Received 09/18/12
Revised 02/13/13
Accepted 05/22/13
DOI: 10.1002/j.1556-6978.2013.00043.x

Moral Distress Within the Supervisory Relationship: Implications for Practice and Research

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Moral distress is the experience that follows when one feels constrained from acting according to what one believes to be ethically correct. A body of literature from counseling and other health-related professions indicating the significant impact of morally distressing dynamics on individual and relational well-being is presented, followed by implications for practice and future research.

A strong working alliance within the supervisory relationship is crucial to the success of the training experience and client welfare (Bernard & Goodyear, 2013; Falender & Shafranske, 2008; Gnilka, Chang, & Dew, 2012). Many threats exist in the alliance between a supervisor and intern, and these have already been documented (e.g., Bucky, Marques, Daly, Alley, & Karp, 2010; Ramos-Sánchez et al., 2002; Sterner, 2009). Role conflicts; skill deficits; multicultural challenges; sexual attraction; gender-based conflict; and problematic supervisee behaviors, emotions, and attitudes can all threaten the supervisory relationship (Ladany, Friedlander, & Nelson, 2005). In this article, we propose that moral distress is yet another threat that has remained absent within the counselor supervision literature. Furthermore, we argue that additional research is necessary to clarify the extent and severity of moral distress in counselor education.

Moral distress is an ethical concern that is well documented in health care research, foremost within nursing literature. Although various definitions of moral distress have been proposed, all tend to address the same central ethical conundrum: knowing what one believes to be the correct ethical action, yet feeling constrained from pursuing it. Perhaps the most inclusive definition is as follows:

> Generally speaking, when individuals make moral judgments about the right course of action to take in a situation, and they are unable to carry it out, they may experience moral distress. In short, they know what is the right thing to do, but they are unable to do it; or they do what they believe is the wrong thing. (McCarthy & Deady, 2008, p. 254)

Drawing from the existing moral distress literature, it appears that relational power imbalances are a key, and perhaps necessary, component of this

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experience. A prominent example of this imbalance is the power differential between a nurse and a physician. Given a similar power differential between counseling supervisors and supervisees (Bernard & Goodyear, 2013; Gray, Ladany, Ancis, & Walker, 2001; Ladany, Hill, Corbett, & Nutt, 1996; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999), it seems reasonable that moral distress might also exist in counseling. Although there is no extant research that examines moral distress among counseling students, related studies strongly suggest its presence and significance.

Moral Distress

The term *moral distress* was coined by nurse–philosopher Andrew Jameton (1984), who first described the phenomenon and argued its relevance to the moral and ethical dimensions of professional nursing. Jameton suggested that a nurse should be considered complicit when a patient is harmed because of unethical behavior, even if that nurse had not initiated the harm. In the last decade, more than 20 peer-reviewed articles, primarily research based, have been published in nursing and other health care specialties (e.g., intensive care, pediatrics, oncology, physical therapy, palliative care). Scholarship in the area of moral distress is almost nonexistent in the mental health professions, although there are a few studies in psychiatry (i.e., Austin, Kagan, Rankel, & Bergum, 2007; Deady & McCarthy, 2010; Musto & Schreiber, 2012; Ohnishi et al., 2010) and one in psychology (Austin, Kagan, Rankel, & Bergum, 2005).

Although the features of moral distress may differ depending on the particular health care context, it is still possible to draw broad conclusions. Foremost is the near universal finding that moral distress is, as its name indicates, emotionally distressing. Jameton (1984) further distinguished between *initial distress* and *reactive distress*. Initial distress occurs when individuals are first thwarted from taking what they believe to be the most ethical course of action; reactive distress occurs when one's response to his or her initial distress is unsuccessful.

The literature also describes several potential sources of moral distress. According to McCarthy and Deady (2008), an individual may be constrained from taking ethical action because of internal factors (e.g., lack of personal fortitude or character) or external factors (e.g., institutional constraints such as policies and procedures, unnecessary medical testing, aggressive treatment of terminally ill patients, lack of institutional support, incompetent or below-standard care from colleagues, and power imbalances). Pressure to control costs has also been recognized as an external factor that constrains individuals from taking ethical action (Sporrong, Höglund, & Arnetz, 2006). Forde and Aasland (2008) found that 51% of Norwegian doctors experienced moral distress, which was mainly attributed to organizational culture and demands.

Regardless of the source, research indicates that moral distress triggers a host of adverse emotional, psychological, occupational, and relational effects (Austin, Bergum, & Goldberg, 2003). These include anger, frustration, guilt

(Gutierrez, 2005; Wilkinson, 1987); hopelessness, lowered self-esteem (Wilkinson, 1987); compromised moral integrity, self-criticism, self-blame (Kelly, 1998), and employee retention (Corley, Elswick, Gorman, & Clor, 2001; Glisson et al., 2008; Hamric & Blackhall, 2007). The interpersonal toll involves strained relationships leading to emotional and physical withdrawal, experiences of distrust, disconnection, isolation, and interpersonal hostility (Gutierrez, 2005). Professional burnout, characterized by emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment (Maslach & Leiter, 1997), results from prolonged or repeated exposure to moral distress (Corley, 1995; Sundin-Huard & Fahy, 1999). There is some evidence that moral distress can also contribute to compromised patient care (Wilkinson, 1987). Benefits of moral distress, although minimal, have been noted: "The experience of moral distress can make individuals more aware of and reflective about their own moral, spiritual, and philosophical beliefs and it can strengthen their resolve to do better next time" (McCarthy & Deady, 2008, p. 257).

Moral Distress in Counseling and Mental Health Care

Existing research is limited to two hermeneutic phenomenological studies. In the first, Austin et al. (2005) examined the experience of moral distress among psychologists working in multidisciplinary institutional settings. Consistent with other disciplines, institutional constraints, interdisciplinary conflict, and team dissension were identified as significant sources of moral distress. The emotional response to moral distress was described as "desperation and anguish" (Austin, Kagan, et al., 2005, p. 210). Participants sought redress through behavioral strategies that included "keeping silent, acting with stealth, seeking compromise, speaking out, and leaving" (p. 210). A particularly compelling account came from a psychologist who, experiencing an overwhelming need to avoid censure, concluded his research interview by saying, "Clearly my behavior was chosen to try to preserve my function within the institution and not get in trouble" (p. 206).

Whereas Austin, Kagan, et al.'s (2005) research on psychologists identified the institutional milieu as central to the experience of moral distress, their later (Austin et al., 2007) research with psychiatrists highlighted the importance of the occupational role. Specifically, they found that experiences of moral distress were triggered by psychiatrists' responsibility to confine those at imminent risk of causing harm to self or others. The authors noted that a psychiatrist's role could be construed as that of a "double agent," serving the interests of both individual patients and society, while feeling constrained from acting according to personal conscience.

Moral Distress in Education and Training

A few studies address supervision in medical and nursing education and tend to focus on specific patient care events that trigger moral distress. Collectively, these studies suggest that health professional trainees are reticent to discuss ethical concerns with their supervisors for fear of an unreceptive or harsh response, and these trainees may become disillusioned when they

fall short of the high ethical standards to which they aspire. Chiu, Hilliard, Azzie, and Fecteau (2008) identified ethical dilemmas faced by surgery residents. Survey data revealed that medical treatment of critically ill patients and disagreements with supervisors about treatment planning were the most distressing aspects of their training. Furthermore, 63% reported objecting to a patient's treatment plan but chose not to discuss this with the attending physician. Although 27% of participants reported witnessing abuses of power and 29% reported unsafe medical practices, participants were more inclined to discuss ethical concerns with friends and family than with hospital staff, even though 91% indicated they were aware of hospital policy requiring them to do so. Thirty-one percent explicitly indicated a decision not to discuss a morally troubling event to a senior staff for fear of reprisal.

Wiggleton et al. (2010) constructed a 55-item moral distress survey to identify the types of situations that foster moral distress among medical students. Mean frequencies were calculated for responses to 5-point scale items that described types of distressing situations, degree of distress, and reasons for not taking action. Wiggleton et al. found that among fourth-year medical students ($N = 106$), all had experienced at least one of the moral distress situations presented in the survey. Examples of distressing situations included patient care, disrespectful behavior, poor communication, suboptimal care, and use of futile procedures. The most frequently endorsed reasons for not taking action were the students' subordinate role on the team ($M = 2.16$, $SD = 1.04$) and insufficient knowledge and understanding of the ethical situation ($M = 2.09$, $SD = 1.08$).

Sporrong et al. (2006) developed an instrument to measure moral distress, which they piloted with 259 health care workers. The instrument consisted of two factors: Level of Moral Distress and Tolerance/Openness (for ethical questioning in the workplace). Although mean scores for distress indicate that the sample was moderately distressed, significantly younger employees were more distressed than were their older peers and viewed their workplaces as less tolerant or open to moral and ethical questioning.

Kelly (1998) conducted a grounded theory study on the experiences of 23 recently graduated nurses and found that preserving moral integrity was a principal theme that connected six psychosocial processes (vulnerability, getting through the day, coping with moral distress, alienation from self, coping with lost ideals, and integration of a new professional self-concept). Moral distress was related to their perceptions of professional responsibility and an idealized professional self-concept on which new nurses based their standards for ethical behavior. When new nurses realized that it would be difficult to live up to their aspirations, they became intensely distressed. Kelly also found that 31% of respondents feared that reporting the unethical behavior of a colleague would result in personal reprisal, especially when a senior colleague was involved.

Moral Distress in Supervision

Moral distress has not been researched specifically in the context of counselor supervision, we describe here likely applicable contributors to moral distress:

supervisee vulnerability, substandard supervision, supervisee nondisclosure, and counterproductive events in supervision. Several other findings from supervision research are also relevant to this discussion, including organizational pressures and conflict in supervision.

Supervisees' Vulnerability

Stage models of counselor development suggest that counselors progress through a series of developmental stages, which require qualitatively different approaches to supervision. The most prominent stage model of counselor development, Stoltenberg and McNeill's (2009) Integrated Developmental Model, distinguishes four stages, or "levels," of counselor development, two of which are relevant to this discussion. Beginning trainees are typically anxious and focus on themselves (Level 1). Anxiety is a function of their lack of confidence and apprehension about evaluation. At Level 2, counselor trainees can implement basic skills and demonstrate increased empathy to clients, enhancing their sense of motivation and autonomy, which may invite them to resist supervisors. Thus, counselor trainees at both Level 1 and Level 2 are vulnerable to moral distress, but for different reasons.

Literature on counselor cognitive complexity (Duys & Hedstrom, 2000; Granello, 2002; Liddle, Packman, Smaby, & Maddux, 2005; Lyons & Hazler, 2002; Welfare & Borders, 2007) indicates that novice counselors display less cognitive complexity than do their more seasoned colleagues. We hypothesized that there is a curvilinear relationship between cognitive complexity and moral distress. Students with low levels of cognitive complexity (and likely, higher anxiety; Stoltenberg & McNeill, 2009) may be less prone to question supervisory directives and more likely to find solace in their supervisors' pronouncements. Students with intermediate cognitive complexity may be more likely to question their supervisors' reasoning and to be distressed. Those operating at a higher level of complexity, which likely facilitates increased empathy and better ability to deal with ambiguity, may be able to formulate a morally satisfying and ethically appropriate response. Moreover, counselor education students' motivation to enter the field is complex.

The Idealism of Novices

In a hermeneutic study of eight master's-level counselor education students, Chang (2013) found that they retrospectively identified several factors that drove their career choice. These factors included feeling emotionally attuned to others because of life experiences, their roles as informal helpers, their experiences of marginalization, their desire for professional upgrading, and their longing to make a significant contribution to society. Prominent clinical psychologists reported similar motivations (Norcross & Farber, 2005). Although they are highly motivated, new graduate counselor education students often feel excited but "over their heads" with self-doubt. Their desire to do well and please their supervisors, who in some respect hold the keys to their professional success, may invite some to comply with supervisors beyond their comfort level. This is particularly relevant consider-

ing Sporrong et al.'s (2006) finding that younger practitioners experienced more moral distress and found their workplaces less tolerant and open to ethical questioning.

Organizational Pressures

Scarce resources pressure both supervisors and supervisees to cut ethical corners. Scheid (2010) noted that counseling organizations are pressured to do more with less as a result of government funding cuts and the increased demands of managed care, which require cost control, performance assessment, and verifiable outcomes, and invite organizations to exert control over counselors' time and resources. Scheid noted that the inception of managed care stimulated disagreements between frontline counselors and management about organizational priorities, increasing the likelihood of burnout. Acker, studying a sample of 591 clinical social workers, found that participants experienced conflict with managed care providers, had low job satisfaction (Acker, 2010a), thought of themselves as less competent (Acker, 2010b), and experienced burnout (Acker, 2010c). Woody (2010) suggested that offering services under managed care increases ethical risk by relinquishing control of treatment to "bean counters" and placing client information in the hands of unqualified persons. When the ethical and professional pressures of managed care reach supervisors and students, the possibility of moral distress increases.

Substandard Supervision

Substandard supervision likely creates a context for moral distress. Rigid supervisor behavior in which the supervisor does not tolerate differences with the supervisee, insists on compliance, and even punishes divergent behavior (Falender & Shafranske, 2008; Magnuson, Wilcoxon, & Norem, 2000) can increase the potential for moral distress. Similarly, supervision that focuses on supervisees' deficiencies, demeans supervisees (Allen, Szollos, & Williams, 1986), and is insensitive (Hutt, Scott, & King, 1983) or defensive (Watkins, 1997) can create undue pressure that renders supervisees more vulnerable to moral distress by setting a context in which they do not feel safe to share their doubts or express differences.

Interpersonal problems often exist in supervisory relationships. In a survey of 158 clinical psychology graduate students, Moskowitz and Rupert (1983) found that nearly 40% experienced a major conflict with their supervisor. Sources of conflict included personality issues, supervision style, and disagreements about therapeutic techniques and approach. Seventy-seven percent of the students discussed it with their supervisors, but more than one third found it unhelpful. The 23% who did not discuss the conflict with their supervisors reported actively concealing difficulties rather than trying to resolve the situation. Supervisees who feel unable to discuss differences with supervisors are more likely to experience moral distress.

Nelson and Friedlander (2001) examined harmful conflicts or relational impasses in supervision among 13 master's- and doctoral-level trainees

in clinical and counseling psychology. Participants described supervisors responding with intense anger to conflict, adding to supervisee distress and the view that the conflict was unresolvable. Supervisees also often felt scapegoated and shamed by their supervisors. In some instances, supervisees described unpredictable mood swings and inappropriate disclosures by their supervisors. A frequent occurrence, highlighting the power imbalance in supervision, was the withholding of supervisees' evaluations. Although supervisees tried to discuss the conflict with their supervisors, such efforts were often met with resistance. According to Nelson and Friedlander, the overall effect on supervisees included loss of trust and safety, powerlessness, guardedness, health concerns, fear, and self-doubt. The lack of a resolution led many participants to feel cynical about supervision, with some participants considering changing professions, and one actually doing so. Such supervisory relationships are contrary to the relational climate necessary for supervisees to discuss troubling ethical situations.

Supervisee Nondisclosure

The likelihood that moral distress exists within counseling supervisory relationships is evidenced by the finding that many supervisees withhold important personal and practice information from their supervisors. Ladany et al. (1996) found high levels of nondisclosure among 108 counselor trainees, with 92% indicating that they had withheld important information from their supervisor, with an average of 8.06 nondisclosures. The content of the nondisclosures was varied and included both negative and positive reactions to the supervisor, personal issues unrelated to the supervision, clinical mistakes, positive and negative reactions to clients, countertransference, attraction between the supervisor and supervisee, concern regarding the supervision setting, and supervisor appearance. Negative reactions to one's supervisor were the most commonly cited form of nondisclosure, reflecting the power deferential between the supervisor and the supervisee or the supervisee's perception that the supervisor was incompetent. In general, supervisees assumed a self-protective posture, fearing that speaking up could lead to retaliation from their supervisor and otherwise jeopardize the successful completion of their training.

In a similar study with 204 counselor trainees, Mehr, Ladany, and Caskie (2010) examined the nature of nondisclosure in supervision and the relationship between nondisclosure, trainee anxiety, and perceptions of the supervisory working alliance. There was ample evidence of trainee nondisclosure, with 84.3% of trainees withholding information from their supervisors in a single supervision session recounted by trainees. Additionally, Mehr et al. found that a stronger working alliance was associated with a greater incidence of trainee disclosure; higher levels of trainee anxiety were related to increased nondisclosure.

Counterproductive Events in Supervision

Finally, research on counterproductive events in supervision strongly suggests moral distress in counseling supervision. Gray et al. (2001) interviewed

13 psychotherapy trainees and found that each had experienced one or more counterproductive events, most of which involved a dismissive or nonempathetic response from their supervisor. Some counterproductive events involved ethical issues, for example, when a participant described feeling dismissed by her supervisor when trying to raise a potential dual relationship. Another participant described a supervisor's inappropriate disclosure. Participants' responses to these events included feelings of anger, shock, confusion, frustration, anxiety, discomfort, invalidation, and a lack of safety, similar to the effects of moral distress (see Austin et al., 2003). It is not surprising that counterproductive events weakened the supervisory relationship and led to what one respondent described as "subservient" behavior (Gray et al., 2001, p. 377). Additional qualitative themes included deference toward supervisors, hypervigilance, nondisclosure of thoughts and feelings, and withdrawal. In a few instances, the trainee sought to proactively improve the supervisory relationship. However, the overall pattern was one of tension and suppression, similar to the emotional and behavioral climate of moral distress. Rarely did trainees disclose the counterproductive event to supervisors; hence, such events typically remained unresolved. Notably, participants in Gray et al.'s study also tended to view counterproductive events and their effects as detrimental to their work with clients.

Further evidence of the concordance between supervision research and the moral distress literature comes from the only study that directly examined the ways in which the ethical behavior of supervisors affected the supervisory relationship and supervisee satisfaction (Ladany et al., 1999). Ladany et al.'s (1999) survey data for 151 counselor trainees revealed that 51% reported ethical breaches by their supervisors, with 33% of these pertaining to unethical evaluation practices. Although many participants in this study noted the unethical behavior of their supervisors, only one third broached the behavior with their supervisor, choosing instead to discuss matters with a friend or peer. Furthermore, Ladany and colleagues found that unethical supervisor behavior was negatively correlated with supervisee satisfaction. This research indicated that the likelihood of unethical behavior among counselor supervisors, combined with the noted tendency for supervisees not to openly discuss their supervisors' questionable behaviors, fulfilled the two requisite conditions that lead to moral distress: unethical behavior and constrained action.

Recommendations for Counselor Supervision

Previous research indicated that moral distress likely occurs within counseling supervisory relationships, resulting from supervisee vulnerability, substandard supervision, supervisee nondisclosure, counterproductive events, and organizational pressures. We include several recommendations to minimize these conditions in supervision.

First, there can be great value in simply naming one's experience. Adding moral distress to the counseling vernacular will help achieve this goal. Second, as the understanding of moral distress in counselor supervision

increases, educators and supervisors can discuss and reflect upon it in ethics courses and practicum or internship seminars. Given that moral distress, by definition, constrains ethical action, examining moral distress can be a valuable addition to course content on ethical decision making. Also, moral distress can be discussed in the context of counselor self-care (Abel, Abel, & Smith, 2012). In clinical training, it can be of great benefit to introduce students to the concept of moral distress at the outset of their training. This can help create an environment in which students can proactively discuss the nature, impact, and potential solutions for moral distress. Third, moral distress can be incorporated into the various counselor supervision models. For example, in Stoltenberg and McNeill's (2009) Integrative Developmental Model, moral distress is most likely to arise in Level 1 of counselor development, where motivation and anxiety are high, and in Level 2 of counselor development, where confidence and motivation fluctuate. With Bernard's (1997) discrimination model, supervisors can use the teacher role to instruct and model sound ethical reasoning; the counselor role to reflect on their thoughts, emotions, or actions in ethically challenging situations; and the consultant role when acting as a resource for students. In Holloway's (1995) systems approach to supervision, moral distress is most likely to be considered in the professional role and emotional awareness domains of supervision. In the common factors approach (Morgan & Sprenkle, 2007), maintaining the supervisory alliance can reduce the likelihood that moral distress will occur. Chang's (2013) contextual-functional metaframework contains the specific role of ethics/risk management consultation, which encourages supervisors to purposefully discuss ethical decisions and their implications.

A Call for Research

Austin and colleagues (Austin, Kagan, et al., 2005; Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Austin et al., 2007) unquestionably identified moral distress as a pertinent area of investigation in counseling; parallels can be drawn between the emotional and behavioral responses noted among participants in this research and those identified in both the counterproductive events research (Gray et al., 2001) and conflict in supervision research (Moskowitz & Rupert, 1983; Nelson & Friedlander, 2001). Evidence of supervisee nondisclosure further points toward the type of self-censorship characteristic of moral distress, although this area of research did not investigate the emotional response to withholding information from one's supervisor.

A theme that connects both the moral distress literature and supervision literature reviewed is the role of relational power. An inherent and arguably inescapable feature of the supervisory relationship is the power differential between supervisor and supervisee (Bernard & Goodyear, 2013). Indeed, the preconditions for moral distress in nursing and medicine (an inherent power differential between supervisee and supervisor, constrained options for action, and ethically charged issues with vulnerable clients) have been well described in counselor supervision research. Circumstantial evidence for

moral distress in counselor supervision is strengthened by research indicating that rather than feeling safe in supervision, many supervisees reported a range of negative experiences that lead to silence, suppression, and the censorship of important information.

Future counseling supervision research on moral distress should use a variety of methodologies. In keeping with the strengths of qualitative research, existing studies have made valuable contributions by providing richly described holistic accounts of the moral distress experience. There is considerable need, however, for qualitative research to be augmented by quantitative and mixed-method designs, the results of which can then be generalized to larger populations. The development of a moral distress scale by Corley et al. (2001) has led to a handful of quantitative studies; however, the utility of this instrument to counseling research is limited by its nursing focus. A broader concern that has hampered moral distress research is a lack of conceptual clarity because of varied definitions of the phenomenon (McCarthy & Deady, 2008), leading some theorists to question whether moral distress is equivalent to psychological distress (Hanna, 2004). Research on moral distress in counselor supervision will ideally proceed with balanced use of qualitative, quantitative, and mixed-method research designs.

We argue that a program of research should be initiated to help answer questions such as the following:

- What is the extent of moral distress among counseling supervisees?
- What is the nature of moral distress among counseling supervisees?
- How does moral distress among counseling supervisees vary according to context?
- How do counseling supervisees respond to moral distress?
- What are the short- and long-term effects of moral distress among counseling supervisees?
- How does culture influence the experience of moral distress among counseling interns?
- What is the relationship between moral distress and developmental factors such as cognitive complexity?
- What is the relationship between moral distress and supervisor factors (e.g., experience, training, skill, interest)?

Moral distress research in counselor education will initially benefit from survey methods to establish its prevalence and obtain descriptive data on the characteristics of moral distress within counselor supervisory relationships. For example, surveying the incidence of moral distress among master's-level trainees at university and college counseling centers would provide important data regarding the frequency, intensity, and effects of this phenomenon. Such research should include a variety of variables, including age, gender, culture, years of counseling experience, strength of supervisory alliance, supervisor and supervisee characteristics, and counseling setting. Qualitative

methods can richly describe the experience of moral distress across various supervisory contexts. Research traditions can frame studies that explore trainees' lived experiences of moral distress (phenomenology), the linkage of the phenomenon to larger cultural stories and social constructions in mental health and educational cultures (critical discourse analysis), or the process of how trainees respond to moral distress (grounded theory). A mixed-method study could examine the effects of moral distress on counseling interns using correlational data, which could then be enhanced by in-depth qualitative accounts of the experience. As the amount of descriptive and qualitative research increases, the resultant findings can then be used to guide the creation of moral distress instruments for use in counselor education research.

Summary

In this article, we defined moral distress and described its precursors and effects. We reviewed the limited research on moral distress in the training of mental health practitioners and in clinical supervision. We then described several factors identified in the counselor supervision literature that we theorize are closely related to moral distress, and made recommendations for supervision practice. Finally, we propose an agenda for research in moral distress in counselor education that will assist the field to understand and respond to this important issue.

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