regarding the salient differences between pharmacists and other health care providers: (1) pharmacists generally reported less MD which, the researchers suggest, may be the result of the kind of care being provided in a pharmacy and, (2) differences in the organization, management, and ownership of a pharmacy. For example, they point out that the individuals whom the pharmacists serve are referred to as customers, as opposed to patients, as in other medical settings.

While it is true that a patient is at the same time, and in a certain sense, a customer and vice versa, the choice of one primary identifier over the other carries a significant message about how that individual is viewed in that care setting and, by extension, how much moral “weight” (and potential distress) he or she carries for the provider for the duration of the time he or she is in either setting. This study concluded that there is less potential for pharmacists, in the conduct
of their occupation, to experience MD as compared to medical providers in direct service to patients.

Social workers are not immune to MD. While it may take a different form compared to other professionals, the underlying sense of moral failure for social workers remains consistent with the same experiences reported by professionals in other health care settings. In her study of social workers in Finland, Van der Kulp (2016) sought to explore the stress experienced by social workers as they attempted to do their jobs with steadily diminishing resources. One Swedish study cited by Van der Kulp indicated that “opportunities to practice ethically responsible social work significantly predicted work-related wellbeing among social workers” (p. 90). Not surprisingly, she found that “moral conflicts and dilemmas related to limited resources are ever-present in the daily work of social welfare workers” (p. 90). The ingredients for MD are already in place for these professionals because a fundamental mandate for social workers in Finland reads: “a social worker is obliged to stand up for human rights in every situation—including when the organization’s actions conflict with the code” (p. 88). This mandate is built into the very structure of the social welfare system in Finland and into the core identity of each social worker just waiting, as it were, to require them to confront threats to human rights whatever the source, which could include other clients, colleagues, employers, or even the government. It would seem that social workers may share a common stressor with nurses—they are often frontline service providers assigned to client or patient situations where resources can be scarce, misappropriated, or denied, while they watch the direct impact take its toll on the very individuals they have been commissioned to help. What, by comparison, might the decision-makers “above” these direct service professionals say are their sources of MD?
In their study, Mitton, Peacock, Storch, Smith and Cornelissen (2010), explored what might create MD for mid- to senior-level managers in healthcare. They concluded that MD does exist for these leaders and that two key examples of it in their work were found to be, (1) having to promote and support a directive that they did not believe in themselves, and (2) having to break obligations to staff and colleagues (Mitton et al., 2010, p. 100). Further, these researchers found that “managers felt distressed when they had to make choices about what to do with limited funding” (Mitton et al., 2010, p. 104). These difficulties would likely be appreciated by many social workers. In these findings can be heard again the “artificial man” dilemma described earlier. The managers may be placed in a position where they must implement policies and procedures that may stand in direct opposition to their core values. The managers in this study described the ongoing struggle they experience in trying to live by their own moral code, while at the same time carrying out directives from senior management that create an intrapersonal schism as they are compelled to act against their core values.

Beginning with nursing, it is evident from these studies that the potential for MD is inherent in a broad spectrum of medical and mental health service delivery settings and professions from hospitals and pharmacies, to psychiatric, psychological, physical therapy, and social work practices. Apart from these front-line direct service environments, one study highlighted how even those a step removed from direct patient care, i.e., managers and supervisors who function as decision-makers and budget allocators can be affected by MD particularly in times of diminishing resources. While several of the studies reviewed come close to framing a discussion about MD in the conduct of mental health practice, none directly considers the professional role, identity, and moral imperatives of professional clinical
counselors and how those variables might or might not influence the vulnerabilities these professionals bring to the performance of their work.

Professional clinical counselors share some common theoretical and, especially ethical, ground with practitioners from all the helping disciplines reviewed. All of these professionals employ counseling as an essential part of their applied practice to varying degrees. At the same time, the literature reviewed for this discussion indicates that practitioners in any of these helping disciplines are susceptible to MD. In light of this, it seems warranted that a theoretical bridge is needed between the robust and original research literature from nursing regarding MD, to professional counseling. To meaningfully accomplish this, two things are necessary: (1) a definition of professional counseling and, (2) an identification of the salient commonalities and differences between nursing and professional clinical counseling.

The *Minnesota Office of the Revisor of Statutes* (2016) defines the scope of competencies for professional clinical counseling (and, by implication, the moral “mission” those with this licensure undertake) stipulating that licensed professional counseling “means the application of counseling, human development, and mental health research, principles, and procedures to maintain and enhance the mental health, development, personal and interpersonal effectiveness, and adjustment to work and life of individuals and families” (Minnesota Revisor of Statues, 2016, 148B.51 Subd. 4).

And further:

Professional counseling treatment interventions "means the application of cognitive, affective, behavioral, systemic, and community counseling strategies which include principles of human development, wellness, and pathology. Counselors provide mental health services for clients whose symptoms significantly interfere with daily functioning
and would most likely not improve in a reasonable time period without intervention.

(Minnesota Revisor of Statutes, 2016, 148B.51 Subd. 5(b))

In the preamble of the Code of Ethics of the American Counseling Association (ACA) (2014) counseling is defined as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 3). The designation for professional clinical counselors varies by state. For this discussion, the designation “Licensed Professional Clinical Counselor” (LPCC), will be utilized. The ACA identifies among the profession’s core foundational values that of “enhancing human development throughout the lifespan” (p. 3). This developmental orientation lies at the theoretical foundation of the profession itself and the counselor’s professional self-understanding.

For the purposes of this comparison, Registered Nurses (RN) will be the group included as opposed to Licensed Practical Nurses (LPN) or Advanced Practice Nurses (APN). Registered nurses, it will be assumed here, are more likely to work with the sustained, direct patient contact that has been described in much of their literature. The analogy proposed here is that an RN is likely to function with approximately the same level of autonomy and accountability to a physician as an LPCC would with a psychiatrist, at least within a medical setting such as a hospital or a multi-disciplinary primary clinic in a community.

The Minnesota Board of Nursing’s definition of professional and practical nursing was revised (Minnesota Revisor of Statutes, 2013) in order to sharpen the distinction between their respective scopes of practice. In doing so a concise and comprehensive overview of the practice domain of RNs is provided for comparison to that of LPCCs. Those specific areas of practice for RNs will be highlighted here as they find an analog in the scope of practice for LPCCs.
The Minnesota Board of Nursing specifies 17 domains within the scope of practice for RNs, (also referred to as professional nursing). Those most akin to the scope of practice for LPCCs are listed below. Professional nurses perform their unique duties by:

1. providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient’s condition;
2. collaborating with the health care team to develop and coordinate an integrated plan of care;
3. developing nursing interventions to be integrated with the plan of care;
4. implementing nursing care through the execution of independent nursing interventions;
5. implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider;
6. providing safe and effective nursing care;
7. providing a safe and therapeutic environment;
8. advocating for the best interests of individual patients;
9. evaluating responses to interventions and the effectiveness of the plan of care (Minnesota Revisor of Statues, 2013, Subd. 15).

A “line-item” comparison of the professions of nursing and clinical mental health counseling is not possible or meaningful. There are significant differences between them regarding what is, and is not, allowable in practice. For example, LPCCs do not engage in the ongoing, and sometimes daily, physical contact between patients and caregivers that legitimately occurs in some instances with nursing. Conversely, RNs do not, in most hospital or community clinic settings, independently assess and diagnose mental illness. However, it is instructive, once
allowing for these differences, to see where in the daily practice of both professions their shared professional and moral mandates lie. It is through these areas of shared mission and professional vulnerability that the research from nursing about MD may most readily provide the counseling profession with an empirical basis for its own exploration regarding how, and to what degree, individuals in this profession might be affected.

In the performance of their direct services to patients or clients, RNs and LPCCs are similarly mandated and licensed to:

1. develop and implement care plans
2. coordinate care with an integrated treatment plan
3. collaborate with, or operate under, the supervision of physicians or psychiatrists
4. provide a safe (and confidential) care or therapeutic environment for their patients
5. evaluate the effectiveness of the treatment plan
6. collaborate with other health care professionals in the implementation of the care plan
7. advocate for the best interests of their patients or clients
8. work preventatively to promote health and wellness by means of education and intervention

Given these shared areas of practice, what would constitute the common ground for these professionals to experience MD in the performance of their duties and in the fulfillment of their respective moral mandates? These professionals are vulnerable to MD in a number of similar ways, chief among them being:

1. Ongoing direct contact with specific patients over time
2. A mandate to advocate for the interests and well-being of their patients
The same limitations of being trained and licensed professionals who are also mid-level providers in most health care settings.

Confined, in many instances, to using resources for patient care that may be closely monitored, restricted, and curtailed at will by outside entities, often without recourse.

Legally and ethically accountable for the well-being of their patients or clients.

Typically not at liberty, financially or professionally, to leave a job at will over ethical or moral conflicts with management.

Operating from a holistic and preventative model versus a strictly medical one, which assumes that wellness involves the whole person, not just his or her symptoms.

Among the professionals involved with the patient’s care most likely to have periodic or ongoing contact with their family members.

A strong sense of vocation to serve others often at considerable personal and emotional cost.

Upon comparison, several underlying shared role characteristics, activities, professional, and moral mandates emerge that also comprise areas of shared vulnerability to MD for both RNs and LPCCs including:

1. Front-line ongoing contact with patients over time (and potentially their families).
2. A mandate to advocate for patients but without sufficient role power to do so.
3. A possible commitment to a holistic model of health and well-being that does not always harmonize with the prevailing medical model.
4. Carrying a moral, professional, and fiduciary responsibility for the welfare of their patients.
5. Functioning in professions in which numerous stakeholders can limit resources.
(6) identifying on an aspirational level both personally and professionally with their roles. These shared areas of vulnerability can serve as the foundation for a theoretical bridge from the nursing literature to that of professional counseling, affording this discipline the opportunity to frame and pursue new research, develop assessments, and generate protocols to intervene when a professional counselor is suffering from the effects of MD.

Assessing MD as it may affect professional counselors constitutes an exploration of new ground both in terms of practice and theory. As Nuttgens and Chang (2013) observed in their article exploring MD within the supervisory relationship with future counselors, “although there is no extant research that examines moral distress among counseling students, related studies strongly suggest its presence and significance” (p. 285). The same can be said currently for the counseling profession at large, leaving a gap in the knowledge needed to assess and intervene with counselors affected by MD.

While the essential crisis of MD remains the same (i.e., the professional knows what the right thing to do for the client is, but he or she is prevented from doing it), assessing the counselor managing and coping with it calls for a new paradigm. Alfred Adler’s *Individual Psychology* (IP) is suggested for this purpose and the discussion going forward will proceed from a Neo-Adlerian perspective.

**A Neo-Adlerian Perspective on Moral Distress**

For the purposes of assessing MD and how it affects professional counselors, IP is ideally suited as a theoretical frame. However, for the purposes of intervention with MD, it is proposed in this discussion that IP does not go sufficiently beyond the psychological dimension (and to be fair, Adler never claimed that it would) and so as a theory it cannot provide the foundation for a model which views MD primarily as a psycho-spiritual affliction. For this purpose, Viktor
Frankl’s Logotherapy will be utilized. As a result, this discussion will proceed from a Neo-Adlerian perspective, which Len Sperry (2007b) described in his typology of the different orientations he noticed individuals take toward Adlerian theory. Sperry identified four ways of conceptualizing one’s identification and acceptance of IP (1) those who accept and seek to conserve Adler’s theory exactly as he formulated it before his death, (2) those who identify as Adlerians but also see value in “expanding, modifying, and extending the applications of Adlerian principles” (p. 130), and (3) those who identify as Adlerian but acknowledge that the “basic Adlerian orientation must undergo development or evolution to remain theoretically viable and clinically useful” (p. 131). According to Sperry this third orientation, the Neo-Adlerian, “may take the form of forging novel aspects or integrating concepts and techniques from other approaches, which, while consistent with the overall spirit of the basic Adlerian orientation, may modify one of its basic tenets” (p. 132). Moral distress, as it is understood today, was not in Adler’s purview at the time that he developed and refined IP. Consequently, he can be forgiven for not anticipating the kinds of moral crises and ethical dilemmas contemporary health care providers of all sorts confront by the convergence of the medical model and cost-driven policies.

**The Medical Model and Assessing Moral Distress**

It is ironic that the medical model, which appears to have such a prominent hand in the creation of morally distressing situations, is arguably the least effective or appropriate one for assessing and treating it. For Adlerians of most kinds, it would be fair to speculate that their relationship with the medical model is at best an uneasy one. Adler himself did not think primarily in terms of pathology and his anthropology of the human is not based upon it—a remarkable departure given the fact that he himself went to medical school, studied and worked
with Freud’s inner circle, and developed his theory in 19th and early 20th century continental Europe. We are left with two predominant choices as clinicians for assessing MD, the medical model or the holistic model.

**Medical Model of Psychopathology**

It can be legitimately asked if MD could be understood as a mental disorder. If it is viewed, for example, as an environmental pathogen, then can counselors become “infected” with this moral crisis? The answer to this question can have far-reaching effects on how MD is assessed, and in how intervention is conducted. The debate hinges, it will be seen, on whether or not MD rises to the level of a psychopathology, for from this decision everything else, from assessment to intervention, falls.

As Close (2017) has previously observed, psychopathology, as understood from a non-Adlerian medical perspective, would best be described by Adler as a *psychology of possession,* i.e., it is by definition, a view of mental illness that, as Adler says, attempts “to trace every kind of symptom to the obscure regions of an uncertain heredity or to such environmental influences as are generally regarded as unsuitable” (Ansbacher & Ansbacher, 1956, p. 205).

Theorists holding to this view, Adler objects, “are concerned with showing what a person brings with him into the world and retains as his possession” (p. 205). He believed that a psychology based solely upon possession was incomplete and did not adequately account for the natural ways in which individuals use what they have and what they find, to not only compensate for weaknesses and limitations but to creatively overcome them and become something better. Adler offered an alternative view to the psychology of possession, the *psychology of use,* by which he proposed that what matters is not what we have inherited, but what use we make of it (p. 205).
In the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (American Psychiatric Association, 2013; DSM-5) mental disorders are considered to be those conditions which are “characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (p. 20). By this definition, what is central is the assessment of functioning. The significance or utility of the symptoms is not important. Psychopathology is an affliction limiting one’s functioning that is often primarily understood from a medical perspective. Here what matters is what malady one “has”, not the use one makes of what one has. Moral distress can certainly cause symptoms included in the DSM-5, however, the etiology of these symptoms is critically different (Close, 2017).

Theodore Millon (Millon & Strack, 2015) differentiates between normal and pathological functioning with a unique view on its etiology: “pathology results from the same forces as those involved in the development of normal functioning” (Millon & Strack, p. 369). This claim, it could be argued, proposes that everyone is provided with the same essential material and existential resources for the construction of a self. Millon elaborates on the definitions of a healthy versus a pathological personality by saying that a normal, non-pathological person can (1) cope with the environment in a flexible manner, and (2) his or her perceptions and behaviors result over time in “increments in personal satisfaction” (Millon & Strack, p. 369). By contrast, Millon described a pathological personality as marked by an (1) inflexible or defective approach to daily responsibilities, or one that (2) perceives and behaves in ways that result in incremental personal discomfort or limit opportunities to learn or grow (p. 369). Sounding closer to an Adlerian perspective, Millon seemed to posit the presence of a unifying self, one who is capable of choice, and who in the use of that capacity, lives with the consequences (Close, 2017).
The medical model, while standing in fundamental contrast to Adler’s formulation of the psychology of use, should not be dismissed out of hand as too reductionist to be of any utility to clinicians. Rather, the medical diagnostic system carries out its intended purpose effectively while having never claimed as its mandate to map the inner existential and moral landscape of the individual. It cannot be assumed that Adler would dismiss this diagnostic system out of hand, although it is probable that he would have put it to a radically different and less prominent use than practitioners do today. Adler was, it will be remembered, a trained physician (Close, 2017).

While MD, normally caused by exogenous and situational factors, does not readily conform to the medical paradigm as a pathology, the DSM-5 does provide two diagnostic categories that are of use in assessing and treating MD. Under *Other Problems Related to the Social Environment*, V62.4 (Z60.4), Social Exclusion or Rejection, describes what can be adapted as a potential risk for counselors contending with MD. Even if a given episode of MD for a professional is handled well, the outcome may result in him or her feeling as if, (or maybe actually being) “purposely excluded from the activities of peers, workmates, or others in one’s social environment” (American Psychiatric Association, 2013, p. 724). This risk speaks to the holistic need to assess MD. Under *Problems Related to Other Psychosocial, Personal, and Environmental Circumstances*, V62.89 (Z65.8), Religious or Spiritual Problem, a counselor struggling with MD may, if left untreated, find him- or herself questioning spiritual values “that may not necessarily be related to an organized church or religious institution” (American Psychiatric Association, 2013, p. 725). It is argued here that intervention in MD must include the dimension of core values and spirituality because it is at this level that the majority of the harm is being done.
The Holistic Approach of Individual Psychology

In contrast to the medical model of psychopathology, Adler’s foundational concept of holism establishes that human beings cannot be reduced to parts, nor can they be fully understood outside the context of the relationships they form and in which they are embedded (Powers & Griffith, 2007). Any condition assumed to be psychopathological would not be reducible to symptoms in the framework of IP, for as Adler says: “One can never regard simple manifestations of the mental life as separate entities, but…one can gain understanding of them only if one understands all manifestations of a mental life as parts of an indivisible whole” (Adler as cited in Powers & Griffith, p. 55). Viewed holistically, an assessment of a counselor coping with MD employing IP would start with the premise that the effects are registering in all domains of human experience, i.e., physically, psychologically, and on the level of his or her core values and spirituality. The effects of MD compromising his or her social connections would of necessity be the arena in which the observable signs of the internal struggle come into sharpest relief against the ongoing demands of daily life and work. These external areas of functioning, in Adler’s theory, are the life tasks of which he posited three including: (1) work and vocation, (2) relationships and community membership, (3) love and sex (Adler as cited in Ansbacher & Ansbacher, 1956, p. 131). Two additional life tasks were later suggested. The fourth one, proposed by Mosak (1967), described the work of getting along with oneself (intrapersonal) and, along with Dreikurs (1967/2000), the fifth, or the spiritual life task, commonly understood as one’s relationship to the transcendent. The assessment and treatment of MD, it is assumed in this discussion, calls for particular attention to the vocational, intrapersonal, and spiritual life tasks.
The Vocational Life Task

Adler drew a connection between the vocational life task and one’s sense of value and efficacy as a member of society. Through his or her occupation and the contribution it makes, the worker “arrives at a feeling of his worth to society, the only possible means of mitigating the universal human feeling of inferiority” (Adler as cited in Ansbacher & Ansbacher, 1956, p. 132). Our value, our significance, is ultimately found in what we contribute through our vocational activities, but it may also serve as a source of psychological healing, for as Stern added “the feeling of being useful to society by our contribution to its welfare is, according to Adler, also the only way to overcome our feeling of inferiority, or neurotic self-centeredness, our maladjustment” (1958, p. 48). Adler elaborated on the significance of this task of life by observing that “the problem of occupation becomes clear to us as a very deeply experienced concern of the whole personality. Occupational choice as well as practice mirror for us the whole personality of the individual” (Adler, as cited in Stone, 2007, p. 97). Of particular relevance to this discussion is the fact that the occupation one chooses in response to the call of the work task of life reveals not only his or her interests or proclivities but is, in fact, a most comprehensive reflection of his or her personality. Adler’s concept of the self-ideal is of central importance here for it is “an expression of the fictional goal of the personality which is an image of success, and the organizing principle of the style of life” (Powers & Griffith, 2007, p. 92). This self-ideal is also described by Adler as the “guiding ideal of the ego as a fiction, thus denying its reality, but we must nevertheless assert that although unreal it is of the greatest importance for the process of life, and for the psychic development” (Adler, 1921, p. 38).

The self-ideal, as Adler formulated it, reflects a “guiding ideal” or the fictional goal that once achieved might free an individual from feelings of inferiority. Through work one’s ideal
self can theoretically be pursued, if not achieved, and self-efficacy can be gained not only through individual achievement but also through contribution to society. The work task can be far more than a career choice (Adler, 1921).

Understood as vocation, work could become a source of individual and social significance. Perhaps by means of it a portion of the self could be created, a sense of worth derived, psychological adjustment improved, and healing from inferiority feelings fostered. If that is true, then the self-ideal discovered and cultivated through the vocational life task necessarily calls for an intrapersonal relationship.

**The Intrapersonal Life Task**

The fourth life task as proposed by Mosak (1967), described the necessity and importance of gaining the ability to “get along with oneself” (p. 51). Getting along with oneself is far more essential than may initially be supposed by this elegant, yet simple formulation. It may lie instead at the very foundation of IP, making all of its other goals possible. Mosak said of it that “the lack of social interest, of a feeling of belonging, reduces our tolerance level in dealing with the problems around us; its counterpart, a feeling of inferiority and inadequacy, prevents us from accepting ourselves as we are” (p. 51). Self-acceptance, it could be said, is the antidote to the feeling of inferiority. As Mosak continued: “getting along with oneself means nothing more nor less than to stop fighting with oneself” (p. 52). Given the holistic foundation of Adlerian theory, a self-divided against itself cannot overcome feelings of inferiority sufficiently to experience the sense of belonging necessary to develop social interest. That, it can be assumed, renders social interest (and the capacity to contribute to the community it enables) impossible. It could be argued that these virtues and goals speak directly to the aspirational motives that in large measure attract people to the counseling profession, and provide a number of the ingredients
these helpers subsequently use to inform and build their self-ideal. Mosak concludes that “if we fight with ourselves, we must be at the same time the one who wins and the one who loses” (P. 52). A small leap of imagination is all that is required to appreciate the complications this inner dichotomy generates for a counselor deliberating an ethical dilemma, to say nothing of the more global struggle with MD.

J. A. Kauffman (2016), a writer and speaker on Mosak’s fourth life task, commented on the potential effects of MD on the perceived self-ideal of a professional counselor observing that under those circumstances “he or she might question whether or not what he or she knows about him- or herself is really true” (J. A. Kaufman, personal communication, June 16, 2017). The implications of this for a counselor’s sense of self-efficacy and intrapersonal integrity as a helper and healer are significant since, as Kaufman said, “our movement influences how we see ourselves in relation to others” (J.A. Kaufman, personal communication, June 16, 2017). As Stein (2013) put it “we claim our place in the stream of social evolution by making our own contribution to the improvement of life for ourselves and others” (p. 8). The inability to act or to move, while already knowing the right thing to do, is a hallmark of the crisis of MD. The professional in this situation may experience a threat to his or her place in the “stream” as Stein aptly put it, for it is via his or her place in it that his- or herself is defined.

Referring to the cumulative effects of MD (moral residue), Kaufman points out that for counselors, exposed over time to repeated episodes of MD, their “authentic self-expression is stifled because every experience affects our working identity over time” (J. A. Kaufman, personal communication, 6/16/2017). Immobilization on this moral level can constitute a very real assault on the self, for as Kaufman says, “we begin to question and lose sight of who we really are because of the interference of external demands” because, she adds, “one can begin to
create the self out of purposeful and mindful action which, when prevented, leads to inauthentic self-expression resulting in an ‘imposter’ experience” (J. A. Kaufman, personal communication, June 16, 2017).

The fourth life task, while never explicitly identified by Adler, certainly appears congruent with the preponderance of his theory. The cultivation of self-awareness and self-acceptance as embodied in the demands of this fourth task seem critical for anyone preparing to enter the practice of counseling where more than likely clients will themselves be challenged.

The Spiritual Life Task

While Adler never explicitly acknowledged or added a fifth life task, Mosak and Dreikurs (1967) proposed that it is implied in various places in his development of IP. The fifth life task, they suggest, “may go under several names—the spiritual, the existential, the search for meaning, the metaphysical, the metapsychological, and the ontological” (p. 259). Of primary concern for this discussion is the ontological dimension.

In their detailed examination of Mosak and Dreikurs’ article, Gold and Mansanger (2000) pointed out that, curiously, of all the domains of the spiritual life task outlined and defined by Mosak and Dreikurs, the ontological one is not developed further. For the assessment of MD, however, it is the most important one.

The term ontology refers to the “philosophical investigation of existence, or being…asking what ‘being’ means, or what it is for something to exist” (Craig, 1998, para. 1). Aristotle (Wheelwright Trans., 1935/1951) devoted to the concept of being a metaphysical category (Ousia) of its own because it is prior to anything else. Something must have its existence which is irreducible to, or dependent upon, anything before it can become something else; or as he states, ousia is “the ultimate subject of predication, which cannot be predicated of
anything further in turn” (p. 79). This notion can be further and more specifically formulated as *identity-dependence* which stipulates that one thing depends for its identity upon another thing or that “x may be said to depend for its identity upon y ... (Tahko & Lowe, 2016, Identity-dependence, para. 3). A concept and an identity, it is proposed here, may be considered equivalent.

What Aristotle has said here about a concept could be applied to a self-concept, or one’s sense of identity. For a counselor that may translate to mean, “for me to be myself, I must be a counselor”, meaning his or her identity is dependent upon being a counselor. If one is prevented from serving as a counselor one risks, existentially and ontologically, losing his or her essential identity and along with it, his or her fundamental way of being. This foundational sense of identity in service as a counselor may be seen as a form of self-transcendence which is, according to Mosak and Dreikurs, the province of the spiritual task.

Adler was well-versed in philosophy, and it is clear from his own comments concerning the necessity of metaphysics in his theory that “every new idea lies beyond immediate experience” (Adler as cited in Ansbacher & Ansbacher, 1956, p. 142). By declaring this, Adler took the bold step of claiming more than a strictly empirical basis for IP. This declaration has considerable bearing on this discussion, particularly in connection with both the self-ideal of counselors and their spiritual task, since every new self initially lies beyond immediate experience, in the realm of the possible, as an aspiration and a means to belong, to overcome, and to contribute.

If the fifth life task is concerned with one’s relationship with the transcendent, then it stands to reason that a counselor, already defining his or her self-ideal as a healer, has already staked both a psychological and an ontological claim to being something more than just a person
with an occupational interest in helping people with their problems in living. He or she is declaring this to be his or her defining purpose in life. It becomes much more than simply an exercise in self-definition. Psychologically speaking, the foundation of his or her existence itself comes to rest upon it. Over time he or she may come to say, “making my contribution by helping people as a counselor not only describes what I do but has come to define who I am.” By extension, doing this work effectively, ethically, and compassionately now lies at the very foundation of his or her sense of being. This belief meets one of the defining criteria of engagement in the fifth life task, i.e., personal meaning is found in a higher calling to serve the community as an interest which lies beyond the concerns of the individual self. As Stein (2013) says, this aspiration comes naturally to us because, “unlike animals, who adapt to environmental niches, humans attempt to transcend their environmental and personal limitations” (p. 8).

Whether or not one anchors this sense of being in a religious faith is not essential to responding to this spiritual task of life. Instead, the primary mission in this domain is to find and devote oneself to something or someone beyond the self. Interestingly, the fourth life task calls upon us to define and accept the self, while the fifth life task calls upon us to give that self away.

A sense of moral failure can reverberate through the tasks of vocation, self, and spirituality when a counselor is rendered powerless to do the right thing for his or her client. The ontological stakes are high when facing the powerlessness inherent in MD, for as Kaufman (2016) said “how individuals experience their power profoundly impacts how they experience every choice and challenge they face” (p. 11). This experience can become a crisis for these largely devoted and intrinsically motivated professionals. Once those aspirations are confounded in a morally distressing situation, the counselor is vulnerable to feelings of inferiority.
Feelings of Inferiority

As Close (2017) has summarized previously, Adler theorized that psychopathology (neurosis), and all of its associated symptoms, are ultimately attributable to the individual’s effort to avoid an unmediated confrontation with feelings of inferiority and that this drive is rooted in our earliest development: “the neurotic individual comes from a sphere of insecurity and, in his childhood, was under the pressure of his constitutional inferiority” (Adler as cited in Ansbacher & Ansbacher, 1956, p. 119). Adler (1925/1983) stated categorically as one of the “new leading principles for the practice of Individual-Psychology” that “every neurosis can be understood as an attempt to free oneself from a feeling of inferiority in order to gain a feeling of superiority” (p. 23). Further, because of this preoccupation with defending against feelings of inferiority, one is unable to engage in any behavior that does not address it because “neurosis is the natural, logical development of an individual who is comparatively inactive, filled with a personal, egocentric striving for superiority, and is therefore retarded in the development of his social interest…” (Adler as cited in Ansbacher & Ansbacher, 1956, p. 241). If these abnormal feelings of inferiority persist unabated over time, they consolidate in the formation of an Inferiority Complex.

The distinction between feelings of inferiority and the inferiority complex is an important one. From an Adlerian perspective, Griffith and Powers (2007) identified feelings of inferiority as “those universal human feelings of incompleteness” (p. 59). They continue to say that these feelings are normal and that for the well-adapted individual they serve as “spurs to effort and as a source of motivation to overcome obstacles, to grow and to improve oneself and the community” (p. 59). It is offered, for the purposes of this discussion, that the inferiority complex can become a deeper, more foundational schema through which a personally depreciating significance might
be assigned to experiences. The detrimental effects of doing so to one’s sense of efficacy and belonging in a professional community would likely become apparent as the isolation increased. As Powers and Griffith (2007) describe it, the inferiority complex, which is comprised of a sense of one’s personal deficiencies, “may come to be felt as so overwhelming that they undermine the courage to move forward with life…and to make a contribution to the community” (p. 59). In the midst of a morally distressing situation, the counseling professional is compromised by the contradictory dynamics of feeling mandated to care for his or her client while feeling powerless to circumvent the external limitations standing in the way. Once feelings of inferiority have consolidated into an inferiority complex, as may happen as moral residue accumulates, the potential usefulness of these feelings is eliminated because they can no longer inspire striving for improvement or contribution. They instead become, as Adler says, pathological (Close, 2017).

When a counselor is confronted with MD in the course of his or her work, he or she encounters the complexity and attendant powerlessness that these episodes have been shown to provoke. An inner moral crisis ensues pitting the counselor against his or her self-ideal. The counselor’s knowledge that in all likelihood his or her client may suffer, or at the least not receive the level of treatment he or she knows to be necessary, can incite MD. Assessing this counselor would require a preliminary step which is to differentiate the effects of MD from three closely related conditions that are more familiar to these professionals: burnout, compassion fatigue, and moral injury. All three are remarkable more for their similarities to MD than for their differences. This may account for why it has taken so long for MD to be identified as a separate syndrome even in nursing, a profession now over a hundred years old.
Burnout, Compassion Fatigue, and Moral Injury

While an exhaustive analysis of these three syndromes is beyond the scope of this discussion clinicians are advised to appreciate the salient similarities and differences between these three and MD. What makes MD unique compared to these related conditions lies not in its symptomology, but rather in its etiology. What matters for assessment and intervention is not ultimately what MD looks like, for it can readily mimic the other three, but where it comes from.

Counselor Burnout

The literature on counselor burnout (CBO) is replete with studies and discussions concerning its causes and its “cure.” As an occupational hazard for counselors, it has been around for a long time. This longevity has not, it appears, necessarily translated into better awareness, preventative planning, or substantial changes at the individual or organizational level addressing its well-known causes.

In their study of burnout and personal efficacy, Morgan, de Bruin, and de Bruin (2014), stated that burnout “consists of three components: emotional exhaustion, depersonalization/cynicism, and personal efficacy/accomplishment” (p. 216). Speaking in reference to marriage and family therapists, Rosenberg and Pace (2006) described burnout as “most frequently characterized as a syndrome of physical and emotional exhaustion resulting from the development of negative self-concept, negative job attitudes, and a loss of concern or feeling for clients” (p. 87). In his discussion of burnout, Figley (2012) stated that burnout can result when individuals are exposed to trauma, fear or uncertainty, loss of economic security or position, and anger over diminished control or circumstances. Prolonged exposure to a stressful and demanding environment is conducive to burnout. This state of emotional and mental exhaustion creates physiological consequences.
including (1) fatigue, (2) irritability, and (3) physical complaints. Burnout unfolds gradually in response to daily assaults of stress (p. 5).

Therefore, during the process of assessing MD, it must be kept in mind that the symptoms listed above can inhere in both syndromes.

**Compassion Fatigue**

The term *compassion fatigue* (CF) was first used by Johnson (as cited in Merriman, 2015) in her research on nurses where she described it as a form of burnout that afflicts nurses whom, she adds, are lead into nursing by the same personality traits that place them at risk for it. Merriman summarized that “burnout is perhaps the most well noted of the concepts that influence compassion fatigue. In counselors, it has been defined as the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (Merriman, p. 371). It is significant to note here that Johnson has implicated burnout as a contributing factor to CF, illustrating again the porous boundaries between these three syndromes.

In his comprehensive definition of CF, Figley stated that compassion fatigue “refers to the emotional and physical exhaustion that can affect helping professionals and caregivers over time” (p. 4). He delineates the specific symptoms as, “desensitization to patient stories, a decrease in quality care for patients and clients…an increase in clinical errors, higher rates of depression and anxiety disorders among helpers, and rising rates of stress leave and degradation in workplace climate” (p. 4, Course Manual, Figley Institute, Accessed 6/6/17). Those afflicted with CF, he continued, may experience their ability to connect with others such as loved ones and friends impacted leading to stress at home, divorce, and isolation (2012). Merriman cited several other symptoms of CF which can include, “a loss of confidence, ineffective self-soothing behaviors, a lowered ability to function, and the loss of hope” (2015, p. 93).
Moral Injury

Moral injury (MI), often researched and identified in combat veterans, is unlike burnout or compassion fatigue in that it is a more severe syndrome. Jinkerson (2016), described it as “a particular type of trauma characterized by guilt, existential crisis, and loss of trust that may develop following a perceived moral violation” (p. 122). It is, he continued, a type of “psychological trauma characterized by intense guilt, shame, and spiritual crisis, which can develop when one violates his or her moral beliefs, is betrayed, or witnesses trusted individuals committing atrocities” (p. 122). In his summary of research on the symptoms of MI, Jinkerson pointed out that most definitions include guilt and shame, but also a loss of trust in oneself, other people, and deity (2016). In connecting MI with psychological trauma, Shay (2014), said that “moral injury is present when there has been (a) a betrayal of “what’s right”; (b) either by a person in legitimate authority (my definition), or by one’s self— “I did it”; (c) in a high stakes situation” (p. 182). He pointed out that “both forms of moral injury impair the capacity for trust and elevate despair, suicidality, and interpersonal violence” (Shay, 2015, p. 182). What distinguishes MI most sharply from either CBO or CF is its effects in the spiritual and existential dimensions including:

…guilt, shame, difficulty forgiving self and others, changes in or losses of spiritual or religious beliefs, difficulty trusting self or others to act morally, loss of a sense of meaning or purpose, fatalism, religious fears, difficulties in relationships with any relevant community of faith, and negative changes in attributions about or relationship with a Higher Power. (Shay, 2014, p. 257)

The symptomatology of MI stands as unique in its broader and deeper effects in a wider range of human experience. The psycho-spiritual impact of MI will reverberate across the domains of the
vocational, intrapersonal, and spiritual tasks of life just as MD does, but at a less traumatic level of severity.

The literature and research on the unique presentations MD may take as it effects clinical professional counselors is scarce. The profession of nursing, as well as two closely-related mental health disciplines, have by extrapolation, provided the counseling profession with the beginnings of a knowledge base from which to build a conceptual framework for an Adlerian approach to assessing it. Assessing MD, it will be argued, is largely a psychological undertaking as it is primarily concerned with exogenous psychosocial stressors and individual endogenous factors as they interact for a given professional in a particular work culture under certain ethical conditions. All of these, Adler would likely agree, are mediated through our universal human struggle with feelings of inferiority and manifest as problems or crises in the domains included in the selected tasks of life examined in this discussion.

Based upon the research and literature reviewed, a common existential symptom of MD across helping disciplines and individual practitioners emerges: suffering. This suffering, while including many of the symptoms of CBO, CF, and to a lesser degree, MI, is ultimately psycho-spiritual in nature and origin as it forces the counselor into a direct and unmediated confrontation with his or her feelings of inferiority, challenging him or her with the ontological extinction of his or her defining self–ideal as a powerful, effective, and benign healer who never fails a client in need, to say nothing of alleviating avoidable suffering. While the physical, psychological, and social dimensions of this suffering are readily and effectively assessed and conceptualized by IP, intervening and treating MD on the psycho-spiritual level where the healing must occur, is best accomplished with Logotherapy.
COUNSELOR MORAL DISTRESS

Logotherapy

Moral distress is an unavoidable experience for health care professionals. The complexity of the demands inherent in the current health care system, coupled with the increasing demands for the efficient and effective delivery of services, including mental health counseling, places considerable pressure on professionals at all levels. In her review of the state of health care in the United States, and the implications of the implementation of the Affordable Care Act for health care professionals, Morrison (2016), a Logotherapist and health care administration expert, stated this change “coupled with the stress inherent in the work of health care, can become so overwhelming that it obscures professionals’ sense of meaning and purpose” (p. 66). She added that “the current health care environment pushes health care staff to wonder, ‘Why am I doing this? Do I make a difference by staying in my profession?” (p. 66).

In distinguishing his theory and method from traditional psychotherapy (PT), Frankl (1955/1968) said that a “psychotherapy which not only recognizes man’s spirit but actually starts from it may be termed logotherapy. In this connection, logos is intended to signify ‘the spiritual and, beyond that, ‘the meaning’” (p. xi). Logotherapy is, first and foremost, a meaning-centered and spiritual approach. Moral distress, it could be argued, is first and foremost a spiritual crisis of personal and professional meaning. Several key logotherapeutic tenets come to bear on its adaptation for intervening with counselor MD.

Will to Meaning

Frankl departed from both Freud and Adler regarding the nature of the most fundamental drive in humans. He said that the “will to meaning” supersedes both the sex drive and the striving for superiority because.
Man’s search for meaning is the primary motivation in his life and not a “secondary rationalization of instinctual drives. This meaning is unique and specific in that it must and can be fulfilled by him alone; only then does it achieve a significance which will satisfy his own will to meaning.” (Frankl, 1959/2006, p. 99)

Our search for meaning, he said, is “not pathological, but rather the surest sign of being truly human. Even if this search is frustrated, it cannot be considered a sign of disease. It is spiritual distress, not mental disease (Frankl, 2010, p. 3).

**Existential Vacuum**

Frankl (1967/1985) used the term *existential vacuum* to describe the sense of a “frustrating inner void” and a “desperate feeling of emptiness” related to a lack of meaning (p.53). In her rendering of the term, Graber (2003) stated that the existential vacuum is characterized by “doubt, inner emptiness, boredom, lack of initiative, apathy, nameless dread, conformism, fatalistic thinking, ambivalence, and a sense that existence is meaningless” (p. 108). It should not be mistaken for pathology, but rather should be taken as a sign that one’s access to a sense of meaning is blocked (p. 108). For logotherapists, the symptoms associated with the existential vacuum point to the experience of *existential frustration*, a crisis in the dimension of meaning.

**Existential Frustration and Noogenic Neurosis**

Frankl stated that existential frustration occurs when the will to meaning is unfulfilled by the failure to “find a concrete meaning in personal existence” (Frankl, 2010, p. 62). This frustration can result in a *noogenic neurosis* which is distinct from a psychological neurosis in that it occurs in the *noogenic* dimension, or the dimension of “anything pertaining to the spiritual core of man’s personality” (Frankl, 2010, p. 62). Noogenic neuroses do not, Frankl emphasized,
“emerge from conflicts between drives and instincts but rather from conflicts between various values; in other words, from moral conflicts, or, to speak in a more general way, from spiritual problems” (Frankl, 2010, p. 62).

**Responsibility**

While the concept of responsibility in common usage is ordinarily understood to mean individual accountability for actions, in Logotherapy as Frankl developed it, responsibleness is “the very essence of human existence (Frankl, 1959/2006, p. 109). We are responsible to discover and fulfill our unique purpose in the world, which, he emphasized, is found in the world, not in our “own psyche, as though it were a closed system” (Frankl, 1959/2006, p. 110). This sense of responsibility to what life is asking of each person is so essential to mental health that Frankl recommended that therapists in their work with clients actually “increase the burden of one’s responsibility to fulfill the meaning of his existence” (Frankl, 1959/2006, p. 76). The connection between discovering and fulfilling one’s purpose, and the sense of being itself, lies at the foundation of Frankl’s anthropology of the human. We exist, he might argue, when we find meaning and act on our responsibility to fulfill it.

**Ultimate Meaning**

Logotherapy, as a psycho-spiritual approach, affirms that our will to meaning is our primary “drive” in living. Frankl later wrote in his classic, *Man’s search for ultimate meaning* (1948/1975) that the drive theories proposed by Freud and Adler lack the most fundamental component of being human, self-transcendence. Self-transcendence refers to the “intrinsic fact that being human always relates and points to something or someone” (Frankl, 1948/1975, p. 138). According to Frankl, self-transcendence replaces self-actualization in the context of the search for ultimate meaning when one knows that self-actualization only truly occurs to the
extent that one gives oneself up through service to a higher cause or to loving another person (1948/1975). While Frankl was a close associate of Adler’s and deeply involved in the Individual Psychology movement in Vienna, he eventually broke with him over the centrality of the role of self-transcendence reflecting later that

Adlerian psychology—does not pay sufficient tribute to self-transcendence. It mainly considers man a being who is out to overcome a certain inner condition, namely, the feeling of inferiority which he tries to get rid of by developing the striving for superiority (Frankl, 1948/1975, p. 138).

Ultimate meaning, as it is understood in Logotherapy, is the fundamental drive that not only motivates us, but also in a higher sense, calls upon us. Striving for, or because of, anything less leaves us vulnerable to existential frustration and the existential vacuum, all of which produce the symptoms of neurosis as they uniquely occur in the noological dimension. Because of this phenomenon, it can be established that MD can trigger symptoms and suffering in both the psychological dimension (a psychological syndrome) and in the noological dimension (a psycho-spiritual syndrome). Both phenomena afflict counselors and require assessment and intervention. The following questions are proposed as a preliminary framework to inform the development of an assessment interview, and a protocol for intervention, specifically for counselors confronting MD.

Discussion

Moral distress, as the literature across several helping disciplines indicates, is an occupational hazard for counselors. This largely unresearched syndrome is only now becoming a topic of serious investigation within the profession of counseling. The literature available from
other helping disciplines supplied the beginnings of a bridge to launch empirical studies specifically related to MD as it impacts counselors.

**Implications for Practice**

It is time for the counseling profession to identify MD as a serious occupational hazard for both counselors and their clients, and to begin filling the gap in its professional literature. Left undetected and untreated, MD has the potential to cause the same, or very similar, harm to counselors as the research in medical professions has already begun to convincingly demonstrate. The concerns posed by MD have both clinical and ethical implications. Counselor impairment and well-being, as well as potential client harm, cannot be ignored. Further, how these conditions are operative in the lives and practices of counselors must also take a more prominent place as the profession evolves. For these reasons, the profession can no longer afford to ignore MD as an important, and in fact essential, area of focused research.

**Assessment.** As a syndrome, MD can affect counselors across multiple domains of functioning which, for the purposes of this discussion, are best understood by the selected Adlerian life tasks identified earlier. The psychological and biological symptoms of MD, (the proper province of an Adlerian assessment) while first identified in the nursing profession, readily translates to counseling with a few notable exceptions related to scope of practice. The lack of literature on the subject of MD as it relates specifically to professional counseling is notable given that this profession has not in any way been spared the pressures brought about by the marked changes in health care affecting providers nationally. Burnout, compassion fatigue, and in some instances, moral injury, are not an impossibility for counselors. The potential threat MD can pose to his or her sense of vocation, self-ideal as a healer, sense of belonging as a member of the community of healers, and existentially speaking, the experience of being itself,
should not be underestimated in terms of potential counselor impairment, and by extension, client harm.

This initial proposal for an Adlerian framework for assessing MD is based upon the assumption that (1) Adler’s holistic theory provides the most comprehensive and operational profile of counselor MD because, unlike the medical model, the individual is seen as an integrated whole even as multiple dimensions of functioning are assessed, (2) moral distress confronts the counselor with the universal struggle all people have with feelings of inferiority due to the felt powerlessness the counselor experiences when intransigent external barriers prevent him or her from following a deeply-held mandate to ease client suffering, (3) moral distress can be effectively assessed by exploring, in particular, its effects on the counselor’s functioning in the vocational, intrapersonal, and spiritual life tasks, (4) an Adlerian assessment of MD must include exogenous factors such culture, ethical work environment, and organizational dynamics and (5) it must include the counselor’s biological, psychological, and social functioning.

While space does not permit the development of a complete assessment protocol, the framework proposed in this review could be integrated into the following interview schedule:

1. Assess the counselor’s core identity (self-ideal)
2. Get the facts of the distressing situation (vs. perceptions based on mistaken beliefs)
3. Identify situational constraints (exogenous and endogenous factors)
4. Identify the counselor’s core principles at risk (ethical worldview)
5. Identify the counselor’s religious or spiritual worldview (teleology)
6. Affirm the counselor’s moral integrity despite the limitations to act (encouragement)
7. Plan for action, or acceptance if no option (social interest vs. inferiority feelings)
8. Affirmation from peers and supervisors (belonging and community feeling)

Among the kinds of situations typically faced by counselors with the potential to cause MD are being (1) required to adhere to employer or agency policies that come into direct conflict with his or her personal and professional core values, (2) required to adhere to employer or agency policies that come into conflict with his or her professional code of ethics, (3) excluded from having direct input and influence in shaping laws, regulations, and policies that have the potential, in his or her view, to effect quality of care for clients or his or her own well-being and effectiveness as a professional, (4) required as a condition of employment or continued employment, to treat too many clients in a day risking fatigue, impaired judgement, documentation errors or omissions, burnout and compassion fatigue, (5) required as a condition of employment or continued employment, to treat populations or client conditions outside of his or her scope of competence or training, (6) unable to obtain further medically necessary reimbursed services for a client who is unable to afford services, (7) unable to coordinate care with other involved professionals due to differences in theoretical orientation, disagreements about diagnoses, general unavailability, or team dysfunction, (8) required as a condition of employment, or continued employment, to document utilizing an electronic health record system which compels the use of certain clinical terms and prevents the use of others, which in the judgment of the counselor provides an inaccurate or harmful depiction of the client or the underlying values informing the treatment.

An Adlerian framework for assessing MD would include the following questions as they might be explored in connection with the vocational, intrapersonal, and spiritual tasks of life:

The Vocational Life Task

1. What is the primary contribution you believe your work makes to the community?
2. When you are doing your work and making this contribution, how do you feel, and what do you think, about yourself?

3. How is the present situation preventing you from making this contribution?

4. To whom or what do you attribute this barrier?

5. If you woke up tomorrow and all the barriers were gone, freeing you to do exactly what you feel is right for your client, what would that be?

6. What or whom can assist you in restoring your sense of congruence with your vocation?

The Intrapersonal Task

1. Describe what you look like on your best day, i.e., when what you are doing aligns completely with who you understand yourself to be.

2. If the dialog could be heard going on inside you right now between the part of you that wants to do the right thing and the part of you that feels unable to act, what would it sound like?

3. Outside of this morally distressing situation where are you able to feel an inner sense freedom from this current inner conflict? What is making it possible to feel that in those settings and circumstances?

4. What or whom could help you mend the division inside you that this morally distressing situation is causing?

The Spiritual Life Task

1. How does being a counselor define you, and what do you believe you become if you fail at being that counselor?
2. What community do you feel most a part of in your professional life? What are the characteristics of that group that lead you to choose them?

3. What community do you serve and how does that service define you?

4. When we are feeling inferior and powerless, what do you believe gives us the strength to keep going?

5. If you accept that in this morally distressing situation you will not be able to do the right thing, where does that leave you as a healer, and what will that mean in the larger scheme of things?

6. What or whom do you believe could help you manage this morally distressing situation and re-establish your sense of integrity no matter how it turns out?

This list of questions is not intended to be complete. While the fundamental core concepts of Individual Psychology are offered as the theoretical scaffolding for an assessment interview, the content and extent of the questions only provide a starting point. In all instances, an Adlerian assessment of MD will, from a conceptual standpoint, have at its center the struggle with feelings of inferiority, and the manner in which MD aggravates that universal experience.

**Intervention.** As Frankl has stated, Logotherapy picks up where psychotherapy ends—in the dimension of meaning where the symptoms of noogenic neurosis can be isolated, properly interpreted as a part of the human condition, and subsequently treated. The task of an Adlerian assessment of counselor MD is precisely to set the stage for the transition from assessment to treatment. It is clear from the foregoing section that the natural point of connection between psychological assessment and noogenic intervention is found in the fifth life task. It is here where self-transcendence serves as the common denominator between the dimension of psychological functioning and the noogenic dimension. In the noogenic dimension the ultimate
spiritual questions related to meaning, suffering, and self-transcendence are naturally encountered. The following items provide the foundation for logotherapeutic intervention with counselors experiencing the psycho-spiritual complications of MD

Existential Frustration

1. Assist the counselor in identifying what higher power, principle, cause, or person constitutes his or her source of ultimate meaning. This source has the unique quality of comprising his or her unfailing and unconditional foundation for resilience and inspiration as the last “line of defense” against feelings of meaninglessness and inferiority in the face of powerlessness.

2. Ascertain how the counselor has utilized this ultimate source of meaning to inform his or her life purpose independently of any results his or her work obtains at any given time.

3. Structure the counselor to identify his or her strengths and gifts by which he or she meets the challenges of the current morally distressing situation. How does this situation challenge or call into question his or her connection to his or her source of ultimate meaning?

4. Explore the counselor’s understanding of the place and use of undeserved suffering as an inevitable part of living. How does his or her source of ultimate meaning form the basis of a response to this fact?

5. Explore how feelings of failure and guilt are contributing to his or her existential frustration. How is the counselor explaining that morally distressing situations do occur despite his or her best efforts causing unavoidable suffering for his or her clients?
6. Assist the counselor in recalibrating the balance between his or her responsibility in the morally distressing situation, and actual power to change it. How can this hard truth be heard apart from feelings of inferiority?

7. Identify what or whom may be of assistance in reconnecting the counselor to his or her source of ultimate meaning in concrete ways that foster acceptance of the limits of freedom to act in the morally distressing situation.

8. Provide the counselor with reading material or resources from the Logotherapy literature to provide a new vocabulary to interpret their own “symptoms” of MD from a noogenic versus a psychopathological perspective.

9. Identify how this noogenic crisis has isolated the counselor from the community of healers (in whatever form that takes) and identify how they can reconnect with them.

10. If the counselor has or had, a faith community (or its analog in some other form) explore a plan to return to it, or to find a new one that resonates with them now (i.e., turn the unavoidable suffering inherent in the MD into a source of transformation).

The singular gift of Frankl’s Logotherapy is its intellectual and spiritual depth which is balanced by its practical utility. Given its deep roots in existential philosophy (and for some, theology) it is eminently useful in articulating the psycho-spiritual complexity of MD, while never straying from the real-world need to intervene and help the counselor struggling with it. This is partly attributable to the fact that Frankl survived the Nazi death camps where he saw and experienced the most extreme situations of MD imaginable. In that existential vacuum, he underwent the stripping away of any idea or theory that could not withstand, or respond to, the moral depravity and random violence around him.
While it is unlikely that a counselor will need to function in that milieu, it is entirely possible that he or she will counsel trauma victims ranging from refugees who escaped with their lives from other countries, to abuse victims quietly suffering in suburban homes undetected by the wider community. He or she might counsel parents suffering MD as the tasks of childrearing increasingly become harder due to economic hardship, lack of societal support, social isolation, and the competing demands of an increasingly dehumanizing and commercialized culture. The corrosive effects of poverty, racism, and terrorism, all of which appear to be on the rise, render it more likely that counselors will experience MD in treating those affected in outpatient clinics and practices that have traditionally served generally higher functioning, ambulatory clients.

**Recommendations for Future Research**

As it concerns the profession of counseling, there is a significant gap in the literature regarding MD. Future research concerning it should include: (1) Further refining and adapting the definition of the term as it uniquely relates to the theoretical foundation of professional counseling, (2) Further distinguish MD from counselor burnout, compassion fatigue, and moral injury to avoid misdiagnosis given the number of areas of symptom overlap, (3) Expand the understanding of causes, effects, and possible interventions with, MD in light of the variables of multiculturalism among both counselors and clients, (4) Identify ways to include the awareness of MD in counselor education programs and their degree curriculums, (5) develop increased awareness and skill among counselors in identifying how spirituality can be competently and ethically used as a resource in cases involving MD.

**Conclusion**

When Jameton first coined the term “moral distress” in his nursing ethics textbook in 1984, he may not have anticipated the significance of his discovery for practitioners in the other
helping disciplines including mental health counseling. In the absence of research and literature concerning MD as it affects counselors, it is hoped that this review serves as a call to the counseling profession to begin building a body of empirical studies and theoretical discussions concerning this occupational hazard in order to increase awareness of it, develop instruments to assess it, and methods to treat it. It has been proposed here that MD, as it pertains to the profession of counseling, can be holistically assessed using Adler’s Individual Psychology which in turn can organically lead to the use of Frankl’s Logotherapy for intervention.
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Appendix A

Universal Declaration of Ethical Principles for Psychologists
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Universal Declaration of Ethical Principles for Psychologists

Adopted by the Assembly of the International Union of Psychological Science in Berlin on July 22nd, 2008.

Adopted by the Board of Directors of the International Association of Applied Psychology in Berlin on July 26, 2008.

Preamble

Ethics is at the core of every discipline. The Universal Declaration of Ethical Principles for Psychologists speaks to the common moral framework that guides and inspires psychologists worldwide toward the highest ethical ideals in their professional and scientific work.

Psychologists recognize that they carry out their activities within a larger social context. They recognize that the lives and identities of human beings both individually and collectively are connected across generations and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members. They recognize that adherence to ethical principles in the context of their work contributes to a stable society that enhances the quality of life for all human beings.

The objectives of the Universal Declaration are to provide a moral framework and generic set of ethical principles for psychology organizations worldwide:

(a) to evaluate the ethical and moral relevance of their codes of ethics;

(b) to use as a template to guide the development or evolution of their codes of ethics;
(c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and

(d) to speak with a collective voice on matters of ethical concern.

The Universal Declaration describes those ethical principles that are based on shared human values. It reaffirms the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail. The description of each principle is followed by the presentation of a list of values that are related to the principle. These lists of values highlight ethical concepts that are valuable for promoting each ethical principle.

The Universal Declaration articulates principles and related values that are general and aspirational rather than specific and prescriptive. Application of the principles and values to the development of specific standards of conduct will vary across cultures and must occur locally or regionally in order to ensure their relevance to local or regional cultures, customs, beliefs, and laws.

The significance of the Universal Declaration depends on its recognition and promotion by psychology organizations at national, regional and international levels. Every psychology organization is encouraged to keep this Declaration in mind and, through teaching, education, and other measures to promote respect for, and observance of, the Declaration’s principles and related values in the various activities of its members.
Principle I

Respect for the Dignity of Persons and Peoples

Respect for the dignity of persons is the most fundamental and universally found ethical principle across geographical and cultural boundaries and across professional disciplines. It provides the philosophical foundation for many of the other ethical principles put forward by professions. Respect for dignity recognizes the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or other such characteristics. This inherent worth means that all human beings are worthy of equal moral consideration.

All human beings, as well as being individuals, are interdependent social beings that are born into, live in, and are a part of the history and ongoing evolution of their peoples. The different cultures, ethnicities, religions, histories, social structures and other such characteristics of peoples are integral to the identity of their members and give meaning to their lives. The continuity of peoples and cultures over time connects the peoples of today with the peoples of past generations and the need to nurture future generations. As such, respect for the dignity of persons includes moral consideration of and respect for the dignity of peoples.

Respect for the dignity of persons and peoples is expressed in different ways in different communities and cultures. It is important to acknowledge and respect such differences. On the other hand, it also is important that all communities and cultures adhere to moral values that respect and protect their members both as individual persons and as collective peoples.

THEREFORE, psychologists accept as fundamental the Principle of Respect for the Dignity of Persons and Peoples. In so doing, they accept the following related values:
(a) respect for the unique worth and inherent dignity of all human beings;
(b) respect for the diversity among persons and peoples;
(c) respect for the customs and beliefs of cultures, to be limited only when a custom or a belief seriously contravenes the principle of respect for the dignity of persons or peoples or causes serious harm to their well-being;
(d) free and informed consent, as culturally defined and relevant for individuals, families, groups, and communities;
(e) privacy for individuals, families, groups, and communities;
(f) protection of confidentiality of personal information, as culturally defined and relevant for individuals, families, groups, and communities;
(g) fairness and justice in the treatment of persons and peoples.

**Principle II**

**Competent Caring for the Well-Being of Persons and Peoples**

Competent caring for the well-being of persons and peoples involves working for their benefit and, above all, doing no harm. It includes maximizing benefits, minimizing potential harm, and offsetting or correcting harm. Competent caring requires the application of knowledge and skills that are appropriate for the nature of a situation as well as the social and cultural context. It also requires the ability to establish interpersonal relationships that enhance potential benefits and reduce potential harm. Another requirement is adequate self-knowledge of how one's values, experiences, culture, and social context might influence one's actions and interpretations.

**THEREFORE,** psychologists accept as fundamental the Principle of Competent Caring for the Well-Being of Persons and Peoples. In so doing, they accept the following related values:
(a) active concern for the well-being of individuals, families, groups, and communities;
(b) taking care to do no harm to individuals, families, groups, and communities;
(c) maximizing benefits and minimizing potential harm to individuals, families, groups, and communities;
(d) correcting or offsetting harmful effects that have occurred as a result of their activities;
(e) developing and maintaining competence;
(f) self-knowledge regarding how their own values, attitudes, experiences, and social contexts influence their actions, interpretations, choices, and recommendations;
(g) respect for the ability of individuals, families, groups, and communities to make decisions for themselves and to care for themselves and each other.

**Principle III**

**Integrity**

Integrity is vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. Integrity is based on honesty, and on truthful, open and accurate communications. It includes recognizing, monitoring, and managing potential biases, multiple relationships, and other conflicts of interest that could result in harm and exploitation of persons or peoples.

Complete openness and disclosure of information must be balanced with other ethical considerations, including the need to protect the safety or confidentiality of persons and peoples, and the need to respect cultural expectations.

Cultural differences exist regarding appropriate professional boundaries, multiple relationships, and conflicts of interest. However, regardless of such differences, monitoring and
management are needed to ensure that self-interest does not interfere with acting in the best interests of persons and peoples.

THEREFORE, psychologists accept as fundamental the Principle of Integrity. In so doing, they accept the following related values:

(a) honesty, and truthful, open and accurate communications;

(b) avoiding incomplete disclosure of information unless complete disclosure is culturally inappropriate, or violates confidentiality, or carries the potential to do serious harm to individuals, families, groups, or communities;

(c) maximizing impartiality and minimizing biases;

(d) not exploiting persons or peoples for personal, professional, or financial gain;

(e) avoiding conflicts of interest and declaring them when they cannot be avoided or are inappropriate to avoid.

**Principle IV**

**Professional And Scientific Responsibilities To Society**

Psychology functions as a discipline within the context of human society. As a science and a profession, it has responsibilities to society. These responsibilities include contributing to the knowledge about human behavior and to persons’ understanding of themselves and others and using such knowledge to improve the condition of individuals, families, groups, communities, and society. They also include conducting its affairs within society in accordance with the highest ethical standards and encouraging the development of social structures and policies that benefit all persons and peoples.
Differences exist in the way these responsibilities are interpreted by psychologists in different cultures. However, they need to be considered in a way that is culturally appropriate and consistent with the ethical principles and related values of this Declaration.

THEREFORE, psychologists accept as fundamental the Principle of Professional and Scientific Responsibilities to Society. In so doing, they accept the following related values:

(a) the discipline’s responsibility to increase scientific and professional knowledge in ways that allow the promotion of the well-being of society and all its members;

(b) the discipline’s responsibility to use psychological knowledge for beneficial purposes and to protect such knowledge from being misused incompetently, or made useless;

(c) the discipline’s responsibility to conduct its affairs in ways that are ethical and consistent with the promotion of the well-being of society and all its members;

(d) the discipline’s responsibility to promote the highest ethical ideals in the scientific, professional and educational activities of its members;

(e) the discipline’s responsibility to adequately train its members in their ethical responsibilities and required competencies;

(f) the discipline’s responsibility to develop its ethical awareness and sensitivity, and to be as self-correcting as possible.
Appendix B

Universal Declaration of Human Rights
Appendix B

Universal Declaration of Human Rights

Preamble

Whereas 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,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, Therefore,
THE GENERAL ASSEMBLY

Proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.

Everyone has the right to life, liberty, and security of person.

Article 4.
No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

**Article 5.**

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

**Article 6.**

Everyone has the right to recognition everywhere as a person before the law.

**Article 7.**

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

**Article 8.**

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

**Article 9.**

No one shall be subjected to arbitrary arrest, detention or exile.

**Article 10.**

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

**Article 11.**

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12.

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13.

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14.

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15.

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16.

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage,
during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Article 18.

Everyone has the right to freedom of thought, conscience, and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship, and observance.

Article 19.

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.
(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability,
widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

**Article 26.**

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available, and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance, and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

**Article 27.**

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

**Article 28.**

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

**Article 29.**
(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

**Article 30.**

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.