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Development and Validation of an Instrument to Measure Moral Distress Among Counselors Working with Children and Adolescents

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DEVELOPMENT AND VALIDATION OF AN INSTRUMENT TO MEASURE MORAL DISTRESS AMONG COUNSELORS WORKING WITH CHILDREN AND ADOLESCENTS

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By

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ABSTRACT

Falender and Shafranske (2004) stated it is "essential for clinicians to develop and understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). The purpose of this study was to meet this professional imperative by developing an instrument designed to assess moral distress among counselors working with children and/or adolescents. Using open-ended surveys and semi-structured interviews, detailed descriptions of participants' experiences of moral distress were obtained in order to gain an initial understanding of the ways in which the phenomenon is experienced in the context of counseling. Based on these participants' experiences, a thematic structure was identified, from which an initial item pool was generated. A 106-item instrument was constructed, which was pilot tested with two samples, one consisting of counselors and counselor educators used to assess item and sub-theme representativeness and acceptability, and the other of laypersons used to assess non-validity issues. Inter-rater agreeability and qualitative feedback was analyzed to arrive at a parsimonious instrument that demonstrated acceptable content and face validity. As a result, a modified instrument consisting of 63 items was finalized, which assesses moral distress across eight domains, and demonstrates promising validity overall.

Keywords: moral distress, instrument development, child and adolescent counselors

DEDICATION

To Caroline, for her adoration, inspiration, and support.

"If I have seen further, it is by standing on ye shoulders of giants" (Newton, 1965).

This dissertation is built on the work of Andrew Jameton, Judith Wilkinson, Elizabeth Epstein, and Ann Hamric, among others.

Henri Poincaré said, "thought is only a flash between two long nights, but this flash is everything" (as cited in Newman, 1956).

This dissertation is the result of many flashes between countless long nights. They are everything.

ACRONYMS

American Association of Critical-Care Nurses..... AACN

American Counseling Association..... ACA

American Nurses Association..... ANA

American School Counselor Association ..... ASCA

Americans with Disabilities Act ..... ADA

Analysis of Variance..... ANOVA

Cardiopulmonary Resuscitation..... CPR

Council for Accreditation of Counseling and Related Educational Programs ..... CACREP

End-of-Life ..... EOL

End-of-Life Care..... EOLC

Ethical Environment Questionnaire..... EEQ

Exploratory Factor Analysis ..... EFA

Frequency x Intensity..... FXI

Hospital Ethical Climate Survey..... HECS

Human Immunodeficiency Virus..... HIV

Index of Content Validity CVI

Intensive Care Unit ..... ICU

Interpretative Phenomenological Analysis ..... IPA

Managed Care Organizations..... MCO

Medical Doctor (Physician) ..... MD

Moral Distress Questionnaire ..... MDQ

Moral Distress Scale ..... MDS

Moral Distress Scale for Counselors – Child and Adolescent Form ..... MDSC-CA

Moral Distress Scale – Revised ..... MDS-R

Moral Distress Thermometer ..... MDT

Neonatal Intensive Care Unit ..... NICU

Portable Document Format ..... PDF

Quality Work Competence ..... QWC

Rational Emotive Behavior Therapy ..... REBT

Registered Nurse ..... RN

Standard Deviation ..... SD

Stress of Conscience Questionnaire ..... SCQ

Statistical Package for the Social Sciences ..... SPSS

Trainees with Problems of Professional Competence ..... TPPC

Verbal Numeric Rating Scales ..... VNRS

Visual Analogue Scales ..... VAS

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CHAPTER ONE

INTRODUCTION

Psychotherapy and counseling exist within a changing context, which has the ability to shape and obscure the ways in which they function, the services that can be provided, and the goals that can be reached (Kent & Hersen, 2000; Tjeltveit, 1999). Since the 1980s, the context of mental health care has changed drastically. Originally, the changing health care climate in the United States was intended to provide cost-effective, time-limited therapies to large populations of clients that previously may not have had access to such services (Kent & Hersen, 2000). As new mental health care delivery models developed, however, some counselors have lost their autonomy and have had to learn new ways to practice and adopt new roles to provide services. Lee, Cho, Kissinger, and Ogle (2010) pointed out that within the current context of counseling, counselors are increasingly expected to provide ethical services despite increased professional demands, including managed care constraints, budget cuts, and burgeoning caseloads. Although these systemic changes, in and of themselves, have caused challenges for counselors, they are exacerbated by training and clinical orientations that run contradictory to the managed health care model. That is, counselors increasingly find it difficult to meet ethical aspirations and provide professional care that respects the rights of their clients and helps promote well-being and autonomy (Blanck & DeLeon, 1996).

Aside from systemic changes, which stem from a shift in health care delivery and a desire for increased efficacy, counselors who work with children and adolescents are particularly prone to other contextual challenges. As a result, such counselors often find it difficult to adhere to

ethical or legal standards of care while still doing what is best for the client. As Hall and Lin (1995) pointed out, because children, or those younger than 18 years old, are typically viewed as

incompetent in their decision-making skills regarding their treatment, adults often assume responsibility and protection of children by making treatment choices on their behalf. Although intended to protect children and adolescents from undue harm, parental assent and their right to access of their children's health care procedures and progress may create a conflict in which counselors have to determine whether what the parent wants or what the child or adolescent wants is in the client's best interest (Hall & Lin, 1995). Similarly, Lawrence and Kurpius (2000) suggested that unique ethical issues, such as counselor competence, the child's rights to confidentiality and informed consent, and responsibilities related to child abuse, consistently emerge when counseling minor clients outside of a school setting. School counselors, however, face unique ethical challenges, too, which can create difficulties and dilemmas in providing adequate and appropriate care while still adhering to ethical, legal, and institutional standards (Bodenhorn, 2006; Kolay Akfert, 2012). These issues and challenges are ever increasing, which is reflected by the addition of nearly 40 new standards (Huey, 2011) to the 2010 American School Counseling Association's (ASCA) *Ethical Standards for School Counselors*, along with revisions to the American Counseling Association's (ACA) *2014 ACA Code of Ethics*. It is apparent that contemporary counseling not only attempts to protect the rights and integrity of clients, but also creates significant challenges to those who provide mental health services.

The beneficial and detrimental outcomes of the changing context of mental care have been well established (Austad, 1996; Austad & Berman 1991; Fox, 1995; Karon, 1995; Shore, 1998), along with the unique challenges that accompany working with children and adolescents

(Bodenhorn, 2006; Dailor & Jacob, 2011; Garland, McCabe, & Yeh, 2008; Hall & Lin, 1995; Koocher, 2008); however, much less is known about the potential consequences they can have on professional counselors. One early study, which examined factors that caused psychological distress among counselors and psychotherapists, revealed that workplace stressors, such as supervisors, policies, and organizational plights, were the second most common occupational hazards, with only relationship problems being more prevalent (Norcross & Prochaska, 1986).

One form of distress, which may result from the factors counselors routinely face, is that of moral distress. Moral distress, or the "experience that follows when one feels constrained from acting according to what one believes to be ethically correct" (Nuttgens & Chang, 2013, p. 284) is a relatively new concept that has grown prolifically in health care research. To date, however, the concept of moral distress is essentially nonexistent within the mental health care literature. The absence of research examining moral distress within the counseling profession is surprising, considering ethical dilemmas, moral values, and moral action are viewed as inherent dynamics of the counseling process and profession (Margolis, 1966; Tjeltveit, 1999*)*. More recently, Goldberg (2007) asserted there is "probably nothing so accepted, assumed, and defended as the many moral tenets that presently rein in psychoanalysis and other mental health endeavors" (p. 31). He further contends that the ambiguity between these moral tenets and ethical absolutes most assuredly cause mental health practitioners worry, discomfort, consternation, and doubt. Such a statement implores an exploration of the conditions that might lead to morally difficult situations, such as moral distress, the domains from which moral distress might arise, and the level and frequency of moral distress among counselors. Because of the unique challenges accompanying clinical work with children and adolescents (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000), the current study limits the initial exploration of

moral distress to counselors who have experience working with children and/or adolescents. By delimiting the current study in such a way, it is thought the experiences of such counselors will yield more robust data from which an instrument can be developed.

Exploring moral distress within the context of counseling is particularly relevant considering many of the contributing factors and constraints that lead to moral distress are present among counselors and within clinical settings. The health care literature identifies factors classified as both internal (e.g., diminished mental fortitude or character) and external (e.g., institutional constraints, lack of support, and power imbalances) (Nuttgens & Chang, 2013) as contributing to moral distress. Both classifications of factors also are cited as common difficulties among counselors (Stoltenberg & McNeill, 2010) and within interpersonal counseling dynamics (Greene, 2002; Scott, Nolan, & Wilburn, 2006; Stoltenberg & McNeill; Willis & Carmichael, 2011). Numerous ramifications of internal and external factors influencing counselors and the process of counseling have been identified, yet the distress that occurs when one faces barriers to moral action has been overlooked.

The absence of moral distress in the counseling literature is surprising given its potential to cause severe negative outcomes (Epstein & Hamric, 2009). The consequences of moral distress can occur at the personal, interpersonal, and organizational levels (Burston & Tuckett, 2013), which are particularly relevant to the counseling profession. For example, moral distress often creates emotional exhaustion (Pendry, 2007), powerlessness in clinical relationships (Ferrell, 2006), workplace strains (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004), and negative impacts on the organizational culture (Nelson, 2009). In her transactional approach to burnout, Cherniss (1980) identified the same three factors (personal, interpersonal,

and organizational stressors) as potential sources of stress that lead to burnout among professional counselors.

Burnout, or the state of physical and emotional depletion that results from negative or stressful conditions of work (Freudenberger, 1974) has gained enormous attention in the counseling literature over the last several decades. It has been found that burnout can be experienced by professionals in nearly any occupational setting; however, those in occupations focused on providing services to others run a particular risk of developing burnout symptoms (Ross, Altmaier, & Russell, 1989). In fact, Maslach (1982) identified this susceptibility as resulting in a burnout syndrome among professionals who continually work with and provide services to other people. A considerable body of research has been devoted to exploring the factors that lead to professional burnout, as well as the consequences thereof; yet it is clear pertinent and robust factors, such as moral distress, may still be unacknowledged.

There is evidence moral distress is a precursor to burnout among health care professionals in other fields (de Lima Dalmolin, Lunardi, Lunardi, Barlem, & Silveira, 2014; Shoorideh, Ashktorab, Yaghmaei, & Majd, 2014; Sundin-Huard & Fahy, 1999), which further provides justification for the exploration of moral distress within the context of counseling. Counselors working with children and adolescents are particularly at risk of developing symptoms of burnout, as they often manage high caseloads and ambiguous professional roles, while receiving very little supervision (Moyer, 2011). Interestingly, each of these professional situations has been found to have an impact on the experience of moral distress. Burston and Tuckett (2013) and Mueller, Ottenberg, Hayes, and Koenig (2011), for example, found that role ambiguity is positively associated with levels of moral distress. Similarly, Musto and Schreiber (2012) and Wilkinson (1989) found that those who engage in regular supervision have less

reports and lower levels of moral distress than those who do not receive consistent supervision. Large caseloads and limited time to provide services have also been found to contribute to nurses' level of moral distress.

Another concept moral distress may be related to is compassion fatigue, which is influenced by some of the same factors that contribute to moral distress. For example, health care professionals who are overworked (Sprang, Clark, & Whitt-Woosley, 2007), are exposed to traumatic situations (Siebert, 2006), and lack support and supervision (Bride, 2007; Thompson, Amatea, & Thompson, 2014) have been found to be particularly likely to develop compassion fatigue. Similarly, burgeoning caseloads (Lee et al., 2010), lack of supervision (Moyer, 2011), and exposure to trauma (Hamilton Houghtaling, 2012) are correlates of moral distress. The consequences of compassion fatigue also overlap with those of moral distress, including boundary violations (Merriman, 2015), ethical violations (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), leaving the profession (Boyle, 2011), and impacts on personal life (Wentzel, 2014). Therefore, because the factors that lead to moral distress overlap with other psychological and emotional responses to common clinical dynamics, and because the consequences similarly overlap, the exploration of moral distress may elucidate unacknowledged factors contributing to well-being.

Because the contextual factors that lead to moral distress among other health care professionals overlap with clinical factors prevalent among counselors working with children and adolescents, those counselors may benefit the most from an exploration of moral distress. In other words, exploring the factors and conditions that lead to moral distress may not only enhance our newly conceptualized understanding of burnout as a heterogeneous phenomenon (Lee et al., 2010; Montero-Marin, Prado-Abril, Piva Demarzo, Gascon, & García-Campayo,

2014), but also aid in both the prevention and alleviation of burnout among child and adolescent counselors.

Due to the applicability and potential ramifications of moral distress to counselors working with children and/or adolescents, there is a gap in the counseling literature that needs to be addressed. In fact, Nuttgens and Chang (2013) recently acknowledged this gap and explicitly challenged counselors to include explorations of moral distress in future research endeavors. Researchers in other health care fields have similarly recognized the need for interdisciplinary research examining moral distress due to factors and outcomes that seem to directly overlap with the field of counseling and other areas of mental health (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005). Exploring moral distress as a phenomenon that is borne out of counseling dynamics and creates potential threats at the personal, interpersonal, and organizational level, is a worthy area of attention. It is hoped that by garnering an initial understanding of moral distress within the context of counseling, valuable insights will be gained about the way it is experienced and the effects it has on counselors and the institutions within which they practice.

Defining the Problem

Stress is an inevitable concomitant of life, and is an undeniable circumstance faced by those in the field of mental health (O'Halloran & Linton, 2000). Harmful stress, however, results when one is unable to cope with threatening situations and results in physiological changes that do not return to homeostasis (Caldwell, 1984), which differentiates stress from distress. One newly recognized form of distress, moral distress, occurs when an individual makes a moral judgment about the right course of action to take, but is unable to carry it out (McCarthy & Deady, 2008). Individuals in the helping and health care professions are particularly likely to experience moral distress, resulting in the potential for anguish on personal,

interpersonal, and organizational levels (Austin et al., 2005; Burston & Tuckett, 2013). A review of the literature reveals that the outcomes of moral distress, short- or long-term, are usually negative, and occur in the personal and organizational domains (Burston & Tuckett, 2013; Poisson, Alderson, Caux, & Brault, 2014). Personal consequences include diminished confidence (Nelson, 2009), self-doubt (Laabs, 2007), loss of self-esteem (Wilkinson, 1989), a feeling of helplessness and hopelessness (Ferrell, 2006), and diminished interpersonal relationships (Wiegand & Funk, 2012). Organizational or systemic consequences include health care practitioners avoiding the patient (Wilkinson, 1988), engaging in arguments with other professionals (Jameton, 1993), and practitioner attrition (Austin et al., 2005; Weissman, 2009). Aside from impacting personal and organizational domains, others also acknowledge moral distress can lead to significant negative effects for the clients or patients served, such as quality and safety of client care (Pendry, 2007; Poisson et al., 2014).

Researchers agree counselors have a responsibility to explore, assess, and maintain their own health and well-being (Iliffe & Steed, 2000; Roscoe, 2009; Sexton, 1999; Wolf, Thompson, Thompson, & Smith-Adcock, 2014), an imperative also corroborated by the American Counseling Association (ACA; 2014). Similarly, Falender and Shafranske (2004) stated it is "essential for clinicians to develop and understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). This study is designed to continue to meet these professional imperatives by conducting an initial examination of counselors' experiences of moral distress and the factors that lead to its existence. Exploring an overlooked phenomenon that has the potential to cause detrimental consequences in multiple domains of life not only promotes the standards established for the counseling profession, but also may generate an

understanding of unrecognized factors that lead to distressing situations among counselors. As such, it was hoped this study would elucidate idiosyncrasies within the counseling profession that would provide insight about how to assess for and prevent moral distress, ultimately enhancing the efficacy of the profession and wellness of counselors.

Purpose Statement

The purpose of this study was to create an instrument designed to measure moral distress among child and adolescent counselors that demonstrated preliminary face and content validity. In order to meet this purpose, several goals were achieved. First, an initial understanding of child and adolescent counselors' experience of moral distress was garnered through interviews and open-ended questionnaire items. Second, counselors' accounts of moral distress were used to identify the domains from which moral distress occurs, which subsequently informed items that were generated for instrument construction. Finally, the developed instrument was pilot tested with a purposeful sample of counselors and experts in order to assess the instrument's initial face and content validity. Modifications were made based on the results of the pilot test, with the goal of enhancing the instrument's validity for future use.

Because this study was exploratory in nature, as the first step in the broader goal of assessing moral distress among child and adolescent counselors, no hypotheses were made. Instead, several research questions served as the guiding principles for the current study, which informed each phase of this study, and established the information needed to achieve its goals and overall purpose. Each research question is briefly described below; however, their utility in guiding the study is described in more detail in Chapter Two.

Research Questions

In order to develop the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA), a qualitative methodology was utilized to explore counselors' experiences of moral distress and the factors that contribute to them. The research questions guiding this exploratory study were:

Research Question 1: What does the experience of moral distress look like for child and/or adolescent counselors?

Research Question 2: What factors, if any, contribute to moral distress among counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 3: What barriers, real or perceived, if any, exist that prevent child and/or adolescent counselors from engaging in moral action?

Research Question 4: What impact, if any, does moral distress have on counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 5: Are there thematic domains from which moral distress occurs for counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 6: Can a Moral Distress Scale for Counselors – CA Form (MDSC-CA) be constructed in order to measure moral distress among counselors who work with children and/or adolescents?

Research Question 7: If the MDSC-CA can be constructed, can its face and content validity be assessed through pilot testing?

Significance of the Study

Due to the dearth of research related to moral distress among counselors and the newly acknowledged relevance of the phenomenon within the field of counseling, this study sought to take an initial step to close this existing gap in the literature. Such an endeavor helped provide clarification about moral distress itself and the factors and conditions that uniquely contribute to moral distress among counselors who work with children and/or adolescents. Atashzadeh Shorideh, Ashktorab, and Yaghmaei (2012) pointed out that the causes of moral distress vary according to the work situation, which suggests the previous literature on moral distress may be inadequate or inappropriate to apply to the context of counseling. Because moral distress has the capacity to pose threats at personal, interpersonal, and organizational levels (Burston & Tuckett, 2013), the present study has significant value to professional counselors who have experience working with children and/or adolescents, the services they provide, and the agencies within which they practice. More specifically, gaining a thorough understanding about the nature of moral distress among these counselors may help raise their self-awareness about personal experiences that can help or hinder them in their professional development and delivery of services. Stoltenberg and McNeill (2010) pointed out that increased self-awareness is a worthy and necessary pursuit, as a counselor's level of self-awareness is a defining feature of competence and professionalism. Additionally, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) explicitly makes it clear that a self-aware counselor is one who engages in professional and competent practice.

The development of an instrument to assess for moral distress also provides significant value to counselors and the counseling profession. Austin (2012) suggested moral distress might act as an "ethical canary" (Somerville, 2000). Just as a canary in a mineshaft can act as an early

warning sign that something is wrong, moral distress can act as an early warning that something is amiss within a society or organization. Austin urges health professionals to pay attention to these early warning signs, which seem to have increased in degree and intensity recently, and, without proper assessment and awareness, can lead to unsatisfactory habitability in institutions and agencies. Without a way to assess for moral distress, health care professionals, including counselors, may undergo continual and unrecognized stressors that lead to problems on personal, interpersonal, and organizational levels. The development of an instrument used to assess for moral distress may serve as the proverbial canary in a mineshaft, within the context of counseling, which can provide mental healthcare professionals with a preventative measure for unrecognized stressors they currently face.

It was hoped that this study would provide a foundational understanding of moral distress within the field of counseling that will differentiate it from conceptualizations within other health care fields. Additionally, was hoped that this study would provide the necessary first steps for future studies examining moral distress with quantitative methods, which will further increase counselors' understanding of the nature of relationships between contributing and moderating factors that potentially effect moral distress.

Statement of Limitations

The researcher recognized the following limitations of the study, which give caution to the implications drawn from the results. First, the sample used to collect initial qualitative data about moral distress among counselors working with children and/or adolescents was recruited from CESNET-L, an online listserv for counselors and counselor educators. Dr. Marty Jencius, the moderator of the listserv, cautions researchers that there is no demographic information for the population of subscribed users. Therefore, although demographic information was collected

in an attempt to ensure participants were, in fact, counselors, there was no way to confirm the credentials and qualifications of the participants. The researcher established eligibility criteria and included exclusionary questions in the questionnaire in an attempt to restrict the respondents to those who had experienced moral distress while counseling children and/or adolescents; however, because participants were protected by anonymity, those fabricating their qualifications could have gained access to the questionnaire and been included in the initial data collection. Therefore, questionnaire respondents' demographic information was self-reported and could not be substantiated or verified.

Second, the retrospective nature of the questionnaire and requirement of self-reported responses pose threats to the validity of the questionnaire used in the current study. As Connor, Barrett, Tugade, and Tennen (2007) warned, despite the pervasiveness of retrospective questionnaires in the social sciences, they rely on the assumption that respondents can accurately reflect on and report past experiences that may have happened over long intervals. Connor et al. suggested this assumption is not warranted and may result in responses that are disproportionally influenced by the strongest, or most troubling, memories of such an experience. Although this limitation did pose a threat to the current study, those memories that are particularly troubling and have left an impact on the participants may provide important and robust data from which to gain an understanding of counselors' experiences. Additionally, the focus of participants' descriptive responses pertained to their perception of the experience, the factors that lead to their moral distress, and the factors that could prevent moral distress in the future, rather than the intensity of those experiences, per se. However, because the instrument to be developed is intended to measure moral distress among counselors who experienced such distress while working with children and adolescents, the establishment of validity may threatened in future

studies. That is, because of the retrospective nature of the questionnaire being developed, participants' strongest experiences of moral distress were likely to be the ones remembered and reported (Connor et al., 2007). As a result, levels of moral distress may have been exaggerated, or otherwise disproportionate to participants' overall and actual experiences of moral distress.

A third limitation exists because the pre-dissertation interviewees were purposefully selected to include counselors who had experienced symptoms of moral distress in the context of their clinical experiences with children and/or adolescents. The exclusive inclusion of targeted counselors was necessary to gain an initial understanding of moral distress in counseling; at the same time, however, it may result in a sampling bias. Therefore, implications drawn from the interviews may not represent counselors at large, but rather over estimate the extent of moral distress and the situations that lead to its experience. Barbour and Kitzinger (1999) pointed out, however, that statistical representativeness is not the goal of most qualitative research. Rather, sampling procedures used in qualitative research often have the goal of exploring the "common and unique manifestations of a target phenomenon across a broad range of phenomenally and/or demographically varied cases" (Sandelowski, 2000, pp. 337-338). Therefore, the questionnaire and interviews were purposefully chosen to help elucidate participants' unique and shared experiences, while still capturing diversity among participants.

Additionally, the sample size of both the questionnaire and the interviews may be a limitation to the current study. Guest, Bunce, and Johnson (2006), for example, acknowledged the infeasibility of achieving saturation in time-limited studies, which may inevitably lead to insufficient data collection. Therefore, because the current study is limited in the time it can be conducted, sample size may be an unavoidable limitation. Similarly, because the data collection was completed prior to the dissertation phase, the determination of an inadequate sample during

analysis was potential limitation of the study. The proposed methodology did not allow for the remediation of an inadequate sample size, which can limit the validity of the results obtained for instrument development.

Finally, the validity of the instrument was established based on a purposeful sample of experts in counseling ethics and those familiar with moral distress. Although there are professional counselors who are familiar with moral distress, there are no known experts on the concept, as it pertains to counseling. Therefore, the current study was limited by the extent to which an instrument measuring moral distress among counselors could truly be validated.

These limitations are acknowledged in the current study and will be elaborated on throughout. Their consideration is especially important in the descriptions of research methodologies in Chapter Three, data analysis in Chapter Four, and the discussion and conclusions sections of Chapter Seven.

Definition of Key Terms

The following section defines each of the terms and concepts that will be used throughout this and the following chapters.

Adolescent

An individual roughly between the ages of 12 and 24 (Siegel, 2013).

Child

An individual roughly between the ages of two and 12 (Woolfolk & Perry, 2012).

Counseling

A clear and consistent operational definition of a counseling is difficult to obtain from the counseling literature. The elusiveness of a consistent definition has plagued the counseling profession for decades, and has spawned a profession-wide charge to unify the various

"memberships, certifying, accrediting, and honor society groups within the profession of counseling" (Kaplan, Tarvydas, & Gladding, 2014, p. 366). One such initiative, the 20/20: A Vision for the Future of Counseling, conducted several Delphi rounds to address the challenges associated with achieving consensus of a definition for a profession as diverse and multifaceted as counseling. That initiative resulted in the definition "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., 2014, p. 366), which has been adopted and endorsed by 30 counseling entities, including the American Counseling Association (ACA; 2014). Although the definition above for counseling has not gained universal acceptance across the counseling profession, it offers a concise, yet inclusive, operationalization of the primary work counselors engage in. As such, it will be used as the definition of counseling for the present study.

Ethical Climate

The term ethical climate refers to "the shared perception of what is ethically correct behavior and how ethical issues should be handled" (Dickson, Smith, Grojean, & Ehrhart, 2001).

Ethics

Ethics are described as being the standards that guide behavior and conduct (Scanlon & Murphy, 2014). Ethics in counseling provide a minimal standard of practice required of professional counselors and serve as a useful tool to explore alternative options and actions when a counselor is faced with an ethical dilemma (Jungers & Gregoire, 2013). There are five ethical principles to which counselors are to adhere, which were derived from Beauchamp and Childress' (1979) work on medical ethics and summarized by (Jungers & Gregoire, 2013, p. 19):

- Nonmaleficence: the duty to do no harm to clients

- Beneficence: the duty to do something good for clients and to add to their overall welfare
- Autonomy: the duty to protect a client's right to live a free and self-directed life
- Fidelity: the duty to act with faithfulness in the relationship with a client
- Justice: the duty to treat all clients fairly and with the same level of goodwill

According to Kichener (1984), each of the five ethical principles described above hold equal importance in ensuring ethical practice and client welfare.

Ethical Dilemmas

Ethical dilemmas are "problems which require a decision in which there are only unsatisfactory solutions and thus contribute to the development of tension and conflict" (Scanlon & Murphy, 2014, p. 100). In clinical practice, ethical dilemmas typically occur when there is a conflict between ethical principles, defined by a code of ethics.

Moral Certainty

Moral certainty is the feeling of absolute moral conviction that compels one to risk self, personally and professionally, to act in accord of that conviction (Wurtzbach, 1996).

Moral Conflict

Moral conflict is a situation in which there is a clash of moral values regarding what one perceives as the right course of action to take (Redman & Fry, 2000). Corley (2002) suggests that moral conflict has six essential features: (1) choice; (2) advocacy; (3) autonomy; (4) pain and suffering; (5) values; and (6) relationship. The "unifying essential feature" (Corley, 2002, p. 646) of the experience of a moral conflict is that of choice; all other features of moral conflict are contained within the fabric of choice.

Moral Commitment

Moral commitment is an "engagement with a moral issue in patient care, loyalty to the values involved, and a willingness to take risks" (Corley, 2002, p. 645).

Moral Competency

Moral competency refers to the ability to make moral sense of situations, utilize good moral judgment, and engage in appropriate moral behavior (Rest, 1986).

Moral Courage

The concept of moral courage, as it relates to health care, was introduced and proliferated throughout the health care literature by Lachman (2007a). She defined moral courage as:

> The individual's capacity to overcome fear and stand up for his or her core values. It is the willingness to speak out and do that which is right in the face of forces that would lead a person to act in some other way. It puts principles into action. (p. 131).

Moral Distress

Jameton (1984) originally defined moral distress as occurring "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). More recently, however, researches have expanded the definition to include newfound factors that contribute to moral distress. Thus, Corley, Elswick, Gorman, and Clor (2001) have provided the updated definition of "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations" (pp. 250-251). Because moral distress has yet to be examined within the field of counseling, a more general and appropriate definition for the purposes of this study is provided by McCarthy and Deady (2008):

> 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 are unable to do it; or they do what they believe is the wrong thing. (p. 254)

Wilkinson (1988) and Jameton (1993) distinguished between two forms of moral distress, initial distress and reactive distress, each occurring at separate times, but together, making up the total experience of moral distress.

Initial distress. Initial distress is the distress one feels at the time of the morally distressing event or the moral choice (Bennett & Chamberlin, 2013).

Reactive distress. Reactive distress is the distress felt after the situation that elicited moral distress ends and is carried forward throughout the individual's life (Bennett & Chamberlin, 2013).

Moral Integrity

Moral integrity refers to adhering to one's moral values and is "importantly tied to our sense of dignity and self-respect" (de Raeve, 1998, p. 486).

Moral Judgment

Moral judgment involves the process of "integrating numerous ethical considerations that count for or against a particular course of action in order to determine what ought to be done in a specific situation" (Corley, 2002, p. 646).

Moral Sensitivity

Moral sensitivity is "the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical

consequences of decision on behalf of the person" (Lützén, Johansson, & Nordström, 2000, p. 521).

Moral Residue

Moral residue is the contemporary conceptualization of reactive moral distress. According to Webster and Baylis (2000) moral residue is "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 218). Additionally, as Webster and Baylis (2000) suggest, the experience of moral residue can be the result of an error or the cause of an error.

Morals

Ascertaining a definition of morals is very difficult, as philosophers, theorists, and researchers describe morals in different ways. Additionally, there are instances in which the terms ethics and morals are used equivocally, further creating confusion about the distinction between the two. Before a definition can be given, therefore, it is appropriate to differentiate morals from ethics. Jameton (1984) offers two interesting ways to distinguish the essence and utility of morals from that of ethics:

1. *"Professional* versus *personal*: In this contrast, *ethics* refers to publicly stated and formal sets of rules or values, such as professional codes of ethics" (p. 5). For example, the American Counseling Association's (ACA) *ACA Code of Ethics* (2014) provide professional ethics. Morals values or principles, on the other hand, can be both formal and informal. "Examples of personal moral principles are 'Do unto others as you would have them do unto you,' 'Always act lovingly,' 'Look out for number one' and 'Give others the benefit of the doubt'" (p. 5).

2. *Commitment* versus *inquiry*: Here, the term *moral* refers to principles and values to which people are actually *committed*, that is, those they follow and defend in daily life. These may include both the professional and personal commitments mentioned above. *Ethics* refers to the systematic study of principles and values, in other words, the theories and research by means of which we question, study, inquire into, critique, and eventually change our morals. (p. 5)

Jameton (1984) summarizes the differences between morals and ethics by stating, "*ethics* is the more formal and theoretical term, *morals* the more informal and personal term" (p. 5).

It is not sufficient to declare that morals are simply personal values, in contrast to professional values. Philosophers have debated the metaphysics and conditions that give rise to morals and morality for centuries. One of the most compelling and important distinctions, however, is that of autonomy. Beauchamp and Childress (1979) highlight the work of Immanuel Kant in our understanding of autonomy, as it relates to morals. Kant was specifically interested in the autonomy of the will, and described autonomy as "governing oneself, including making one's own choices, in accord with moral principles which are one's own and which are universalizable, i.e., can be willed to be universally valid for everyone" (Beauchamp & Childress, 1979, p. 57). In contrast, and relevant to moral distress, is the antithesis of autonomy, or heteronomy. Heteronomy, according to Kant, is rule by other persons or conditions and subjection of the will to any rule or motive outside itself. Therefore, in order to have morals and act morally, one must have autonomy of will, which allows one to act in accord of one's own moral principles.

Professional Counselor

The term *professional counselor* has seen a great deal of disparity and inconsistencies in its definition across the counseling literature. Early definitions were overtly vague and ambiguous and did not include any educational or professional standards. For example, Chaplin (as cited in Neukrug, 2012, p. 5) revealed that an early definition of a professional counselor was any professional who practices counseling. In the 1950s, a more specific definition was proposed that included desirable qualifications, such as:

> A bachelor's degree from an accredited institution and must meet fully the regular State educational requirements for a teacher's certificate … [and] at least the equivalent of a master's degree with major emphasis in the essential areas of the guidance program. (Hamrin & Paulson, 1950, p. 323)

More recently, Neukrug and Milliken (2011) suggested that professional counselors are typically those who have a master's degree in counseling, while others (Moss, Gibson, & Dollarhide, 2014) distinguish professional counselors from non-counselors as those who are Licensed Professional Counselors (LPC). Creating even more ambiguity, however, are complications brought about by the intrastate commerce designation mental healthcare holds, such as various state requirements to obtain licensure, individual licensure boards that oversee licensing laws, as well as the lack of license portability (Wilkinson & Suh, 2012). Licensure requirements alone create numerous complications in defining what exactly professional counseling is. For example, while all 50 states, the District of Columbia, Guam, and Puerto Rico license counselors, some use a tiered system, which differentiates between associate and general counselors, others differentiate between standard professional and clinical professional counselor, and still others delineate according to the level of licensure (Institution of Medicine of

the National Academies, 2010). As a result, there is no nationally recognized consensus about the "number of clinical and supervisory hours required, the educational requirements, the examination, and the title of the credential" (Wilkinson & Suh, 2012, p. 20-21) to identify professional counselors.

A review of the ACA Code of Ethics (2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards (2009) does little to clarify the requirements of counselors, as they omit a clear definition of what constitutes being a counselor. That is, while the American Counseling Association (ACA; 2014) defines counseling as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 20), no definition is given to professional counselors. Similarly, CACREP specifically describes the educational and experiential requirements for counseling programs and their counselors-in-training, however, no definition is provided for counselors or professional counselors.

Because definitions of the term professional counselor vary considerably in the counseling literature, the present study chooses definition that provided a reasonable balanced between Chaplin's overly inclusive definition and the more restrictive requirements of some state licensure boards (ACA, 2010). To include a broad range of professional counselors, the current study identified professional counselors as those who have completed their Masters degree in counseling, regardless of counseling specialty, and have at least one year of post-Masters, supervised clinical experience. It is likely that this definition identifies those who have completed appropriate educational requirements to become a professional counselor, while still allowing variation in the breadth and focus of their clinical experiences. As a result, it is hoped

that a more complete understanding of counselors' experiences with moral distress may be obtained, along with a diversity of contextual factors that contribute to those experiences.

Conceptual Underpinnings of the Current Study

The current study is primarily based interpretative phenomenological analysis (IPA). Because a new instrument is being developed, IPA was essential to analyzing the qualitative data collected in order to identify thematic domains from which moral distress occurs, that are unique to counselors working with children and adolescents. The following section briefly summarizes the basic tenets of IPA, as they relate to their inclusion in the current study.

Interpretative Phenomenological Analysis (IPA)

Interpretative phenomenological analysis is a relatively new form of qualitative analysis with roots grounded in three areas of philosophy: phenomenology, hermeneutics, and idiography (Smith, 2004). Its is phenomenological in nature in that it is the study of experience, or what the human experience is like, in terms of those things that matter to us (Smith, Flowers, & Larkin, 2009). The presupposition underlying phenomenology is that experience should be examined in the way in which it occurs (Smith et al., 2009). At the same time, phenomenology cannot be reduced to one area of philosophical thought, as several philosophers contributed to its development. As a result, the phenomenological influence on IPA involves returning to the data itself in a reductive way to get to the essential features of an experience (Dahlstrom, 2015), including the interpersonal, affective, and moral nature of such experiences (Smith et al., 2009).

Interpretative phenomenological analysis also incorporates tenets of hermeneutics, which at its core, focuses on the context of a text's production and the text's interpretation (Smith et al., 2009). Again, several philosophers influenced the development of hermeneutics, and many of their ideas are included in IPA. As a result, IPA also focuses on a sensitivity to and

understanding of the context in which a text was produced. Additionally, because IPA is interpretative in nature, and because interpretations are filtered through one's preconceptions, it requires the researcher to engage in bracketing and reflective practices to overcome one's biases (Smith et al., 2009). Finally, hermeneutics influences IPA in that it involves a constant fluctuation between the parts of a text and the text in its entirety. This process is referred to as a "hermeneutic circle" (Smith et al., 2009, p. 27) and helps the researcher to understand parts of a text (e.g., a word) in the context of the whole (e.g., the sentence).

Lastly, IPA incorporates tenets of idiography, which involves a deep focus on the particulars of an experience (Frost, 2011). Interpretative phenomenological analysis' commitment to the particulars operates at two levels. First, as Smith et al. (2009) describe, the particulars refers to a sense of detail and depth of analysis. Second, they note that particulars also refer to the ways in which a phenomenon has been interpreted and understood by particular people in a particular context. Therefore, IPA is idiographic in the sense that it focuses on a detailed exploration of certain instances, typically in the form of a case study or over a small group of cases.

The tenets of all three areas of philosophy that comprise IPA had an emphasis on and were deemed particularly appropriate for the current study for several reasons. First, it involves a process of data reduction, while maintaining complexity the complexity of the human experience. Additionally, it includes a focus on interrelationships, connections, and patterns that emerge through the data analysis process (Smith et al., 2009). Finally, IPA provides a thorough and well-organized series of steps used to identify themes that emerge within and across participants. Identification of these themes, or domains, is the main goal of the qualitative portion of the present study, which makes IPA an ideal method to reduce data for this purpose.

Overview

Chapter One provided a contextual foundation for the present study, focusing on the applicability of moral distress in counseling and a need to focus research efforts to gain an understanding on the factors that contribute to morally distressing situations. A clear gap in the counseling literature pertaining to moral distress as a factor that has the potential to impact multiple domains of counselors' lives, as well as treatment efficacy and organizational dynamics, necessitates an initial exploration of moral distress within the context of counseling. In Chapter Two, an extensive review of the literature is provided with special attention to the emergence of moral distress in health care literature, the conceptual development of moral distress since its inception, the history of ethics and morals in counseling, important considerations in measurements of moral distress, a review and appraisal of the available instruments used to measure moral distress, an evaluation of the development of an instrument, and a description of the Moral Distress Scale for Counselors-CA Form. In Chapter Three, a thorough review of the methodology is offered, with emphases placed on theoretical frameworks, research methodology, and statistical procedures. Chapter Four presents the results of the qualitative data and the ways in which they informed domain and sub-theme development, which guided instrument structure. Chapter Five presents additional qualitative data analysis, which informed item generation and instrument construction. Chapter Six covers results of the pilot tests and the ways in which they guided instrument modification, in an effort to increase face and content validity. Lastly, Chapter Five provides an overview of the study, summary and discussion of the findings, recommendations for future research, and limitations associated with the study.

CHAPTER TWO

REVIEW OF THE LITERATURE

Numerous factors contribute to the process, quality, effectiveness, and outcomes of clinical work (e.g., Bernard & Goodyear, 2009; Bucky, Marques, Daly, Alley, & Karp, 2010; Fife, Whiting, Bradford, & Davis, 2014; Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013; Simon, 2012; Ulberg et al., 2013). Falender and Shafranske (2004) highlighted the breadth of those factors and emphasize the impact they can have on the counseling by stating it is "essential for clinicians to develop an understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). In fact, they suggest a main goal of counselor development is to increase awareness of personal values and beliefs that can influence and guide therapeutic processes (Falender & Shafranske, 2004). Stoltenberg and McNeill (2010) corroborate this point by distinguishing advanced counselors from entry-level counselor trainees partially based on a counselor's level of self-awareness. While counselor beliefs and values have been studied considerably, as well as counselor self-awareness, other factors that may impact the process of counseling, have received much less attention.

The purpose of this study was to explore one such factor, moral distress, which has received very little attention in the counseling literature. It was hoped that an initial understanding of the contextual factors that contribute to moral distress among counselors who work with children and/or adolescents would be obtained, as well as the development of an instrument to measure the level of moral distress among such counselors. First, the emergence

of moral distress in the health care literature is discussed, with a special focus on its conceptual evolution over the past two decades. Second, important considerations in the measurement of moral distress are discussed. Third, an overview of the available methods to measure moral distress, along with their efficacy, is provided. Fourth, tenets of moral distress are applied to counseling children and adolescents, with a special focus on situations that may give rise to moral distress, and the unique characteristics of counseling children and adolescents that may make counselors working with those populations more vulnerable to moral distress than others.

History of Moral Distress

The concept of moral distress has a history through philosophical literature, although the term moral distress was only introduced, in its more contemporary conceptualization, in 1984 by Andrew Jameton. Initially, Aristotle wrote about the concept of *akrasia*, which literally means "'not in command' and is variously rendered in English as 'lack of control,' 'weakness,' 'moral weakness' [and] 'weakness of will'" (Pakaluk, 2005, p. 233). As Jameton (2013) notes, akrasia essentially refers to what is now understood as the internal factors that act as barriers to moral action. In 1993, Williams revisited Aristotle's akrasia, defining it as "consciously doing what one has less reason to do instead of what one has more reason to do" (p. 45). Pakaluk summarizes the condition of akrasia, and the ways in which it is similar to moral distress, which will become apparent shortly, in the following table:

Table 2.1.
Characteristics of Aristotle's Ethical Conditions

	Virtue (arête)	Self-control (enkrateia)	Lack of self-control (akrasia)	Vice (kakia)
What he thinks he should do	✓	✓	✓	×
What he has impulses to do	✓	×	×	×
What he in fact does	✓	✓	×	×

Note. Adapted from *Aristotle's Nicomachean Ethics: An Introduction* (Pakaluk, 2005, p. 234)

In addition to the internal factors that prevent moral action, originally described by Aristotle, Williams (1993) writes about external factors that act as barriers to moral action due to the power of others. These internal and external barriers to moral action, taken together, comprise the contemporary understanding of the conditions that give rise to moral distress. Although philosophers have written about moral distress from both an external and internal perspective, the contemporary understanding of moral distress, which includes both, is the result of philosophical shifts in health care, the awareness of the human experience of ethical dilemmas, and research and reflection on moral distress in a variety of health care fields.

The concept of moral distress first appeared in the nursing ethics literature in the late 1800s by Fouillee (as cited in Jameton, 2013, p. 298) and early 1900s (Elmer, 1909). At that time, moral distress reflected job-related stress that centered on arguments with physicians, which was acknowledged in the nursing literature even earlier, and later brought to awareness by Florence Nightingale (Skretkowicz, 2010) and Isabel Hampton Robb (Robb, 1900). It was not until the late 1970s and early 1980s that moral distress became a recognized phenomenon in nursing and nursing ethics, however, and not until the 1990s that it became a prominent concept in nursing research (Jameton, 2013). During that time medical schools experienced a major philosophical shift, which placed a newfound interest in and importance on bioethics in both professional practice and in the classroom. Additionally, the study and presentation of bioethics underwent a simultaneous shift in focus from that of dilemmas to one of distress (Jameton, 1993). As a result, previously described workplace stressors, as well as their psychological ramifications, gained considerable attention. As the understanding, appreciation, and discussion of ethics in medicine and nursing broadened, new perspectives on ethical dilemmas, the

contextual factors that contribute to them, and their psychological and emotional ramifications emerged.

Precursors to the Awareness of Moral Distress in Bioethics and Nursing

In his reflection on moral distress, Jameton (2013) identifies several socio-political, philosophical, and professional factors that lead to the awareness of moral distress in nursing: (1) bioethics' shift in focus from dilemmas to distress; (2) feminist philosophy applied to nursing and bioethics, and (3) a recognition of the affective domain in nursing.

A shifting focus from dilemmas to distress. As mentioned briefly above, prior to the 1970s, bioethicists tended to focus on ethical dilemmas in both teaching and practice (Jameton, 1993). For decades, dilemmas had been easy to present and analyze, resulting in a useful teaching tool in medical schools that allowed the evaluation of fundamental ethical principles underlying a clinical problem. Additionally, as Jameton acknowledged, dilemmas offer both the teacher and the student a way to analyze and discuss the philosophical and ethical principles of autonomy and beneficence, without having to discuss differences in moral judgment, which minimizes conflict with others. The dilemma, itself, acted as a scapegoat that softened the difficult task of applying one's values to ambiguous clinical situations. While ethical dilemmas were regarded as an effective method of teaching, much of the experience of facing a dilemma was lost.

Jameton (1993) suggested that when experiencing moral distress, one actually does face a dilemma, albeit a slightly different dilemma than what was typically discussed in medical training. That is, the dilemma is not one of patient autonomy in conflict with medical care, but rather a dilemma about "what to do when one knows the right thing to do and faces institutional obstacles and the conflicting judgments of others" (p. 544). Therefore, an awareness of moral

distress in bioethics more fully captured the experience of facing a dilemma, as it acknowledged the psychological effects of internally wrestling with oneself, which naturally leads back to the dilemma that caused the moral distress in the first place. In effect, focusing on moral distress remediates the tendency to overlook important emotional factors interwoven in the human experience of facing ethical issues, yet still allows a discussion of the underlying philosophical principles and professional responsibilities (Jameton, 1993).

Feminist philosophy applied to nursing and bioethics.

Prior to the 1970s, sexism, or discrimination based on sex, was rampant in health professions and manifested itself as a clear division of labor between nurses and physicians (Jameton, 1984). The pervasiveness of sexism, particularly in nursing, cannot be overstated, and was, at one time, called to attention as the nursing profession's most fundamental problem (Cleland, 1971). Women in nursing were victims of a patriarchal culture that Millett (1970) described as power-structured dynamics in which one group of persons is controlled by another. A more contemporary and complete definition of gender discrimination is "any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights" (Cottingham et al., 2000, p. 49). Cleland suggested these power-structured relationships were solidified by the stereotypical socialized roles emphasizing that males display "aggression, intelligence, and efficiency; the female, passivity, ignorance, docility, virtue and ineffectuality" (p. 1542). Erlen and Frost (1991) acknowledged the role the media played in establishing and perpetuating these stereotypes by portraying nurses as less knowledgeable then their physician counterparts, which allowed the stereotypes to permeate the public view of the profession. In the decades preceding this shift in

awareness, these discriminatory structures were supported by every social and economic force, without much critique or question.

Betty Friedan became the voice of many women in the 1960s and 1970s as her concept of the feminine mystique served as one of the impetuses for the feminist movement and feminine introspection (Friedan, 1974). The basis of her argument is succinctly summarized as such:

> The feminine mystique says that the highest value and the only commitment for women is the fulfillment of their own femininity. It says that the great mistake of Western culture, through most of its history, has been the undervaluation of this femininity. It says this femininity is so mysterious and intuitive and close to the creation and origin of life that man-made science may never be able to understand it. But however special and different, it is in no way inferior to the nature of man; it may even in certain respects be superior. The mistake, says the mystique, the root of women's troubles in the past is that women envied men, instead of accepting their own nature, which can find fulfillment only in sexual passivity, male domination, and nurturing. (p.9)

Additionally, in 1985 Marilyn Frye wrote about the oppression of women and their choice and responsibility under such conditions (Wendell, 1990). Similar to the effects of Friedan's work, Frye's writings raised philosophical, psychological, and political questions relating to women's freedom and autonomy in making responsible choices. Most applicable to the nursing profession and the introduction of moral distress in ethics, Frye asserted:

> Much of what women appear to do freely is chosen in very limiting circumstances, where there are few choices left to us. Even where the circumstances present many choices, it is often the case that our knowledge, our ability to judge, and our desires have been so

> distorted and manipulated by social influences as to make a mockery of the idea that we choose freely. (Wendell, 1990, pp. 17-18)

The component of feminist philosophy that explicitly addresses women's inability to choose and act freely highlighted the plight of nurses at the time and increased awareness about the ways in which nurses were constrained within their occupations. Additionally, Frye explicitly challenged women to examine the extent to which they internalized the oppression experienced from a patriarchal society, which served as a call to action in raising awareness, standing together, and changing the coercive structures that distorted women's ability to act in accord to free will.

The feminist criticism of the nursing profession led to an examination of nurses' status in the "patient-nurse-physician triangle" (Jameton, 1984, p. 48). The traditional view of nurses suggested that they were particularly appropriate for and limited to providing "basic domestic care-giving duties, such as washing, cleaning and feeding" (Gray, 2010, p. 350). Introspection and examination of the socialized roles of nurses led to a newfound understanding of the therapeutic potential nurses offered, and were already providing, which was diametrically opposed to the traditional roles nurses previously assumed. The result of this awareness was what is often referred to as "new nursing" (Gray, 2010, p. 350), which is depicted by increased altruism, autonomy, therapeutic use of self, and increased efficacy of care and services provided (Hunter & Smith, 2007; Salvage; 1990; Staden, 1998). This new form of nursing emerged as a response to stereotypes and with a desire to "redefine the nurse's role in order to assert its unique contribution to healing" (Salvage, 1990, p. 42).

It would be a mistake to say that women immediately gained equality in health care systems following the acknowledgement of the affective domain in nursing or the reflective awareness that led to the new nursing. In fact, some researchers suggest that gender inequality is

still a dominant problem that continues to plague the nursing profession, even if it has shifted its discriminatory angle (Gray, 2010; Scanlon & Murphy, 2014). Yet, the recognition there was significant untapped potential, or at least unrecognized potential, among women in the medical profession, gave nurses a more prestigious role in the therapeutic and emotional labor now understood to be a definitive characteristic of the nursing profession.

Affective domain in nursing. The shift in focus from dilemma to distress introduced the previously overlooked affective domain in ethical issues, which led to a shift in the conceptualization of nurses and the services they provide. Prior to the 1970s, the dominant view of nursing was a misunderstood one that depicted nurses as women who naturally had the qualities of Florence Nightingale – caring, patient, and having an innate ability to manage the laborious requirements of emotional care (Aldridge, 1994; Gray, 2009). Around the late-1970s, it was becoming increasingly understood that nurses were the ones who were closest, physically and emotionally, to the stressors of patient care, which had the potential to cause emotionally distressing consequences. In fact, as Peter and Liaschenko (2004) acknowledge, the essential spatiotemporal quality of nursing, along with the complications caused by proximity and nearness to the patient, have become defining characteristics of the nursing profession. A new recognition that nurses were particularly vulnerable to the psychological effects of the difficult and intimate nature of the care they provided their patients was beginning to emerge.

Hochschild (1983) coined the term *emotional labor*, which conveyed this new understanding in nursing and highlighted the emotional requirements and coping strategies needed to successfully manage emotionally taxing work. Specifically, she suggested emotional labor "requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others—in this case, the sense of being cared for in a

convivial and safe place" (p. 7). This type of work comes with a price, but it delicately balances on the border between whether that cost will fall on the worker or the patient. That is, the successful suppression of feeling teeters between two often mutually exclusive situations: successful suppression of feelings protects the patient at the cost of the worker, whereas the expression of feelings may protect the worker at the cost of the patient (Hochschild, 2012).

Cecil, Glass, and Nurs (2014) indicated that, in nursing and other areas of emotional labor, emotional containment "remains a professional expectation, whereby explicit signs of negative emotion such as distress, sadness or anger are considered contextually inappropriate" (p. 2). In fact, Gray (2010) found that staff, more experienced nurses, and physicians viewed emotional expression as a weakness. Others describe this process as putting on a new face, or a professional face (Bolton, 2001), or putting on a show of normality (Aldridge, 1994). In each situation the goal was to "preserve hospitals as humane places and not the cold, technological, profit-trolling, computer-driven Frankensteins they have the capacity to be" (Jameton, 2013, p. 299). Similarly, Kovács, Kovács and Hegedűs (2010) found that emotional dissonance, or the discord between felt and expressed emotions, was higher among nurses than physicians, demonstrating that nurses tend to suppress their real emotions and express emotions that are not congruent with their reality. The short-term effects of this type of emotional regulation can be both positive and negative, helping people continue to engage in stressful conditions (Roth et al., 2014) and decreasing life satisfaction (Yamasaki, Sasaki, Uchida, & Katsuma, 2011); however, the long-term effects of continued emotional suppression generally results in intense personal difficulties (Roth et al., 2014).

It was the recognition of nurses' vulnerability in the intimate interactions they have with their patients, along with evidence that emotional regulation, or emotional suppression, can cause

emotional difficulties and distress (Kovács et al., 2010; Bakker & Heuven, 2006; Pugh, Groth, Hennig-Thurau, 2011) that were the catalysts for the affective domain of ethical issues in bioethics. No longer were nurses seen as innately resilient or emotionally and empathically privileged (Grady, Stewardson, & Hall, 2008). Rather, they were beginning to be understood as agents on the frontlines of emotional warfare, who were vulnerable to emotional wounds and scars.

Contemporary Conceptualization of Moral Distress

Throughout its short history in health care, moral distress has been marred by conceptual inconsistencies, resulting from shifting conceptualizations and confusing nomenclature. Definitions vary considerably among theorists and researchers from different decades and across disciplines. Andrew Jameton, a philosopher and professor in the College of Public Health at the University of Nebraska Medical Center, was the first to discuss the concept and phenomenon of moral distress in its contemporary conceptualization. Because of the changes in nursing and bioethics described above, Jameton was sensitive to the emotions and experiences of his nursing students and was aware of the psychological impact their newly acknowledged inequalities and roles were having on them. By focusing on the emotionality of nursing, especially in the context of bioethics, Jameton realized ethically ambiguous situations were more complex and hazardous than the current frameworks of that time accounted for.

Jameton (1984) originally described moral distress as a situation in which "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). At the time of the concept's inception, moral distress was understood to be caused by external, situational constraints or barriers preventing moral action, including:

- Patients
- Other nurses
- Supervisors and administrators
- Physicians
- Aides, orderlies, and attendants
- Technicians, pharmacists, and other health care workers
- Hospitals
- Potential Patients
- Family and friends of patients
- Professional associations and unions
- Licensure boards
- The law
- Society

In his book *Nursing Practice: The Ethical Issues* (1984), Jameton describes the nature of ethical and moral problems and decisions that were typical to the nursing profession and were emerging at that time. Among other contributions, Jameton delineates the nature of moral and ethical problems in nursing and other areas of health care, which he suggests, can be grouped into three classifications:

1. Moral uncertainty, which according to Jameton (1984), is a situation in which an individual is unsure of what ethical or moral principles apply, or even of what the moral problem is.
2. Moral dilemmas "arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" (p. 6).

3. Moral distress, on the other hand, "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).

From the descriptions above, it became clear that moral distress is not simply a term synonymous with other moral and ethical situations, but rather a unique moral threat that represents a perceived requirement to sacrifice one's core values or professional obligations, distinguishing it from other ethical dilemmas or situations of ambiguity (Hamric, Borchers, & Epstein, 2012). If, then, moral distress is to be considered to be a truly distinct phenomenon, it warrants closer examination.

Jameton's (1984) original conceptualization of moral distress suggested that it differed from moral or ethical uncertainty, or cases where one is unsure of the nature of the problem or the principles that apply to it, in that the very essence of moral distress occurs because of an internal struggle between what one perceives to be right and what one is able to carry out. More specifically, moral distress occurs when one is confident that he or she knows the ethically appropriate action to take but is unable to do so for some reason (Epstein & Delgado, 2010).

A moral dilemma, on the other hand, is a situation in which one may or may not know the correct or right thing to do, but in either case, available choices support mutually exclusive actions and outcomes. As Kälvemark et al. (2004) put it, "more than one principle applies and there are good reasons to support mutually inconsistent courses of action" (p. 1077). This differs from moral distress, of course, because in a morally distressing situation, one believes he or she knows the correct thing to do but is unable to do so because of constraints. The morally distressing problem stems from an inability to carry out moral action, rather than a struggle to determine which, of at least two conflicting values, is the most appropriate for the given situation

(Jameton, 1993). Often, however, an ethical dilemma in health care presents itself in the form of conflicting values that relate to the patient's wishes and that of the health care provider's duties. The philosophical conundrum underlying an ethical dilemma is one of beneficence and respect for autonomy, whereas the philosophical conundrum underlying a morally distressing situation is often one of integrity and compliance (Jameton, 1993; Laabs, 2007; Webster & Baylis, 2000).

Kälvemark et al. (2004) noted the presence and identification of an ethical dilemma is a prerequisite for moral distress to occur. That is, moral distress "is built upon the identifying of a dilemma" (p. 1077). In order to experience moral distress, one must first understand that they are facing a dilemma between two separate values, typically his or her own and that of another colleague or endorsed by the health care institution. The individual facing the dilemma then makes a moral judgment about the right course of action to take, however, real or perceived constraints make it impossible, or seem impossible, to carry out that action. The result is the feeling of moral distress, which is described more thoroughly below. The elements (moral dilemma, moral judgment, and constraints) that lead to moral distress were first proposed by Wilkinson (1988) and are presented below in her graphical representation of an equation for moral distress.

Jameton (1993) and Wilkinson (1988) further suggested morally distressing situations occur when one has a moral judgment about care that differs from that of those in charge. Implicit in the original definition was the suggestion that discrepancies in moral perspectives had the potential to lead to profound emotional distress, especially among those who found themselves below others in the occupational and professional hierarchy common among medical institutions. It is important to note, however, that moral distress does not occur solely from a moral decision, more commonly referred to as a moral judgment in philosophical literature

(Jameton, 1993). A moral decision does not require an action in response to the decision. The action one takes, particularly an action that does not correspond to the moral decision, is the catalyst for the distress one feels in a morally distressing situation. In other words, while one's particular moral judgment may cause confusion, the resulting action, or even lack thereof, causes moral distress. Acting in accord with one's moral values does not lead to moral distress, whereas an action that does not correspond to one's moral values, or the prevention of an action completely, does lead to moral distress (Jameton, 1993).

Wilkinson's Contributions

Wilkinson (1988) conducted the first exploratory study on moral distress among nurses and contributed to the conceptualization of moral distress in several significant ways. First, she expanded the original definition of moral distress by stating it was "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (p. 16). Most importantly in Wilkinson's subtle revision in the way moral distress was conceptualized was the explicit inclusion of the psychological ramifications of moral distress, as they were understood at the time. Of the 24 participants included in Wilkinson's study, nearly all indicated their experience of moral distress had detrimental effects to their personal or professional wellness. Although the expanded definition above highlights the psychological ramifications, it does not include the behavioral and physical symptoms the participants of the study identified. Wilkinson found participants endorsed a lack of self-worth, interpersonal difficulties, depression, nightmares, crying, and various physical symptoms. This study, although limited in its generalizability, indicated moral distress had significant effects on nurses that permeated several domains of life, which extended beyond their institutional setting and occupational duties.

Second, Wilkinson's (1988) study contributed to Jameton's (1984) rudimentary conceptualization of moral distress in that it differentiated it from moral outrage, a concept simultaneously gaining attention among those in the health care professions. In contrast to the causes of moral distress, moral outrage occurs due to an inability to alter or stop the immoral or unethical actions of others (Wilkinson, 1988). The moral judgment in this case is not one that solely reflects personal values, but one that truly judges the actions of others who act in contrast to one's own value system. Wilkinson makes this distinction plain in her equations for moral distress and moral outrage presented in Table 2.2.

Table 2.2
The Moral Distress Equation

Moral Distress							
Moral Situation	+	Moral Decision About Right Action	+	Perceived Inability to Act	=	Painful Feelings and Psychological Disequilibrium

Moral Outrage							
Moral Situation	+	Moral Decision – Belief that Others are Acting Immorally	+	Perceived Inability to Stop Them	=	Painful Feelings and Psychological Disequilibrium

Note. Wilkinson (1988)

Jameton (1993) clarified this distinction further by stating that both moral distress and moral outrage have a shared element of perceived powerlessness; however, in moral distress one is central to the ethical challenge and engaged in the wrongdoing, whereas in moral outrage one is removed from the ethical challenge and others are engaged in the wrongdoing.

Identifying powerlessness and engagement in the wrongdoing as two essential components to moral distress reveals a connection between the phenomenon of moral distress and clinical work with children and adolescents. First, the introduction of managed care across

the mental health care fields has created a substantial loss of power among counselors. Cooper and Gottleib (2000) found the merging of mental health and business removes mental health providers' autonomy in determining what is in the client's best interest and the client's self-determination, replacing them with restraints that limit the length and scope of counseling. As a result, counselors, including those working with children and adolescents, are increasingly facing ethically challenging situations in the face of powerful bureaucratic organizations. Additionally, an increase in ethical challenges requires an increased amount of time to address them, although time is limited. This depiction of mental health care demonstrates a cyclical pattern of powerlessness and involvement in ethically challenging situations, which, according to previous literature, likely creates moral distress among counselors.

Counselors working with children and adolescents often have significantly less power in providing the best possible care for their clients, due to child protection services. Darlington, Feeney, and Rixon (2004) raise awareness to some of the challenges practitioners face when child protection services is involved in ensuring a child's welfare. Most notably, they point out that collaboration between child protection services and mental health services often is unsuccessful, creating a lack of cohesion in treatment. Additionally, under-resourced child protection services often result in premature termination of services, making treatment less effective, disrupting collaboration between systems, and creating additionally ethical challenges as circumstances are largely beyond counselors' control (Scott, 1997). Darlington et al. notes a few positive experiences with child protection services, however, numerous difficulties were reported in the areas of communication, role clarity, competing primary focus, contested mental health needs, contested child protection needs, and resources, several of which have been identified as barriers leading to moral distress (Kälvemark et al., 2004; Moyer, 2011).

Wilkinson (1988) last contribution was the development of a model of moral distress that elucidates underlying cognitive processes, feelings, competencies, and desires that determine its course and severity. Specifically, according to Wilkinson, nurses often find themselves in situations in which they understand the moral issue and believe they are responsible for acting in response to it. The nurse makes a decision about what the correct moral action is that applies to the case, which is influenced by his or her moral framework, feelings of empathy, and desire to help the patient. Additionally, the level experience and knowledge of available actions affect the nurse's ability to overcome real or perceived constraints and follow through with the identified moral action. Inability to act in accordance with the nurse's morals results in moral distress and its accompanying negative feelings and psychological discomfort and distress. The severity of the negative ramifications is influenced by "the degree to which the nurse identifies with the patient, and by her/his perception of the nursing role in terms of passive rule-following vs. active decision-making" (p. 27). Finally, the degree to which the distress is sustained depends on the nurse's coping mechanisms and strategies.

Wilkinson's (1988) study significantly advanced the understanding of moral distress, from the factors contributing to it, to the determinants of its progression, the level of severity, and its potential duration. While such advances were impressive, leaps and liberties were taken to reach them, due to a homogenous sample, small sample size, and the novelty of the phenomenon itself. As a result, generalizability was limited; however, the study and the complexity of the resulting conceptualization and model of moral distress stimulated widespread interest in moral distress, leading to numerous studies exploring its nature even further.

Advances in the 1990s

Jameton continued to be central to the exploration and conceptualization of moral distress into the 1990s. Most notably in his second publication on the phenomenon, he made two significant contributions to the literature on moral distress. First, he further clarified the nature of moral distress as a "second-order" (Jameton, 1993, p. 544) or secondary moral dilemma. That is, the distress one feels in a situation of moral distress stems, not from the traditional conflict between patient autonomy and medical benefit, but rather from a institutional barriers and oppositional judgments that restrict moral action. Whereas Jameton previously attempted to distinguish between dilemmas and distress, he more explicitly acknowledged that the one experiencing moral distress does, in fact, face a dilemma, albeit a dilemma completely separate from ethical dilemmas typically discussed in bioethics and other areas of health care. The two were understood to be intertwined in ways that were not previously understood nor articulated by Jameton and others.

Second, and more significantly, Jameton (1993) distinguished two separate sub-phenomena in the overall concept of moral distress. Specifically, he identified both the experience of initial distress and reactive distress, which together comprised the experience of moral distress as a whole. Both concepts are described in detail below.

Initial moral distress. Initial moral distress occurs due to the plethora of options nurses and others in health care have in response to bureaucratic obstacles and oppositional colleagues (Jameton, 1993). At first glance, this description seems to be in opposition to Jameton's original definition of moral distress describing it as the perceived inability to act in accordance with one's morals. However, initial distress does not occur simply because of the sheer number of choices available, but rather due to the less than desirable outcomes of those choices. As Jameton

describes it, moral distress may arise from initial distress "partly because so *many* of these choices intimate unpredictable and marginally useful outcomes" (p. 544). While hospitals and other health care facilities might provide nurses with numerous ways to handle ethical dilemmas, in a case of moral distress, none of those options allow the nurse to engage in moral action. As a result, the available choices require "taking risks, possible unpleasantness, extra work, and the operation and interest of others" (p. 545). In addition to their undesirable outcomes, they may only be marginally effective at best, and do nothing to resolve the immediate problem.

Nurses experiencing initial distress find themselves entangled in large philosophical questions pertaining to individual responsibility, rather than moral principles or values. Conflicting inner voices, similar to the proverbial angel and devil on one's shoulder, impel different perspectives on personal responsibility and create a psychological disequilibrium that causes distress. Jameton (1993) describes this external struggle in the following way:

> One voice urges us to limit responsibility and to avoid becoming burdened with problems that should be the concern of others; another voice urges us to do as much good as we can in the world. One voice recommends defining a clear and circumscribed realm of personal responsibility; another voice recommends connectedness with others. (p. 545)

Initial distress, as Austin, Bergum, and Goldberg (2003) put it, involves negative feelings that are a result of institutional obstacles and value conflicts with others leading to difficult choices and undesirable outcomes.

Reactive moral distress. Although Jameton (1993) coined the term reactive distress, the concept is a derivation of Wilkinson's (1988) study and resulting model of moral distress, along with Fowler's (1989) expansion of concepts. Fowler suggested that chronic, long-term moral distress, what Jameton calls reactive distress, contributes to burnout and attrition from the

nursing field. While reactive distress may arise from immoral action, more often it arises from inaction. Over time, if not immediately, reactive distress typically manifests itself as guilt and regret about failing to act in a situation that warranted a decision to act, regardless of whether that action was perceived to be moral or immoral (Jameton, 1993).

More central to the concept of reactive distress, as opposed to initial distress, is the feeling of powerlessness. That is, while nurses have the power to participate in action in health care procedures, often they do not have the power to change institutional policies and practices that result in morally reprehensible actions (Jameton, 1993). Additionally, as Wilkinson (1988) suggested, a defining characteristic of moral distress is a situation in which one's values or morals differ from another person or another group. Due to the paternalistic structure, common in hospitals, nurses often find themselves lacking power to voice opinions and perspectives that conflict with that of their colleagues (Jameton, 1993). The perceived inability to express one's voice, or change the status quo, can result in long-term silence, and thusly, long-term moral distress. Therefore, prolonged inaction or immoral compliance, along with the accompanying chronic complications, is the hallmark of reactive distress.

Responsibility. A defining characteristic of being a health care professional is the obligation to fulfill fiduciary duty. Grovier (1997) reminds us "a professional is one who 'professes' the ability and intention to help others, promising in effect to help those who need it" (p. 79). Although responsibility is implied in Grovier's definition, Barber (1983) was much more explicit in her claim that a responsibility to serve the interests of clients and the general public is one of the essential features to being a professional. While responsibility can be seen as a fundamental principle to professionals or within professions, responsibility varies in form, foci, and extent.

As has been mentioned, moral distress occurs when individuals are unable to engage in moral action and, as a result, feel as though they have not met their perceived responsibilities (Austin, 2012). Jameton (1993) suggested that how one defines his or her responsibility and perceives its extent is a pivotal factor in the experience of moral distress. For example, someone who defines his or her responsibility narrowly may mitigate the experience of moral distress and shift that experience to moral outrage. In this situation, the professional allows oneself to be removed from the morally reprehensible action, which leads to outrage about the immorality of others, rather than distress about the constraints to one's own actions. On the other hand, however, one who defines his or her responsibility broadly may accentuate the experience or increase the prevalence of morally distressing situations. In essence, the individual is involved in a wide range of situations in which he or she is responsible, yet may not have the power, authority, or autonomy to act in desirable ways. Thus, the extent to which one perceives his or her responsibility and participation in professional practice impacts the likelihood and emphasis of the morally distressing experience.

Jameton (1993) contends that judging the extent and focus of personal responsibility is highly controversial. Wendell (1990), however, proposed a four-part analysis of responsibility, which helps delineate different approaches to or perspectives on responsibility. Three of these perspectives are helpful in analyzing moral distress and each is briefly described below, in its relation to and impact on the experience of moral distress.

The perspective of the oppressor. According to Wendell (1990), the oppressor, who is unjustly imposing constraints on individuals or groups of lesser status, always assigns responsibility to the victim. That is, the oppressor blames the victim for outcomes and social problems in order to gain benefit or keep the unequal distribution of power in his or her favor.

Oppressors work very hard to keep their high status and to ensure that the oppression they inflict and the advantaged position they enjoy is concealed from others. Additionally, and most applicable to the concept of moral distress, Wendell suggests oppressors use their "power to make their perspectives the perspective of the whole society. Insofar as they succeed, the perspective of the oppressor is embodied in social institutions, such as the law, and represented as the truth throughout the culture" (p. 24). It is not difficult to ascertain the connection between the oppressor's view of responsibility and moral distress. The victims of the unequal distribution of power and coercion may feel powerless to redistribute power, stand up for what they perceive as the right thing to do, and act in accordance. Wendell notes that this type of manipulation and victimization is often a self-perpetuating pattern, which highlights the difficulty of breaking the cycle and changing the plight of the oppressed.

Interestingly, the victim in the oppressor-victim relationship can, and often does, take the perspective of the oppressor, as well. Although this sounds counterintuitive, Wendell (1990) describes the protective nature of the oppressor's perspective, when assumed by the victim. In this way, the victim takes much, if not all, of the responsibility for the problem, protecting the oppressor from blame and responsibility. At the same time, however, the victim is able to deflect the painful psychological effects of helplessness and loss of control, both of which are contributing factors of moral distress, described in detail below. Truth is lost in this perspective and the distorted perspectives of responsibility help keep the self-perpetuating pattern going indefinitely. In order to see the truth, and gain a realistic perspective of the distribution of power and imposed constraints, one must adopt another perspective entirely.

The perspective of the victim. According to Wendell (1990), those victims who give up the perspective of the oppressor typically assume the perspective of the victim. This perspective

is the antithesis of the perspective of the oppressor, in that it "recognizes the oppressor's responsibility and assigns blame to the oppressor" (p. 26) and directs little or no responsibility on that of the victim. In situations of unequal power, the perspective of the victim is a more realistic one than the perspective of the oppressor, as it places responsibility for the problem where it belongs. With a more realistic perspective of the unjust dynamics previously at play, the victim may be able to rid him or herself of the guilt her or she previously felt and the burden of trying to change the oppressor.

In relation to moral distress, the perspective of the victim allows one to accurately assess the constraints that are being imposed, and often results in empathy or compassion for the victim, while at the same time robbing the oppressor of the credit they may have received otherwise (Jameton, 1993). Additionally, when one assumes the perspective of the victim, he or she often realizes that they are not alone in their victimization. This realization "fosters solidarity among victims and motivates co-operative political action against the oppression" (Wendell, 1990, p. 27), or what Cahn calls moral heroism (as cited in Corley, 2002, p. 647). Some researchers (Peter, Macfarlane, & O'Brien-Pallas, 2004) suggest this is the perspective taken by many nurses, whereas others (McCarthy & Deady, 2008; Paley, 2004) warn that inviting nurses to discuss their experiences of moral distress may invite whining, gossip, or adopting the story of the victim. At its best, this perspective can foster and enhance the effectiveness of challenges to the powers that be, through appropriation of responsibility, unity among the victims, and increased compassion for the victimized group. At its worst, as Paley (2004) suggests, this perspective leads to a cessation in serious thinking, concluding the health care system is morally uninhabitable, all through a painful guise that tries to take the moral high ground.

While the perspective of the victim has many advantages, it also has disadvantages. Accompanying this perspective is a subtle shift in power between the oppressor and the victim, as the victim appropriately places responsibility on the oppressor. However the focus of this perspective remains on past and present victimization that the oppressor inflicted, along with the oppressor's responsibility. As a result, the advantages–increased power and choices–may be overlooked. Wendell (1990) clarifies this unfortunate disadvantage by suggesting this perspective may induce a sense of hopelessness and passivity, as the victim fears having to make important choices, and finds comfort in the blamelessness they now possess. As a result, in respect to moral distress, professionals may find their newly cleared conscience enough to satisfy them, leading to no rectification the ethical problem at hand. Again, as Paley (2004) suggests, this perspective is likely to lead to a lack of serious analysis about how health care systems work, an only superficial, if any, efforts to rectify problematic conditions.

The perspective of the responsible actor. Individuals who adopt the perspective of the responsible actor do not ruminate on the past and present, but rather uses the past as a guide for the present and future (Wendell, 1990). The hallmark of this perspective is curiosity about the nature of the problem he or she is facing, and seeking out a realistic perspective of the appropriation of responsibility, the available choices, and the possible consequences. Wendell also suggests the perspective of the responsible actor involves self-reflecting, making difficult decisions, and taking good risks. This is a perspective of determination, empowerment, and forgiveness with the goal of realistically approaching and overcoming the challenges currently faced, and those that will be faced in the future.

It is not difficult to see how the perspective of the responsible actor relates to the concept of moral distress. The professional, who has been victimized in the past, realistically assess the

situation, lets bygones be bygones, and summons the strength to take and appropriate action that challenges the oppression faced in the past in order to enact change. Others have described the effects of this perspective as moral courage, or the "willingness to take a controversial stand or one that challenges the health care organization or those in it, even when a person's job may be jeopardized (Corley, 2002, p. 647). While this perspective sounds highly desirable, it is much more difficult to assume than the other perspectives (Wendell, 1990). In cases where the professional is part of an institutional system, this perspective becomes even more difficult to adopt. Jameton (1993) notes that roles, responsibilities, praise, and blame are all viewed very differently from different members of the institutional system. That is, "there must be a persistent tension between institutionally established assessments of responsibility and the [professional's] personal perspective on power and responsibility" (p. 547). Indeed, this perspective is likely the most effective in facing moral distress; yet, it creates its own challenges in rectifying the oppressive person, group, or system.

Wendell's (1990) analysis of responsibility offers professionals a clear and distinct way to conceptualize the focus and extent of one's responsibility. In addition, as discussed briefly above, her thorough description of each of the three perspectives sheds light on the ways in which real or perceived distribution of power, along with perception of responsibility for a problem, can perpetuate or break the oppressive system that created the problem in the first place. As will be discussed in more detail below, the victim's perceptions of the contextual dynamics and contributing factors ultimately determine the pervasiveness and severity of one's moral distress.

Responsibility in counseling. It is also easy to make a connection between complications involving responsibility among counselors working with children and/or adolescents and the

potential for experiences of moral distress. One of the most common difficulties child and adolescent counselors face is that of confidentiality (Lawrence & Kurpius, 2000), which presents such counselors with difficult decisions regarding the extent and focus of their responsibility. Lawrence and Kurpius (2000) have identified four positions regarding confidentiality with minor clients and summarize the ethical challenges that might lead to moral distress in determining which position one takes:

> The confidentiality issues that arise when working with minors sometimes place the counselor in a Catch 22 situation. If, on one hand, the counselor chooses to maintain complete confidentiality in a situation in which parental consent is necessary, he or she may risk legal reprisals from the parents. On the other hand, if the counselor chooses any of the remaining three positions, minors in need of treatment may not seek treatment or may terminate prematurely once they understand what information their parents have a right to know. (p. 134)

It is clear in this case that counselors working with children and adolescents may find themselves in situations where moral beliefs dictate with whom their responsibility lies. Differing views of responsibility may justify acting in an illegal way in order to do what is best for the client; conversely, an alternative view of one's responsibility may warrant breaking ethical guidelines in order to avoid litigation. In either case, one's view of responsibility determines potential outcomes, and the fear of such consequences may restrict one from engaging in moral action.

The situations described above depict incidents in which counselors, especially those providing services to children and adolescents in the school setting, have to determine the perspective they take on responsibility. For example, if a school counselor is providing brief therapy at a school that endorses the brief therapy model, yet realizes the model is minimally

effective, he or she has to adopt a perspective on their responsibility, which will partially determine how they handle the situation. Similarly, if a counselor recognizes that colleagues do not have the requisite skills or knowledge to provide services, their perspective on responsibility will impact the effect of the ethically challenging situation. Additionally, the real or perceived barriers to moral action may influence their perspective of responsibility, which has the capacity to help or hinder the change process necessary to alter the unethical behaviors in which they are engaging or involved.

Chronicity of problems. Jameton (1993), taking an econometric stance on action and change, added to the literature on moral distress a discussion about the ways in which problems related to moral distress are sorted, juggled, and tackled. Professionals in health care experience a plethora of problems, and in most cases, it is unrealistic or even inappropriate, to solve all of them (Jameton, 1993). Even if each problem were to cause distress, it is likely that some problems would be left for another time or for someone else to rectify. However, many problems health care providers face warrant an action to effect change.

Jameton's (1993) explication that the chronicity of problems is a precursor to action makes an important point in the understanding of how morally distressing circumstances are handled. He pointed out incidents that inspire moral distress must occur frequently and over a relatively long period of time. Due to the nature of moral distress, described above, at the same time these long-term incidents are experienced, nurses feel a sense of powerlessness and inability to change the conditions that lead to the problematic situation. While the chronicity of the problem leads to distress, its extended duration also compels one to engage in action and efforts toward reform (Jameton, 1993). Moral distress, then, is peculiar and troubling in that it stems

from and perpetuates a sense of powerlessness, yet the chronicity of the problem causing the distress necessitates an action to rectify the problem.

Tying his discussion of the chronicity of problems and their impact on moral distress and moral action to Wendell's (1990) identification of various perspectives of responsibility, Jameton (1993) suggests various responses to isolated incidents and chronic problems, based on one's perspective of responsibility. For example, the adoption of the responsible actor perspective may lead one to overlook particular incidents that occur with less frequency and focus on the overall systemic problem that has plagued him or her in the past and present. By focusing on the overall problem, rather than obfuscating it with minor incidents, efforts to enact change may be more worthwhile than focusing and directing energy to problems that may or may not occur again. As mentioned above, while this perspective is more flexible and may alleviate distress occurring from minor incidents (Wendell, 1990), it is very difficult to act on, especially in situations of unequal power, which typically accompany morally distressing situations.

On the other hand, for example, one who adopts the perspective of the victim may assign blame to the oppressor for both minor and chronic problems. While this is likely a realistic perspective in situations of unequal power, Wendell (1990) notes that it leads to a shift in responsibility where the victim is largely blameless and not responsible for changing problematic situations. That is, regardless of the duration of the problem, an individual with the perspective of the victim is likely to become passive and apathetic, endorsing a position of powerlessness that thwarts attempts to engage in moral action. In this case, unfortunately, the chronicity of the problem is ineffectual in its power to compel the victim to act.

Recent Advances

Research on moral distress during the 1990s focused on garnering an understanding of what constituted moral distress and distinguishing it from moral and ethical dilemmas. More recently, however, research has focused on four main areas of investigation with respect to moral distress: (1) constraints to moral action; (2) the situations leading to moral distress; (3) moral residue; and (4) the consequences, both positive and negative, of moral distress in multiple domains of professional and personal life. While all four areas were initially postulated and investigated during the 1980s and 1990s (Jameton, 1984; Jameton, 1993; Wilkinson, 1988; Wilkinson, 1989), recent investigations have significantly contributed to the understanding of moral distress, resulting in a more complete and accurate conceptualization of the phenomenon. Additionally, recent research has extensively examined the effect moral distress has on nurses and other professionals in health care, widening the applicability of moral distress to professions beyond the profession it originally emerged from. The following section reviews the literature on constraints to moral action, the situations leading to moral distress, moral residue, and its consequences.

Causes of Moral Distress

The causes of moral distress are typically described as constraints preventing moral action from being carried out; however, recent research has also identified repeated and unaddressed clinical situations as additional causes of moral distress (Hamric et al., 2012). Although the causes have largely and consistently been described as barriers or constraints to moral action, they have undergone a considerable conceptual shift since the introduction of moral distress in 1984. As mentioned briefly above, at the inception of the concept of moral distress in health care, the constraints or barriers to moral action were understood to be

exclusively external. Jameton (1984) suggested that contextual factors in the hospital milieu, in which the nurses have neither the authority nor access to change, cause stagnation in moral action. That is, moral distress was thought to be caused by organizational or institutional barriers to moral action, such as supervisor, physician, executive authority, legal constraints, or lack of staff time (Nelson, 2009). Interestingly, however, the causes and scope of moral distress broadened shortly after its introduction into the realm of health care. In her groundbreaking study of moral in the nursing profession, Wilkinson (1988) found that subjects identified both internal and external constraints to moral action. Although the constraints that subjects endorsed varied considerably, the discovery that nurses' personal characteristics contributed to their experience of moral distress was significant in understanding both the nature and causes moral distress. The introduction of internal constraints, along with external constraints, allowed our understanding of moral distress to reflect the multifaceted nature of the concept, in which nurses were not simply passive victims of oppressive institutions.

Recently, several researchers have proposed that clinical situations themselves can be the root cause of moral distress (Epstein, 2008; Gutierrez, 2005; Hamric et al., 2012). As Redman and Fry (2000) suggested, the majority of these clinical situations revolve around ethical conflicts with disagreements about the quality of medical care given to patients. While the acknowledgement of the power certain clinical situations have to result in moral distress has been a beneficial addition to the health care literature, as will be seen below, some researchers seem to straddle the line between constraints to moral action and clinical situations. That is, what some researchers identify as a constraint others identify as a clinical situation. Untangling the distinction between the two has become more and more difficult as researchers from other fields and with alternative understandings of moral distress have applied the concept to new

settings or disciplines. Nevertheless, a summative look at the literature supporting clinical situations as causes of moral distress is worthwhile.

While the barriers to moral action have been described differently by various theorists and researchers, taken together, these constraints are considered to be either internal (e.g., diminished mental fortitude or character) or external (e.g., institutional constraints, unnecessary treatment, lack of support, incompetence or sub-standard care by colleagues, and power imbalances) (Hamric, Davis, & Childress, 2006; Nuttgens & Chang, 2013). Aside from morally constraining situations, some clinical situations can be a cause of moral distress, as well. The following section describes in detail external and internal constraints, along with the clinical situations that are commonly identified as causes of moral distress.

External constraints. The external constraints contributing to experiences of moral distress vary considerably across the literature. Indeed, the experience of moral distress is borne out of the context in which one exists. In fact, Wilkinson (1988) described the factors that contribute to moral distress as contextual in nature. Jameton (1984) initially described external constraints as those stemming from the institution in which one was affiliated. These constraints "make it nearly impossible to pursue the right course of action … [because] staff nurses employed by the hospital have neither the personal authority nor access to decision-making channels needed to change the practice" (p. 6). Jameton listed several external, institutional constraints, including administrators, the law, hospital policies, and physicians, which were corroborated by Wilkinson several years later. Since the introduction of moral distress to health care literature, external constraints have gained increased attention and consistent identification.

Throughout the history of moral distress, researchers have consistently found and described institutional constraints as significant contributing factors to feelings of moral distress

(Burston & Tuckett, 2013; Fernandez-Parsons & Goyal, 2013; Hanna, 2004; Kopala & Burkhart, 2006; Radzvin, 2011; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Shorideh et al., 2012; Unruh, 2010; Woods, 2013; Zuzelo, 2007) and across fields (Austin et al., 2005). The consistency of institutional constraints, however, does not indicate that they are the most prevalent or the most problematic, in terms of the severity of resulting moral distress, although some researchers have found that to be the case (Shorideh et al., 2012). Rice et al. (2008), for example, found the prevalence of institutional constraints among medical and surgical nurses was lower than that of other external constraints. Similarly, Zuzelo found institutional constraints were not among factors that led to the most severe moral distress, whereas Rice et al. (2008) found institutional constraints resulted in moral distress that was uniformly intense across other categories of situations and Hamric, Borchers, and Epstein (2011) reported that institutional barriers did not rank among the top causes moral distress.

As the findings described above would suggest, researchers have found that external constraints are diverse and vary according to context and clinical setting. While institutional constraints defined the causes of moral distress for nearly two decades, Corley et al. (2001) revisited the concept of external constraints and expanded the definition of moral distress to result from obstacles such as "lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations" (pp. 250-251). More recently, O'Connor (2013) found that external barriers include organizational policies impeding on morally acceptable health care and the drive for more efficient health care delivery and cost control, which Sporrong, Höglund, and Arnetz (2006) also found to be barriers to moral action. Woods (2013) suggests external constraints are those that "include socio-political factors beyond individuals' control" (p. 31). Clearly the external constraints identified by researchers have

increased in number and specificity, which again reflects the contextual nature of moral distress, as well as the changing landscape of health care.

One external constraint that warrants brief attention is that of ethical climate. Olson (2002) defines ethical climate as an organizational characteristic that can be modified in order to improve the workplace environment, which pertains to how an organization handles ethical issues. Corley, Minick, Elswick, & Jacobs (2005), Hamric and Blackhall (2007), Lützén, Blom, Ewalds-Kvist, & Winch (2010), Pauley, Varcoe, & Storch (2009), and Silén, Svantesson, Kjellström, Sidenvall, and Christensson (2011) have found that perceptions of the ethical climate at one's unit or institution impacts one's experience and level and/or frequency of moral distress. More specifically, health care systems with well-developed and strong ethical climates should, and have been found to be less likely to foster situations from which moral distress might arise (Silén et al., 2010). Although this finding has been consistently reported for nurses, the relationship between ethical climate and moral distress seems to be less robust for physicians (Corley, 2005; Silén et al., 2010). Because moral distress stems from ethical situations in which one cannot act on their moral resolve, it makes sense that working in an environment with a weak ethical climate might be more conducive to morally distressing situations.

In response to the growing identification of external constraints, some researchers have sought to identify categories or themes in which external constraints seem to exist most often. Variations exist across the literature, due to the contextual nature of moral distress and its contributing factors, however, the patterns they have recognized provide insight into how moral distress arises and can be understood within the context that it exists. Kälvemark et al. (2004) provided an early thematic representation of external constraints within the health care system. The results of their study indicated that external constraints can be collapsed into four categories:

(1) lack of resources; (2) rules and regulations; (3) conflicts of interest; and (4) lack of supporting structures. More recently, Shorideh et al. (2012) found institutional barriers and constraints could be grouped into six subthemes: (1) legal and organizational conditions; (2) medical supervision; (3) accountability; (4) ignoring and injustice to nurse; (5) large financial burden to the patient; and (6) forced cardiopulmonary resuscitation (CPR). Finally, in their comprehensive review of the moral distress literature, Burston and Tuckett (2013) classified external constraints as either site specific (including resourcing, staffing, care, and world of work) or as broader external influences (including economic factors, issues of efficiency, the law, and third parties).

Others have synthesized the literature to loosely identify areas from which external constraints stem; however, they call attention to the limited engagement with policy makers and organizational structures often identified as external barriers to moral action (Pauly, Varcoe, & Storch, 2012). That is, while some themes can be identified, more importantly are thorough understandings of how the structures within those themes operate and contribute to oppressive circumstances that lead to experiences of moral distress. Clearly more research is needed to fully identify, classify, and understand the external barriers to moral action that seem to plague some health care workers.

A complete list of external barriers is not necessary or even desirable, however, in order to understand the general interpersonal and systemic dynamics that give rise to morally distress situations. That is, much of the literature on moral distress suggests the underlying dynamics tend to be those that create feelings or perceptions of powerlessness, helplessness, lack of control, or a sense that the situation is out of one's hands (Ferrell, 2006; Pendry, 2007; Rice et al., 2008; Wilson, Goettemoeller, Bevan, & McCord, 2013). This finding is not surprising, given

the nature and definition of moral distress as a phenomenon in which one is unable to overcome barriers to moral action. That is, the very nature of moral distress necessitates that one feels powerless to act according to one's moral resolve, or a sense of hopelessness in changing the ethical situation from which the distress originates (Corley et al., 2001). Specific barriers to moral action are useful in context, but broadly speaking, each external constraint, whether institutional, economic, legal, interpersonal, etc., creates a sense of inability to act in one's morally desirable way.

External constraints in counseling children and adolescents. Counselors who work with children and adolescents are particularly vulnerable to contextual factors that present ethical challenges. As a result, such counselors often find it difficult to adhere to ethical or legal standards of care while still doing what is best for the client. Interestingly, the vulnerability counselors face reveals a parallel process between the counselors themselves and their child or adolescent clients. In the preface of a comprehensive book on the challenges faced when counseling children, Dugger (2007) notes that children lack considerable control over their lives and are vulnerable to the consequences of the decisions made by important adults in their lives. Before even delving into the specific challenges, barriers, and possible outcomes, it is clear that child and adolescent counseling is decidedly complex, and unfolds in a delicate process that has far-reaching implications for both counselors and children.

Hall and Lin (1995) pointed out, because children, or those younger than 18 years old, are typically viewed as cognitively incompetent in their decision making skills regarding their treatment, adults often assume responsibility and protection of children by making treatment choices on their behalf. Sutton (1997) acknowledges similar issues of conditional autonomy when working with adolescents, regarding who has sufficient authority to take responsibility

about what will or will not be done in adolescent mental health care. While intended to protect children and adolescents from undue harm, parental assent and their right to access of their children's health care procedures and progress may create a conflict in which counselors have to determine if what the parent wants or what the child wants is in the client's best interest (Hall & Lin, 1995). Similarly, Lawrence and Kurpius (2000) suggest that unique ethical issues, such as counselor competence, the child's rights to confidentiality and informed consent, and responsibilities related to child abuse, consistently emerge when counseling minor clients outside of a school setting.

Darlington et al. (2004) raised awareness to some of the challenges practitioners face when child protection services involved in ensuring a child's welfare. Most notably, they point out that collaboration between child protection services and mental health services often is unsuccessful, creating a lack of cohesion in treatment. Additionally, under-resourced child protection services often result in premature termination of services, making treatment less effective, disrupting collaboration between systems, and creating additionally ethical challenges as circumstances are largely beyond their control (Scott, 1997). Darlington et al. (2004) noted a few positive experiences with child protection services, however, numerous difficulties were reported in the areas of communication, role clarity, competing primary focus, contested mental health needs, contested child protection needs, and resources.

Informed consent and confidentiality are ongoing areas of concern for all counselors (DePauw, 1986); however, they present unique ethical challenges for those working with children and adolescents (Lawrence & Kurpius, 2000). These challenges are not specific to counselors, as school nurses (Burston & Tuckett, 2013) and pediatric nurses (Austin, Kelecevic, Goble, & Mekechuk, 2009) also have reported them. Among counselors in and out of the school

setting, however, these issues are highly complex and stem from confusion about who the client actually is – child, guardian, grandparents, etc. – and the fact that legal, ethical, and professional codes occasionally present conflicting information about the right course of action to take (Duncan, Williams, & Knowles, 2013). In addition, confusion exists about what constitutes harm, when it should be reported, how much should be reported, and to whom it should be reported (Kämpf, McSherry, Ogloff, & Rothschild, 2009). As a result, counselors are required to make decisions about which ethical or professional guideline to follow, which involves a balancing act between what is best for the client, what is best for the counselor, and how to situate those considerations within the legal context (Lawrence & Kurpius, 2000).

An additional concern with confidentiality, especially in the school setting, is ensuring administrators, as well as others involved in decision-making, understand and adhere to ethical and legal requirements. Engaging in collaborative and cooperative relationships with both administrators and parents are suggested by both ACA (2014) and ASCA (2012), yet establishing these relationships are often difficult, as the rights and interests of each party often compete (Darlington et al., 2004; Isaacs, 1999). While this has been reported throughout the counseling literature, it was reported in the qualitative phase of the present study, which is described in detail in Chapter Three. Several participants reported the ethical challenges present when working with children and adolescents in which others were involved in the process, but one explicitly described his or her situation in the following way:

> I felt I that I needed to be keeping the clients confidentiality as best I could, but the director reported to the parent how therapy was going and they felt the client was doing. I feel that I should have requested the director refrain from discussions with the parent, as

the individual was of legal age and was not aware of the director disclosing information to the parent.

This example specifically highlights the complexities of ensuring confidentiality when more than just the counselor or therapist has access to the client's information.

Mental health professionals in schools face significant ethical challenges, too, which can create difficulties and dilemmas in providing adequate and appropriate care while still adhering to ethical, legal, and institutional standards (Bodenhorn, 2006; Valkyrie, Creamer, & Vaughn, 2008). Dailor and Jacob (2011) investigated the ethical transgressions witnessed by school psychologists in the last year and found that of the 44 reported, 21 had been witnessed by at least 35% of the school psychologists surveyed. Additionally, they identified categories in which each of the ethical transgressions fell, including assessment, intervention, administrative pressure, informed consent, parent conflicts, school records, job competence, confidentiality, and conflictual relationships (reported from highest to lowest percentage of participants witnessing transgressions). A number of these categories have been identified as causes of moral distress (Nordam, Torjuul, & Sørlie, 2005; Solum, Maluwa, & Severinsson, 2012), which demonstrates not only the potential ethical challenges present when counseling children and adolescents, but also the relevance of moral distress to counselors working with them. Specifically, for example, Silén, Tang, Wadensten, and Ahlström (2008) and Tiedje (2000) found that economic and financial constraints lead to moral distress, which was also reported by 44% of the school psychologists in Dailor and Jacob's (2011) study. Solum and Schaffer (2003) and Hamric and Blackhall (2007) also reported some of the situations leading to the highest levels of moral distress pertained to yielding to administrative pressure to act unethically, which was also found

to be among some of the most common, and concerning, ethical transgressions witnessed by school psychologists (Dailor & Jacob, 2011).

Other examples of the unique nature of working with children and adolescents have been identified by throughout the literature. For example, Austin (2012) notes that social messages pertaining to children and their welfare, such as do not let children suffer, do not harm children, or do not let children die, place additionally expectations and challenges on health care providers who work with children. These issues and challenges are ever increasing, which is reflected by the addition of nearly 40 new standards (Huey, 2011) to the 2010 American School Counseling Association's (ASCA) *Ethical Standards for School Counselors*, along with revisions to the American Counseling Association's (ACA) *2014 ACA Code of Ethics*. It seems apparent that contemporary counseling not only attempts to protect the rights and integrity of younger clients, but also creates significant challenges to those who provide mental health services.

The literature on counseling children and adolescents seems rife with examples of ethically challenging situations that parallel situations in other areas of health care, which have been found to lead to moral distress. These similarities suggest moral distress has applications beyond that of medical health care, which provides a contextual basis for the initial exploration of moral distress among counselors working with children and adolescents. It is precisely these experiences, situations, and factors that are a focus of exploration in the current study.

Internal constraints. Prior to moral distress in the context of health care, Aristotle wrote about akrasia, or a weakness of will, which Williams (1993) defined as "consciously doing what one has less reason to do instead of what one has more reason to do" (p. 45). Shortly after the introduction of moral distress within the context of health care, internal personal factors and psychological responses (Corley, 2002), similar to that of akrasia, were acknowledged among

nurses experiencing moral distressing situations. In her study, Wilkinson (1988) found that all subjects were able to identify both external and internal constraints to moral actions. Identified internal constraints included "[socialization] to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage" (Wilkinson, 1988, p. 21). The last three of the internal constraints certainly seem to reflect personal factors, and the identification of internal factors was a significant step in understanding the ways in which nurses' beliefs and perceptions uniquely contributed to a restriction of moral action.

Since Wilkinson's (1988) discovery, other researchers have helped elucidate the personal factors that contribute to experiences of moral distress. McCarthy and Deady (2008), for example, found those experiencing moral distress described a lack of personal fortitude or character and fear of negative consequences. Wilson et al. (2013) classified internal barriers as lack of awareness, lack of confidence, incompetence, or lack of courage. Lack of courage, Tiedje (2000) suggested, may be the single most difficult obstacle to overcome in the pursuit of movement from moral distress to moral action, highlighting the significance of identifying one's personal characteristics that influence experiences of moral distress.

In addition to the negative self-relevant feelings and lack of awareness described above, Pendry (2007) suggested internal barriers stem from one's belief system, such as unrealistically high expectations for oneself, personal responsibility, and beliefs about quality of life (Tiedje, 2000). In their summary of the literature on moral distress, Burston and Tuckett (2013), similarly, reported that a nurse's worldview and cultural background both had the potential to create obstacles to moral action. That is, the extent to which a nurse accepts his or her marginality (Tiedje, 2000) and the degree to which one's values align with that of the institution or colleagues (Austin et al., 2003) has the capacity to create or eliminate obstacles that might

lead to moral distress. In other words, feelings of powerlessness due to unequal power distributions and their marginalized position, and beliefs incongruent with those of the majority or those in power, are barriers in and of themselves.

Wilkinson (1988) proposed another internal barrier, experience, which has become a focus of several recent studies (Meaney, 2002a; Meaney, 2002b; Rice et al., 2008). The literature exploring the association between experience and moral distress, however, remains divided and is largely speculative. For example, Corley et al. (2001) found no relationship between years of experience and moral distress, whereas Corley et al. (2005) found a significant but low negative correlation between experience and moral distress. Additionally, whereas Rice et al. posited increased experience might lead to increased exposure frequency of incidents of moral distress, and Elpern, Covert, and Kleinpell (2005), Epstein and Hamric (2009), and Hamric and Blackhall (2007) found professionals with more years of experience have higher levels of moral distress, Wilkinson (1988) suggested more experienced nurses are likely to experience or perceive fewer incidents of moral distress. As Burston and Tuckett (2013) pondered, it is unclear "if this is simply a reduced encounter rate, an evolved perception of what constitutes 'real' moral distress, an improved ability to pre-empt and resolve issues more rapidly or a dampening of the psyche from frequent exposure to morally difficult situations" (p. 315).

Convoluting the exploration of the relationship between moral distress and experience even further are discrepancies in how experience is defined. Wilkinson (1988) and Corley et al. (2001) originally referred to experience as years of professional experience in the nursing. Others, however, describe experience as one's familiarity with addressing ethically difficult situations, which may come from life experiences or prior exposure to similar situations, in addition to professional experience (Corley et al., 2005; Meaney, 2002a; Meaney, 2002b). While

conflicting results exist about the relationship between professional experience and moral distress, there is consensus, albeit speculative, that less experience managing ethically challenging situations creates challenges in successfully moving from moral distress to moral action (Corley et al., 2005; Meaney, 2002a).

Clearly, as both Burston and Tuckett (2013) and the conflicting nature of the relationship between experience and moral distress suggest, more research and clearer goals are needed to untangle the complexities between the two. The speculative posits about the correlation between experience with or exposure to morally challenging situations and moral distress seem to make intuitive sense. Questions pertaining to the sensitivity and desensitivity to moral ambiguity, increased wisdom about moral choices and responsibility, and efficacy of efforts to resolve issues, however, create additional doubt and confusion about how the amount of experience differentially acts as a barrier or catalyst to moral action.

Internal constraints in counseling children and adolescents. As previously mentioned, the lack of competence and education have been consistent ethical concerns contributing to feelings of moral distress (Kälvemark et al., 2004; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Winland-Brown, Chiarenza, & Dobrin, 2010), In addition, those deficiencies have been identified as the factors that lead to the highest levels and frequencies of moral distress (Silén et al., 2011). Kälvemark et al. (2004) have identified educational training as a particularly important organizational resource that can be provided to thwart the experience of moral distress. These findings and suggestions overlap with the literature on mental health care, especially in reference to counseling children. Dugger (2007), for example, acknowledges the unique challenges such counselors might face when entering the professional workplace:

> Almost universally, counseling techniques courses concentrate on communication and intervention skills better suited to adolescent and adult clients. Counselors who are schooled in such traditional training programs often find themselves lacking when it comes to counseling these "little boppers," children for whom words are not the primary mode of communication" (p. ix)

That is, lack of training, feelings of incompetence, or witnessing incompetence among others, may be particularly common among counselors working with children, who may not have received the requisite training prior to beginning professional practice, as suggested by Lawrence and Kurpius (2000). As in other areas of health care, these counselors may find themselves managing ethical concerns revolving around competency issues, which counselors working with other populations may not face to a similar degree.

Nuttgens and Chang (2013) identified a number of internal constraints to moral action that might be present in the supervisory relationship. Although these internal constraints might apply to other counselors, there is certainly reason to believe that they might be present among counselors working with children and adolescents. For example, they describe a "lack of personal fortitude or character" (p. 285), which seems to describe the well-established phenomenon in which counselors-in-training experience anxiety, fear, confusion, lack of certainty, or discomfort in initial clinical experiences (Stoltenberg & McNeill, 2010). Goldberg (2007) necessarily notes that these feelings are equally common among seasoned mental health practitioners, as we face a moral relativism that never arrives at the truth for any one of us, or for all time. McCarthy and Deady (2008) similarly found that a lack of fortitude was a commonly described internal barrier to moral action among nurses.

The literature examining ethical concerns that stem from internal constraints among counselors working with children and adolescents is much less expansive than that relating to external constraints. The moral distress literature, however, suggests internal factors are prevalent among health care providers and are significant constraints to moral action. Therefore, while there is currently a lack of relevant literature that identify internal factors that present ethically challenging situations for child and adolescent counselors, it is thought that these factors exist, but may have been overshadowed by external constraints resulting from overt changes in modern mental health care delivery.

Subjective nature of constraints. Wilkinson (1988) was the first to suggest that the consequences of moral distress have little to do with whether or not the constraints are grounded in reality. That is,

> It appears that a nurse's perception of the constraint is more important than whether the constrain is actually "real." Nurses seemed to fear severe, but unlikely, consequences (e.g., loss of license to practice) as much as they did the more likely, but less severe consequences (such as physician anger). (p. 21).

Wilkinson found that the perceptions of both the barriers to moral action and their consequences were more realistic among more experienced and more knowledgeable nurses, and therefore, they were less likely to experience morally distressing situations in the clinical work.

In her qualitative dissertation exploring end-of-life (EOL) experience among patients, nurses, and physicians in a neonatal intensive care unit (NICU), Epstein (as reported in Epstein and Hamric, 2009) found reports of past experiences of moral distress in which very troubling constraints to moral action existed. Although the nurses' claims cannot be confirmed, Epstein suggests that whether or not the memory was objectively true, was of little importance. Instead,

the nurses' interpretation of the situation and the constraints to moral action caused moral distress at the time, and continued to cause moral distress during the study. Therefore, as she and Wilkinson (1988) purport, the "truth" behind the perceived constraints is inconsequential, in comparison to the perception or interpretation of those constraints; it is the perception that leads to the feelings of distress.

Clinical situations. Constraints to moral distress describe the actual barriers to moral action, whether real or perceived. A similar concept, and one that is sometimes intertwined in the moral distress literature, is that of the situations that lead to moral distress. Often described as sources of moral distress, these situations have the potential to lead to moral distress, whereas the constraints restrict individuals from morally acting or responding to the situation. As discussed above, the true sources of moral distress are constraints, such as powerlessness resulting from hierarchical structures, which restrict one from acting according to his or her morals (Epstein & Hamric, 2009); therefore, describing the clinical situations in which moral distress might occur as the actual source of moral distress seems misguided. According to organizational power and conflict theory (Glisson et al., 2008), organizational situations typically do not create conflict and/or resistance to change; rather, social norms, social pressures, sanctions, unequal distribution of power, and the like are determine the ways in which individuals within an organization can respond to situations. Nevertheless, a review of the literature presenting clinical situations as root causes of moral distress follows.

Corley et al. (2001) were the first to formally identify common situations that caused moral distress, which were included in the construction of the Moral Distress Scale (MDS). Additionally, an exploratory factor analysis yielded three categories in which those common

situations appeared to group. Although the MDS, its construction, and testing is described in detail later in this chapter, the following list identifies some of their initial findings:

- Individual Responsibility
    - Perform procedure without patient consent
    - Medical students practicing on patients
    - Discontinue care of patient who cannot pay
    - Ignore patient abuse
- Not in Patient's Best Interest
    - Follow family wishes I don't agree with
    - MD orders for unnecessary tests
    - Life-saving treatment that prolongs death
- Deception
    - MD request not to discuss code with patient
    - IV medication if patient refuses it orally

Since the initial development of the MDS, many other researchers have attempted to verify the finding s of Corley et al. (2001) or have presented additional lists or themes of common clinical situations that result in or cause moral distress. McCarthy and Deady (2008), for example, identified a host of situations, such as unnecessarily aggressive treatment of patients, unnecessary medical testing, and incompetence among nurses and physicians. Similarly, Rice et al. (2008) found common situations that cause moral distress could be described by the categories of physician practice, nursing practice, futile care, deception, and euthanasia.

In their study examining moral distress among staff nurses in an intensive care unit, Elpern et al. (2005) identified the six most frequently occurring items on the MDS:

1. Continue to participate in care for hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to "pull the plug"
2. Follow a family's wishes to continue life support even though it is not in the best interest of the patient
3. Initiate extensive life-saving actions when I think it only prolongs death
4. Follow the family's wishes for the patient care when I do not agree with them but do so because the hospital administration fears a lawsuit
5. Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients
6. Provide care that does not relieve the patient's suffering because the physician fears increasing doses of pain medication will cause death

Interestingly, Epstein (2008) found prolonged and aggressive treatment to be a common source of moral distress, without the qualifier that the treatment is unnecessary, which also was reported by Hamric and Blackhall (2007).

In a similar study exploring ethical conflicts among nurses, Redman and Fry (2000) reported that moral distress resulted from situations in which the result "was thought to be significant pain and suffering for little gain, or if it expressly violated patients' wishes" (p. 363). This description of clinical situations is very similar to some of the more recent descriptions above; however, it suggests that it is not the clinical situation itself that causes moral distress, but rather the result of the situation. This description, while semantically different in only subtle ways, seems to correspond with the definition of moral distress in ways the other descriptions do not. That is, it is not the situation itself that causes moral distress, but the inability of the individual to act on their own moral resolve, for whatever reason, which results in pain and

suffering (Redman & Fry, 2000). This subtle distinction, between situation and constraint, is where the underlying root cause of moral distress seems to become lost in more recent literature. Previously, it was the barrier to moral action in any given situation (e.g., Corley et al., 2001; Hanna, 2004; Sporrong et al., 2006); more recently, the root cause has been described as the situation itself (e.g., McCarthy, 2013; Rice et al., 2008).

Again, while this distinction is subtle, it indicates the evolving nature and understanding of moral distress that continues three decades after its inception, and highlights the potential for confusion among researchers and consumers (McCarthy, 2013). However, clinical situations that cause moral distress have been identified and proposed across a broad landscape of professions in health care, including pediatric surgery nurses (Chiu, Hilliard, Azzie, & Fecteau, 2008), psychiatric nurses (Ohnishi et al., 2010), palliative care nurses (Brazil, Kassalainen, & Marshall, 2010), pharmacists (Kälvemark, Höglund, & Arnetz, 2006), medical students (Lomis, Carpenter, & Miller, 2009), community care nurses (Eizenberg, Desivilya, & Hirschfeld, 2009), physical therapists (Carpenter, 2010), and counselor trainees (Nuttgens, & Chang, 2013).

Hamric et al. (2012) provide an excellent summary of the categories of root causes that lead to moral distress that have been identified throughout the health care literature, which can be seen in Table 2.3.

Table 2.3
Major Root Causes of Moral Distress

Clinical Situations	
• Providing unnecessary/futile treatment	• Using resources inappropriately
• Prolonging the dying process through aggressive treatment	• Providing care that is not in the best interest of the patient
• Inadequate informed consent	• Providing inadequate pain relief
• Working with caregivers who are not as competent as care requires	• Providing false hope to patients and families
• Lack of consensus re: treatment plan	• Hastening the dying process
• Lack of community care	• Lack of truth-telling
• Conflicting duties	• Disregard for patient wishes
Internal Constraints	
• Perceived powerlessness	• Lack of knowledge of alternative treatment plans
• Inability to identify the ethical issues	• Increased moral sensitivity
• Lack of understanding the full situation	• Lack of assertiveness
• Self-doubt	• Socialization to follow others
External Constraints	
• Inadequate communication among team members	• Following family wishes of patient care for fear of litigation
• Differing inter- (ex. RN to MD) or intra-professional (ex. RN to RN) perspectives	• Tolerance of disruptive and abusive behavior
• Inadequate staffing and increased turnover	• Compromising care due to pressures to reduce costs
• Lack of administrative support	• Hierarchies within healthcare system
• Policies and priorities that conflict with care needs	• Lack of collegial relationships
	• Nurses not involved in decision-making
	• Compromised care due to insurance pressure or fear of litigation

Note: Taken from Hamric, Brochers, and Epstein (2012)

Clinical situations in counseling children and adolescents. Numerous characteristics of the profession itself, along with the challenges faced in balancing personal values and professional absolutes, and restrictive governing bodies, all present situations in which one may not be able to satisfy both personal and professional obligations. Austin (2012) acknowledges that discord has always existed in the health care professions, which involve "complex human situations where the question of the right thing to do must answer not only to individual suffering

but the allocation of resources and to the negotiation of public policy" (p. 32). For those reasons, moral distress is very likely to be a phenomenon experienced by many counselors, yet one that has gone unacknowledged and unexplored. Examples of ethical situations that might act as or create barriers to moral action are described below. Most are anecdotal, yet they stem from the literature on ethics and morals in counseling.

Cooper and Gottleib's (2000) study exploring the impact of managed mental health care on counseling psychologists demonstrates that complications introduced by MCOs clearly overlap with those reported in the nursing literature. For example, Hamric et al. (2006) found that substandard practice and questionable practitioner competence were potential sources of moral distress among health care professionals. As Cooper and Gottleib (2000) noted, mental health care practitioners are likely to experience issues with competence, either in themselves or others, due to increasing demands imposed by MCOs.

An additional ethically challenging situation that may be introduced due to MCOs is that of futile or inappropriate treatment. As has been discussed above, futile and inappropriate care has emerged as a concept strongly related to moral distress among nurses in a wide variety of settings (Ferrell, 2006; Oberle & Hughes, 2001; Rice et al., 2008, Brazil et al., 2010). "An intervention can be perceived as futile when its goals are not achievable or its degree of success is empirically implausible and is considered not in the patient's best interest" (Rice et al., 2008, p. 361). Copper and Gottleib (2000) point out that under managed mental health care, practitioners are pushed, if not obligated, to endorse the brief therapy model. Practitioners must determine if such a model is in the best interest of the client, and if not, may need to refer him or her to a practitioner who has not joined a managed care panel. If, on the other hand, the practitioner or his or her colleagues begin brief therapy with a client where it is unlikely that the

goals will be achieve, the practitioner may be faced with a morally distressing situation. Finally, the brief therapy model promoted by MCOs requires practitioners who are not competent in brief therapy or crisis management to assess whether or not they have the requisite skills needed to be effective (Cooper & Gottleib, 2000). In a study examining counselors' opinions of the most important current and emerging ethical issues in counseling, ensuring that counselors practice ethically was the number one issue reported (Herlihy & Dufrene, 2011). It is reasonable to conclude that counselors are likely to engage in or witness treatment of which a practitioner is not competent, which can create ethically challenging situations that might lead to moral distress.

A similar situation that might have the potential to lead to moral distress among school counselors is that of student-to-counselor ratio. Moyer (2011) alludes to the potential for ethically inappropriate treatment due to excessively high student-to-counselor ratios by stating the most successful counseling programs are typically those with lower ratios. Similar conclusions have been drawn from studies exploring the benefits of low student-to-counselor ratios in Missouri (Lapan, Gysbers, Stanley, & Pierce, 2012), Alabama (Reback, 2010), and Connecticut (Lapan, Whitcomb, & Aleman, 2012). These findings suggest that school counselors practicing in systems with higher student-to-counselor ratios may find themselves in situations where the quality of care they or others provide decreases. The potential for this situation to occur seems high. For the 2010-2011 school year, only three states (New Hampshire, Vermont, and Wyoming) had student-to-counselor ratios below the American School Counselor Association's (ASCA) recommended ratio of 250-to-1 (United States Department of Education, 2011). The bleak state of recommended student-to-counselor ratios might create ethically challenging situations in which lower standards of care are established, which could result in moral distress.

Because the counseling literature is devoid of moral distress researcher, the implications drawn above are hypothetical at best; however, it seems reasonable to identify parallel factors and situations present in counseling, especially among those working with children and adolescents, that resemble those which have been well established in the health care literature. Again, it is some of these factors and situations that are the focus of the current study in the author's attempt to gain an initial understanding of the experience of moral distress among child and adolescent counselors.

Moral Residue and the Crescendo Effect

As described above, Jameton (1993) originally conceptualized moral distress as having two distinct parts: (1) initial distress and (2) reactive distress. Although much of the literature on moral distress follows Jameton's framework, recently, moral distress has been conceptualized slightly differently. Webster and Baylis (2000) were the first to describe initial distress as the total experience of moral distress, and reactive distress as an experience qualitatively different from moral distress, described as lingering feelings after a morally problematic situation has passed. They suggest moral distress is a singular, acute phenomenon, whereas the lasting effect, which is moral residue, is "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Baylis, 2000, p. 218). Their view of moral residue resonates well with Jameton's view of reactive distress, which he defined as "the distress that people feel when they do not act on their initial distress" (p. 544). Schluter, Winch, Holzhauselm, and Henderson (2008) and Epstein and Hamric (2009) revisited the concept of moral residue and have laid the theoretical and empirical basis for its existence and distinction from moral distress, which has been explored even further more recently by Bennett and

Chamberlin (2013). Epstein and Hamric (2009) cautioned, however, that moral residue is challenging to characterize because it does not occur consistently across individuals nor throughout time. As a result, and due to its relative novelty in the moral distress literature at this time, research explicitly examining the concept is nonexistent.

With a basic understanding of moral residue, the crescendo effect model can be introduced. Epstein and Hamric (2009) suggested moral distress and moral residue interact in such a way that two different, but relatively predictable, increases in their experience can be observed: (1) the moral distress crescendo and (2) the moral residue crescendo. Both are described in detail below.

Moral distress crescendo. First, the moral distress crescendo generally occurs during one of the situations that cause moral distress, described above. Moral distress begins at the onset of the situation and gradually increases until the situation is stopped or resolved. At the conclusion of that particular incident, the clinician's acute moral distress typically decreases. Although that particularly distressing incident has ceased, the painful feelings one might experience are not completely eliminated; rather, some feelings remain in the form of moral residue, which sets a new baseline for moral distress in the future (Epstein & Hamric, 2009).

Evidence of the moral distress crescendo. Epstein and Hamric (2009) reviewed the previous literature on moral distress and its effect and present the following findings as evidence of a moral distress crescendo. First, Epistein's dissertation (as reported in Epstein & Hamric, 2009) involved interviewing nurses (n = 21) and physicians (n =11) shortly after the death of an infant for whom aggressive treatment was withdrawn. Of the 21 nurses interviewed, six reported increasing feelings of moral distress in the period leading up to the treatment cession and infant's death. Epstein claims that each of the six nurses reported moral distress clearly as result of

perceived aggressive treatment that was unnecessarily prolonged. Additionally, each nurse recalled a point at which they were certain the infant would not survive, although the aggressive treatment continued.

Epstein and Hamric (2009) highlighted the importance and peculiarity of a healthcare provider's feeling of knowing a patient's outcome will be poor. That experience of knowing becomes a significant and powerful source of the distress created by prolonged aggressive treatment in hopeless cases. Epstein and Hamric (2009) reported the following quote from one of the participants illustrating his or her sense of knowing and the distress that accompanies it:

> My grief comes from walking in the unit and seeing a baby suffering for weeks and weeks and weeks on end – knowing in your mind, knowing what's going on and knowing that the child's not going to survive, so why is this happening? (p. 334)

Physicians also reported problematic findings, although the instances were less emotionally charged. Additionally, in a study examining moral distress among third-year medical students, instances involving a lack of resources and deception created moral distress:

> This case was a difficult one for me because it was clear that this gentleman would require months of rehabilitation with little hope for significant return to function/improvement. He certainly was not making any noticeable progress during his hospital stay. His wife continued to ask the attending if this or that movement was a sign of progress, and the attending was generally optimistic in talking with her, but pessimistic outside of her presence. While I understand the importance of hope, I strongly value realistic hope. I felt that the patient's wife was being misled. (Lomis et al., 2009, p. 109)

Epstein and Hamric (2009) note the participants described above reported a noticeable decrease in moral distress after the end of the situation that created the moral distress. This

finding suggests that moral distress, does in fact, increase throughout the experience and decreases following its cessation or resolution. Chiu et al. (2008) also found statements about a baseline level of stress among some of the participants in their study. One participant in particular mentioned:

> Moral distress to me is related to the overall amount of patient care and the high demands/expectations to provide care while learning. I have always felt "backed up" but there is a baseline level of stress—some of it moral—in the intense training we receive. (p. 990)

Combined, the experiences reported by Epstein and Hamric (2009), and Chiu et al. (2008), support the crescendo effect model, described in more detail below.

Moral residue crescendo. As moral distress is continually experienced and the accompanying moral distress crescendos are repeated, the residual feelings similarly increase. The steady but gradual increase of moral residue is the second crescendo in the crescendo model proposed by Epstein and Hamric (2009) and also results in a new, higher baseline moral residue with each crescendo. Such increases in baseline moral residue create increasingly higher crescendos as "new situations evoke stronger reactions as a clinician is reminded of earlier distressing situations" (p. 333). Webster and Baylis (2000) originally depicted moral residue as lasting and powerful feelings concentrated in our thoughts and memories, or what Schuluter et al. (2008) call a psychological scar; therefore, it makes conceptual sense that individuals facing chronic moral distress would be aware of previous experiences, which might intensify more recent experiences. The moral residue crescendo is particularly seen when an individual is part of a system, unit, institution, or team that effectively constrains his or her moral action and, as a result, the problematic situation or system dynamics continue to go unresolved. The crescendo

effect model depicted in Figure 2.1 demonstrates how moral distress and moral residue are closely linked, while still being conceptually distinct phenomena. That is, as Epstein and Hamric (2009) put it, "a buildup of moral residue appears to be dependent upon repeated experiences of moral distress" (p. 333).

Evidence of the moral residue crescendo. According to the crescendo effect model (Epstein & Hamric, 2009), following a crescendo and decrescendo of moral distress, residue lingers if the distress is not adequately and satisfactorily resolved. Although no studies exist that have tested the model, Epstein and Hamric (2009) present findings from previous research that support the existence of moral residue and the increase, or crescendo, of unresolved moral residue over time. First, Epstein (as reported in Epstein and Hamric, 2009) notes that the MD and RA participants in her dissertation consistently recalled unprompted previous experiences of moral distress. Those experiences stemming from moral distressing situations conjured past feelings of powerless, anger, and frustration. This would suggest participants were still carrying with them unresolved moral residue from previous distressing situations that were brought to the surface again with new experiences of moral distress.

Wilkinson (1988) also reported nurses' experiences that seem to suggest a buildup of moral residue over time:

> I'm really tired of that whole system … it hurts too much to have to spend a lot of time with those patients because you know you're helpless to change the situation for them … I think what it's done is make me decide to get out of nursing because I don't like being in a situation where I feel helpless or continually have to deal with situations where I have to do things I think are wrong. (p. 25)

Despite the lack of studies explicitly examining moral residue, Epstein and Hamric (2009) present some quantitative findings in previous research that support lingering moral residue. First, in a study examining the relationship between moral distress, years of experience, years in current position, age, and level of education, Hamric and Blackhall (2007) found a significant correlation between level of moral distress and the number of years nurses had been in their current position ($r = 0.210$; $p = 0.007$). Additionally, they found a significant positive correlation between the number of overall nursing experience and level of moral distress ($r = 0.164$; $p = 0.037$). In a study examining moral distress among nurses in a medical ICU, Elpern et al. (2005) found that nurses' years of experience was positively correlated with moral distress scores ($r = 0.0476$; $p = 0.02$). As Epstein and Hamric (2009) propose, the findings that moral distress increases over time supports the validity of the crescendo effect model is valid. However, they caution readers that drawing conclusions about moral residue based on previous studies should be limited for several reasons. First, they acknowledge that since no studies have been designed to directly measure moral reside, previous data supporting its existence are indirect measures of the phenomenon, at best. Second, other researchers have found little to no correlation between experience and level of moral distress (Corley et al., 2001). While previous studies yielded mixed conclusions about the validity of the crescendo effect model, Epstein and Hamric (2009), in their diligent review of the moral distress literature, have discovered other quantitative results that give credence to their model.

Epstein and Hamric (2009) have identified three patterns that pertain to individuals' experiences of moral distress, as they relate to the possibility of a crescendo effect. First, health care providers experiencing moral distress may simultaneously experience a numbing of their moral sensitivity and withdraw from ethically challenging situations. Second, health care

providers may engage in conscientious objection, or what Lachman (2014) describes as "the rejection of some action by a provider, primarily because the action would violate some deeply held moral or ethical value about right and wrong" (p. 196), referring to a report by Odell, Abhyankar, Malcolm, and Rua (2014). Hanna (2005) found those experiencing ongoing moral distress might engage in conscientious objection, which, as Epstein and Hamric (2009) noted, requires substantial courage, as objections may lead to potential risks for the objector. Because of the riskiness of conscientious objection, Epstein and Hamric (2009) suggest repeated exposure to similarly ethically challenging situations might impact a health care provider's willingness to take action, or object. Thus, as they contend, "it is likely that conscientious objection does not occur with the first occurrence, but after repeated occurrences of moral distress" (p. 337).

Finally, the third pattern Epstein and Hamric (2009) identified that supports the crescendo effect is the experience of burnout, which often leads health care providers to leave either a position or the profession entirely. Maslach and Leiter (1997) state that common sources of burnout are feelings of powerlessness, conflicting values, and coercion, all of which are defining characteristics of moral distress (McCarthy & Deady, 2008; Redman & Fry, 2000), and burnout has been associated with repeated experiences of moral distress (Corley, 1995; Hamric, & Blackhall, 2007). The experience of burnout and the decision to leave a position or profession are not, as Epstein and Hamric (2009) suggest, likely a result of the routine burdens health care providers face. In fact, Kearney, Weininger, Vachon, Harrison, and Mount (2009) and Weissman (2009) claim that for many health care providers, caring and advocating for patients is what keeps them in their current position and profession. Rather, burnout is likely to be a result of a long-term feeling of powerless, stemming from distressing issues beyond one's control. Put

differently, experiences of burnout provide some evidence that moral distress increases over time and from repeated instances.

Taken together, these patterns and the previous literature on moral distress offer support for Epstein and Hamric's (2009) model of the crescendo effect. More specifically, the three patterns of withdrawal and passivity, conscientious objection, and burnout or attrition from a position or profession, suggest repeated exposure to morally distressing situations has the potential to cause a buildup of moral residue, which eventually results in extreme responses not seen among those with less frequent exposure to moral distress. Figure 2.1 depicts the crescendo effect model that Epstein and Hamric (2009) proposed, which more thoroughly illustrates the gradual progression of both moral distress and moral residue over time.

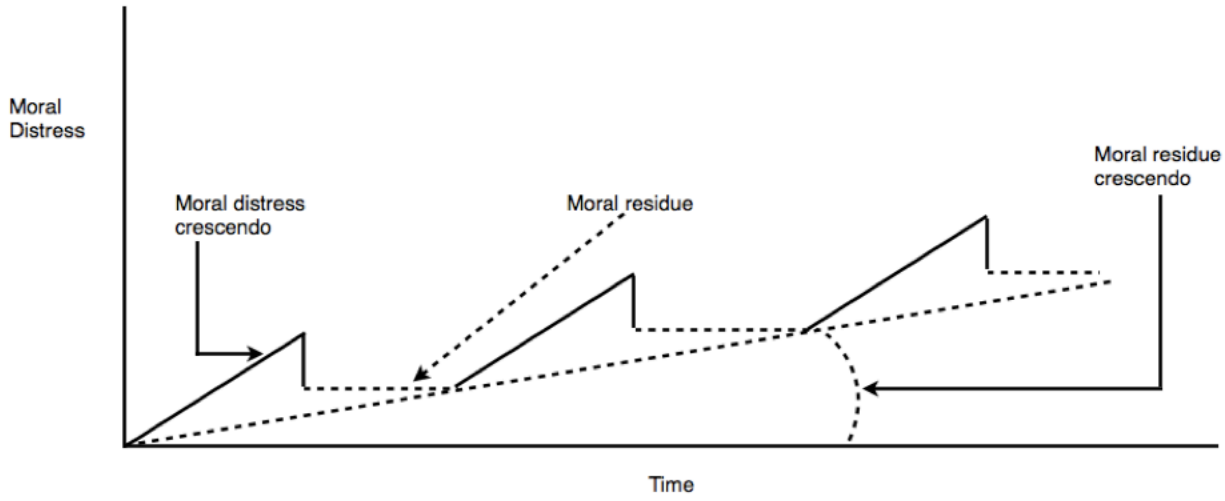


Figure 2.1. Model of the crescendo effect.

Webster and Baylis (2000), who originally introduced the concept of moral residue, offer an alternative proposal of how moral residue negatively affects an individual over time. They

propose, in contrast to moral residue's benefits, which were described above, moral residue can lead to future errors. Those errors, will take one of three forms: (1) denial of the incoherence between beliefs and actions; (2) trivialization of the incoherence between beliefs and actions; of (3) unreflective acceptance of the incoherence between beliefs and actions.

The first instance involves self-deception, which relies on "distorted reasoning, deliberate ignorance, and self-directed lies" (Martin, 1986). As a result, the individual remains ignorant to any wrongdoing and can conclude that his or her moral integrity is still in tact. Webster and Baylis (2000) suggest this can occur in one of two ways. First, the individual compartmentalizes the self, and overlooks certain truths, as personal and professional roles are completely separate from one another. Therefore, compromises that occur in the workplace are of no threat to personal integrity. The second strategy involves narrowing the definition of personal roles and responsibilities so one can absolve oneself of moral decisions and moral responsibilities in the workplace. "So long as one does one's (limited) job, professional integrity is not compromised" (p. 225).

The second instance, as Webster and Baylis (2000) describe, involves trivializing any incoherence between beliefs and actions by concluding that such inconsistencies are inconsequential. Over time, one may lose sight of what constitutes truly trivial transgressions and those that pose serious risks to self or others. From this perspective, however, "no transgression is ever so serious that it cannot be trivialized" (p. 226). In the third instance, an individual tries to compensate for inconsistencies between beliefs and actions by altering or completely abandoning previously held values. As a result, actions once viewed as morally wrong are no longer perceived as such. Webster and Baylis (2000) acknowledge the fluid characteristic of morals and values and qualify this third strategy by stating "there is a significant

difference between a change occasioned by life experience and critical reflection, and a change motivated by fear, expedience, or self-preservation" (p. 226). Poisson, Alderson, Caux, and Brault (2014) also have reported that, by analyzing moral distress from a psychodynamic framework, it is clear nurses develop defensive strategies in order to help manage and protect them from the suffering that accompanies experiences of moral distress.

While Epstein and Hamric (2009) and Webster and Baylis (2000) propose different models of moral residue's effect, the two still seem to complement each other. The evidence suggesting chronic moral distress may result in increased experiences of distress may be reflected by the personal strategies Webster and Baylis (2000) outlined. By deceiving oneself or functioning in denial, previous instances of moral distress likely are not resolved. As new instances of moral distress are experienced, lingering effects of previous morally distressing events may result in heightened distress as one has difficulty distinguishing between inconsistencies and transgressions. As a result, the new events or results may shock an individual who did not see the transgression coming. On the other hand, as Webster and Baylis (2000) suggest, long-term moral residue can result in a complete abandonment of previously held values. As such, new experiences of moral distress may, in fact, be less threatening and emotionally reactive. While this has yet to be examined in the literature, from this view, the two theories of moral distress suggest vastly different effects and developmental trajectories.

Consequences of Moral Distress

The consequences of moral distress have been a large focus of research since the concept was introduced in health care literature. This continues to be the case and recent research examining the consequences of moral distress has provided substantial insight for health care professionals across fields, as well as their patients. Most commonly, consequences are

understood to be negative and potentially detrimental to the individual, their relationships, and the organizations in which they work or are affiliated. Less commonly, but equally interesting and impactful, researchers have found moral distress can have positive consequences, which often manifests itself as personal growth (McCarthy & Deady, 2008), a heightened sense of autonomy (Meaney, 2002a), and increased motivation (Weissman, 2009). The following section reviews the literature on the impact moral distress can have in a number of life domains, relational dynamics, and institutions, beginning with the negative and concluding with the positive.

Adverse Consequences

Prior to delving into the literature on adverse consequences, a caveat needs to be stated. Wilkinson (1988) and Jameton (1993) differentiated between initial moral distress and reactive moral distress, both in kind and effect. Initial moral distress, they suggested, occurs when individuals are first restricted from doing what they judge to be the morally appropriate action and results in feelings of frustration and anxiety. Reactive moral distress, on the other hand, is an additional experience of distress that occurs after one does not respond to their initial moral distress, which results in feelings of "powerlessness, guilt, self-criticism and low self-esteem, as well as physiological responses such as crying, loss of sleep, nightmares, and loss of appetite" (McCarthy & Deady, 2008, p. 256). While this distinction is admirable, it is no longer the current view of moral distress, as was discussed above. As such, the negative consequences of moral distress will be discussed in their totality, irrespective of when those consequences occur. However, the chronicity of moral distress and the literature pertaining to its effects will be briefly discussed.

Personal. The personal implications of moral distress have been a focus of research and literary discussion since shortly after its introduction into health care. Initially, Wilkinson (1987) found moral distress leads to anger, frustration, and guilt, which were later corroborated by Gutierrez (2005). Since Wilkinson's explication of the psychological complications moral distress can have, many other adverse personal consequences have been identified over the last two decades. A review of the literature suggests that personal consequences occur, or affect, three domains of life: (1) emotional/psychological; (2) physical/physiological; and (3) sleep disturbances. Each of these areas of consequence is described below.

Emotional/psychological. McCarthy and Deady (2008) suggest experiences of moral distress may have both emotional and psychological effects, which has been reported as far back as the first published study on moral distress (Wilkinson, 1988). That is, researchers have consistently found that those experiencing moral distress have reported an emotional toll consisting of frustration and anger (McCarthy et al., 2008), anxiety (Wilkinson, 1988), powerlessness, loss of self-esteem, and self-criticism (Corley et al., 2001; Kelly, 1998). These emotional and psychological effects, however, can vary broadly in intensity and severity (Hanna, 2005). In her narrative study examining moral distress among nurses witnessing futile care, for example, Betty (2006) found the emotional ramifications of moral distress ranged from frustration and anger to failure, sorrow, and betrayal. In his summary of findings, Woods (2013) identified a number of general implications that affected participants on a personal level, including anger, frustration, exhaustion, confusion, feeling overwhelmed, job dissatisfaction, despondency, cynicism, and depression. In more restrictive situations in which individuals perceive moral action impossible, or nearly impossible, more extreme effects have been reported, such as horror and anticipatory dread (Hanna, 2005).

Other personal effects have been reported longer after the experience of moral distress, which seem to indicate negative consequences of moral residue. For example, the lasting tension between what was done and what should have been done results in experiences of guilt (Tiedje, 2000; Ferrell, 2006), remorse (Hanna, 2005), the pain of regret (Laabs, 2007), feelings of helplessness, hopelessness, and demoralization (Ferrell, 2006), and an increased sense of personal grief (Hanna, 2005). Similarly, some health care professionals have reported situations of chronic moral distress, emotional exhaustion, depersonalization, and a feeling of reduced personal accomplishment (Corley, 1995; Maslach & Leiter, 1997). Finally, Tiedje (2000) found that exposure to chronic moral distress had the potential to cause the deleterious effects of burnout, which can create complications outside of one's personal life, including patient care and occupational attrition. Weissman (2009) indicates that symptoms of burnout among nurses occurs with "numbing regularity," (p. 865), and even lead to a stage beyond burnout he simply calls "being done" (p. 865). These reports highlight the prevalence and severity of chronically experienced moral distress, leading Weissman to question whether or not moral distress is inevitable.

Physical/physiological. In addition to the detrimental emotional and psychological effects of moral distress, described above, several researchers have found reports of negative physical and physiological consequences. In comparison to the prevalence of other personal effects of moral distress, however, the physical and physiological effects are somewhat less commonly reported. Fry, Harvey, Hurley, and Foley (2002) reported that, among military nurses who had experienced moral distress over an extended period of time, the effects manifested themselves in the form of crying, headaches, loss of appetite, heart palpitations, and changes in body functions.

Sleeping dysfunctions. Wilkinson (1988) was the first to report sleep dysfunctions among those experiencing moral distress. More recently, however, sleep disturbances have been found in a number of studies with several types of health care providers. McCarthy and Deady (2008) and Woods (2013), for example, noted that participants who had experienced moral distress reported decrease amounts of sleep, which corroborated Wilkinson's earlier work. Similarly, Weissman (2009) reported that the palliative care professionals with whom he worked found their constraints to moral action so disturbing that they could not sleep at night. Finally, Unruh (2010) hyperbolically titled her manuscript "Moral Distress: A Living Nightmare," however, she noted that nurses did, in fact, report experiencing nightmares in the wake of moral distress. While Unruh did not report the content of nightmares, Foley, Minick, and Kee (2000) found that some nurses expressed having nightmares about being treated in the same way they had treated their patients. Although no study has specifically looked at the effects moral distress has on sleep patterns, it is apparent that moral distress can be disturbing enough to disrupt sleep, as these effects have been reported for nearly three decades.

Interpersonal/social. Gutierrez (2005) highlighted the interpersonal implications of moral distress, which include strained relationships, both emotional and physical withdraw, distrust of others, disconnection from others, isolation, and hostility toward others. Similarly, strained relationships with other team members emerged as a theme among nurses in critical and transitional care units (Wilson et al., 2013).

Organizational. Organizational consequences seem to vary less than other types of consequences, however, their effect can be detrimental to the organization and to the individual experiencing moral distress. Most notably, much of the literature on organizational or institutional consequences suggests that moral distress can lead to employee attrition (Betty,

2006; Corley et al., 2001; Glissen et al., 2008; Hamric & Blackhall, 2007). Weissman (2009) described this best in his paraphrased statement of the palliative care nurses and physicians he worked with by stating that some of them hung up their palliative care shingle and declared "I just can't do it anymore, I am so angry with the system I can't meet the needs of my patients in a manner that lets me sleep at night" (p. 865). This statement, which Weissman indicated was common among the nurses he had worked with, indicates how the effects of moral distress do not occur unilaterally; rather, they overlap and what starts as a personal factor can have implications for other domains of functioning.

The attrition rate due to moral distress is not completely clear, but Corley et al. (2001), found that 15% of critical care nurses reported leaving a position due to moral distress. More recently, Wilson et al. (2013) found that 24% of nurses in their study reported that they had left a position due to moral distress and 80% indicated that they had considered quitting a position. Winland-Brown et al. (2010) found attrition due to moral distress was especially likely among nurses under the age of 30, as they do not have the "the tools to deal with inter/or intra professional situations … nor have developed critical communication skills to deal with physicians and other in the workplace" (p. 9). In a study comparing registered nurses (RNs) to physicians (MDs) in a community and university-affiliated hospital, large differences existed in the percentage of RNs who reported either leaving a position or considering leaving a position compared to MDs (Hamric & Blackhall, 2007). More specifically, Hamric and Blackhall (2007), found that 45% of the nurse participants had considered leaving a job due to moral distress, whereas only 3% of MDs had; similarly, 17% of the nurse participants had actually left a job due to moral distress, whereas 0% of the MDs had. While large differences in sample sizes (RN *n* =

190; MD $n = 29$), these findings indicated that dynamics inherent to both positions differentially impact the experience of moral distress.

It is also unclear which conditional factors relate to attrition due to moral distress, but Wilson et al. (2013) suggested that chronicity of the distress may play a key role in decision to leave a position, which is also supported by the crescendo effect model of moral distress and moral residue described above (Epstein & Hamric, 2009). Additional speculation came from Tiedje (2000), who proposed that those who leave the nursing setting or profession might be those who are the most sensitive to moral issues or those who are particularly altruistic and advocating for patients. Winland-Brown, Chiarenza, and Dobrin (2010) also mentioned that personal characteristics, such as poor interpersonal skills and undeveloped communication skills, are likely to contribute to higher levels of moral distress, and thus, higher attrition rates. Finally, Hamric and Blackhall (2007) found that in comparison to nurses who had low moral distress scores (the lower 33% of moral distress scores in their study), nurses who had high moral distress scores (the top 33% of moral distress scores) had significantly lower satisfaction with care quality than nurses who had low moral distress ($F_{2,164} = 16.52$; $p < 0.001$). As a result, Hamric and Blackhall (2007) suggested that quality care satisfaction is likely a powerful factor in nurse turnover. Referring to previous research (Thomas, Sexton, Helmreich, 2003; Oberle & Hughes, 2001), in relation to their finding about MDs and RNs, Hamric and Blackhall (2007) also suggest that differences between MDs and RNs may be due to differences in their responsibilities, status, authority, gender, training, or differences between medical and nursing cultures. These findings provide initial data for understanding the causes of turnover related to moral distress, however, much more research is needed to elucidate the factors that uniquely contribute to job attrition.

Patient/family. Wilkinson (1987) was the first to propose that the consequences of moral distress could be transferred onto patients and clients. However, studies exploring the consequences of moral distress seem to have largely overlooked this aspect of the implications moral distress can have on self and others. Much of what exists in the literature is hypothetical or theoretical, which makes intuitive sense, but lack an empirical basis. Other reports are anecdotal, portraying cautionary tales of the powerlessness to say no, which among nurses, can even result in near-fatal incidents (Dingwall, 2011). Wiegan and Funk (2012) sought to address the need for empirical evidence of the effects of moral distress on patients and families by exploring health care providers' perceptions of the clinical implications of moral distress. Through open-ended surveys, the authors used a descriptive approach to gaining insight about the ways in which nurses' moral distress impacted their clients.

The results of Wiegan and Funk's (2012) qualitative analysis revealed that nurses not only described real consequences for their patients, as well as their families, but also possible consequences for future patients. Consequences affecting patients were grouped into several categories: (a) suffering, (b) prolonged dying, (c) undignified dying, (d) quantity versus quality of life, (e) inappropriate care, (f) delayed treatment, (g) prolonged hospitalization, (h) disrespect, (i) the inability to be with family, and (j) false hope. Only one positive patient consequence was identified, which was categorized as comfortable dying. Wiegan and Funk (2012) also reported consequences that affected family members, which were mostly negative and were grouped into the following categories: (a) suffering, (b) not being prepared, (c) being overwhelmed, (d) grief, (e) guilt, (f) financial burden, (g) fatigue, (h) stress, (i) anger, (j) being unable to spend time at the patient's bedside, and (k) organ donation. The only positive consequence that emerged for families was having the time to process and begin the grief process. Unfortunately, the family

who experienced this positive consequence had the time to process the medical situation due to the patient's aggressive treatment and prolonged death.

Finally, several of the nurses in Wiegan and Funk's (2012) study reported potential consequence for future patients, of which, two were negative and one was positive. Interestingly, all three situations involved ethical issues and consequences surrounding organ donation practices. First, one nurse reported experiencing moral distress due to the donation of organs from a patient who might have been positive for human immunodeficiency virus (HIV), which would create serious consequences for future recipients. The second situation involved a physician who prevented an organ donation procurement representative from contacting a family for organ donation, which denied future patients receipt of the donated organs. The third situation involved prolonged treatment of a patient who was eligible for organ donation, yet the family's wishes were not known. Prolonged treatment allowed the nurse and physician to determine that the family wished to donate the patient's organs, which allowed availability of organs to future patients.

Positive Consequences

An overwhelming majority of the literature pertaining to moral distress focuses on the negative consequences of moral distress on multiple domains of life; however, some researchers have found that moral distress has the potential to lead to positive consequences, as well. For example, Webster and Baylis (2000) suggest that moral residue, in particular, has the capacity to result in good outcomes. That is, the effects of chronic moral distress can help one to more accurately distinguish between situations that warrant withdrawal and those that can be tolerated. In other words, moral residue helps one "clarify one's personal moral boundaries and thresholds" (p. 225).

Similarly, Meaney (2002a) found that, among case mangers that experienced chronic moral distress, some grew to experience a heightened sense of autonomy. Based on his focus group analysis, Meaney (2002a) concluded that the positive experience of increased autonomy was a function of maturity, or "'seeing the broad picture' and being able to offer clients more choices after learning how to coordinate different systems" (p. 33). McCarthy and Deady (2008) also acknowledge arguments that moral distress can help individuals increase self-awareness about their own moral, spiritual, and philosophical beliefs. Additionally, just as Meaney (2002a) suggested, they propose moral distress can help individuals strengthen their moral resolve to do better in future ethically challenging situations. Among nurses in the intensive care unit, Lantos (2007) found moral distress has the potential to be viewed as a sign of progress in which previously taken for granted decisions are reevaluated and new lines of communication and discussion can be opened. Moral consensus, as Lantos notes, is not always correct, and rigidly established views of consensus may need to be reexamined and modified to reflect up to date information or best practices. For him, moral distress offers an avenue to ethical progress and moral development. Hanna (2004) may have provided the most compelling statement regarding the prevailing pessimistic view of moral distress that overlooks its potential for personal development:

> Moral distress has been viewed as a negative experience to be avoided or healed. Yet it could be viewed as a life challenge that develops moral character for those who manage it well. It might also be viewed eventually as a potential therapeutic intervention for certain groups of people. (p. 77)

Hanna (2004) and others make a compelling argument; however, Epstein and Hamric (2009) explicitly argue against their optimistic view of moral distress. They acknowledge the

benefit of new ethical discussions, but reflect on the true nature of moral distress, which indicates a lack of meaningful ethical discussions among colleagues, other professionals, and stakeholders. As a result, they remind us that individuals experiencing moral distress feel as though they have no other option but to act in ethically inappropriate ways. Moral distress often stems from an inability to voice one's opinion or have that opinion heard (Gordon & Hamric, 2006). Epstein and Hamric (2009) concluded:

> Moral distress, therefore, cannot be viewed as a healthy phenomenon precisely because of this lack of, or exclusion from, ethical discussion. It is the violation of one's core values and obligations that makes moral distress such a powerfully negative phenomenon. (p. 331)

Epstein and Hamric (2009) ground their rebuttal in theory about the phenomenon of moral distress, as well as its original conceptualization. However, shortly after its introduction by Jameton (1984), other philosophers were contemplating, and arguing about, the potential benefit moral distress could offer. Waldron (1987), for example, referenced John Stuart Mill's (2001) proposal of the Harm Principle, in which the outrage and disturbance that deviance evokes is something to be welcomed. Although moral distress, to Mill and Waldron, are considered in slightly different contextual and political arenas, the tenets reflect very similar principles. As Waldron points out, Mill suggests a twofold benefit of the ethical confrontation that stems from moral distress: first, it contributes to the emergence of new, and possibly better ideas; second, it makes an important contribution to the ways in which ideas are held in society. That is, "when ideas and lifestyles clash in open debate, each is put on its mettle, and its adherents are required to continually reassert and therefore to re-examine the content and

grounds of their new views" (Waldron, 1987, p. 415). Mill conveys the importance and power of this type of discovery in the following way:

> To discover to the world something which deeply concerns it, and of which it was previously ignorant; to prove to it that it had been mistaken on some vital point of temporal or spiritual interest, is as important a service as a human being can render to his fellow creatures, and in certain cases, as in those of the early Christians and of the Reformers, those who think with Dr. Johnson believe it to have been the most precious gift which could be bestowed on mankind. (p. 28)

In their moral cascade model, Rambur, Vallett, Cohen, and Tarule (2010) provide another argument against the wholly negative quality of moral distress. They hypothesized that the obverse of moral distress is moral eustress, a theoretical phenomenon stemming from Selye's (1974) modern stress theory. The prefix "eu" is derived from the Greek word for "well" or "good," suggesting ethically difficult situations can produce moral stress that is productive and has positive implications, such as moral development and enhanced ethical complexity. "It is how an individual responds to the stress, or is able to respond within environmental and other constraints, that determine[s] whether stress is ultimately positive and life enhancing or negative and deleterious" (Rambur et al., 2010, p. 43). Their proposal hinges on the assumption that individuals are more resilient than others exploring moral distress have suggested.

It is clear that Mills (2001), Rambur et al. (2010), among others, value the importance of the ethical confrontations that might result from moral distress; however, as Epstein and Hamric (2009) dutifully remind us, moral distress is, in and of itself, a lack of ethical confrontation, at least interpersonally. Benefits that may follow moral distress are not truly benefits of moral distress, but rather rewards that accompany overcoming moral distress. In other words, benefits

require the move from moral distress to moral action, and as Tiejde (2000) makes it clear in the following section, moral action is not a part of moral distress and is much harder to achieve than the optimistic views above may purport.

Moving from Moral Distress to Moral Action

A fundamental assumption, according to Tiejde (2000) is that all nurses, among other health care professionals, have the capacity to develop inner strength; however, one's level of personal strength is dependent on the quality and amount of experiences one has had. Wilkinson (1988) corroborates this assumption by stating that the totality of one's experiences and knowledge of available options impacts whether or not nurses can move from moral distress to moral action. Prior to the late 1990s, however, little was know about how experience and knowledge, among other things, influenced one's ability to overcome the real or perceived obstacles preventing moral action. Over the last decade, researchers interested in moral distress have begun to broaden the focus from exploring the experience, determinants, consequences, and situations related to distress to one that now includes factors and interventions, both preventative and remedial, that help individuals more successfully overcome barriers to moral action.

Tiejde (2000) presented a comprehensive model of both the moral distress process, which according to her involves the "recognition that a decision is difficult to act upon; experiencing the emotional distress inherent in that situation; reflecting on the situation; choosing strategies; and then acting" (p. 38). Tiejde also presented the model visually, as seen in Figure 2.2 below.

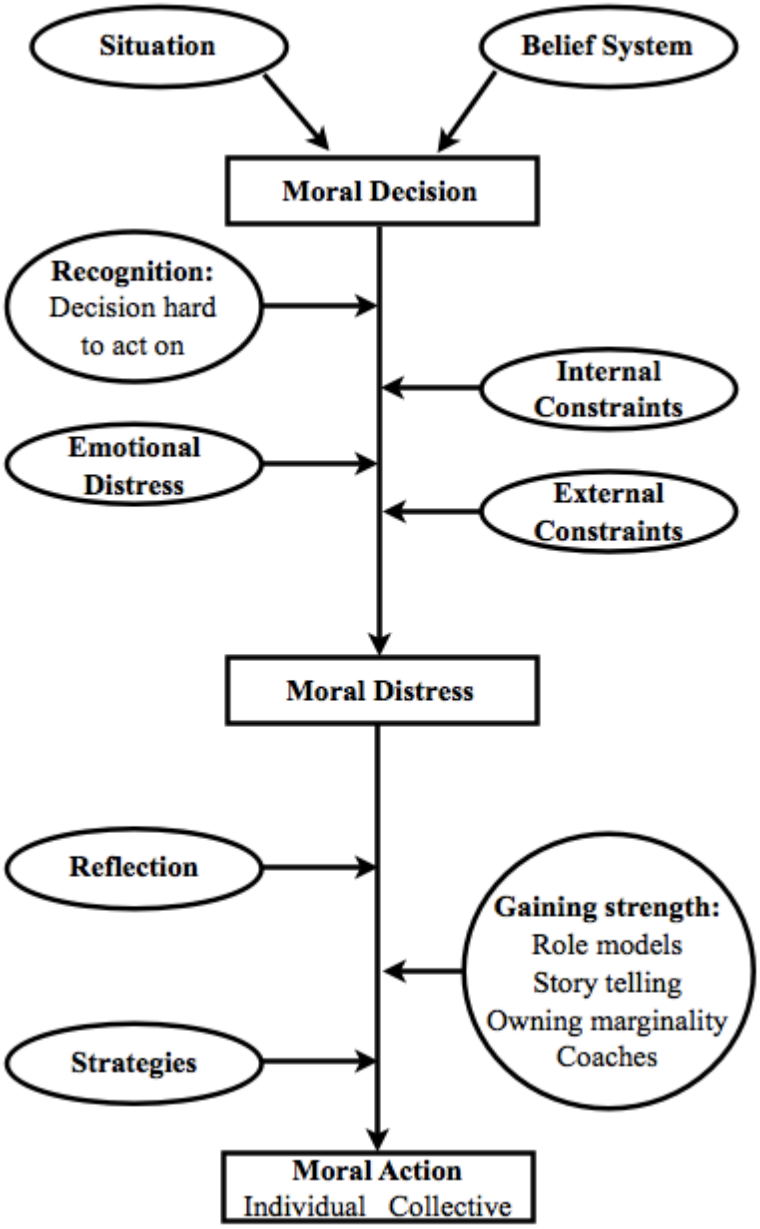


Figure 2.2 Moral distress process (Tiedje, 2000)

Successful completion of her moral distress process model involves reflecting on and exploring how much resistance to change should be given, and results in moral action, either individual or collective. Although she presented a fairly straightforward model, Tiejde acknowledged that moving from moral distress to moral action is typically an exceptionally

difficult task and often requires personal fortitude and external support. Taking the risks necessary to act morally in the midst of ethical challenges occurring in oppressive systems also requires courage, which she suggests is the most difficult part of the moral distress process. The difficultly to find the courage to stand up for one's moral values, especially when they conflict with others, is evidenced by one nurse interviewed in Epstein's (as reported by Epstein & Hamric, 2009) study:

> You know, maybe there was enough time. And I didn't realize I had that avenue. And I don't know if it was because [one parent] was a physician in the hospital …. But I was so berated in that situation. I didn't have enough courage to then … I was just like, okay, I'm wrong. I'm bad, that's it. (p. 336)

Fortunately, Tiejde proposed methods that might be useful and efficacious in developing the inner strength needed to carry out his or her resolve to move from moral distress to moral action: (1) role models; (2) storytelling; (3) owning marginality; and (4) acquiring a coach. Although Tiejde's suggestions lack empirical support and are largely anecdotal, they still offer a compelling and unique perspective, which warrants a brief review.

Role Models

The first method of increasing inner strength, identification of and identifying with role models, suggests that strength can be garnered though previous examples of altruism, advocacy, and courage. That is, Tiejde (2000) suggested inspiring stories of others in similarly morally challenging situations should have a carry-over effect on those currently facing morally distressing situations. While the health care field certainly has enough examples of courageous individual from which to draw inspiration, the efficacy of this suggestion has yet to be explored or substantiated.

Storytelling

Storytelling, the second method of gaining inner strength in Tiejde's (2000) model, is an extension of the first method. Both listening to and reading about others' successful negotiation of morally distressing situations, along with sharing one's one struggle, have the power to emancipate individuals from the shackles restricting moral action. Drawing on tenets of narrative therapy (White & Epston, 1990), Tiejde suggests those using stories and engaging in storytelling can describe the process of their distress and reflect on it, ultimately identifying strengths, insights, and gaining strength to engage in moral action. Again, while this suggestion has not been substantiated in the context of moral distress, the core tenets on which Tiejde draws may well translate to those experiences morally distressing experiences. Smith (2012) highlights the powerful impact borrowing stories and engaging in storytelling can have for grieving individuals, and others regard storytelling and narrative construction as a central concept in forms of psychotherapy (McLeod, 1997; Ramey, Tarulli, Frijters, & Fisher, 2009; White & Epston, 1990). As Smith points out, "borrowing an historical or biographical narrative fragment gives the client an opportunity to make a link to the story … [and] find permission in the story to honor their story" (p. 3). Ultimately, making a link with, or finding inspiration through another's story, plants a seed for the future and provides an opportunity to reinvent oneself or one's world (Neimeyer, 2009). It is reasonable to follow the logic in Tiejde's second method of strength development, as the tenets of narrative therapy and storytelling address the central struggles of powerlessness, stagnation, and oppression.

Owning Marginality

Tiejde's (2000) third method of gaining strength offers a paradoxical perspective of the oppression and marginality nurses often feel in health care systems. She proposes:

> Being at the margins means having the distinct perspective of being part of the health care delivery scene, but in some sense, not in it at all. "Outsiders within" may see things others do not see … [and] may, because of their very powerlessness and marginality, be more able to identify with and focus on the mother/infant/family in times of crisis. (p. 41).

Tiejde suggests it is from the margins of systems that new visions may come from. As a result, one might discover new areas of need or new opportunities for change. Identifying needs, of which others are blind to, can instill a sense of power and have a significant positive impact on otherwise powerless individuals.

Acquiring a Coach

Finally, Tiejde (2000) suggests that acquiring a coach can help individuals gain the skills, knowledge, and courage needed to take risks. Just as children should be provided a secure base to explore their environment and take risks from (Bowlby, 2005), Tiejde advises individuals struggling with moral distress to acquire a coach who can provide a secure base with financial and interpersonal components, and listen, guide, and offer feedback. In essence, a coach can supplement the courage that one lacks, in order to take risks, open oneself to failures, and learn from mistakes. As Professor Van Helsing famously said to Dr. Seward, "We learn from failure, not from success!" (Stoker, 1897, p. 172). Similar sentiments have been championed by others (Adler, 1927; Ellis, Carette, Anseel, & Lievens, 2014; Yang, Milliren, & Blagen, 2010), suggesting that having the courage to be imperfect and a willingness to learn from failures is essential for healthy personal development. In her application of the power of failure and courage to moral distress, Tiejde suggested that even if one is initially unsuccessful in moving from moral distress to moral action, supportive failures could benefit future risk taking. Recall,

however, that Wendell (1990) cautions that engaging in risk taking behavior, although desirable in situations of moral distress, is often extremely difficult. Research is needed to determine whether or not simply having a coach to support risk taking is sufficient in enough for its implementation.

Addressing Moral Distress

In 2005, The American Association of Critical-Care Nurses (AACN) identified attention to moral distress as a priority goal and called for new programs and strategies to address moral distress. Since then, the moral distress literature has been rife with program and strategy proposals, along with research examining their efficacy. In 2006, the AACN's Ethics Work Group proposed four strategies they outlined in *The 4 A's to Rise Above Moral Distress*, which focused on personal exploration and individual strategies to take moral action. As suggested by Tiejde (2000) above, *The 4 A's to Rise Above Moral Distress* address one of the most difficult internal barriers to moral action: the development of strength and courage. Following the AACN's (2006) publication, much of the literature on preventing and minimizing moral distress revolved around the concept of moral courage. Lachman (2007a) has pioneered the exploration of moral courage, which has spawned much discussion pertaining to its development and benefit in the health care professions. More recently, however, the importance of an ethical work environment has become a focus of awareness for the prevention and remediation of moral distress in the workplace. Currently, no research exists that empirically investigates strategies for managing and minimizing moral distress. As a result, best practices are not known, and the existing strategies are based on theoretical assumptions and research on similar concepts. A brief review of literature pertaining to addressing moral distress from both personal and organizational perspectives is presented below.

Personal

The most explicit and comprehensive document outlining considerations and strategies for addressing moral distress was published by the AACN (2006) in their *The 4 A's to Rise Above Moral Distress*. While it does not specifically address moral courage, it does provide a four-stage model for self-reflection, affirmation, assessment of ability and necessity to act, and guidelines for action. Following the AACN's publication, others began to look at moral courage as a way to address and prevent moral distress (Kidder, 2005). Both topics are discussed below, beginning with the AACN's guide, followed by the literature on moral courage.

The 4 A's to Rise Above Moral Distress. In their *The 4 A's to Rise Above Moral Distress*, the AACN proposed the following four-stage, cyclical process for addressing moral distress: (1) ask; (2) affirm; (3) assess; and (4) act. The steps for each stage are outlined in a relatively clear and manageable manner; however, the AACN acknowledges the difficulty in moral action. As a result, the model is intended to be a cyclical and repetitive process, as addressing moral distress involves making difficult changes that often cannot be achieved immediately. Each of the four A's are briefly discussed below.

Ask. The first stage in the AACN's (2006) model involves self-awareness and self-reflection, in an effort to become more aware of one's distress and its effects. Because moral distress is a multifaceted phenomenon that manifests itself in many different ways, the AACN suggests asking oneself two questions to gain clarity about its unique expression for oneself or others around them:

1. Am I, or members of my team, feeling symptoms or showing signs of suffering?
2. Have coworkers, friends, or family members noticed these signs and behaviors in me?

The AACN notes that individuals experiencing moral distress may be unaware of the exact nature of the problem, but know they are feeling distress. The two questions above are intended to raise self-awareness about the nature and sources of the distress. Interestingly, however, the list of responses to suffering are taken from Rushton's (as cited in AACN, 2006) book entitled *Caregiver Suffering in Palliative Care for Infants, Children, and Adolescents: A Practical Handbook*. While these responses may be common among such caregivers, roughly half of them have been explicitly identified in the health care literature as symptoms of moral distress.

Affirm. The affirmation stage of change involves acknowledging one's distress, validating one's feelings and perceptions, and affirming professional obligations to act. As noted in the consequences of moral distress above, prolonged or unrecognized moral distress can have a negative impact on one's personal and professional life. The AACN (2006) reminds health care providers that they have a responsibility to contribute to a healthy work environment, which will help free oneself from moral distress.

Validating one's feelings involves talking to coworkers, health care providers in other settings, or friend and family. Affirming one's professional responsibility to act involves a review of the American Nurses Association's (ANA) Code of Ethics (2015) and accepting one's moral responsibility to define and communicate their values to their employees and to the public. Additionally, the ANA explicitly charges nurses as accountable for upholding their personal values. The goal of this stage is to accept one's professional responsibility for moral action and to make a commitment to address moral distress.

Assess. The third phase of assessment involves identifying personal and environmental sources of one's distress. Part of this process includes determining the severity of distress and its symptoms, and beginning to contemplate one's readiness to act. The AACN (2006) provides a

"Readiness to Act Barometer" (p. 5), which serves as a guide for moral action. One's barometric pressure, or moral pressure, is determined by rating responses to the following six questions based on a scale of 0 to 5 (0= not too; 5 = very):

1. How important is it to YOU to try to change the situation?
2. How important would it be to your colleagues/unit to have the situation changed?
3. How important would a change be to the patients/families on your unit?
4. How strongly do you feel about trying to change the situation?
5. How confident are you in your ability to make changes occur?
6. How determined are you to work toward making this change?

The next part of the assessment stage involves contemplating one's readiness to act. A main requirement of this phase is considering the risks and benefits of making a change to rise above moral distress. Again, the AACN (2006) provides an exercise to help one determine the level of risks and benefits, which will provide insight about their ability to act and the necessity to act. This stage ends with a reflection on the 4 R's: relevance, risk, rewards, and roadblocks. The AACN (2006) provides guides for self-reflection on each of the four items. The goal of these exercises and this stage is to make an action plan that one can successfully carry out.

Act. The final stage involves preparing to act and making a commitment to act boldly. The AACN (2006) suggests addressing internal and external barriers, reducing risks, and maximizing one's strengths are necessary to take action. To assess and achieve each of these factors, the AACN recommends developing a self-care plan, identifying appropriate sources of support, and investigating outside resources for guidance.

After one gains the necessary support and takes the appropriate action, one should take steps to maintain the desired change. The AACN (2006) provides the following suggestions, which are designed to help ensure the chosen act is successful and will make a lasting impact:

1. Anticipate and manage setbacks – the process of change often involves setbacks. These are to be anticipated and should not be considered as a failure! Every step you take will bring you closer to your goal. Don't be discouraged. When setbacks occur, learn from them and continue toward your goal. Plan for how you will handle reoccurrence of the distress:
    - Make your self-care plan part of your daily and weekly routine.
    - Stay in touch with identified sources of support. Be a source of support to other coworkers to foster relationships that benefit both of you.
    - Continue to seek out information from journals, Web sites, and professional organizations that help you understand and address sources of moral distress.
    - Attend conferences that aid in your professional development, strengthen your ability to effect change, and offer the opportunity to connect with nurses who experience similar sources of distress.
    - If you see alternative employment, research the new environment carefully.
2. Continuous reevaluation:
    - The circle of ASK, AFFIRM, ASSESS, and ACT indicates that this is an ongoing process. Turn the negative effects of moral distress into motivation to create change. You will still encounter distressful situations, but you will have the power to rise above them. (p. 11)

If these stages are successfully completed, it is hoped that one will have achieved adequate self-awareness of his or her moral distress and its causes and effects, along with sources of support and guidance. With a realistic appraisal of the distress and available support, the AACN's (2006) model should help one assess the necessity of action and begin contemplating and planning for action. Finally, by reviewing and aligning oneself with the suggested actions, one can hopefully act in an appropriate manner and plan for reoccurrences of morally distressing situations in the future.

The 4 A's to Rise Above Moral Distress (AACN, 2006) provide a clearly organized approach to overcoming moral distress. However, the model is an optimistic one that might overlook the true nature and reality of the challenges one might face in the move toward moral action. Again, as Tiejde (2000) cautions, gaining the strength and courage to overcome real or perceived barriers and engage in moral action can be extremely difficult. Even with adequate preparation and self-reflection, a lack of courage may prohibit one from acting in morally congruent ways. A recognition and appreciation of this difficulty prompted others to explore moral courage and propose ways in which moral courage can be fostered and acquired.

Moral courage. Moral courage has a rich history in religion and philosophy, and the concept formally emerged in the health care literature in the mid 2000s. Rielle Miller (2005) is credited with formally applying the concept to health care and Lachman (2007a) was largely responsible for giving it legitimacy in the literature. Lachman (2007a) defined moral courage as:

> The individual's capacity to overcome fear and stand up for his or her core values. It is the willingness to speak out and do what is right in the face of forces that would lead a person to act in some other way. It puts principles into action …. Moral courage enables

individuals to admit wrongdoing and ethical dilemmas steadfastly and self-confidently. (p. 131)

Lachman's (2007a) definition clearly depicts the ways in which moral courage relates to moral distress, and she specifically identified it as a viable, valuable, and worthwhile concept in its potential to prevent and rectify the pain and suffering one might experience in morally distressing situations. Additionally, she presents a model for obtaining moral courage in health care settings.

In an effort to help readers understand and remember the tasks involved in gaining moral courage, Lachman (2007a) proposed the acronym CODE, which identifies the foundational components necessary for moral courage. The first letter in the acronym refers to the courage needed to be moral. The other three letters will be briefly described below, as outlined by Lachman.

O – obligations to honor. To be moral means to do good, or to be ethical, in the case of health care (Lachman, 2007a). However, ethical obligations vary by profession, culture, community, religion, worldview, and lifestyle. Lachman (2007a) acknowledges the difficulty in determining which obligations take precedent, but points to professional codes as an ethical compass for health care professionals. Because Lachman (2007a) is an RN, she suggests referring to the Code of Ethics for Nurses (ANA, 2015), which establishes values and obligations to patients, colleagues, communities, and the nursing profession. A review of the American Counseling Association's Code of Ethics (ACA, 2014), however, yields very similar obligations. Drawing on the work of Beauchamp and Childress (1979) and Kitchener (1984), the ACA adopted six ethical principles of professional ethical behavior:

- *Autonomy*, or fostering the right to control the direction of one's life;

- *Nonmaleficence*, or avoiding actions that cause harm;
- *Beneficence*, or working for the good of the individual and society by providing mental health and well-being;
- *Justice*, or treating individuals equitably and fostering fairness and equality;
- *Fidelity*, or honoring communities and keeping promises, including fulfilling one's responsibilities of trust in professional relationships; and
- *Veracity*, or dealing truthfully with individuals with whom counselors come into professional contact. (p. 3)

Additionally, the ACA provides the following professional values as a conceptual basis for the ethical principles above: (1) enhancing human development throughout the lifespan; (2) honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; (3) promoting social justice; (4) safeguarding the integrity of the counselor-client relationship; and (5) practicing in a competent and ethical manner.

The code continues to identify counselors' ethical obligations in supporting the principles and values above. As Lachman (2007a) points out, however, making good moral choices requires more than an awareness of these values or ethical principles; it requires the courage to act.

D – danger to manage. As identified in the definition of moral courage, the need for courage implies that danger is present. In terms of moral courage, danger refers to a threat to one's conscience, ethics, or core values. Lachman (2007a) has identified two important skills that aid in managing the fear that often accompanies this type of danger and helps one gain courage in its face. The first is self-soothing, which involves both relaxation and cognitive

reframing techniques. Relaxation strategies, according to Lachman (2007a), prevent frontal cerebral function paralysis, whereas the cognitive reframing strategies involve self-reflection, evaluation of thoughts, and changing thoughts to those that would better serve the person in solving the problem. This process is crucial so individuals can effectively manage their emotions in order to maintain a realistic perception of the true nature of the threat, as well as its consequences.

The second task in the danger to manage step is assessing the risk involved in standing up for one's beliefs or values in situations that require moral courage. Lachman (2011) notes that this involves assessing the consequences that might follow from possible options, which is a process similarly supported and encouraged by Tiejde (2000) and AACN (2006). The difficulty in this process is that an "individual may experience obligations as a certainty, but uncertainty in the outcome" (Lachman, 2007a, p. 133). Both Lachman (2011) and the ACA (2014) recommend consulting with available sources in order to minimize the risk of loss and to form alliances with other colleagues. Additionally, the ACA strongly encourages and expects individuals faced with ethically challenging situations to carefully consider an ethical-decision making model, of which numerous examples are available to mental health care professionals (e.g., Corey, Corey, & Callanan, 2011; Cottone & Claus, 2000; Luke, Goodrich, & Gilbride, 2013; Vergés, 2010). As others have acknowledged, Lachman (2007a) cautions, "resolving wrenching moral choices requires the willingness to persevere in ethical choice, even though the journey is unknown" (p. 133).

E – expression and action. Having an awareness of professional obligations and personal values is not the same as acting in accordance to those obligations and values. Rather, there is a void between the two, which is bridged by moral courage (Lachman, 2007a).

Traversing the bridge from knowledge to action requires the specific skills of assertiveness and negotiation, as action in morally distressing situations typically runs counter to established norms of the majority. Just as Tiedje (2000) suggested acquiring a coach to foster the development of inner strength, Lachman (2007a) and Aultman (2008) recommend acquiring a mentor to aid in the development of moral courage. Reviewing the biographies of others who have triumphed when faced with similar challenges also has been identified as a source of courage among healthcare professionals (Lachman, 2007a). Because clinical practice is rife with opportunities to stand up and advocate for patients, families, self, and others, ensuring that one can successfully acquire the courage necessary to uphold personal integrity and honor patients and the profession is an essential virtue for health care professionals (Lachman, 2007a; Lachman, 2007b; Murray, 2010).

It is clear that moral courage is desirable in situations in which one's personal values conflict with unethical or immoral actions taken by others. Murray (2010) cautions health care providers, however, to reflect on inner values in an effort to avoid moral arrogance or moral certitude. Gert, Culver, and Clouser (as cited in Murray, 2010) define moral arrogance as a situation in which one believes his or her moral judgment is the only correct stand in a controversial issue, while others equally believe other beliefs are morally acceptable. Moral certitude, on the other hand, is a belief in one's inner convictions that is so strong that they are unable to consider a perspective contrary to their own (Murray, 2010). In either case, open discussion and deliberation regarding ethical issues, absent in situations of moral distress (Epstein & Hamric, 2009), may be completely suppressed. In other words, as Murray argues, an overly rigid view of one's convictions may produce the very ethical environment that fosters feelings of moral distress. For Murray, open dialogue, practice, and regular application are

essential for avoiding the detrimental pitfalls of moral arrogance and moral certitude, as well as developing moral courage.

Organizational

A majority of the literature on moral courage focuses on personal characteristics and strategies necessary for its development and maintenance. Others, however, have acknowledged the organization's role in providing resources and creating environments that foster moral courage. Corley et al. (2005), for example, implore health care organizations to target those experiencing moral distress and take responsibility for providing the necessary resources. Murray (2010), on the other hand, charges academic programs and healthcare organizations to recognize their responsibility in addressing ethical issues and creating expectations that moral courage is desirable and necessary to face ethical challenges that threaten values pertaining to the workplace. Additionally, Murray encourages healthcare organizations and academic institutions to make resources that might assist with ethically difficult situations available to healthcare providers. Among the resources called for, and described above, Murray explicitly makes recommendations for policies that support and maintain an ethical work environment, which has gained attention in the ethics and healthcare literature related to moral distress and ethics.

Ethical work environment and ethical climate. The concept of an ethical environment, or an ethical climate, is not specific to healthcare and has seen proliferation across literature pertaining to numerous disciplines and professions. To reduce ambiguity and confusion, Olson (1995) found that the terms "moral climate," "ethical work climate," and "ethical environment," among others, all refer to the same phenomenon. As such, these terms will be used interchangeably, respective to the term used by the authors of the reviewed literature. The focus of this section will be the relationship between the ethical environment and moral courage, but

will review broader ethics literature pertaining to definition, development, and maintenance of an ethical environment. Olson (2002) defines ethical climate as an organizational characteristic that can be modified in order to improve the workplace environment, which pertains to how an organization handles ethical issues. Additionally, Olson characterizes the ethical climate as:

> [Consisting] of perceptions of organizational practices and conditions that facilitate the discussion and resolution of difficult patient care issues. As with other types of organizational climates, it emerges from interaction with others in the workplace, is influenced by leadership, and in turn, influences the behaviors and beliefs of employees. Ethical climate provides the context for ethical decision-making in the clinical setting of healthcare organizations. (p. 3)

No studies have directly examined the relationship between ethical environment and moral courage; however, several have examined the relationship between ethical environment and moral distress. As such, some implications can be drawn about the ways in which an ethical may influence the experience of or need for moral courage. The first study to examine the relationship between ethical environment and moral distress was conducted by Corley et al. (2005). They reported that nurses identified ethical conflict with hospital policies as a source of stress, which was supported quantitatively in their study. Scores on the Ethical Environment Questionnaire (EEQ) significantly predicted moral distress intensity ($F = 1.65$; $p = 0.038$) and a negative relationship was found between EEQ and moral distress frequency ($r = -0.42$; $p = 0.01$).

Pauly, Varcoe, Storch, and Newton (2009) conducted a similar study using the Hospital Ethical Climate Survey (HECS; Olson, 1998) and found the overall mean score for moral distress was negatively correlated with the overall HECS score ($r = -0.420$; $p < 0.01$), which was also found by Hamric and Blackhall (2007; $F_{2,165} = 8.04$; $p < 0.001$). Additionally, the HECS

was negatively correlated with moral distress intensity (r = -0.160) and frequency (r = -0.419). That is, "the higher the score for the ethical climate (indicating a more positive ethical climate) the less intense the reported levels of moral distress" (p. 568). Finally, Hamric and Blackhall (2007) found nurses, in comparison to physicians, reported experiencing more moral distress and more negative view of ethical climate. Taken together, these studies indicate the ethical environment has an impact on experiences of moral distress, although more research is needed in this area before drawing specific conclusions about the nature of the relationship.

According to Brown (as cited in Olson, 2002), five conditions must be present for ethical reflection and discussion to occur: (1) power, (2) trust, (3) inclusion, (4) role flexibility, and (5) inquiry. The condition of power is present when individuals are able to voice opinions about difficult patient care problems or situations. When they feel like they can take a stand that conflicts with others without repercussion, the condition of trust is met. Inclusion refers to collaborative decision-making processes among those with a vested interested in the outcome (i.e., nurses, physicians, patients, family). Role flexibility exists when there is freedom to alter views and opinions with updated information, and inquiry is present when the organization fosters an atmosphere of questioning, learning, growth, and development.

In relation to moral courage, it is not difficult to see how ethical climate is theoretically associated with moral courage. A review of Lachman's (2007a) definition makes the association clear:

> The individual's capacity to overcome fear and stand up for his or her core values. It is the willingness to speak out and do what is right in the face of forces that would lead a person to act in some other way. It puts principles into action …. Moral courage enables

individuals to admit wrongdoing and ethical dilemmas steadfastly and self-confidently. (p. 131)

Brown's (as cited in Olson, 2002) conditions of a positive ethical climate specifically address key characteristics of moral courage. First, the condition of trust, or the feeling that one can disagree with others without fear of reprisal, directly describes a condition that should reduce the need to overcome the fear of standing up for one's core values. Additionally, if moral courage is needed in order to overcome moral distress, which often stems from a sense of powerlessness, the conditions of power and inclusion, giving one some power in the decision-making process, describe a situation in which the need for moral courage should decrease. Taking Corley et al. (2005) and Pauly et al. (2009) findings into account, these assumptions make even more sense. That is, situations, or ethical climates, in which feelings of moral distress are reduced, should also reduce the need for moral courage. With a decrease in the frequency of constraints restricting one from acting in accordance with one's morals or values, moral courage is needed less often; with a decrease in the intensity of moral distress, gaining courage to act morally should be less difficult.

Supervision and Ethical Dialogue

The second resource health care organizations can make available to those experiencing moral distress is that of an open forum for discussing ethical and/or availability of clinical supervisors who can provide ethical and moral direction. Brown (as cited in Olson, 2002) touched on the importance of this resource in his description of the five conditions that must be present for ethical reflection and discussion to occur. The condition of power is present when individuals are able to voice opinions about difficult patient care problems or situations; however, an open discussion among colleagues and administrators may not be enough for some

who are experiencing moral distress in a restrictive environment. Instead, Musto and Schreiber (2012) found those who experienced moral distress and regularly met with a supervisor unanimously stated it was helpful for them to work through the distress and essential for maintaining ethical practice. Conversely, those who did not meet with a supervisor reported feelings of isolation and devaluation. Their finding is not surprising; much earlier Wilkinson (1989) insisted on those experiencing moral distress to seek out assistance for dealing with its consequences. That these findings and recommendations continue to emerge in the moral distress literature indicates the substantial impact supervision can have in the resolution of moral distress.

Participants in Musto and Schreiber's (2012) study described the qualities of their supervisors that were particularly beneficial, which included:

> Being trustworthy, being a safe individual, having values similar to those of the participant, being experienced and practising in a way that the participant respected, having an understanding of the work setting, being non-judgmental, and having a non-disciplinary role in the participant's work life. (p. 141)

These descriptions indicate that, while a healthy or positive ethical work environment is helpful in a number of ways, those outside of the workplace, yet familiar with the setting and the potential difficulties, are particularly helpful. In some cases supervisors with these characteristics are seen as essential to managing and resolving moral distress and the ethical issues from which it arises. Again, this finding implies the importance of resources beyond an ethical work environment, as those within the work environment, although they may be understanding and supportive, may also put the individual experiencing moral distress is a vulnerable position.

Musto and Schreiber (2012) found four dimensions that made up the experience of dialogue about moral distress with others: (1) supportive/unsupportive; (2) validating/invalidating; (3) heard/silence; and (4) sharing emotional space/being dismissed. Interestingly, they found all participants' descriptions of the dialogues they had with others, including their supervisors, had negative dimensions; however, if the overall quality of the dialogue was positive and supportive, they were able to make sense of the incident and ameliorate their experience of moral distress. Many participants also described the worst thing that could happen when seeking help and discussing their moral distress was having their feelings dismissed and experience invalidated. These types of negative responses led to additional feelings of hopelessness, helplessness, powerlessness, anger, and frustration. On the other hand, positive, validating responses helped participants make sense of the complexity of the situation, even if the morally distressing situation did not change.

The most important change Musto and Schreiber (2012) found was not necessarily a modification of the system, which could help resolve the morally distressing situation, but rather a change in the participant's perspective. This shift in perspective was only possible if the individual had a supervisor that responded positively and in an understanding and supportive manner, which allowed the individual experiencing moral distress to view the ethically challenging incident within the broader context of the health care delivery system. Rather than internalizing the incident and viewing it as a result of their own personal practice, individuals receiving positive supervision were able to understand the vast complexities of the situation and more realistically make sense of their role in it. The converse situation allowed no resolution of the situation and often led participants to either leave their current position or contemplate leaving it (Musto and Schreiber, 2012).

In a very similar vein, researchers have suggested organizations increase two types of education, with two different purposes: (1) inter-professional education to increase collaboration and facilitate understanding of others' perspectives; and (2) ethics education with the goal of raising awareness to potential moral issues and applicable policies and laws (Burston & Tuckett, 2013). These assumptions have not been demonstrated empirically; however, they are presented here to illustrate the experiences of those who have encountered moral distress and the factors that helped in the resolution or sense-making process. While the theoretical basis for this argument exists, research is needed to truly understand the relationship between ethical climate and moral courage, supervision and resolution, and education and reduction. Nevertheless, these recommendations provide excellent starting points for organizations wishing to provide resources for those experiencing moral distress. In particular, and in summary, health care organizations should focus on fostering a positive ethical work environment, provide opportunities and engage in additional ethics education.

Ethics in counseling. Although ethics education has been proposed as a way to reduce moral distress among nurses, it is unclear whether or not the same recommendation would be appropriate for counselors. Turning to ethical codes may be helpful; however, Corey et al. (2011) assert that, not only do ethical codes not convey the ultimate truth, they do not provide ready-made answers to the difficult situations mental health care practitioners are likely to face. Complicating thing even further, managed mental health care is changing at a pace in which ethical code revisions cannot keep up (Cooper & Gottleib, 2014). This is troubling, as a study exploring the types of ethical problems mental health professionals faced revealed that most respondents described incidents that were ethically difficult, rather than clear-cut violations of codes of ethics (Jacob-Timm, 1999). As Dailor and Jacob (2011) summarize, these "ethical

tugs" (p. 620) were a result of competing ethical principles, conflicting requirements between ethics and laws, dilemmas pertaining to the dual roles of employee and client advocate, conflicting interests of clients and guardians, poor practices that resulted in harm to students or clients.

Welfel (2005) notes counseling ethics typically focus on the identification and prevention of gross misconduct and responding appropriately to serious ethical infractions. Counseling ethics literature offers some guidance for responding to major ethical infractions, but offers much less for minor ethical violations. Welfel, however, challenges counselors to demonstrate professionalism and uphold the integrity of the profession by taking nonegregious ethical violations seriously and identifying appropriate ways to address such infractions. Meeting this professional and ethical aspiration, as we have seen with nursing, is often a very difficult task (Tiedje, 2000), as external and internal barriers may impede one's efforts to engage in ethical or moral action, or make action seem impossible (Jameton, 1984). This might especially the case when minor ethical violations are witnessed or committed, which may seem inconsequential to some and more legitimate to others.

Again, it is unclear whether or not increased ethics education would be an appropriate preventative measure, if moral distress is found to occur among counselors working with children and adolescents. Based on the considerations above, additional counseling ethics education may provide little benefit when dealing with a moral dilemma, as the ACA's ethical standards may provide minimal guidance and even ambiguity in some situations.

Summary of Strategies to Address and Overcome Moral Distress

Epstein and Hamric (2009) and Epstein and Delgado (2010) reviewed the moral distress literature and identified common recommendations or strategies for addressing and reducing

moral distress. Table 2.4 summarizes strategies for addressing moral distress and Table 2.5 summarizes strategies for reducing moral distress, which overlap with each other. While an excellent summary of strategies, Weissman (2009) rightfully points out that moral distress is not a simple problem and there is no simple solution; rather, systemic changes in how we approach and think about moral distress, as well as how we interact with others are required to remedy and prevent experiences of moral distress.

Table 2.4
General Strategies for Addressing Moral Distress

Strategies
• Speak up: recognize and name moral distress and insist on dialogue with other parties in the situation
• Be deliberate in decisions and accountable for actions
• Build support networks to empower colleagues and speak with one authoritative voice
• Focus on desired changes in the work environment that preserve moral integrity
• Use mentoring and institutional resources to address moral distress
• Actively participate in educational activities and discussions regarding the impact of moral distress
• Design and use forums for interdisciplinary problem solving such as family meetings or interdisciplinary rounds
• Address root causes in institutional or unit culture that perpetuate moral distress and damage collaboration among members
• Develop policies to encourage any provider to raise ethical concerns or initiate ethics consultation

Note: Taken from Epstein and Hamric (2009)

Table 2.5
Strategies to Reduce Moral Distress

Strategy	Implementation
Speak up!	Identify the problem, gather the facts, and voice your opinion.
Be deliberate	Know who you need to speak with and know what you need to speak about.
Be accountable	Sometimes, our actions are not quite right. Be ready to accept the consequences, should things not turn out the way you had planned.
Build support networks	Find colleagues who support you or who support acting to address moral distress. Speak with one authoritative voice.
Focus on changes in the work environment	Focusing on the work environment will be more productive than focusing on an individual patient. Remember, similar problems tend to occur over and over. It's not usually the patient, but the system, that needs changing.
Participate in moral distress education	Attend forums and discussions about moral distress. Learn all you can about it.
Make it interdisciplinary	Many causes of moral distress are interdisciplinary. Nursing alone cannot change the work environment; Multiple views and collaboration are needed to improve a system, especially a complex one, such as a hospital unit.
Find root causes	What are the common causes of moral distress in your unit? Target those.
Develop policies	Develop policies to encourage open discussion, interdisciplinary collaboration, and the initiation of ethics consultations.
Design a workshop	Train nursing staff to recognize moral distress, identify barriers to change, and create a plan for action.

Note: Taken from Epstein and Delgado (2010)

Measuring Moral Distress

Efforts attempting to measure moral distress have spanned two decades and have gone through several revisions. As our understanding of moral development has developed, assessment instruments similarly been updated to capture more of the complexity of the phenomenon. Additionally, with a better recognition of the contextual nature of moral distress,

several researchers have adapted instruments or created new ones that are applicable to a specific context or population. These efforts reflect the multifaceted nature of moral distress and the unique ways in which it manifests itself across clinical situations. Because moral distress is a relatively new and evolving concept, instrument development is an ongoing part of research focusing on moral distress.

The first attempt to measure moral distress was carried out by Corley and Selig (1994) using a single-item visual analog scale. Among the participants included in the study, 80% reported medium to high levels of moral distress, which spawned additional research and a more thorough and reliable instrument to measure moral distress. Over the last two decades, numerous instruments have been developed to measure moral distress among diverse healthcare professionals in varying health care disciplines and settings. The following section reviews the development of the Moral Distress Scale (MDS) and its revisions, along with other instruments used to measure moral distress, which have been developed more recently.

Moral Distress Scale (MDS)

Shortly after Corley and Selig's (1994) single-item visual analog scale, the MDS was developed to measure the intensity and frequency of moral distress (Corley et al., 2005). Using a convenience sample of critical care nurses and occupational health nurses (n = 158), Corley et al. (2001) evaluated the instrument using an exploratory factor analysis, with a principal component factor technique. Orthogonal rotation of extracted factors was carried out by varimax rotation in order to determine the underlying dimensions of the MDS. A criterion of eigenvalues grater than 1.0 yielded a five-factor solution with 21.7% of the variance explained. Conceptual clarity of the factors could not be ascertained, and two of the five factors were composed of three items or less. Scree plot analysis revealed one major factor and leveled off after three factors. As a

result, forced rotation was used for further analysis, which yielded three-factor solution, with each factor being theoretically meaningful. The resulting solution was a 30-item, three-factor instrument that demonstrated relatively good reliability. The three factors that emerged were:

1. Individual Responsibility: 20 items (mean = 4.98; SD = 1.53; Cronbach's alpha = 0.97, with all factor loadings > 0.42; scale = 1-7);
2. Not in Patient's Best Interest: 7 items (mean = 4.93; SD = 1.12; Cronbach's alpha = 0.82, with all factor loadings > 0.52; scale = 1-7); and
3. Deception: 3 items (mean = 4.34; SD = 1.61; Cronbach's alpha = 0.84, with all factor loadings > 0.66; scale = 1-7).

Additionally, all three factors had acceptable levels of internal consistency (0.97-0.82). The total variance explained by the three factors was 19.38 and the theta test was 0.96 for the entire instrument (Corley et al., 2005). However, the scale only met the unidimensionality requirement that subsequent factors have similar, but declining, amounts of variance, rendering a total score meaningless.

The results of the first attempt to evaluate the MDS revealed several important findings and considerations, aside from the psychometric properties reported above. Specifically, both critical care nurses and occupational health nurses were recruited as participants, however, their reported experiences were markedly different. The critical care nurses reported experiences with the items on the MDS and their responses indicated moderate to high levels of moral distress. The occupational health nurses, on the other hand, did not report experiences with the items on the MDS and, as a result, reported no moral distress (Corley, 1995). These results confirmed earlier hypotheses that the experience of and situations contributing to moral distress are highly dependent on the context in which it exists (Wilkinson, 1988). As a result, Corley et al. (2001)

acknowledge the limited utility of the MDS, cautioning its use with other health care professionals. Instead, they suggest that a modified version of the MDS may be more appropriate for other occupational settings.

A second interesting finding was that 15% (n = 23) of the critical care nurses reported that they had left a previous position due the moral distress they experienced in it (Corley et al., 2001). Corley et al. (2001) note, however, that additional research is needed to identify the factors that contributed to those decisions and the threshold level of moral distress required to cause resignation. Finally, none of the demographic variables (age, education, and gender) nor work experience variables (work setting, years as a nurse, and years in current position) significantly added to the prediction of moral distress (Corley et al. 2001). The finding that years of experience had no relationship with moral distress contradicted the hypotheses of both Wilkinson (1988) and Rice et al. (2008), which were described above.

MDS Revision (Corley, Minick, Elswick, & Jacobs, 2005)

The MDS was revised for a second study examining moral distress and ethical work environment (Corley et al., 2005). Revisions included eight additional items relating to pain management, managed care, and incompetence among colleagues and other personnel, resulting in a 38-item scale. Additionally, a zero response option was added to the Likert scale used to report intensity of moral distress (0-6, with 0 = none and 6 = great extent) and the scale used to report frequency (0-6, with 0 = none and 6 = very frequently). As reported by Corley et al. (2005), Cronbach's alpha for the revised MDS intensity scale was 0.98 (mean = 3.71; SD = 1.57; range 0-6) and 0.90 for the MDS frequency scale (mean = 1.54; SD = 0.68). Results indicated the mean distress intensity scores ranged from 2.61 and 4.70 (SD = 2.28 and 1.65, respectively) with a mean MDS score of 3.64 (SD = 1.57). The mean moral distress frequency item scores

ranged from 0.08 to 3.05 (SD = 0.33 and 1.88, respectively) with a mean scale score of 1.45 (SD = 0.67). Additionally, according to Corley et al. (2005), correlations between all variable were calculated. The correlation between moral distress intensity and moral distress frequency was significant ($r = 0.42$; $p = 0.01$). Age was negatively correlated with moral distress intensity ($r = -0.215$; $p = 0.05$). Among the race variables included, only African American was correlated with moral distress intensity (Kendall's tau = 0.27; $p = 0.01$). Finally, a moral distress/intensity score was created by multiplying the intensity score by the frequency score, and was used in the analysis but yielded non-significant findings with demographic variables and the other scale, the Ethical Environment Questionnaire (EEQ) used in the study.

MDS Revision (Hamric & Blackhall, 2007) and Moral Distress Scale – Revised

Hamric and Blackhall (2007) conducted a second revision of the MDS in an effort to shorten the scale and make it more applicable to critical care nurses and physicians. The resulting Moral Distress Scale – Revised (MDS-R) was comprised of 19 items that focused on end-of-life care (EOL) and intensive care unit (ICU) settings and described situations that could engender moral distress. Two hundred nineteen physician (MD; n =29) and registered nurse (RN; n = 190) participants from two clinical settings responded to Hamric and Blackhall's (2007) study. The first site was a 631-bed community hospital in southwest Virginia and the second site was 481-bed university-affiliated hospital in urban eastern Virginia. Participants rated both the frequency and level of disturbance, or intensity, that the situations caused on a Likert scale from 0 (never occurring/not disturbing) to 4 (occurred very frequently/greatly disturbing). In order to measure the current level of moral distress, the frequency and disturbance scores were multiplied together for each item, which ranged from 0 to 16 for each item. Each item frequency/disturbance product was summed to obtain a composite moral

distress score. This product-scoring scheme allowed items scored as never occurring or not disturbing to be removed from the composite score, reflecting participants' true moral distress. The Cronbach's alpha for internal consistency reliability for the 19-item MDS-R, using the product score for each item, was 0.83 (MDs = 0.81; RNs = 0.85).

Results of Hamric and Blackhall's (2007) study using the 19-item MDS-R revealed several important findings. First, MDs and RNs differed significantly in their perception and reporting of moral distress, with RNs experiencing more moral distress than MDs ($p < 0.001$). Second, differences existed in reported moral distress between RNs at site one ($M = 80.38$; $SD = 33.74$) and RNs at site two ($M = 70.21$; $SD = 33.22$); however, the differences did not reach statistical significance ($p = 0.125$). While differences in reported moral distress existed between MDs and RNs, in general the same clinical situations evoked feelings of moral distress for both groups of participants. The most distressing clinical situations for both groups were those involving feelings of pressure to continue unnecessarily aggressive treatment. Interestingly, there was no statistically significant difference in the level of moral distress reported between MDs ($M = 52.12$; $SD = 11.06$) and RNs ($M = 55.80$; $SD = 9.56$) at site one ($t = 1.51$; $p = 0.139$); however, in terms of frequency, RNs ($M = 27.05$; $SD = 9.56$) perceived morally distressing situations occurring more frequently than did MDs ($M = 18.35$; $SD = 6.99$; $t = 5.23$; $p < 0.001$). This difference accounted for most of the difference in scores between groups.

The MDS-R, referred to as the MDS 2009 was updated to reflect current nomenclature in 2009, based on personal communications between Corley and Hamric in 2008 (as cited by Wocial & Weaver, 2012) and the modifications described above by Hamric and Blackhall (2007).

Major MDS Revision (Hamric, Borchers, & Epstein, 2012)

Hamric et al. (2012) conducted a third, and major revision of the MDS. Their revision was conducted in an effort to accomplish three objectives: (1) include more root causes of moral distress; (2) expand its applicability and utility for non-ICU settings; and (3) make it appropriate for use by multiple health care disciplines. As the authors stated:

> The goal was to develop an instrument with utility for healthcare organizations wishing to assess and address the levels of their healthcare professionals' moral distress, as well as by researchers needing a reliable, valid, and feasible measure of moral distress. (p. 3)

Initial item revision focused on shortening the scale and removing items that reflected either outdated or infrequently experienced expectations among nurses and other health care professionals. Remaining items from the original MDS were reevaluated for clarity and reworded so items were applicable beyond critical care nurses to a broader array of health care professionals. Additionally, new items were included that more accurately reflected the root causes of moral distress, borne out of recent literature. For the fist time, Hamric et al. (2012) included two free-response items in which respondents could add situations specific to their particular practice, in an effort to gain further data on root causes. The resulting scale included 21 items, which was shorter than the original MDS by nine items.

Keeping in line with Hamric et al. (2012) original goal of making the MDS more applicable to health care professionals beyond the ICU, the authors developed six parallel versions of the new scale. Three separate scales were developed for nurses, physicians, and other health care professionals who practice in adult settings, while the remaining three were developed for the same providers in pediatric settings. Although item wording was changed across scales, the authors were sensitive to those changes and minimized differences in order to

ensure the same root causes were being assessed across scales. Table 2.6 displays sample items from three of the newly developed scales.

Table 2.6
Sample Items From Three Parallel Versions of the MDS-R

Item number	Adult nurse version	Pediatric physician version	Adult other healthcare professional version
6	• Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	• Feel pressure to order what I consider to be unnecessary test and treatments.	• Carry out the physician's orders for what I consider to be unnecessary tests and treatments.
12	• Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	• Provide care that does not relieve the child's suffering because I fear that increasing the dose of pain medication will cause death.	• Participate in care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.
13	• Follow the physician's request not to discuss the patient's prognosis with the patient or family.	• Request nurses or other providers not to discuss the child's prognosis with the family.	• Follow the physician's request not to discuss the patient's prognosis with the patient or family.
17	• Work with nurses or other healthcare providers who are not as competent as the patient care requires.	• Work with nurses or other healthcare providers who are as competent as the child's care requires.	• Work with nurses or other healthcare providers who are not as competent as the patient care requires.
21	• Work with levels of nurse or other care provider staffing that I consider unsafe.	• Work with levels of nurse or other care provider staffing that I consider unsafe.	• Work with levels of nurse or other care provider staffing that I consider unsafe.

Note: From Hamric, Borchers, and Epstein (2012)

Other changes included updating introductory material to more explicitly define moral distress, expanding the final question that asks about leaving or contemplating leaving a position due to moral distress, and revising the coding scheme. Rather than using Corley et al.'s (2001) original 1-7 Likert scale, Hamric et al. (2012) used a 0-4 Likert scale for all six newly developed scales. Similar to the original MDS, participants rate both the intensity and frequency of the potentially morally distressing items. Thus, the scale for frequency ranges from 0 (never) to 4 (very frequently) and for intensity from 0 (none) to 4 (great extent). The 0-4 Likert scale was used so that items that have never been experienced or are not considered to be morally distressing are not factored into an individual's level or moral distress or to their MDS-R score.

Each scale has the potential to result in a frequency and intensity score by summing the respective items, both of which can be examined separately. Additionally, a composite moral distress score can be computed in a two-part procedure: (1) the frequency and intensity scores are multiplied for all 21 items, which results in a new variable for each item called the frequency × intensity (FXI) score, and which ranges from 0 to 16; and (2) the composite score is calculated by summing the FXI scores for each item. Again, the 0-7 coding scheme allows for items that are marked as either never experienced or not distressing to be removed from the composite score, resulting in a more accurate reflection of an individual's actual moral distress. The resulting composite score, based on the 21 FXI scores, can range from 0-336.

Four experts on moral distress tested the content validity of the MDS-R, which resulted in an 88% interrater agreement on root causes of moral distress, or 100% agreement on 19 of the 21 items. As a result, Hamric et al. (2012) reworded one item and eliminated the other, replacing it with a new item that reflected a conceptually different root cause. Five other items were reworded based on the experts' review. Finally, another nurse and physician evaluated the

revised and updated 21-item scale for appropriateness and content clarity, both of which supported all revision and the resulting scale.

Thirty-seven physicians (25 adult; 12 pediatric) and 169 nurses (131 adult; 38 pediatric) participated in the study to determine the scales' psychometric properties. Cronbach's alphas were calculated in order to determine the reliability of the instrument for nurse (0.89) and physician (0.67) populations, as well as for all participants combined (0.88), resulting in acceptability for the nurse and overall populations, and slightly questionable reliability for the physician population. Epstein and Delgado (2010), do point out that Knapp and Brown's (1995) recommendation of 0.70 as the general cutoff level to demonstrate acceptable reliability should be regarded as a guideline, rather than a statistical absolute or commandment. As a result, the authors conclude that, although the reliability for the physician population is modest, it is not sufficiently low to render the scale unreliable. Construct validity was evaluated though hypothesis testing (see Hamric et al., 2012, for a full description of construct validity evaluation). Sixteen respondents added an additional item at the end of the scale. Of those, 77% reflected already included root causes; however, five of the additional items offered potentially novel sources of moral distress.

The initial testing of the reliability and validity of the MDS-R are promising; however, several limitations warrant caution in its use and conclusions drawn from Hamric et al.'s (2012) study. First, the data were collected at one institution, the differences in MD and RN sample sizes are substantial, and the initial data were derived from MDs and RNs at only ICUs. Due to the limitations of this study, a broader study to test the MDS-R more thoroughly across multiple types of healthcare providers and medical unit types is in the data analysis phase. In the

meantime, Hamric et al. (2012), suggest the current version of the MDS-R is a good base for future research, however, it should be revised for other context-specific settings.

Moral Distress Questionnaire (MDQ)

The first major departure from the MDS and the MDS-R came in 2006 when Sporrong, Höglund, and Arnetz attempted to develop and test an instrument to measure moral distress that would be applicable to most health care settings. Their study was conducted using qualitative and quantitative methods, through focus groups and exploratory factor analysis using varimax rotation (eigenvalues > 1.5).

Focus groups. Three focus groups, comprised of between five and seven participants, were conducted in order to identify situations commonly occurring in daily practice, which contain ethical challenges and are likely to be stressful. Participants from a pharmacy in the Uppsala/Stockholm region of Sweden represented physicians, nurses, auxiliary nurses, medical secretaries, pharmacists, prescriptionists, and pharmacy assistants (Sporrong et al., 2006). Analysis of items pertaining to moral distress revealed 15 statements for the pharmacy setting and 15 statements for the clinical setting. Further analysis revealed that eight of the statements were essentially identical for both settings. Items were rated on a four-point scale, ranging from "not at all stressful" to "very stressful." Several items were added that addressed the relationship between colleagues, which were rated on a four-point scale ranging from "totally agree" to "not agree at all" (Sporrong et al. 2006). Respondents were asked whether or not items were relevant to their work settings, with 82% indicating that they were.

Data collection. In addition to the developed questionnaire, the Quality Work Competence (QWC; Arnetz & Arnetz, 1996) questionnaire was disseminated to participants at three pharmacies and four clinical departments. The response rate was approximately 71%,

resulting in a sample of 259 staff members. The moral distress items underwent an exploratory factor analysis (EFA) with varimax rotation and Cronbach's alphas were used to estimate the instrument's internal consistency (Sporrong et al., 2006). Additionally, *t*-tests and analysis of variance (ANOVA) were used to analyze differences between groups. Finally, linear regression with a significance level of 0.05 for two-sided tests was used to explore correlations between the subscales of the developed instrument and the QWC.

The EFA resulted in a two-factor model. Factor one consisted of six items with a Cronbach's alpha of 0.78. Factor two consisted of three items with a Cronbach's alpha of 0.62. Both factors were transformed into scales of 0-100, which made it easier to interpret the values and compare results. Factor one can be described as the level of moral distress in practice situations, whereas factor two can be described as tolerance and openness regarding ethical issues at the workplace (Sporrong et al., 2006). In order to ensure the developed instrument actually measured moral distress, rather than nonspecific stress, the correlation between the instrument and the QWC was tested using a linear regression model, correcting for a violation of the independence assumption. Due to colinearity between the instrument and the leadership subscale of the QWC, the subscale was removed from subsequent analyses. The regression analysis revealed no significant relationship between factor one and the remaining QWC subscales. Significant differences were found between pharmacy and clinical departments for the second factor ($p = 0.004$). Additionally, the second factor significantly correlated with the remaining QWC subscales ($r = 0.61$; $p = 0.00$), raising questions about its necessity.

The results indicated that factor one is an appropriate measure of moral distress in everyday practice as it did not significantly correlated with the QWC subscales, excluding leadership. That is, stress measured on the developed instrument reflected situations specific to

moral distress, whereas the QWC measures stress related to other factors (Sporrong et al., 2006). The authors conclude that the instrument is appropriate for measuring moral distress in everyday clinical situations, which differentiates it from other measures of moral distress. However, the authors also address the need for further research using the instrument to better demonstrate its validity

MDQ Revision (Eizenberg, Desivilya, & Hirschfeld, 2009)

Eizenberg et al. (2009) developed and tested a 15-item questionnaire partially based on the MDS and Glasberg et al. (2006) Stress of Conscience Questionnaire (SCQ). The purpose of their questionnaire was to develop and test the psychometric properties of a culture-sensitive instrument to assess for the nature and intensity of moral distress among nurses in a variety of settings. Aside from using the MDQ and SCQ as moral and ethical references, their questionnaire was developed organically through a two-phase method. First, Eizenberg et al. (2009) conducted a qualitative, exploratory case study, which served as the basis for the question item formulation. The second phase involved testing the psychometric properties of the questionnaire.

Qualitative phase. The qualitative phase involved 30 Israeli nurses participating in five different focus groups, and interviews of the directors of nursing services at two large university hospitals in and around Israel. Eizenberg et al. (2009) findings indicated that moral distress was primarily a result of external constraints, institutional constraints, or internal pressure. Additionally, the qualitative stage of development revealed that most respondents viewed conflicting professional approaches to care between nurses and physicians a precursor to moral distress. Nurses indicated they were focused on patient dignity and well-being, whereas physicians focused more on ensuring patient survival (Sörlie, Kihlgren, & Kihlgren, 2005).

Based on the findings from the qualitative phase, combined with items from the MDQ and the SCQ, a revised 15-item version of the MDQ was constructed. Eizenberg et al. (2009) identified seven of the items from response themes in the qualitative analysis (items 3, 4, 8, 10, 11, 13, and 15), three from the SCQ, which were modified to reflect the qualitative findings (items 2, 5, and 12), and five were based on the MDQ, but again adapted based on the qualitative findings (items 1, 6, 7, 9, and 14). Items represent everyday situations nurses might face and are rated on a 6-point Likert scale based on the extent to which the situation caused the respondent to experience moral distress (1 = not at all; 6 = very large extent).

Quantitative phase. The quantitative phase involved disseminating the developed scale and testing its psychometric properties. A convenience sample of 179 nurses was used, which is an acceptable number of responses, based on Devellis' (2003) recommendations for factor analysis. Exploratory factor analysis was carried out using Principal Component Analysis (PCA) with oblique rotation. Due to cross-loading items, two analyses were conducted, both of which resulted in a three-factor model, identified as relationships, resources, and time, with internal consistencies of 0.851, 0.791, and 0.804, respectively. The first factor explained 47% of the variance, the second explained 11%, and the third explained 11%, with a cumulative percent of variance explained of 69% (Eizenberg et al., 2009). Discriminant validity and construct validity were evaluated with the use of independent samples *t*-tests, which demonstrated statistically significant differences between the relationship and time factors. Finally, stability of the measures was examined by test-retest reliability. The correlations between the two administrations was 0.624 ($p < 0.001$), 0385 ($p < 0.05$), and 0.535 ($p < 0.01$), respectively.

Based on the three factors identified through exploratory factor analysis, the authors suggest that their instrument more accurately assesses the sources of moral distress, rather than

the restrictions to moral action. That is, they suggest that by measuring specific moral difficulties, rather than general problem, as previous research had, they were able to identify the nature of moral distress from a different perspective. As a result, the authors point out the importance of developing research instruments that are appropriate for specific contexts and cultures. While their instrument can be used with individuals from diverse cultural backgrounds, they recommend modifying it to more accurately reflect cultural differences and elucidate local variations in moral distress. Further research also should be conducted to further demonstrate the questionnaire's validity.

Chiu, Hilliard, Azzie, and Fecteau (2008)

Chiu et al. (2008) developed an online survey used to identify and qualify the ethical dilemmas experienced by pediatric surgery trainees. The survey consisted of five sets of questions pertaining to moral distress and five demographic questions. The questions related to moral distress were identified by a survey previously used to explore experiences of moral distress among pediatric trainees in focus group discussions (Hilliard, Harrison, & Madden, 2007). Questions on the survey consisted of categorical variables (rated as either yes or no), variables that potentially applied to individuals (rated by checking all that apply), and free response questions (allowing participants to describe their experience). Internal validity was assessed by duplicate inquiries, and Chi square tests ($p < 0.05$) were conducted to determine whether or not categorical answers differed between trainees.

Forty respondents from 25 pediatric surgery training programs completed the online survey. Of the 40 respondents, 27 were in training programs in the United States and 13 were in training programs in Canada. Twenty-seven respondents were male, and 32 were married, with 65% of the respondents reporting that they had children. The survey assessed respondents'

views about several factors, including the adequacy of their bioethics training, the basis of the moral conflict between trainee and staff, as well as gender differences in perceived sources of moral distress. Results revealed several interested differences in perspectives about factors, training, and sources of distress; however, because the survey targeted such a specific population, details will not be discussed here.

The Moral Distress Thermometer

Wocial and Weaver (2012) conducted a study to validate the psychometric properties of a visual analogue scale (VAS) designed to measure moral distress, the Moral Distress Thermometer (MDT), by evaluating convergent and concurrent validity. Because moral distress is completely subjective, the authors support the notion that VAS and verbal numeric rating scales (VNRS) are appropriate methods of measuring subjective and quantifying experience with interval level data. Using "an 11-point scale ranging from 0-11 with verbal descriptors to help anchor the degree of the distress in a meaningful way" (Wocial & Weaver, 2012, p. 169), respondents are instructed to reflect on their clinical experience over the last two weeks and identify on the MDT their level of moral distress.

Using an electronic survey, participants were invited to complete the pediatric or adult MDS 2009 (Eizenberg et al., 2009), the MDT, and questions about leaving a position because of moral distress. One hundred seventy two participants completed the survey including the pediatric MDS and 357 participants completed the adult MDS. Testing the reliability for the single-item visual analogue MDT was not feasible due to the exclusion of repeated measures needed for single-item reliability and because the dynamic characteristic of moral distress is not amenable to test-retest approaches used to establish reliability. Construct validity was estimated using convergent and concurrent validity. Pearson's correlation coefficient was used to test

convergent validity between the MDT and MDS 2009 (Wocial & Weaver, 2012). One-way ANOVAs with planned comparisons were used to assess concurrent validity by comparing mean MDT scores between nurses who had never considered leaving a health care position due to moral distress, nurses who had considered leaving a position but did not leave, and nurses who had left a health care position due to moral distress.

The adult and pediatric MDS 2009 were used to test convergent validity with the MDT. Correlation coefficients indicated low to moderate correlation between the instruments (adult MDS 2009: $\alpha = 0.404$, $p < 0.001$; pediatric MDS 2009: $\alpha = 0.368$, $p < 0.001$). Assessment of concurrent validity indicated significant differences between the three groups ($F_{2, 254} = 26.8$; $p < 0.001$). The planned contrasts indicated that nurses who had never considered leaving a position due to moral distress had lower mean MDT ratings than did those who considered leaving ($p < 0.001$) and those who had left ($p = 0.004$). This finding is consistent with levels of moral distress measured by the MDS 2009.

Generalizability is limited due to the lower response rate (28.3%); however, testing of the MDT's psychometric properties indicated that the instrument demonstrates acceptable reliability and shows support for concurrent validity. Convergent validity, tested by correlations between the MDS 2009 and the MDT, indicated low to moderate validity. However, as Wocial and Weaver (2012) note, no "gold standard cut-off exists for the correlation coefficient that defines convergent validity" (p. 171). Additionally, the modest correlation makes sense because of the difference in time frame reference, in that the MDS 2009 measures distress over one's entire career, whereas the MDT measures moral distress over the previous two weeks. Evidence for concurrent validity was established due to differences between groups.

Results from this study suggest that the MDT is a viable instrument for providing a quick numerical representation of one's level of moral distress. Additionally, due to its brevity, the authors point out that the MDT offers statistically significant advantages over the MDS 2009. That is, due to the correlation between the two instruments, the MDT may offer an easy way to identify nurses who are at risk of leaving their positions due to moral distress. The MDT may also be beneficial in its potential to track changes over time. Despite the robust findings reported in Wocial and Weaver's (2012) study, the authors recommend using the MDT in future studies in order to further determine whether or not there are MDT cutoff points that might identify individuals who are at an elevated risk of adverse outcomes, such as leaving a health care position.

Exploring Moral Distress Within the Context of Counseling

Until now, moral distress has been explored in numerous health care contexts, such as end-of-life care (St Ledger et al., 2013), long-term care (Edwards, McClement, & Read, 2013), daily care (de Veer, Francke, Struijs, & Willems, 2013), across health care professions, including nurses in critical care units (De Villers & DeVon, 2012), transitional care nurses (Wilson et al., 2013), emergency nurses (Fernandez-Parsons et al., 2013), surgical nurses (DeKeyser Ganz, & Berkoviz, 2012) and trauma nurses (Hamilton Houghtaling, 2012), and in several countries (Maluwa, Andre, Ndebele, & Chilemba, 2012; Ohnishi et al., 2010; Shoridehet al., 2012; Sílen et al., 2012). These studies provide significant insight into the nature of moral distress, how it is experienced, its contributing factors, and consequences; however, moral distress is understood to be a contextually dependent phenomenon that varies widely in its cause and expression (Wilkinson, 1988; Wilkinson, 1989). Philosophers and researchers have continually recognized the far-reaching applicability of moral distress beyond the nursing profession, yet very little

research has been conducted in other fields. Johnstone (2013), for example, notes that other professions and clinical environments that are plagued by uncertainty and complexity are equally likely to encounter moral disagreements and ethical challenges that might lead to moral distress. Others have acknowledged the need for interdisciplinary research examining moral distress due to factors and outcomes that seem to directly overlap with the field of counseling and other areas of mental health (Austin et al., 2005).

Exploring moral distress within the context of counseling is particularly relevant considering many of the contributing factors and external constraints that lead to moral distress are present among counselors and within clinical settings. As described earlier, the health care literature identifies the contributing factors of moral distress to be internal, such as diminished mental fortitude or character, and external, such as institutional constraints, lack of support, and power imbalances (Nuttgens & Chang, 2013). Both classifications of factors also are cited as common difficulties among counselors (Stoltenberg & McNeill, 2010) and within interpersonal counseling dynamics (Greene, 2002; Scott et al., 2006; Stoltenberg & McNeill, 2010; Willis & Carmichael, 2011). Numerous ramifications of internal and external factors influencing counselors and the process of counseling have been identified, yet the distress that occurs when one faces barriers to moral action has been overlooked.

The absence of moral distress in the counseling literature is even more surprising when considering its negative outcomes. That is, the consequences of moral distress can occur at the personal, interpersonal, and organizational levels (Burston & Tuckett, 2013), which are particularly relevant to the counseling profession. For example, moral distress often creates emotional exhaustion (Pendry, 2007), powerlessness in clinical relationships (Ferrell, 2006) and workplace strains (Kälvemark et al., 2004), and negative impacts on the organizational culture

(Nelson, 2009). In her transactional approach to burnout, Cherniss (1980) identified the same three factors (personal, interpersonal, and organizational stressors) as potential sources of stress that lead to burnout among professional counselors.

Burnout, or the state of physical and emotional depletion that results from negative or stressful conditions of work (Freudenberger, 1974) has gained enormous attention in the counseling literature over the last several decades. While burnout can be experienced by professionals in nearly any occupational setting, previous research indicates that those in occupations focused on providing services to others run a particular risk of developing burnout symptoms (Ross, Altmaier, & Russell, 1989). In fact, Maslach (1982) identified this susceptibility as resulting in a burnout syndrome among professionals who continually work with and provide services to other people. A considerable body of research has been devoted to exploring the factors that lead to professional burnout, as well as its consequences; however, it is clear that pertinent and robust factors may still be unacknowledged. That is, since others have reported the relationship between moral distress and burnout (Corley, 1995; Epstein & Hamric, 2009; Fowler, 1989; Hamric & Blackhall, 2007) exploring the factors and conditions that uniquely lead to moral distress among counselors may enhance our newly conceptualized understanding of burnout as a heterogeneous phenomenon (Lee et al., 2010; Montero-Marin et al., 2014), serve as an "ethical canary" (Sommerville, 2000) for experiences of burnout, and aid in both the prevention and alleviation of burnout among those in the counseling profession.

The long-term recognition of counselors' vulnerability to burnout also indicates that the extent to which counselors' experience of moral distress may be chronic or severe. Epstein and Hamric (2009) suggest, for example, that the experience of burnout and the decision to leave a position or profession are not likely to be the result of routine burdens health care providers face.

Rather, burnout is likely to be the result of long-term feelings of powerlessness, conflicting values, or coercion, all of which are defining characteristics of moral distress (McCarthy & Deady, 2008; Redman & Fry, 2000) and have been linked to burnout among other health care providers (Epstein & Hamric 2009). In other words, the fact that counselors experience moral distress (Lent & Schwartz, 2012; Thompson, Amatea, & Thompson, 2014) indicates that moral distress is being encountered, is not being assessed or addressed properly, and, as a result, is increasing over time for many counselors.

Exploring moral distress as a phenomenon that is borne out of counseling dynamics and creates potential threats at the personal, interpersonal, and organizational level, is a worthy area of attention. Due to the negative implications and consequences of moral distress, which have been well documented in other areas of health care, assessing the extent to which moral distress occurs and measuring counselor's levels of moral distress is an appropriate first step in elucidation the nature of the concept in among counselors working with children and adolescents. With a better understanding of the contributing factors that lead to moral distress, its prevalence, and the degree to which it exists, child and adolescent counselors may be able to identify its symptoms early enough to prevent heightened levels of moral distress or moral residue. Again, this type of exploration and assessment is a worthwhile effort as researchers agree that all counselors have a responsibility to explore, assess, and maintain our own health and well-being (Iliffe & Steed, 2000; Roscoe, 2009; Sexton, 1999; Wolf et al., 2014), an obligatory standard also set forth by the American Counseling Association (ACA; 2014). Therefore, an exploration of moral distress among counselors who work with children and/or adolescents seems reasonable, if not essential, in order to meet the professional imperatives of

self-advocacy and assessment of wellness among counselors, just as counselors do for their clients.

The Need for a New Instrument

A preceding section of this chapter described the instruments that have been developed thus far to measure moral distress among nurses. Some of those instruments demonstrate promising initial psychometric properties and applicability; however, the authors of those instruments explicitly encourage researchers to conduct context-specific studies and develop instruments to measure moral distress that reflect the cultural, organizational, and professional contexts in which it exists (Eizenberg et al., 2009; Hamric et al., 2012; Sporrong et al., 2006). Therefore, the adaptation of previously developed instruments to counseling settings would be inappropriate, even after modification. Eizenberg et al. (2009) recognized the danger in using previously developed instruments, even among similar professions and clinical settings. In order to address the inappropriateness and risks involved with culture- or context-specific instruments, they designed a new instrument from the ground up that would be more culturally sensitive and applicable across settings.

The same perspective and rationale are adopted for this study. That is, introducing a concept and phenomenon into a new field presents increased risks and challenges, especially if viewed through the incorrect lens. Making assumptions about the phenomenon based on previous literature in other fields is a grossly inappropriate and can result in questionable or inaccurate findings. As a result, the development of a new instrument to measure moral distress among counselors is justified and will follow a similar developmental method as to how Eizenberg et al. (2009) developed their revised MDQ. In order to more completely understand counselors' perspectives of and experiences with moral distress, a qualitative phase will be

conducted. Based on analyzed qualitative data, items will be selected for instrument development, which will be tested in a pilot study with counselors from across the country. The methodology of this study is discussed in much more detail in Chapter Three, however, it is mentioned here in response to the considerations others have taken in their instrument development, as well as the recommendations they have made for future development to overcome the limitations of current instrument

CHAPTER THREE

METHODOLOGY

The previous two chapters presented the research focus and a thorough review of the literature pertaining to moral distress among health care practitioners. Due to the lack of an instrument specifically designed to measure moral distress among counselors working with children and adolescents, the present study was designed to construct and pilot test the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). The development of the MDSC-CA involved two phases: (1) a pre-dissertation qualitative data collection phase, and (2) a dissertation phase, including data analysis, instrument construction, pilot testing, and instrument modification. Both phases are briefly described below, with a detail description following.

The first phase, or the pre-dissertation phase, was completed prior to the author's prospectus and served as the foundation for exploring moral distress among counselors and instrument construction. This process included two stages, the first of which (P1) involved the development and distribution of a questionnaire, via Qualtrics, to solicit counselors' responses about their experiences of moral distress and the factors that contributed to it. The questionnaire can be found in Appendix A. Additionally, demographic questions were included to gain an understanding of the demographic makeup of and variation among the respondents. Finally, the questionnaire provided respondents with the option of including their email address in order to be contacted for an interview regarding their experiences of moral distress. The second stage (P2) involved semi-structured interviews with the questionnaire participants who provided their

email address and colleagues of the researchers. The semi-structured interview protocol (see Appendix B) included questions focusing on three areas of moral distress: (a) participant's experience, (b) factors contributing to moral distress, and (c) potential factors that could have prevented moral distress. These procedures are described in more detail in the following sections.

The second phase, or the dissertation phase, included six stages. The first stage (D1) involved the analysis of the qualitative data collected from both the pre-pilot questionnaire and the semi-structured interviews through the use of interpretative phenomenological analysis (IPA). The second stage (D2) involved extracting themes within and across analyzed data in order to identify content domains from which moral distress occurs, and which define the concept of moral distress in counseling. Following domain identification, the third stage (D3) involved generating effect indicator items to measure moral distress among counselors who have experienced moral distress while working with children and adolescents. The fourth stage (D4) involved the formal construction of the MDSC-CA, based on the generated effect items from the previous stage. Stage D4 also included development of the scaling procedures used to measure the level and frequency of moral distress. Following instrument construction, the fifth stage (D5) involved pilot testing the newly constructed MDSC-CA with counselors and counselor educators who had experienced moral distress, were familiar with it, were familiar with ethics related to counseling children and/or adolescents. Pilot testing was conducted with the purpose of assessing the MDSC-CA's face and content validity. In the sixth stage (D6), quantitative and qualitative data collected during the pilot testing was analyzed. Finally, the seventh stage (D7) involved instrument modification based on the results of the pilot test. Modification focused on strengthening the instrument's face and content validity, so that it may be used in future research.

Table 3.1 provides a graphical representation of the stages included in both the pre-dissertation and dissertation phases of the current study.

Table 3.1
Stages Involved in Pre-Dissertation and Dissertation Phases of the Current Study

Pre-Dissertation		Dissertation	
P1	Development and distribution of the pre-dissertation questionnaire	D1	Analysis of qualitative data using interpretative phenomenological analysis
P2	Development of pre-dissertation interview guide and conducting interviews	D2	Identifying themes within and across interview participants' responses in order to determine content domains
		D3	Generating the effect indicator items and selecting those to be included on the initial version of the MDSC-CA
		D4	Construction of the MDSC-CA and scaling procedures used to measure level and frequency of moral distress
		D5	Pilot-testing the MDSC-CA with previously interviewed participants and counseling ethics experts
		D6	Analysis of quantitative and qualitative data collected during pilot testing.
		D7	Modification of the MDSC-CA to improve the instrument's face and content validity

Note. Stage D3 originally involved developing the nomological net; however, this stage later was considered inappropriate for the current study. Additionally, D6 was added in order to separate data analysis and instrument modification for clarification purposes.

To reiterate, the goals of this study were (1) to gain an understanding of counselors' experience of moral distress as it pertains to their clinical work with children and adolescents, (2) identify the domains from which moral distress occurs, (3) generate items that reflect counselors' experiences across identified domains, (4) construct an instrument that can be used to measure moral distress among counselors working with children and adolescents (the MDSC-CA), and (5) pilot test the MDSC-CA in order to determine its initial validity. This chapter begins with a description of the methodologies used and participants recruited in the pre-dissertation phase in order to achieve the first goal. Following the pre-dissertation phase, the methodologies used to achieve the second, third, fourth, and fifth goals, along with the description of the participant recruitment process for the dissertation phase, will be discussed in detail. The procedures, research design, and participants are described in the order in which they were completed throughout this study, starting with the qualitative pre-dissertation phase, and finishing with the data analysis, instrument construction, pilot testing, and instrument modification stages, which will comprise the dissertation phase.

Phase One: Pre-Dissertation

Phase one, or the pre-dissertation phase, included two stages. The first stage (P1) involved the development and distribution of a Qualtrics questionnaire for the purposes of collecting qualitative data pertaining to respondents' experiences of moral distress, along with quantitative demographic data. The second stage (P2) involved interviews of counselors who had experienced moral distress while working with children and/or adolescents. Because studies exploring moral distress among counselors are completely absent from the counseling literature, there exists an equally absent understanding of the phenomenon in the context of counseling. As a result, qualitative approaches to an initial exploration of moral distress were found to be

especially appropriate. Berríos and Lucca (2006) have identified the characteristics of qualitative work that make it particularly important and applicable to the field of counseling. First, they note "qualitative research provides a complete and in-depth description in the natural language of the phenomenon being studied" (p. 181). Therefore, qualitative inquiry provides an opportunity to discover the idiosyncratic ways in which counselors working with children and/or adolescents express and think about moral distress.

Berríos and Lucca (2006) also noted that qualitative research requires researchers to abandon, or attempt to abandon, preconceived hypotheses about the phenomenon in an effort to discover the depth and richness of the phenomenon as it exists in its natural environment. Rather than making assumptions from previous research in other fields, qualitative inquiry provides an opportunity to discover the idiosyncratic ways in which counselors working with children and/or adolescents experience moral distress in the context of their clinical work. Finally, Berríos et al., highlighted an analytic process directly applicable to the current study in its goals to identify content domains from which items can be generated for the development of a new instrument. That is, qualitative analysis allows researchers to identify emergent themes through the use of critical judgment, without being restricted by predetermined categories. Qualitative analysis, therefore, is used to identify the unique categories from which moral distress arises in child and/or adolescent counseling, which are not limited to those previously identified in the health care literature (e.g., Hamric et al., 2012).

Trainor and Leko (2014) noted qualitative research is especially important to social science research, in which manifold issues, human perspectives, and individual and group experiences are explored. Accordingly, the stages of the pre-dissertation phase were designed to explore counselors' perspectives about moral distress and the conditions and barriers leading to

it, as well as their experiences of moral distress, as it relates to their clinical work with children and adolescents. The fist stage (P1) involved the development and dissemination of a questionnaire with the goals of obtaining qualitative accounts of participants' experiences of moral distress, as well as demographic information about the participants. The second stage (P2) involved interviewing participants who either voluntarily provided their email address in the questionnaire or were colleagues of the researchers who were thought to meet the eligibility criteria and agreed to participate. Both stages are discussed in detail, beginning with the pre-pilot questionnaire, followed by the interviews exploring participants' experiences of moral distress and relevant contextual factors.

Stage P1: Pre-Dissertation Questionnaire

The first stage of the pre-dissertation phase involved the development and distribution of a questionnaire to explore counselors' experiences of moral distress, as it pertains to their clinical work with children and adolescents, as well as an informed consent form for the questionnaire (see Appendix C). The questionnaire included four open-ended questions designed to allow participants to voice their beliefs and perceptions about their experience of moral distress. A questionnaire was used in an attempt to obtain unbridled accounts of participants' experiences, free of direction or bias from the author. The pre-dissertation questionnaire also included demographic questions used to gather data about participants' gender, race/ethnicity, age when they experienced moral distress, current age, number of years of counseling experience when they experienced moral distress, current years of experience, geographic location when moral distress was experienced, current geographic location, clinical setting in which moral distress was experienced, current clinical setting, and primary counseling specialty. Demographic data was collected in order to gain an understanding of the participants and the counseling settings

within which moral distress has occurred. The last question on the pre-dissertation questionnaire gave participants an opportunity to provide their email address and asked whether or not they would be interested in participating in an interview about their experience of moral distress. The entire pre-dissertation questionnaire can be found in Appendix A.

Questionnaire development. Two important considerations guided the development of the pre-dissertation questionnaire. First, the questionnaire was intended to collect data specifically from counselors who have experience working with children and adolescents and experienced moral distress in the context of their clinical work. As such, special consideration was given to developing a way to restrict responses only to the counselors of interest. Second, as Punch (2003) implores, questionnaire development should be guided by the research questions, and therefore, the questions and prompts were selected to answer the research questions and achieve the research goals. Both considerations are briefly discussed below.

Exclusionary questions. An attempt to restrict responses to the counselors of interest was made by providing two exclusionary questions. First, in order to restrict responses only to counselors who had experienced moral distress, consenting participants were immediately presented with the following question:

1. Have you experienced moral distress, as defined below, within the context of your counseling experience?

   Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

Participants who answered "No" to this question were taken directly to the end of the questionnaire and thanked for their participation. Those participants who answered "Yes" to the first question were taken to a second exclusionary question, designed to restrict responses only to those participants who had experienced moral distress while working with children and adolescents:

2. Did your experience of moral distress occur while you were working with children and adolescents? By applying Siegel's (2013) definitions, children and adolescents, in this case, include individuals roughly between the ages of two and twenty-four.

Participants who answered "No" to this question were taken directly to the end of the questionnaire and thanked for their participation. Those participants who answered "Yes" to the second exclusionary question met the eligibility criteria and, thus, were taken to the remainder of the questionnaire.

Although it is impossible to ensure all participants who completed the questionnaire met the eligibility criteria and were, in fact, representative of the counselors of interest, the above measures were taken to help ensure that was the case. The self-reported nature of the exclusionary criteria and the demographic questions is a limitation to this study, which was briefly described in Chapter One and will be elaborated on in Chapter Five.

The guiding role of research questions and goals. Punch (2003) describes the questionnaire development process as one that situates the questionnaire between the research questions and the data collection process. The developmental process, therefore, relies on the assumption that research questions organize the research project, define its scope and boundaries, and identify the data needed to answer the questions themselves. As such, the development of the questionnaire used in the pre-pilot study was heavily guided and informed by the current

study's research questions and goals and was selected due to the desired data collection methods. A review of the research questions and corresponding qualitative questions and prompts included on the Qualtrics questionnaire, presented in Table 3.2, will make this process clear:

Table 3.2
Comparison of Research Questions and Qualitative Questions/Prompts Included on the Pre-Dissertation Questionnaire

	Research Question	**Qualitative Question/Prompt**
1.	What does the experience of moral distress look like for child and/or adolescent counselors?	Please briefly describe your experience of moral distress as it relates to your counseling experience.
2.	What factors, if any, contribute to moral distress among counselors who have experience moral distress while working with children and/or adolescents?	What factors, if any, contributed to your experience of moral distress?
3.	What barriers, real or perceived, if any, exist that prevent child and/or adolescent counselors from engaging in moral distress?	What barriers, if any, were present that prevented you from engaging in moral distress?
4.	What impact does moral distress have on counselors who have experienced moral distress while working with children and/or adolescents?	In what ways, if any, did your experience of moral distress impact you?
5.	Are there thematic domains from which moral distress occurs for counselors who have experienced moral distress while working with children and/or adolescents?	Not addressed in the pre-dissertation phase
6.	Can a Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) be constructed in order to assess for moral distress among counselors who work with children and/or adolescents?	Not addressed in the pre-dissertation phase
7.	If the MDSC-CA can be constructed, can its validity be assessed through pilot testing?	Not addressed in the pre-dissertation phase

Note. The entire pre-dissertation questionnaire can be found in Appendix A.

As can be seen from Table 3.1, the research questions guiding the current study, directly guided the qualitative questions and prompts included on the Qualtrics questionnaire used in this phase.

Several characteristics of the questions in Table 3.2 should be discussed. First, Aiken (1997) recommends using open-ended questions when "a more detailed picture of the respondents' attitudes, beliefs, and thoughts is needed, and when the variables of concern are not defined clearly enough to be assessed by close-ended questions" (p. 41). Because the current study was designed to explore participants' experiences related to a phenomenon not yet understood nor defined, open-ended questions were deemed particularly appropriate. Additionally, the qualitative open-ended questions presented in Table 3.2 directly addressed the research questions and attempted to achieve the first research goal. Therefore, aside from the exclusionary questions, they were considered to be the most important questions included in the questionnaire. As such, they were placed directly after the exclusionary questions, in order to avoid participant boredom, fatigue, or time pressure. Aiken (1997) recommends designing questionnaires in such a way in an effort to increase the likelihood that important questions will not only be completed but also will be answered conscientiously and completely. Conversely, the demographic questions, discussed below, only indirectly addressed the research questions, and therefore, were placed after the open-ended questions.

The quantitative demographic questions included on the pre-dissertation questionnaire were also guided by the research questions, although less explicitly, and most directly by the first research question. Table 3.3 indicates how the quantitative questions were informed by and can help answer the first research question:

Table 3.3
Comparison of the First Research Question and Quantitative Questions Included on the Pre-Dissertation Questionnaire

Research Question	**Quantitative Question**
What does the experience of moral distress look like for child and/or adolescent counselors?	How many morally distressing experiences have you encountered?
	Gender?
	Race/Ethnicity?
	Age when you experienced moral distress?
	Number of years of counseling experience, after completing your master's degree, at the time when you experienced moral distress?
	Geographical location in which you experienced moral distress?
	Clinical setting in which you experienced moral distress?
	Primary counseling specialty?

Note. The entire Qualtrics questionnaire can be found in Appendix A.

The connection between the first research question and the quantitative questions is less apparent; however, the quantitative questions may provide insight into how the counselors of interest experience moral distress. The development of these questions reflects Punch's (2003) second recommendation that survey and questionnaire questions should not only be designed to answer the research questions, but also to achieve the research goals. As such, the demographic questions included in Table 3.3 were included in order to help the researchers gain an understanding of counselors' experience of moral distress as it pertains to their clinical work with children and adolescents. More specifically, those questions were thought to have the

potential to help elucidate what the experience of moral distress is like for whom, in which clinical settings and specialties, at what point in one's counseling career, and in which geographical locations. It was hoped that these questions would contribute in meaningful ways to the current study, and future research endeavors.

Questionnaire format. The questionnaire was created in Qualtrics for online distribution via CESNET-L, a listerv for counselors and counselor educators. The use of the Internet as a research platform has become increasingly popular over the last decade and is a particularly appropriate way to implement traditional methods of data collection, such as questionnaires, as well as more complex methods, such as idiographic assessment (Fraley, 2007). Additionally, Fraley points out that the use of Web-based questionnaires has been identified as a useful approach to assessing individual trait differences.

Qualtrics was chosen as the questionnaire development and distribution platform for several reasons. First, Qualtrics makes the questionnaire extremely accessible, as most anyone with a computer and an Internet connection is able to complete it. Second, Qualtrics allows researchers to recruit participants almost completely independent of location. As a result, participants from all over the world who are subscribed to CESNET-L are potential participants, which can help increase sample size and participant variation. Additionally, because of the complex item display, flow, and skip options, participants were able to complete the questionnaire in a way that was tailored specifically to them, based on eligibility criteria and personal characteristics. This also helped ensure the researchers captured responses only from target participants, and excluded those who should be excluded for a variety of reasons.

Pilot testing the questionnaire. Following the development of the questionnaire and its creation in Qualtrics, it was pilot tested, in order to accomplish several goals. First, Punch (2003) has identified three purposes for pilot testing:

- Newly written items and questions need to be tested for comprehension, clarity, ambiguity, and difficulty in responding to. We need to ensure that our data collection questions 'work', in the sense that people can quickly, easily and confidently respond to them.
- The whole questionnaire needs to be tested for length, and for time and difficulty to complete.
- The proposed data collection process itself, of which the questionnaire is the main feature, needs testing. This includes issues of access and approach, ethical issues, covering letters, and so on. Care taken during this stage is likely to help increase response rates. (p. 34)

Second, Brace (2008) highlights the importance of establishing the validity of the questionnaire or survey before it goes live. Brace recommends evaluating the following issues related to validity:

- Can respondents answer the questions?
- Are the response codes sufficient and do they provide enough discrimination?
- Do the questions elicit the intended answers?

In order to address the concerns identified by Punch (2003) and Brace (2008), the Qualtrics questionnaire was pilot tested with a colleague, a friend, and a family member of the principal investigator. Two of the pilot testers held doctorate degrees and the third had a high school education. The three pilot testers were sent the research announcement email with a link

to the questionnaire. Each tester was instructed to read the announcement, access the questionnaire via the provided link, and read the informed consent, and record the time it took them to read the informed consent in its entirety and complete the questionnaire. Instructions also included the disregarding of any typos or grammatical errors so they could answer each question unencumbered by the tediousness of such scrutiny. Because only one pilot tester was familiar with moral distress, it was thought that responses would demonstrate a range of times needed to complete the questionnaire. That is, it was assumed those unfamiliar with moral distress would take longer to complete the questionnaire than the pilot tester more familiar with the concept of interest. Additionally, they were instructed to make up humorous answers to each of the questions. The rationale for humorous answers was that thinking of and typing out a humorous answer might take longer than it would take a counselor to express his or her own experience with moral distress. After each question was completed, pilot testers were instructed to submit the questionnaire, which allowed the principal investigator to ensure Qualtrics was appropriate for data collection and could provide participants anonymity. Finally, each pilot tester was asked to access the questionnaire a second time and pay particular attention to sentence structure, ease of comprehension, typos, and grammatical errors.

Each pilot tester reported their findings and recorded times after completing the questionnaire. There was ambiguity about the spelling of master's (e.g., master's program), and after further discussion and consultation, the term was changed from Master's to master's. Two participants suggested adding a period after the bulleted eligibility criteria, which was subsequently added. Aside from those two minor changes, access to the questionnaire was determined to be easy and understandable, and the informed consent and questionnaire were deemed to be grammatically correct, comprehensible, and appropriate for the targeted age and

population. Additionally, readability statistics were calculated for the research announcements (all three combined), informed consent, and Qualtrics questionnaire, and are displayed in Figure 3.1, 3.2, and 3.3, respectively. Readability statistics indicated the reading level for each document was appropriate for the target population.

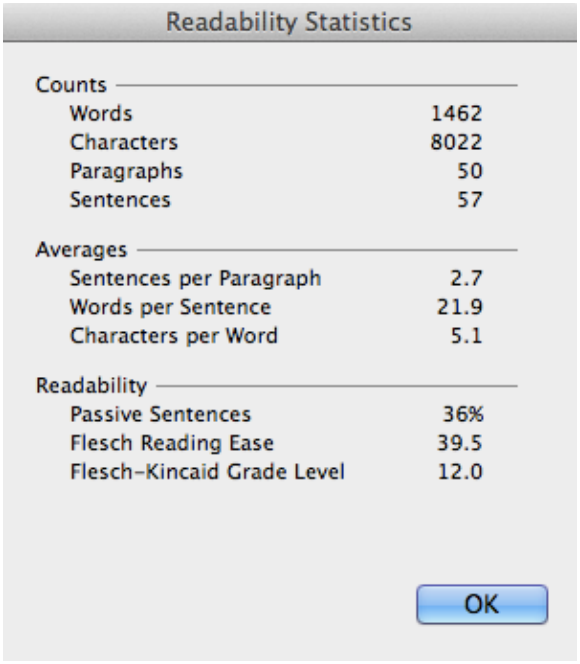


Figure 3.1. Readability statistics for the research announcements.

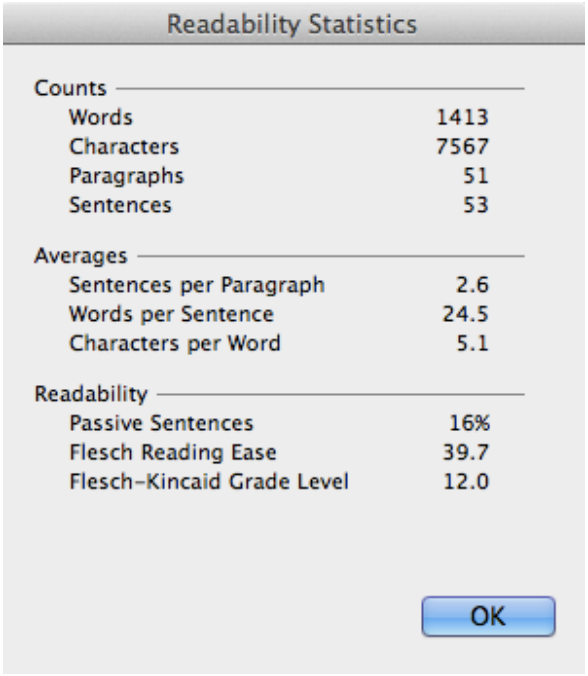


Figure 3.2. Readability statistics for the informed consent form.

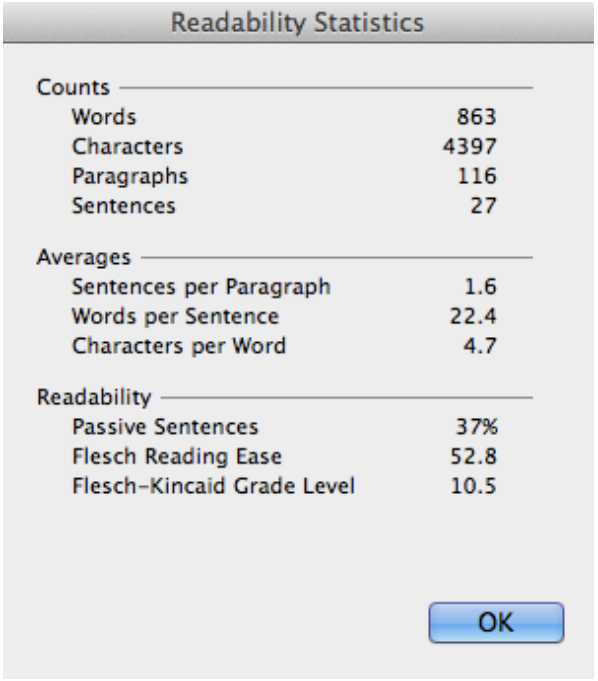


Figure 3.3. Readability statistics for the Qualtrics questionnaire.

Questionnaire distribution and participant recruitment. The professional listserv for counselors and counselor educators (CESNET-L) was used to distribute the Qualtrics questionnaire. Prior to distributing the questionnaire to the population of interest, however, the approval of Dr. Marty Jencius, the moderator of CESNET-L, was acquired. The approval process included emailing Dr. Jencius the questionnaire, recruitment announcement with a link to the questionnaire, and research methodology in order to ensure the study was appropriate for the CESNET-L community and its subscribers. Upon approval, the first recruitment announcement (see Appendix D) was uploaded to CESNET-L, which distributed the announcement to 2,967 recipients subscribed to the listerv. The first announcement informed potential participants of the purpose of the study, participation procedures, eligibility criteria, IRB approval, and provided a link to the informed consent and questionnaire.

Although the recruitment announcement was sent out to a group of counselors and counselor educators that presumably represent a wide variety of clinical specialties and work with diverse clientele, the recruitment announcement explicitly included eligibility criteria. Because counselors who had experienced moral distress in the context of their clinical work with children and/or adolescents, the following criteria were presented:

- You have completed at least a master's degree in counseling,
- You have at least one year of supervised, post-master's degree, counseling experience
- You have experience counseling children and/or adolescents, and
- You have experienced moral distress, as defined above

These criteria were intended to attract only the counselors of interest, as described above. Additionally, the informed consent form for the Qualtrics questionnaire included the same eligibility criteria, and as mentioned above, the questionnaire itself included to exclusionary

questions prior to any questions pertaining to counselors' experience of moral distress. Due to these measures, it assumed that the recruitment procedures were appropriate and adequate for attracting and including the counselors of interest and either deterring or excluding counselors who did not meet the eligibility criteria.

Following the initial recruitment announcement, two follow-up recruitment announcements were distributed through CESNET-L. In the week following the initial announcement, a reminder announcement was uploaded and distributed to 2,980 CESNET-L subscribers in an attempt to recruit additional eligible participants (see Appendix E). The first reminder announcement thanked those who had already participated in the questionnaire and reiterated the purpose, procedures, and importance of the study. It also explicitly asked participants to complete the questionnaire and briefly mentioned the potential benefits of the study. The remainder of the email was identical to the first recruitment announcement, including the eligibility criteria.

In the second week after the first reminder announcement (three weeks after the initial announcement) a second and final reminder announcement was uploaded and distributed through CESNET-L to 3,001 subscribers (see Appendix F). The second reminder announcement thanked those who had already participated and reiterated the purpose, procedures, and importance of the study. It explicitly requested participation of eligible counselors and indicated the second reminder announcement would be the last time subscribers would be contacted. Additionally, the second reminder announcement informed potential participants that the questionnaire would be available until midnight Pacific Standard Time (PST) on Thursday, January 30th, 2015. At such time, the questionnaire was disabled in Qualtrics and a report of the initial results was downloaded in both Microsoft Excel and Statistical Package for the Social Sciences (SPSS)

format. Qualitative and quantitative data analyses were conducted following the prospectus defense and subsequently reported and described in the dissertation phase below.

Sample size. The response rate for the pre-dissertation questionnaire was quite low. Despite sending the third study announcement to 3,001 subscribers of CESNET-L, only 30 responses were collected. Of those 30, only 18 were complete and included responses to the free-response questions. This response rate was less than desirable, and was a limitation of the study; however, the sample size is not outside of the range of acceptability in phenomenological qualitative studies. There are no absolutes, and only a few guidelines for determining the adequate sample size exist in the qualitative literature. One such guideline is that of saturation, which can help qualitative researchers determine the adequate sample sized needed for a particular study. Saturation is defined as a period in data collection in which "the collection of new data does not shed any further light on the issue under investigation" (Mason, 2010, para. 2) and has become the gold standard for determining purposive sample sizes (Guest et al., 2006). Walker (2012) noted the qualitative literature reveals the use of saturation in phenomenological studies, making it an available option in guiding sample size.

Very few guidelines exist for determining an adequate sample size for achieving saturation. Cresswell (1998), however, suggested a minimum of five responses as an adequate sample size for achieving saturation in phenomenological studies. Bertaux (as cited in Mason, 2010) indicated a minimum of 15 responses is necessary for all forms of qualitative research. Because the open-ended questions on the Qualtrics questionnaire were not intended to elucidate the experience of moral distress in its entirety, but rather were used to obtain specific data to address the research questions, 18 responses were deemed to be adequate. Possibly the most important statement to consider, regarding saturation, is "although the idea of saturation is

helpful at the conceptual level, it provides little practical guidance for estimating sample sizes for robust research *prior* [emphasis added] to data collection" (Guest et al., 2006, p. 59). Therefore, saturation guided the determination of adequate sample size in the current study, yet was informed and assessed only during data analysis. Arbitrarily predicting an adequate sample size prior to analysis is ill advised and may limit the depth of data collection. The current study assessed saturation based on the 18 questionnaire responses received in order to determine whether or not the sample size is adequate.

It should be noted that some researchers have argued against the use of saturation as a method of determining sample size in qualitative studies. The strongest argument is based on the presumption that saturation may lead to prematurely concluding that sufficient data has been collected (Dey, 1999). As a result, pertinent information may be overlooked completely, limiting the validity of the conclusions drawn and applications of analysis. Regardless, however, Guest et al. (2006) acknowledged the infeasibility of achieving saturation in time-limited studies, which may inevitably lead to insufficient data collection. Therefore, because the current study was limited in the time it could be conducted, sample size was an unavoidable limitation.

Additionally, because the data collection was completed prior to the dissertation phase, the determination of an inadequate sample during analysis was a limitation of the study. The proposed methodology does not allow for an inadequate sample size to be remedied. These vulnerabilities to the study were monitored and are discussed in Chapter Seven.

Stage P2: Participant Interviews

The second stage (P2) of the qualitative pre-dissertation phase consisted of one-on-one interviews conducted with counselors who had experienced moral distress while working with children and/or adolescents. Interviews were chosen as the second qualitative method of inquiry

for two reasons. First, data collection was informed by the data analysis procedure chosen for the dissertation phase of the current study. Interpretative phenomenological analysis (IPA), a relatively new qualitative analytic procedure developed specifically to address questions in the social sciences (Smith et al., 2009), was found to be particularly applicable to the current study and its research questions. The core tenets, applicability, and analytic procedures of IPA are discussed in detail in the dissertation-phase of this chapter. Interpretative phenomenological analysis is worth mentioning here, though, as Shinebourne and Smith (2009) noted IPA requires a data collection method that will "invite participants to offer a rich, detailed, first-person account of their experiences and phenomena" (p. 54). It was thought that such accounts would allow the author of the current study to acquire the information necessary to thoroughly answer the research questions and extract emergent themes that would inform the generation of scale items and instrument development. Additionally, Shinebourne and Smith (2009) have found that semi-structured, one-to-one interviews are the most common data collection method used with IPA.

The second consideration leading to the selection of interviews stems from their potential to generate the robust data desired to accomplish the goals of the current study. Frost (2011) indicates interviews used in an exploratory fashion typically have the ability to elucidate others' experiences in order to generate contextual data, such as illustrative stories or cautionary tales, to arrive at indexical expressions or coding categories. Indeed, one purpose of the interviews in the pre-dissertation phase was to build a lexicon of contextual factors that describe and contribute to the experience of moral distress in the context of counseling children and/or adolescents. Further, interviews used in such an ancillary way were particularly appropriate for the initial

exploration of a topic or phenomenon in which very little is known or previous research is lacking (Pett, Lackey, & Sullivan, 2003; Silverman, 2006).

Brinkmann (2013) referenced the long history of conversation as a tool to gain knowledge about those around us and learn about how they experience the world. Today, refined conversations, or interviews, are often considered the method of choice for social scientists and researchers to engage with others and explore important issues that are new to us (Rapley, 2001). As mentioned above, due to the dearth of research pertaining to moral distress among counselors, moral distress was an unknown phenomenon in the context of counseling. Byrne (1998) and Fontana and Prokos (2007) have noted the utility of qualitative interviewing as a method for uncovering individuals' attitudes, views, and values. As such, interviews were further thought to have been a particularly useful method of exploring moral distress, with the potential to elucidate previously unknown views about the unique experience of and context-specific factors contributing to moral distress among counselors working with children and adolescents. Additionally, because the concept was applied to counseling from other fields in health care, interviews provided a way to decrease the researchers' vulnerabilities to bias from previously established knowledge, in order to "learn something about what is beyond ourselves and our preexisting assumptions" (Josselson, 2013, p. 2).

It is well established that interviews have the potential to yield robust data, which may lead to an understanding of the meanings and processes underlying a particular phenomenon (Josselson, 2013). The main purpose of P2 was to obtain information that can be used to uncover themes and content domains from which morally distressing situations occur within the context of counseling. Fortunately, interviews are well suited for uncovering descriptive data, which can be analyzed to reveal underlying meanings. In this sense, as they pertained to the

current study, interviews had the potential to explicate normative data that could result in emerging themes within and across participants' experiences (Josselson, 2013).

Finally, one of the central tenets of interview research is the brining to awareness thoughts and ideas that are usually taken for granted. Under normal circumstances, individuals often are not permitted to elaborate or ruminate on, or express, assess, and examine their underlying normative assumptions and cognitive structures (Josselson, 2013). It is precisely the unexamined character of moral distress that may lead to its existence and persistence in the first place (McCarthy & Deady, 2008). Interviews, on the other hand, offer a potential remedy to the unexamined aspects of self, which are constrained by social norms, as the dialogue and reflection inherent to interviews invite awareness and elaboration on the phenomenon under investigation (Josselson, 2013). As such, interviews not only provided an ideal method of exploration of morally distressing experiences, they also aligned with professional imperatives in counseling and the identified steps that may lead to liberation from moral distress. More specifically, Falender and Shafranske (2004) stated that developing an understanding of "unresolved conflicts at the margin of awareness" (p. 81) is an essential component of professional development and clinical practice, which also is an imperative established by CACREP (2009). Additionally, the AACN (2006) identified the self-awareness of moral distress as an essential first step in overcoming its distressing consequences.

Due to these theoretical considerations, the author believes the methods used to explore moral distress among counselors working with children and adolescents were ideal and would yield desirable and appropriate data for an initial exploration of moral distress in the context of counseling. It was hoped such data would allow the author to extract themes from within and across participants' responses, which is an appropriate, if not essential, goal in instrument

development (Pett et al., 2003). Such themes informed the identification of content domains and aided in the generation of the effect items that comprise the MDSC-CA.

Interview participant recruitment. Interview participants were recruited in two ways. First, all participants who provided their email addresses in the last question of the pre-dissertation questionnaire were emailed an interview recruitment announcement (see Appendix G). Second, networked recruitment (Josselson, 2013) was used to identify colleagues of the primary researcher and research advisors who were thought to have met the eligibility criteria for the study. All participants identified through networked recruitment were contacted by phone. In each recruitment process, the initial contact included details about the purpose and nature of the interview, including information about audio recording, transcription, limits to anonymity, actions taken to help ensure confidentiality, pseudonym assignment, and how the interview will be used in the present study and in the future. Those contacted by email also were provided a link to a second Qualtrics questionnaire, which provided an informed consent form for the interview and a dichotomous Yes/No prompt to indicate whether or not they consented to participate in an interview (see Appendix H). Those who consented to participate were taken to the second questionnaire, where they were asked to provide several items: (1) email address, (2) whether they preferred a telephone or Skype interview, (3) respective phone number or Skype name, (4) their first name, or the name in which they wanted to be referred to during the interview, and (5) time(s)/day(s) when they were available for an interview (see Appendix I). Those who did not consent to participate in an interview were directed to the end of the questionnaire and thanked for their participation.

Interview participants. All participants were intended to be professional counselors who had experience working with children and/or adolescents and had experienced moral

distress in their clinical work with such clients. Because the questionnaires were anonymized and due to the limitations regarding self-report questionnaires mentioned in Chapter One and earlier in this chapter, the true identity of the participants recruited through the Qualtrics questionnaire, their profession, and the clientele with which they work, could not be verified. The participants who were recruited through the researchers' networks, however, were verified to meet the eligibility criteria, and thus, were appropriately included in the study.

Sample size. As mentioned above, determining the sample size for qualitative studies prior to data collection is inappropriate (Guest et al., 2006). However, due to the time limitations of the current study, some considerations were taken into account to guide sample size selection. First, Guest et al. (2006) found that only six interviews were needed to generate 34 of the 36 codes they identified in their study, which included a total of 60 interviews. Their conclusion was that for phenomenological studies, "six studies may [be] sufficient to enable development of meaningful themes and useful interpretations" (p. 78). Their findings indicate that sufficient data collection may be achieved with as few as six interviews, with only minimal data loss. Second, Creswell (1998) noted that a minimum of five interviews was needed to achieve saturation in phenomenological studies.

Although Cresswell's (1998) recommendation is not empirically validated, it will be used as a minimum standard in the current study. As Guest et al. (2006) acknowledged, achieving saturation in time-limited studies often is infeasible, which may inevitably lead to insufficient data collection. Therefore, because of the time-limited nature of the current study, the potential for insufficient data collection was considered and acknowledged as a limitation. It as hoped that, as Guest et al. (2006) reported, an overwhelming majority of the data necessary to identify

themes and make meaningful interpretations will be collected through the interviews conducted within the time limited parameters of this study.

Interview procedures. After participants provided their contact information and availability, the principal investigator sent an email confirming the date, time, and format of the scheduled interview. The primary researcher initiated contact on the scheduled date and time, in order to absolve participants from being responsible for telephone fees that might have been accrued during the interview. Prior to starting the interview, the primary researcher informed participants of the purpose and procedures for the interview. Special attention was given to the procedures for audio recording the interview, recording storage, transcription procedures, and transcription storage. Interview participants were provided an opportunity to ask questions or voice concerns, all of which were addressed before the interviews began. When participants indicated that they understood the purpose and procedures and that they had received satisfactory answer to questions, they were asked to give verbal consent to participate in the interview. Once verbal consent was obtained and recorded, the interview began.

For the duration of the interview, participants were only referred to by their first name, or the name they provided on the contact information questionnaire, if they were referred to by a name at all. Names will be removed during transcription, and replaced with an arbitrary pseudonym. The interviews were semi-structured, following a loose interview protocol, which can be found in Appendix J; however, the nature of the interviews allowed for flexibility in order to follow up on pertinent information, use question probes, and add questions based on previous interviews, if needed. All interviews were conducted at the primary researcher's home office or school office, both of which provide ample privacy. Each interview was audio recorded with QuickTime for Macintosh and saved as .M4A audio files in order to capture the entirety and

complexity of participants' responses. All audio files are stored in a digital folder on an encrypted hard drive to which only the principal investigator has access. Each audio file has been given a code that will serve as the respective participant's pseudonym. An example of the code is J-3-28, which does not pertain to any of the participant's identifying information, and does not reveal the date of the interview.

At the end of each interview, participants were asked whether or not they had any questions. If so, they were addressed before the interview ended. To complete the interview, participants were thanked for their time and invited to follow up with the principal investigator if they have any questions or concerns about their participation, or if they would like to add additional information to their responses. Additionally, they were asked whether or not they would like to be emailed the initial instrument after it is constructed in the dissertation phase of the current study. If so, their information was securely retained in Qualtrics so they could be included as a pilot tester during the dissertation phase of the current study. If they preferred not to be contacted in the future, they were informed that the completion of the interview terminates their participation in the study and the researchers will not initiate any further contact.

Development of the interview protocol. The interview protocol included several sections: (a) introduction, which included a greeting, review of the informed consent form with special attention paid to what they have indicated by their online consent, acquisition of verbal informed consent from the participant, and a description of the purpose of the interview; (b) questions designed to explore the participant's experience of moral distress; (c) questions designed to explore the factors that contributed to their experience of moral distress; (d) questions intended to explore factors that could help reduce or prevent moral distress in the future; and (e) closing comments, including two additional questions and a statement of gratitude

for the participant's time and participation. Again, the semi-structured interview protocol can be found in Appendix J.

Very similarly to the pre-pilot Qualtrics questionnaire, the semi-structured interview protocol was informed by the research questions and goals, and were designed to help ensure the questions could be answered and the goals could be achieved.

Table 3.4

Comparison of Research Questions and Interview Protocol Questions

	Research Question	Interview Question
1.	What does the experience of moral distress look like for child and/or adolescent counselors?	Would you tell me about the moral distress you experienced? What was that experience like for you? What happened? How did you know you were experiencing moral distress? How severe was your moral distress? What would have helped you overcome the experience of moral distress, if anything? Having gone through a morally distressing situation already, what advice would you give to another counselor experiencing moral distress? Having experienced moral distress, what would be different if you found yourself in a similar situation in the future?
2.	What factors, if any, contribute to moral distress among counselors who have	Where did the moral distress you experienced stem from? What clinical setting were you in when you experienced moral distress? What was it about that setting that contributed to your experience of moral distress? Would you describe the ethical climate of that setting or institution? Were there any interpersonal dynamics that contributed to your experience of

	experience moral distress while working with children and/or adolescents?	moral distress? In what ways did your clinical role contribute to the experience of moral distress, if at all? Did others assume roles that made them less vulnerable to moral distress? If so, what were they? What other conditions or factors contributed to your experience of moral distress, if any? What role do you think you might have played in your experience of moral distress, if any?
3.	What barriers, real or perceived, if any, exist that prevent child and/or adolescent counselors from engaging in moral distress?	What were the barriers that prevented you from engaging in moral action, if any?
4.	What impact does moral distress have on counselors who have experienced moral distress while working with children and/or adolescents?	In what ways, if any, did your experience of moral distress impact you? How severe was that moral distress to you?
5.	Are there thematic domains from which moral distress occurs for counselors who have experienced moral distress while working with children and/or adolescents?	Not addressed in the pre-dissertation pre-pilot phase
6.	Can a Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) be constructed in order to assess for moral distress among counselors who work with children and/or adolescents?	Not addressed in the pre-dissertation pre-pilot phase
7.	If the MDSC-CA can be constructed, can its validity be assessed through pilot testing?	Not addressed in the pre-dissertation pre-pilot phase

Note. The entire semi-structured interview protocol can be found in Appendix J.

As can be seen in Table 3.4, each interview question was constructed to probe the overall research questions further than the pre-pilot questionnaire did, in hopes that interview participants would describe more of their experience and perceptions of moral distress. Because this stage was designed to include a semi-structured interview, probe questions were included as appropriate to further invite participants to elaborate or to explore unique aspects of a participant's experience.

After all participants had been interviewed, the pre-dissertation phase of this project was completed. The next steps were to present and defend the prospectus, as described in this section, for dissertation committee members. Upon committee approval, the author began the qualitative data analysis and instrument development, described below. Following the development of the MDSC-CA, the researcher obtained the IRB's approval to recruit participants for the pilot-testing phase. Finally, the MDSC-CA was modified based on the result of the pilot test, which marked the completion of the current study and fulfilled the dissertation requirements for the degree of Doctor of Philosophy in the Department of Leadership and Counselor Education at The University of Mississippi.

Phase Two: Dissertation

The dissertation phase of the current study consisted of seven stages, and concludes with the construction of a modified Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). The first stage in this process (D1) involved the initial analysis of the qualitative data collected from both the pre-dissertation pre-pilot questionnaire and the semi-structured interviews. All data were analyzed through the use of interpretative phenomenological analysis (IPA) with the purpose of identifying themes within and across participants' accounts of their

lived experience of moral distress. Following initial data analysis, the second stage (D2) involved identifying content domains from which moral distress occurs, and which define the experience of moral distress among counselors working with children and/or adolescents. This stage builded on the initial data analysis and synthesized the themes identified in the previous step. In the third stage (D3), the construction of the MDSC-CA informally began. This stage involved generating effect indicator items to measure moral distress among counselors who have experienced moral distress while working with children and adolescents. This stage was informed by the data collected in the pre-dissertation phase, which was analyzed and synthesized in the previous three steps, but also incorporated literature on ethical issues in counseling children and adolescents. The combinatorial approach to this stage was utilized in order to broaden the applicability of the instrument to be developed beyond the participants included in the current study.

In the fourth stage (D4) the construction of the MDSC-CA formally began. This stage was based on the generated effect items from the previous stage, which comprise the initial version of the MDSCA-CA, as described below. Instrument construction also included the identification of appropriate scaling procedures, which respondents will use to indicate their level of moral distress based on the items included in the MDSC-CA. In the fifth stage (D5) the MDSC-CA was pilot tested with a group of counselors who are either familiar with moral distress or have experienced it first hand, or are knowledgeable about counseling ethics. Pilot testing was conducted with the purpose of assessing the MDSC-CA for face and content validity. The fifth stage (D6) involved the analysis of both the quantitative and qualitative data collected during pilot testing. Results from this stage will be used to inform and guide the sixth stage, involving instrument modification. Instrument modification was conducted in the last stage (D7)

which was based on pilot tester feedback and assessment of the instrument's validity. From this stage, an initial version of the MDSC-CA was constructed, with the hope that it can be used in future studies.

Interpretative Phenomenological Analysis

The qualitative data collected in phase one, including both the questionnaire responses and interviews, was analyzed using interpretive phenomenological analysis (IPA). The history and philosophical background of IPA is briefly provided below, followed by a detailed description of IPA as an analytic process and how it was used in the current study.

Core Tenets and Philosophical Underpinnings of IPA

Interpretive phenomenological analysis formally emerged in the mid 1990s (Smith, 1996) with the goal of reviving a pluralistic psychology, as envisioned by William James, by creating a qualitative approach that centered in psychology and captured the experiential and qualitative in one method (Smith et al., 2009). While it is true that IPA is a relatively new form of qualitative analysis, its roots are grounded in three areas of the philosophy of knowledge that have a much richer history: phenomenology, hermeneutics, and idiography (Smith, 2004). A brief description of each, as well as their connection to IPA, follows.

Phenomenology. Phenomenology, in its most essential form, is a philosophical approach to the study of experience, or what the human experience is like, in terms of those things that matter to us (Smith et al., 2009). Several philosophers have shaped the phenomenological project, and each phenomenologist gives different degrees of priority to the fundamental character of our knowing about the world, as they see. At the same time, however, each phenomenologist has accepted and built on the underlying presupposition that experience should be examined in the way that it occurs (Smith et al., 2009). For Husserl, who originally argued

for phenomenology as a programmatic system in philosophy, phenomenological inquiry focuses on the intentionality of an individual's conscious experience. In other words, "experience or consciousness is always conscious of something – seeing is seeing of something, remembering is remembering of something, judging is judging of something" (Smith et al., 2009, p. 13). In order to explore that "something," we need to adopt a phenomenological attitude, which involves purifying consciousness through a process of bracketing, or abstaining from considering the sources of experience so our perceptions, thoughts, judgments, and values of that experience can be understood (Cerbone, 2006). This process also involves a series of reductions, each of which offers a different lens through which to view the phenomenon at hand and allows us to move beyond, or transcend, the barriers to knowledge (Dahlstrom, 2015). As a result, we are able to discover the essence of the phenomenon, rather than simply the facts. According to Smith et al. (2009), it is this process of getting to the content, or the essential features, of an experience that have most significantly influenced IPA.

Other philosophers, including Heidegger, Merleau-Ponty, and Sartre also have shaped phenomenology, and IPA incorporates some of their core ideas. A complete description of each philosopher's stance on phenomenology is beyond the scope of this paper; rather, a summary of each philosopher's key contributions, as they relate to IPA will be discussed, as summarized by Smith et al. (2009). First, Heidegger suggested that we are always in relation to something, and our experience is always perspectival. As a result, our interpretation of experiences is a central tenet of IPA. Similarly to Husserl, Merleau-Ponty argued that we need to "return to the phenomena" (Cerbone, 2006, p. 98) or return to the things themselves. This return involves returning to that which preceded knowledge, or focusing on the physical and perceptual affordances, rather then the abstract or logical, of the body-in-the-world (Anderson, 2003). The

view that perception and representation always occur in the context of the body in relation and engagement with the world is also a critical idea incorporated into IPA. Finally, Sartre emphasized personal and social relationships in that our experiences are contingent on the presence or absence of our relationships with those around us (Smith et al., 2009). Interpretative phenomenological analysis also emphasizes the interpersonal, affective, and moral nature of experiences, which were so vividly presented by Sartre.

Through a brief review of phenomenology, we begin to understand that IPA is a research method that appreciates the complex understanding of experience, which involves a lived process and an unraveling of perceptions and meaning, which are contextualized through interpersonal relationships (Smith et al., 2009). Thus, it is interpretive in that it seeks to understand one's relationship with the world, and meaning-making as it strives to make sense of one's experiences.

Hermeneutics. The second major philosophical underpinning of IPA is that of hermeneutics, which is the theory of interpretation. Hermeneutics started as a method to more accurately interpret Biblical texts, and as such, focuses on the context of a text's production and the text's interpretation (Smith et al., 2009). Several philosophers influenced the development of hermeneutics and their contributions will be summarized, according to Smith et al. (2009), as they relate to IPA.

First, Schleiermacher suggested that, due to the individuality of a writer or speaker, along with the context of the text or speech, an author is able to impress a meaning on to text, which can then be interpreted by the analyst (Smith et al., 2009). Essential to this process is the understanding of and sensitivity to the context. If these conditions are met, the interpreter may be able to extract an interpretation that the author cannot, as the author's conventions and

expectation influence his or her own interpretation (Smith et al., 2009). Thus, the IPA analyst is able to offer a perspective that the author is unable to. Additionally, as Smith et al. (2009) point out, Heidegger made two key contributions to hermeneutics, which are incorporated into IPA. First, Heidegger's conceptualization of phenomenology is explicitly interpretive, which characteristically describes IPA as well. Second, Heidegger claims that interpretations are filtered through one's preconceptions about the experience or phenomenon. As a result, an interpreter must engage in bracketing and reflective practices in an effort to overcome one's biases. Finally, Gadamer introduced the idea of a "hermeneutic circle" (Smith et al., 2009, p. 27) in which interpretation involves a constant fluctuation between the parts of a text and the text in its entirety. Logically, this results in circular interpretation, but allows the interpreter to understand parts of a text (e.g., a word) in the context of the whole (e.g., the sentence). As such, a useful method of analysis and thinking is provided to IPA researchers.

Idiography. Idiography is the third theoretical underpinning of IPA. An idiographic approach involves a deep focus on the particulars of an experience (Frost, 2011). Interpretative phenomenological analysis' commitment to the particulars operates at two levels. First, as Smith et al. (2009) describe, the particulars refers to a sense of detail and depth of analysis. Second, they note that particulars also refers to the ways in which a phenomenon has been interpreted and understood by particular people in a particular context. Therefore, IPA is idiographic in the sense that it focuses on a detailed exploration of certain instances, typically in the form of a case study or over a small group of cases.

Epistemological Position of the Research Question and IPA

Shinebourne (2011a) fervently recommends choosing a research methodology that is consistent with the epistemological position of the research questions. The research questions in

the current study are focused on in-depth and detailed descriptions of participants' lived experiences of moral distress, in order to gain an initial understanding of what those experiences look like in the context of counseling. Similarly, as Shinebourn details, IPA is concerned with "the in-depth exploration of personal lived experience and with how people make sense of their experience" (p. 53). Additionally, IPA typically addresses dilemmatic or chronic issues, which, as described in the previous chapter, describe the ethical conflict and moral discord characteristic of moral distress. Because the research questions in the current study are open and exploratory, focusing on lived experiences, there is considerable coherence between the research question and the analytic methodology, making IPA an ideal approach for both the study as a whole and the type of data collected.

Data Analysis

Data analysis was conducted through a six step IPA procedure. Each step is described in detail below, as they apply to the analysis of the qualitative data collected in the pre-dissertation phase. Following data analysis, instrument construction and pilot testing is carried out in four stages, each of which also are described in detail below.

Stage D1: Data Analysis

As described above, IPA focuses on the detailed examination of lived experience, and as the name suggests, is interpretative, which stems from Heidegger's conceptualization of phenomenology. Interpretative phenomenological analysis utilizes the contextual information in which an experience happens or a person exists, examining it with great detail (Smith et al., 2009). As such, IPA was an ideal analysis method that will elucidate unique experiences and characteristics of those experiences, which enabled the author to gain a more complete understanding of the phenomenon of interest, in the context of counseling. An overview of the

steps of IPA are described briefly below, and are more thoroughly described in Chapters Four, as the analysis of the qualitative data serves as the first part of the results for the current study. In should be noted, however, Roberts (2013) points out that IPA should not be viewed as a prescriptive methodology, but rather as a flexible and fluid method, allowing the researcher to return to data as needed throughout the process. As such, the steps are described as linear function of analysis, although they were carried out in a nonlinear fashion.

Step 1: Reading and re-reading. The first step in the process of analysis was, of course, reading and re-reading the available qualitative data. This process involved immersing oneself in the original data, which in this case will be comprised of both free-responses from the questionnaire and transcriptions of subsequent interviews. The main purpose of this process is to slow down our tendency to attempt to analyze or understand text in a relatively short amount of time (Smith et al., 2009). Part of this process, was recording initial reactions to and thoughts about the interview, which can serve as bracketing guides. That is, exploring the text with an awareness of one's biases was done in order to help the researcher delve further into the texts and more accurately interpret their meaning.

Step 2: Initial noting. The second step involved initial noting, which is often the most detailed and time consuming. Smith et al. (2009) describe this step as a process that "examines semantic content and language use on a very exploratory level … [and] the analyst maintains an open mind and notes anything of interest within the transcript" (p. 83). As a result, steps one an two actually merged as the analysis repeatedly returned to the original data in order to make and evaluate notes, allowing the interpreter to begin to identify the ways in which the participant understands the phenomenon of interest. Smith et al. (2009) suggested the notes should have three different foci: (1) descriptive comments, which simply takes things at face value, but

highlights all key words and phrases which might matter to the participant; (2) linguistic comments, in which the analyst focuses on the presentation of the content, meaning-making through language, and even non-verbal cues, such as pauses; (3) conceptual comments, which are more interpretative and represents a transition away from the explicit words of the participant and moves to the overall understanding of meaning of the matter they are discussing. Each of these approaches shared a fluid process of exploring meaning, detail, and interpretation.

Step 3: Transforming notes and comments into emergent themes. The third step in the IPA procedure marked a shift from working with the original data collected from the research participants, to primarily working with the exploratory notes, comments, and interpretations that were obtained during the first two steps of analysis. Those exploratory annotations served as the platform from which emergent themes were subsequently built, and from which the initial item pool was developed. This step also marks a procedural shift from managing data to reducing data and "the volume of detail (the transcript and the initial notes) whilst maintaining complexity, in terms of mapping the interrelationships, connections and patterns between exploratory notes" (Smith et al., 2009, p. 91). If the exploratory annotations were done carefully and comprehensively, they will be fundamentally connected to the source material, more concisely capturing the overall meaning of the participants' experiences.

Identifying emergent themes from exploratory comments required and acute focus of small sections of transcripts, while still considering the panorama of data, experience, and meaning. Additionally, it required the researcher to reflect on and consider what was learned through the exploratory analysis (Smith et al., 2009). This process clearly represents understanding achieved via the circular hermeneutic process whereby "misunderstandings are *filtered out through the interplay of the whole and the parts*" (Debesay, Nåden, & Åshild, 2008,

p. 58). As it relates to the current study, the hermeneutic circle lead the researcher to gain an understanding of the participants' experiences by analyzing exploratory comments in relation to the original data, in their respective parts and holistically. It should be noted, however, that the new understanding that emerged through this analytic process should not be regarded as a better understanding, but as a different way of understanding the phenomenon of interest (Gadamer, 1989). This step, as well as the remaining steps in IPA, therefore, are carried out in an attempt to achieve a lucid, clear understanding of something that appears unclear (Ramberg & Gjesdal, 2014).

Step 4: Clustering themes: The fourth step of analysis involved developing clusters of emerging themes within a single transcript. This process was one of data reduction, while maintaining complexity, through identifying interrelationships, connections, and patterns between one's exploratory notes (Smith et al., 2009). As such, this step involved formulating concise phrases that still contained enough particularity to remain connected with the original text, yet enough abstraction to offer a conceptual understanding. In order to achieve these goals, the hermeneutic circle, in which one looks closely at chunks of the transcript while also referring back to what has been learned through analysis, is heavily utilized. Pietkiewicz and Smith (2014) add, this process involves synthesizing the emergent themes and reducing data if themes do not correspond well with the developing structure or if there is inadequate evidence to support their existence. This step typically is accompanied by the development of a graphical representation of the emerging thematic structure. Chapter Four includes a detailed description of these components in order to thoroughly describe the analytic processes conducted during this step.

Step 5: Repeating the process with new data. The fifth step involves moving to the next participant's transcript and repeating the process described above. Smith et al. (2009) pointed out that it is important to treat the new transcript on its own terms in order to capture the participant's unique experiences and meaning thereof. In keeping with IPA's idiographic commitment, the researcher engaged in a process of bracketing before moving to each new transcript in an attempt to put aside his repertoire of knowledge, the ideas already emerging from analysis, and beliefs about the data (Chan, Fung, & Chien, 2013). Following bracketing, each step described above was carried out for each additional transcript, one at a time, in the order they were obtained.

Stage D2: Domain Identification

The next section describes the procedures used to analyze themes across all cases in order to develop the thematic domains and sub-themes, which were used to develop and structure the MDSC-CA.

Step 6: Looking for patterns across cases. The sixth and final step in the IPA process tied all of the data together by looking for patterns and themes within and across cases. Interpretative phenomenological analysis involves a dual-quality process of analysis at this step, in which individual themes reflect idiosyncratic instances, yet also share higher order, or overarching, qualities across cases (Smith et al., 2009). Once again, not all themes were incorporated into analysis. Irrelevant themes, or themes that did not fit the emerging structure were discarded, allowing data reduction, as guided by the scope of the research questions (Frost, 2011). This process also was interpretive, but the level of interpretation existed along a continuum. Placement along the continuum often is dictated by the analyst's qualitative

expertise, where novice analysts tend to be overly conservative and more experienced analysts produce less descriptive interpretations of the data (Smith et al., 2009).

Shineborne (2011) recommended creating a table of themes in which individual responses and descriptions of experience are grouped together under thematic headings. Line numbers can also be included in the table and associated to the respective data, as this process is iterative and will inevitably involve a process of checking, rechecking, and amending themes, as appropriate. The construction of the final table, Shineborne noted, relies on the prevalence of data, but also should heavily consider the "richness of the extracts and their capacity to highlight the themes and enrich the account as a whole" (p. 60). Therefore, there was a balance between quantity and quality of data extracts and descriptions, which relied on both accurate representation and analyst interpretation.

This step allowed the researcher to identify connected themes across the analyzed transcripts and free-responses. Through this process, domains from which moral distress occurs were elucidated, which guided item construction and selection for the instrument being developed, discussed in the next section.

Instrument Development

The final four stages of the dissertation-phase of the current study comprised the initial development and modification of the MDSC-CA. Each stage in the development phase was informed by the scale development process identified by Hinkin (1998), although they were altered slightly in order to meet the goals of the current study. The first stage built on the data analytic procedures described above in order to generate the pool of items from which the items included in initial instrument development will be selected. The instrument construction stages

continued with pilot testing the instrument to establish validity, and finally instrument modification in order to arrive at an instrument that may be used in future studies.

Stage D3: Item Generation and Selection

Item generation can be accomplished in two ways. First, when a well-established theoretical foundation exists, it may, in and of itself, provide enough information needed to generate an initial set of items (Hinkin, 1998). This approach, "requires an understanding of the phenomenon to be investigated" (Hinkin, 1998, p. 106), in addition to a theoretical definition of the construct under examination. As such, the deductive approach to item generation could not be used in the current study. Because this study involved the exploration of an abstract construct in a new context, neither an understanding of the phenomenon nor a theoretical definition existed. For such situations, Hinkin identifies an inductive item generation procedure, which was used in the development of the MDSC-CA.

The inductive approach to item generation usually involves researchers asking a sample of respondents to provide detailed descriptions of their feelings, experiences, or behaviors (Hinkin, 1998). Responses are then classified into separate domains or categories through the use of content analysis or a similar approach to qualitative data analysis and from these categories items are generated. Hinkin acknowledged the challenges in this method, as generating conceptually consistent items from the interpretation of respondents' descriptions is much more difficult than deriving items from theory and construct definition. This technique also makes instrument development vulnerable to extraneous content domains and inaccurate or inappropriate domain labeling (Schriesheim & Hinkin, 1990).

In light of the above warnings about the inductive item generation method used in the current study, several considerations were taken into account. DeVellis (2012) and Netemeyer, Bearden, and Sharma (2003) have identified several such considerations, which are relevant to the current study. First, theoretical assumptions about the concept or phenomenon to be measured were considered. Careful thought was given to the items generated and the ways in which they related to one another to represent a content domain. DeVellis (2012) suggested that each item should be thought of as a test of the latent variable in its own right.

Devellis (2012) also encouraged creativity in the creation of new items. Because domain sampling theory assumes that items chosen are from a theoretically infinite number of items pertaining to the construct of interest (Kline, 1998), considering other ways to word items to get at the same construct is essential. Creative options should be exhausted, as the instrument will only be as good as the thought and effort put into generating the items that comprise it. Additionally, Devellis noted that it is not good enough, or even appropriate, to group items simply based on a category; rather, the items should be grouped based on a theoretical construct, in which they all have in common. Specifying categories is sometimes a helpful method in determining the concept that underlies a category. For example, rather than grouping items based on barriers, identifying the specific barriers and grouping items accordingly ay more accurately represented the construct or category of constructs to be measured.

Second, Netemeyer, Bearden, and Sharma (2003) suggested that thought should be given to the size of the initial item pool and the response format for the items. DeVellis (2012) recognized that there is no way to determine the number of items that should be included in an initial pool, but he recommended including considerably more than you anticipate including in the final scale. In fact, he pointed out that it is not uncommon to begin with three to four times

more items than will remain in the final instrument. The general rule of thumb is to include as many items as possible, while still ensuring the instrument can feasibly be administered on a single occasion.

After the item pool was generated, the individual items were assessed for their appropriateness by sub-theme, mainly based on item specificity and the the degree to which they captured the sub-theme meaning. Items that were thought to accurately reflect the sub-theme's meaning were selected for inclusion in the initial version of the MDSC-CA, while those considered too specific or less meaningful, were removed from the item pool. The resultant item pool consisted of 106 item across sub-themes. The entire MDSC-CA, in its original form can be found in Appendix R, which is the version used in pilot testing.

Stage D4: Instrument Construction

The fifth stage of the dissertation phase involved creating the MDSC-CA from the item pool generated in the previous stage, as well as making decisions about scaling procedures. This stage addressed issues related to whether items should be dichotomous or multichotomous, rated on a Likert-type scale or multiple choice, positively or negatively worded, whether or not the items were appropriately written for the target audience, and instrument length. During this stage, attention was given to the content validity of the instrument in an effort to ensure that the generated items actually measure what they were intended to measure, as least theoretically, at this point.

Instrument length. Instrument length was a considerable area of focus during the instrument development process. Conflicting views and theories pertaining to the appropriate length of an instrument have resulted in an ongoing debate about this facet of instrument development. Although, as Hinkin (1998) noted, there are no absolute imperatives guiding this

decision, several important points should be considered, which may help a researcher determine the relative appropriateness of the initial number of items included in an instrument. First, Yeo and Frederiks (2011) indicated that long instruments or measures (those 36 items or longer) are useful for domain sampling and internal consistency; however, long instruments often are less than satisfactory when the researcher plans repeated measures designs. Additionally, as Netemeyer, Bearden, and Sharma (2003) caution, lengthy instruments, resulting from a too broadly defined construct, can result in the inclusion of extraneous factors or domains. The inclusion of extraneous factors is troublesome and often difficult to detect because those items may be highly correlated with relevant domains of the construct, which creates what has been referred to as "*construct-irrelevance variance"*(Netemeyer et al., 2003, p. 89). In other words, extraneous variables may result in the assessment of a latent construct other than the target construct. One last concern with lengthy instruments is that it may demonstrate high internal consistency regardless of the intercorrelations of the items (Cortina, 1993; Iacobucci & Duhachek, 2003).

Conversely, several points about short instruments were considered. First, Schmitt and Stults (1986) suggested that brief instruments minimize the pitfalls of response bias that might result from boredom experienced with longer measures. Thurston (1947) reminded us that the ultimate goal of instrument development is to identify a factor structure that retains as much information as possible from the initial pool of items, while still being as simple, or parsimonious, as possible. Hinkin (1998) therefore suggested that each construct domain should contain approximately four to six items in the final construct measurement. While parsimony is fully carried out with factor analysis procedures, these considerations and reminders are important at this phase, because Hinkin also noteed researchers should expect to remove

approximately half of the items contained in the original item pool. Therefore, an appropriate number of items can only be determined after the construct domains are identified. As such, a guiding formula for instrument length was:

$$N = [(D * 4)(2)]$$

or

$$N = [(D * 6)(2)]$$

where:

N equals the number of items included in the initial pool, and

D equals the number of identified domains.

The above formula served as a guide for the current study; however, it was not viewed as imperative to stay within its upper and lower bounds. Therefore, while the range was considered, the MDSC-CA initially included more items than Hinkin suggested. The initial item pool is discussed in much more detail in Chapter Five.

Scaling procedures. Most scale items consist of two parts: (1) the stem and (2) a series of response options (DeVellis, 2012). When measuring psychological constructs or phenomena, the stem often is a declarative statement that reflects a domain or dimension of the variable of interest. The response options, or rating scale, follows the stem and typically consists of either dichotomous or polytomous response formats (Simms & Watson, 2007). Several considerations need to be made when determining which type of response format to use, and if polytomous responses are to be used, the researcher has to determine how many response options to include in what way they will be labeled. Although dichotomous responses offer some advantages over polytomous response options (Comrey, 1988), the development of the MDSC-CA will use the most common form of polytomous scales, the Likert- scale (Simms & Watson, 2007) in order to

measure both level and frequency of moral distress. Both uses are briefly described below and examples of how they may be used in the current study are provided.

Polytomous rating scale. Two key decisions need to be made when using polytomous items as a response scale. First, as Simms and Watson (2007) note, the number of response options must be considered. Second, deciding how to label those options is equally important. There is no hard and fast rule about the number of items to include in a scale, and as a result, opinions vary widely on what should be considered the optimal number. Comrey (1988) for example, suggests that including more response options for each item results in more reliable scales. Conversely, Clark and Watson (1995) argue "increasing the number of alternatives actually may reduce validity if respondents are unable to make the more subtle distinctions that are required" (p. 313). Therefore, Kaplan and Saccuzzo (2008) recommend considering the fineness of distinctions participants are able to make for a given construct or phenomenon.

Level of moral distress. In order to measure counselors' level of moral distress, a Likert-type scale was chosen, in which participants rate each item pertaining to construct domains. In response to the above considerations, the Likert scale used in the MDSC-CA has an odd number of response items, with an additional "irrelevant" item. Presenting an odd number of responses will allow respondents to choose a midpoint level of moral distress, rather than being forced to choose levels that reflect high or low levels (DeVellis, 2012). The additional "irrelevant" response option allowed respondents to indicate that the respective situation does not occur in the respondents' clinical practice (Eizenberg et al., 2009). That is, it is thought that the addition of the "irrelevant" response will make a distinction between situations that do occur but do not cause moral distress, and those that do not occur at all, and therefore of course, are irrelevant to the respondent's experience. The rating scale for level of moral distress used on the MDSC-CA

is presented in Table 3.5, and also is found in Appendices U and X on the initial and modified versions of the MDSC-CA.

Table 3.5
Example Item Response Scale

The following statements represent everyday situations associated with clinical work with children and adolescents. Please indicate to what extent each situation makes you experience moral distress. If you are not currently counseling, but have experienced moral distress, please indicate the level to which each situation made you experience moral distress. In the event you have not experienced a situation, please mark that situation "Irrelevant."

Item	None	Some	Moderate	High	Extreme	Irrelevant
1.	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐
.						
.						
.						
N	☐	☐	☐	☐	☐	☐

Note. Instructions adapted from Eizenberg, Desivilya, and Hirschfeld (2009).

Frequency of moral distress. In a similar vein, a polytomous, Likert scale was chosen to measure the frequency in which counselors experience each potentially morally distressing situation. Likert scales often are used to measures frequency in general (Simms & Watson, 2007) and have been used in other instruments developed to measure moral distress levels and frequencies (e.g., Corley et al., 2005). Once again, careful consideration should be given to both the number of response options and the way in which those options are labeled. Although it is unlikely counselors face a particular morally distressing situation every day, the response choice "Always" was used as an extreme response level in the Likert scales measuring moral distress

frequency. Conversely, "Never" was used as the opposite extreme response level, indicating that the participant has never experienced the associated potentially morally distressing situation.

An odd number of responses was again used in order to provide participants with a midpoint level of frequency. Although DeVellis (2012) warns odd numbered scales may provide apathetically disinterested respondents with an easy go-to option, forcing a respondent to choose an option that might be marginally higher or lower than the true frequency of a particular morally distressing situation was deemed inappropriate. Therefore, a midpoint option of "Sometimes" was used. The Likert scale used to measure frequencies of moral distress is provided in Table 3.6 and also is found in Appendices U and X on the initial and modified versions of the MDSC-CA.

Table 3.6
Example Item Response Scale

The following statements represent everyday situations associated with clinical work with children and adolescents. Please indicate how frequently you experience each situation in your clinical work. If you are not currently counseling, please indicate how frequently you experienced each situation while you were practicing.

Item	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
1.	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐
.							
.							
.							
N	☐	☐	☐	☐	☐	☐	☐

Note. Instructions informed by Corley, Minick, Elswick, and Jacobs (2005).

Development in Qualtrics. The MDSC-CA was created in Qualtrics and distributed online for pilot testing. The use of the Internet as a research platform has become increasingly popular over the last decade and is a particularly appropriate way to implement traditional methods of data collection, such as questionnaires, as well as more complex methods, such as idiographic assessment (Fraley, 2007). Additionally, Fraley pointed out that the use of Web-based questionnaires has been identified as a useful approach to assessing individual trait differences.

Qualtrics was chosen as the questionnaire development and distribution platform for several of the same reasons it was chosen for the questionnaire distributed during the pre-dissertation phase. First, Qualtrics increases accessibility to the MDSC-CA, as most anyone with a computer and an Internet connection is able to complete it. Similarly, this method increases ease of both distribution and participant completion, which can reduce threats to content validity (Netemeyer, Bearden, & Sharma, 2003). Second, Qualtrics and Internet distribution allows researchers to overcome the barriers associated with attempting to recruit participants from diverse geographical regions. Using other methods (e.g., paper and pencil, mail distribution) are much less efficient and would likely result in significantly higher financial costs to distribute the MDSC-CA. As a result, participants from all over the world can become potential participants, which can help increase sample size and participant variation. Additionally, the financial costs associated with the current study are minimal as a Qualtrics membership is provided to graduate students at The University of Mississippi and use of the Internet for instrument distribution is essentially free.

Lastly, because the pilot test procedures targeted particular participants, described below, exclusionary criteria could be established prior to allowing access to the MDSC-CA. While this

measure does not and cannot guarantee only eligible target participants will complete the instrument, the complex item display, flow, and skip options direct those who do not meet the eligibility criteria to the end of the instrument, without an option to act as a participant. It was thought that the appropriately applied Qualtrics options would discourage those who did not meet the eligibility criteria from completing the MDSC-CA during the pilot-testing phase.

Stage D5: Pilot Testing the MDSC-CA

Clark and Watson (1995) purport "it has become axiomatic that assessment instruments are supposed to be reliable and valid" (p. 309). Although establishing the reliability of the MDSC-CA is beyond the scope of the current study, Netemeyer, Bearden, Sharma (2003) highlighted the value of pilot testing for assessing face validity and content validity, which are benefits Kline (2005) suggested cannot be overstated. Of particular importance is assessing the extent to which the instrument exhibits content validity, or "the degree to which elements of an assessment instrument are relevant to and representative of the targeted construct for a particular assessment purpose" (Haynes, Richard, & Kubany, 1995, p. 238). Due to the complexity of validity issues, several authors implore researchers to carefully approach the pilot-testing phase (Clark & Watson, 1995; Netemeyer et al., 2003). In regard to validity, it is useful to have pilot test participants from relevant populations, rather than friends and family, although they can still provide valuable information relating to other areas. In this case, and described in more detail below, counselors who have experienced moral distress while working with children and/or adolescents were the main target participants included in the pilot testing phase. Additionally, counselors and counselor educators who consider themselves experts in counseling ethics also were targeted as pilot test participants. Both counselors and experts, were highly valuable in the

assessment of face and content validity in that they more appropriately assessed how relevant they considered the items to the phenomenon intended to be measured (DeVellis, 2012).

Other goals of pilot testing were to have participants focus on item clarity and conciseness (Netemeyer et al., 2003). Aside from the participants described above, Kline (2005) recommended having colleagues, friends, family members, and groups of potential samples, complete the scale in order to identify areas of ambiguity, confusion, and difficulty, along with typos and grammatical errors. Other researchers suggest asking reviewers to provide recommendations on other ways to tap into the concept is a particularly helpful way to identify items that may have been overlooked (Netemeyer et al., 2003). Finally, pilot sample size and sample composition are essential components to successful pilot testing, both of which are described in detail below.

Pilot tester recruitment. With the above considerations and recommendations in mind, following the initial instrument development, the MDSC-CA was pilot tested with laypersons, the participants who were interviewed in the pre-dissertation phase of this study and who volunteered to review the instrument, counselors who have experienced moral distress, and counseling ethics experts. Recruitment procedures varied according to type of pilot tester, but in all cases, pilot testers were emailed a Qualtrics link that directed them to the informed consent form for pilot testing and an initial version of the MDSC-CA that corresponded to their pilot tester classification. The professional version of the instrument provided those pilot test participants who are counselors an opportunity to judge item representativeness and rate several characteristics of the items, sub-themes, and instrument as a whole (Haynes et al., 1995). A second version of the instrument, the layperson version, provided layperson pilot testers with an opportunity to judge non-validity issues of the items as they are intended to be presented in the

final version of the MDSC-CA. At all stages of both versions of the pilot test instruments, participants were presented with a dialog box in which they could provide feedback about the validity of the instrument, suggest modifications, point out any grammatical errors, and raise concerns about item difficulty, clarity, or ambiguity.

Laypersons. Pilot testers considered laypersons consisted of family, friends, and acquaintances of the researcher. These participants were included to provide information about item clarity, conciseness, ambiguity, confusion, and difficulty, along with grammatical errors (Kline, 2005; Netemeyer et al., 2003). Some were recruited by telephone and some will be recruited by email, depending on the nature of the relationship between the researcher and the pilot tester. Closer friends and family were recruited by telephone, whereas acquaintances were recruited by email. In either case, however, all participants who were considered laypersons were emailed a recruitment announcement that provided information about the purpose of the study, their participation procedures, and a Qualtrics link to the layperson version of the MDSC-CA (see Appendix K). Prior to being able to access the MDSC-CA, participants were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix L). Participants were required to give their informed consent before proceeding to the instrument itself. Although the layperson pilot testers will not provide information pertaining to instrument validity, they still might be able to provide valuable information pertaining to the instrument's construction and accessibility.

Interview participants. Those participants who were interviewed in the pre-dissertation phase and indicated interest in reviewing the developed instrument, were contacted via email and sent a pilot test announcement with the link to the Qualtrics version of the MDSC-CA (see Appendix M). Prior to being able to access the MDSC-CA, previously interviewed participants

serving as pilot testers were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix N).

Target population and experts. Colleagues of the author and dissertation committee, who are counselors, counselor educators, and experts were recruited for pilot testing. Each potential pilot tester was emailed an recruitment announcement, which summarized the current study and provided information about the MDSC-CA (see Appendix O). Because moral distress is a new phenomenon in the context of counseling, the announcement was designed to target those who have expertise in counseling ethics, especially ethics pertaining to counseling children and/or adolescents, as the genesis of moral distress is understood be ethical complications (Jameton, 1984). Additionally, counselors or counselor educators who have experienced moral distress while working with children and/or adolescents were targeted as pilot testers. Prior to being able to access the MDSC-CA, pilot testers were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix P).

Pilot test sample size. Sample sizes varied considerably during different instrument development phases. During the pilot test phase, or what others refer to as the content validity pretest step (Hinkin, 1998), several researchers recommend that relatively small sample sizes, ranging from 20 (Gerbing & Anderson, 1988) to 65 (Schriesheim, Powers, Scandura, Gardiner, & Lankau, 1993) are adequate for achieving this phase's goals, described above. Simms and Watson (2007), however, recommend using a larger pilot test sample (e.g., 100 participants) in situations where a convenience sample is available, such as undergraduate students. Because the current study was interested in obtaining a sample that is not particularly convenient to access,

and because pilot test participants with substantial ethical knowledge or previous experience with moral distress were being targeted, the pilot test used in the current study was on the lower side of the above recommendations. Therefore, the target sample size was 15, consisting of each of the above pilot test participant groups, as an adequate sample to assess face and content validity.

Pilot test procedures. Again, the main goals of pilot testing are to establish face validity and content validity. Netemeyer et al. (2003) have provided several valuable recommendations in the process of pilot testing an initial instrument, which increase both types of validity. First and foremost, the researcher should have all elements of the instrument judged by pilot testers. This includes, but is not limited to, the items themselves, the response scale labels, the number of scale response options, and instructions. The validity assessment procedures can be carried out in several ways.

First, as Netemeyer et al. (2003) recommend, at least five expert judges should be used to asses content validity and at least five target population judges should be used to assess face validity. The validity assessment relies on Likert scale ratings for both types of validity by both groups of judges. Netemeyer et al. (2003) propose a three-response Likert scale should be sufficient to rate the representativeness of the items based on the construct definition and domains. They suggest that this rating scale should include the following responses: "not representative," "somewhat representative," and "clearly representative" (p. 103). Haynes et al. (1995), on the other hand, advocate for rating scales that include five or seven responses related to the items representativeness, specificity, and clarity. In this case, the rating scale should be used by at least five pilot testers and only those items with high interrater agreement should be included on the instrument being developed. Regardless of the scale used, however, Netemeyer et al. indicate a general rule of thumb is the more pilot test raters the better.

The pilot test procedures used in the current study loosely followed the recommendations provided above, as well as the highly detailed steps presented by Haynes et al. (1995). However, there were two separate instrument presentations and pilot testing procedures: (1) those for the layperson testers to judge non-validity issues and (2) those for the interviewed participants, experts, and counselors or counselor educators with a focus on validity. In each case, the instrument was constructed in Qualtrics for online distribution to the respective pilot testers. Both instrument presentations and pilot test procedures are described in detail below.

Layperson pilot tester procedures. The first MDSC-CA was a version presented as it is intended to be used in future studies with counselors who have experienced moral distress (see Appendix Q). This version included the instructions, items, and both the moral distress level and frequency rating scales, as described above. A Qualtrics link to this version was sent to the layperson pilot testers who were instructed to critically review all elements of the MDSC-CA, paying particular attention to issues of ambiguity, confusion, clarity, grammatical errors, typos, and instrument flow. Because these participants' attention as to be directed to those issues, they were not instructed to complete the instrument, in the sense that they would provide ratings for each item. Restricting their responses was accomplished in an attempt to minimize distraction from the issues on which they are to focus.

This version of the instrument began with the instructions where participants were presented with the dichotomous ("Yes, the instructions are acceptable" / "No, the instructions are not acceptable") rating scale in order to indicate whether or not they believed the instructions were acceptable. Regardless of their response all participants were presented with a dialogue box in whch they were able to provide feedback, comments, or suggestions.

All 106 items included on the initial MDSC-CA were presented to the layperson pilot testers and each included a response prompt relating to clarity, ambiguity, and so forth. The response prompt asked whether or not each particular item was acceptable, in terms of the issues described above. Response options were dichotomous (e.g., "Item is Acceptable" / "Item Needs to be Revised") Again, regardless of response, participants were provided an opportunity to provide feedback for each item. This procedure continued for all elements of the instrument. At the end of the instrument, after each element is rated, layperson pilot testers had an opportunity to provide overall feedback. If no overall feedback was provided, the pilot testers were instructed to simply submit their ratings by pressing the forward flow (arrow right) button at the bottom of the page. They were thanked for their time and feedback, and provided the researcher's contact information in the event they had questions or desired to add to or amend their ratings. Unless they contacted the researcher for those reasons, their participation in the current study was terminated.

Interviewed participants, experts, and counselor or counselor educator procedures. The second version of the MDSC-CA included all of the same elements the first (layperson) version included, but were presented differently, and had a different rating scale, aside from that corresponding to the instructions (see Appendix R). This version of the instrument began with the instructions where participants were presented with the dichotomous ("Yes, the instructions are acceptable" / "No, the instructions are not acceptable") rating scale in order to indicate whether or not they believed the instructions were acceptable. Regardless of response, all participants were given an opportunity to provide feedback.

Following the instructions rating and optional comments, participants were taken to a section that included all items in the initial MDSC-CA item pool. Items were presented by

construct domain and associated sub-themes in order to have these pilot testers, who were more familiar with counseling ethics and moral distress, rate the degree to which they believed the individual items represented their respective sub-theme. In this case, testers were presented with a group of items under the sub-theme heading and were asked to rate each item individually using a three-response option Likert scale (e.g., "Not Representative," "Somewhat Representative," and "Clearly Representative") as recommended by Netemeyer, Bearden, and Sharma (2003). Each item also included the dichotomous rating scale the layperson pilot testers saw, giving these testers an opportunity to determine whether or not each item is acceptable or needs to be revised.

After all items were rated in terms of their representativeness to their respective sub-theme, these testers were presented with sub-themes in relation to their respective domain. Procedures for this section were identical to the item to sub-theme representativeness ratings above, in that each sub-theme was rated in terms of its representativeness to its associated domain. Again, these pilot testers rated sub-theme acceptability and had an opportunity to provide feedback for each sub-theme.

Just as the laypersons were restricted from actually completing the instrument, these pilot testers will be restricted from actually indicating their level and frequency of moral distress. This restriction was intended to minimize the possibility that they would distracted from the goals of this section, namely assessing face and content validity. At the end of the instrument, after each element was rated, these pilot testers had an opportunity to provide overall feedback. If no overall feedback was be provided, the pilot testers were instructed to submit their ratings by pressing the forward flow (arrow right) button at the bottom of the page. They were thanked for their time and feedback, and provided the researcher's contact information in the event that they

had questions or desired to add to or amend their ratings. Unless they contacted the researcher for such reasons, their participation in the current study was terminated.

Stage D6: Analysis of Pilot Test Data

Data analysis involved both quantitative and qualitative procedures. Quantitative data was analyzed with Fleiss' kappa statistic, a generalized form of Scott's pi (1955), which allowsthe assessment of inter-rater agreement among three or more judges. Representativeness and acceptability data was analyzed for the counselor version of the MDSC-CA, where as only acceptability data was collected and analyzed for the layperson version. Qualitative data, in the form of comments and feedback provided by participants during pilot testing, was also analyzed in an effort to strengthen the face and content validity of the instrument. Together, the results of this stage informed modifications of the instrument, which occurred in the next stage.

Stage D7: Instrument Modificaiton

Instrument modification refers to what Lichtenstein, Ridgway, and Netemeyer (1993) call item purification. Item purification is a process of instrument modification that relies on the pilot test results in an effort to increase the validity of the measure. As Netemeyer et al. (2003) suggest, this process relied on the feedback provided by pilot testers. Such feedback directly influenced any necessary alterations to item construction and wording, as well as the items to be retained for the modified version of the MDSC-CA.

The goal of this stage was reduce the item pool to a more parsimonious group that is judged to have acceptable face and content validity. Preliminary establishment of face and content validity represented the culmination of the current study; however it is hoped that the initial version of the MDSC-CA will be valid enough to use in future studies to further test its

psychometric properties and subsequently measure moral distress among counselors who have experienced the phenomenon while working with children and/or adolescents.

Summary

This chapter thoroughly describes the methodologies utilized in this study, which were implemented in two phases. The first phase was completed prior to the researcher's prospectus defense and included the collection of qualitative data used in the second phase. The second phase served as the reseacher's formal dissertation study and was carried out in seven stages, including data analysis, instrument construction, pilot testing, and instrument modification. The employment of these methodologies was intended to provide an opportunity to explore child and adolescent counselors' experiences of moral distress, with the goal of constructing a valid instrument to measure moral distress among such counselors in the future. Chapter Four describes the analysis of the qualitative data collected during the pre-dissertation phase and how the results informed the domain and sub-theme development. Chapter Five covers describes the development of the initial item pool, item reduction, and instrument construction based on the analyzed qualitative data, identified domains and sub-theme structure, and relevant counseling literature. Chapter Six covers the analysis of the pilot test data and how the results informed instrument modification, concluding with an modified and parsimonious version of the MDSC-CA with increased validity. An overview of the study, summary of the findings, suggestions for future research, and limitations are included in Chapter Seven.

CHAPTER FOUR

RESULTS: DOMAIN AND SUB-THEME DEVELOPMENT

As described above, IPA focuses on the detailed examination of lived experience, and as the name suggests, is interpretative from the outset, which stems from Heidegger's conceptualization of phenomenology. Interpretative phenomenological analysis utilizes the contextual information in which an experience happens or a person exists, examining it with great detail (Smith et al., 2009). As such, IPA was an ideal analytical method that helped elucidate unique characteristics of those experiences, which subsequently enabled the author to gain a more complete understanding of the phenomenon of interest, in the context of counseling. Throughout analysis it is important to recognize that the goal is not simply to make meaning of the data, but rather to find meaning in the data (Guest, MacQueen, & Namey, 2012). Therefore, meaning should organically emerge from the available data, rather than being derived from current knowledge of, previous experience with, or assumptions about the phenomenon under investigation.

Stage D1: Analysis of Qualitative Data

The steps of IPA analysis are described briefly below, as they were applied to and conducted with the qualitative data collected in Stages P1 and P2. It should be noted, however, Roberts (2013) points out that IPA should not be viewed as a prescriptive methodology, but rather as a flexible and fluid method, allowing the researcher to return to data as needed

throughout the process. As such, the steps are described as a linear function of analysis, although they were carried out in a nonlinear fashion

Transcription. Interpretative phenomenological analysis requires all data collection processes and events to be recorded verbatim (Smith et al., 2009). As such, each of the audio-recorded interviews collected during Stage P2 were transcribed in their entirety by converting audio files to .wav form and importing into Express Scribe for playback manipulation. The interviews were typed as line-numbered transcripts in Microsoft Word, which served as the initial data to be analyzed. Because the goal of IPA is interpretative in nature, it does not require pedantic transcriptions; however, each of the transcripts developed for the present study included the prosaic details, as pauses and nonverbal and repetitive utterances were thought to have utility in the interpretation of distressful experiences. Therefore, transcripts were verbatim in terms of verbal and nonverbal communication, and both types of data were considered in analysis.

Step 1: Reading and re-reading. The first step in the process of analysis is reading and the available qualitative data. This process involves immersing oneself in the original data, which in this case was comprised of both free-responses from the questionnaire and transcriptions of subsequent interviews. The main purpose of this process is to slow down the tendency to attempt to analyze or understand text in a relatively short amount of time (Smith et al., 2009). Part of this process is recording initial reactions to and thoughts about the interview, which can serve as bracketing guides. Engaging in bracketing, as Smith et al. (2009) suggest, has the capacity to help the researcher delve further into the texts and more accurately interpret their meaning. As such, bracketing was conducted before each interview and subsequent transcription in an effort to explore the data with an awareness of one's biases, which is described below.

The reading and re-reading process was started as soon as possible after transcription, typically within one day. Transcripts were read one at a time in the order of which they were obtained, with the first review accompanied by the respective audio recording, as suggested by Pietkiewicz and Smith (2014). This process allowed the tone of voice and nonverbal utterances and pauses to be reflected upon and noted when necessary, and was conducted with each transcript. As many IPA researchers suggest, the immersion process was iterative and continued with each stage of data analysis (Brocki, & Wearden, 2006; Biggerstaff & Thompson, 2008; Smith et al., 2009; Bonner & Friedman, 2011; Vincent, Rana, & Nandinee, 2015). As such, identified and emergent meaning units, clusters, and themes were reconsidered in the context of the original data in order to help ensure meaning was understood, to the extent it may be possible, and interpretations were well grounded in the data (Lundkvist, Gustafsson, Hjälm, & Hassmén, 2012). This step and those described below are essential to IPA research due to its assumption that individuals interpret experiences and construct stories that are unique and subjective (Brocki & Wearden, 2006). Therefore, an appreciation of participants' stories, demonstrated through continued reflection on their reported accounts, is a methodological imperative in order to achieve goodness of qualitative research.

Bracketing. Bracketing, as Chan et al. (2013) describe, is a process of "holding in abeyance those elements that define the limits of an experience when the [researcher] is uncovering a phenomenon about which s/he knows a great deal" (pp. 1-2). Bracketing, as it relates to the current study, and to IPA more generally, was deemed seemingly essential due to the author's complete consumption of the moral distress literature and resulting knowledge of the phenomenon; however, IPA provides no step in executing bracketing and only describes it peripherally (Giorgi, 2011). Reflecting on the roots of IPA, however, suggests bracketing may

be an overlooked, yet necessary, step in the process of IPA. For example, Husserl's phenomenology involved a process of replacing our natural attitude, or everyday experience, with the phenomenological attitude, which requires an examination of our perceptions of objects and experiences. Smith et al. (2009) pointed out an essential step in adopting the phenomenological attitude is bracketing our taken-for-granted worlds in order to concentrate on our perceptions. Similarly, Merleau-Ponty (2002) described a process of returning to the phenomena, or returning to the things themselves, which requires an examination of things beyond our present knowledge of a phenomenon:

> To return to things themselves is to return to that world which precedes knowledge, of which knowledge always *speaks*, and in relation to which every scientific schematization is an abstract and derivative sign-language, as is geography in relation to the country-side in which we have learnt beforehand what a forest, a prairie or a river is. (pp. ix-x)

The process of returning to something overlooked, as described by Merleau-Ponty, is so inherent to phenomenology that it serves as its founding assumption (Cerbone, 2006). Therefore, bracketing was carried out as precursor to data collection and analysis in an effort to overcome a potential limitation of IPA as an analytic methodology, and in an attempt to examine the experience of moral distress beyond the author's current knowledge and understanding of the phenomenon. To do otherwise, Auebach and Silverstein (2003) warn, may lead the researcher to interpret data "based on the researcher's prejudices and biases, without regard to the participants' experience" (p. 83).

Step 2: Initial noting. Noting is a cyclical process, which often requires researchers and analysts to return to the data several times in order to fully develop categories, themes, or concepts (Saldaña, 2009). Initial noting in IPA, however, is approached from an exploratory

paradigm, and usually manifests itself as textual analysis free of prescription (Smith et al., 2009). At this point of analysis, there is no requirement to develop codes or ascribe meaning units to the data; rather, the goal is to obtain a set of comments, which will aid in the next steps of analysis. As such, initial noting takes the form of face value analysis, including initial reactions, speculative summaries, and questions, examples of which are depicted in Figures 4.1, 4.2, and 4.3.

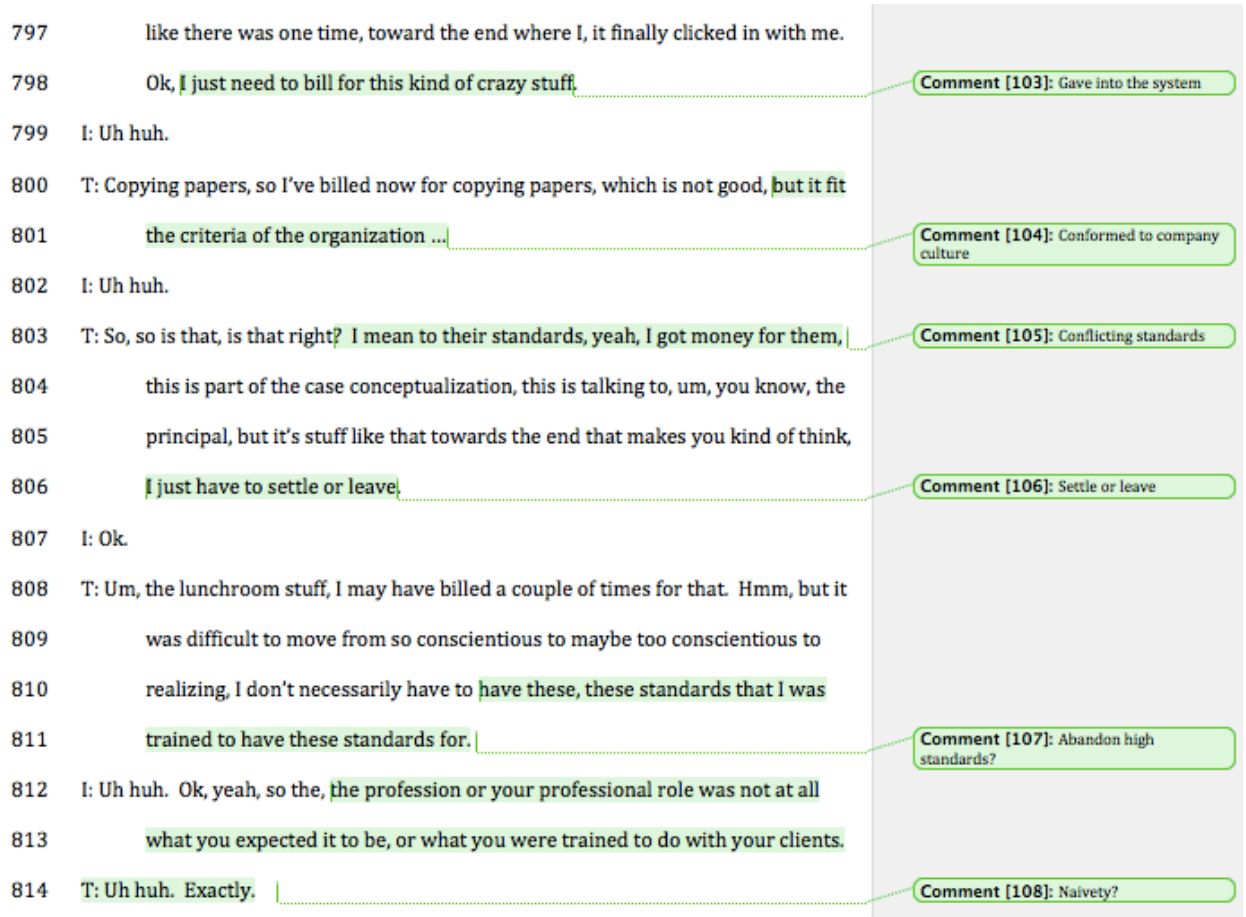


Figure 4.1. Example of initial noting of the interview transcript for participant D-14-24-T.

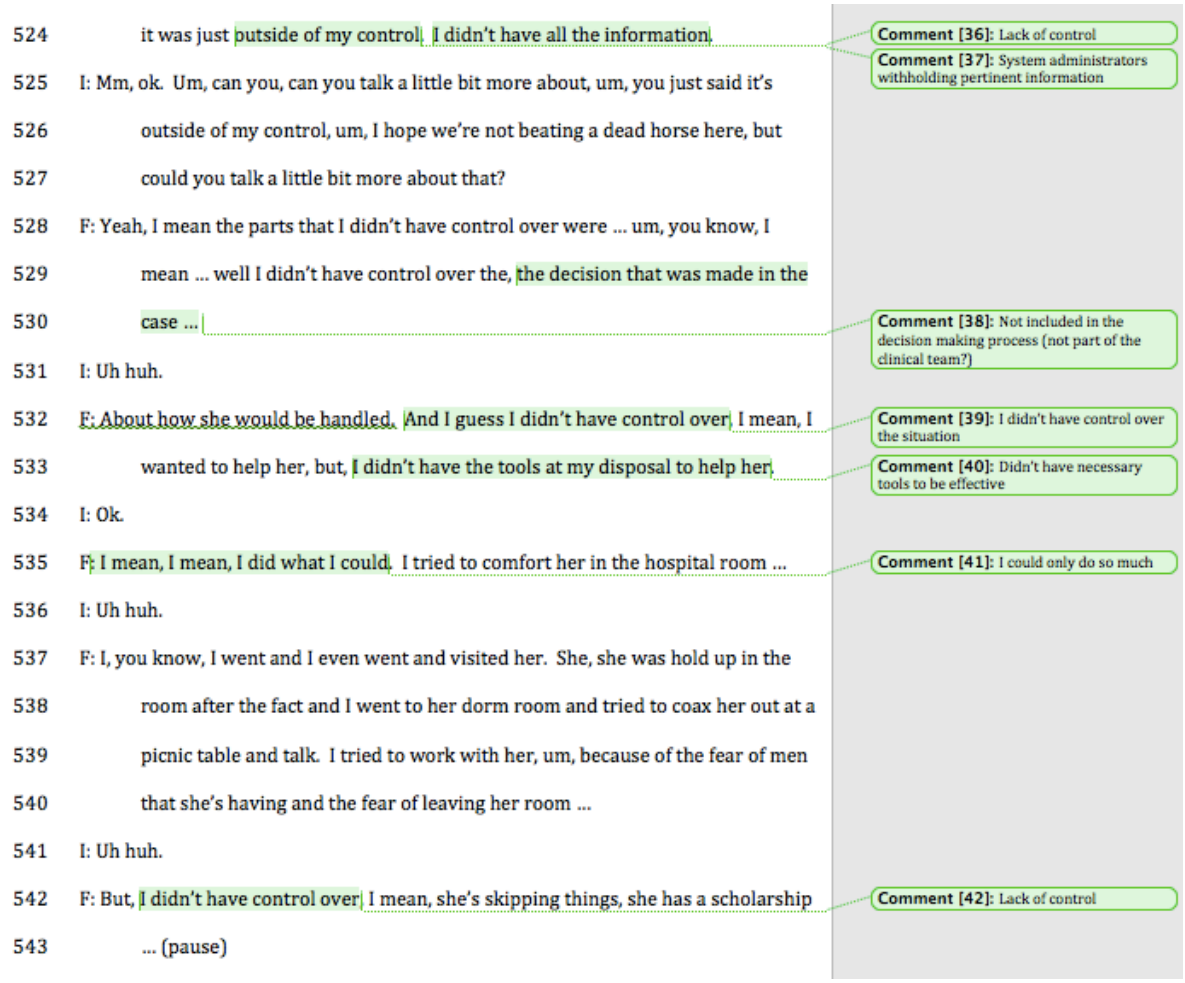


Figure 4.2. Example of initial noting of the interview transcript for participant P-14-19-F.

Figure 4.3. Example of initial noting of the interview transcript for participant R-13-38-J.

During initial noting, researchers remain connected to the participants' explicit accounts, and therefore, typically focus on description and meaning, which later, develops into noting that is more interpretative in nature. Smith et al. (2009) describes this process as one involving "looking at the language that [participants] use, thinking about the context of their concerns (their lived world), and identifying more abstract concepts which can help you make sense of the

patterns of meaning in their account" (p. 83). As can be seen in the examples above, initial noting closely resembles the participants' language; departures from direct connections to participants' language and phrasing are typically presented in the form of exploratory questions, which will be revisited in subsequent analysis in the coding process described in the next section.

Smith et al. (2009) delineated several levels of comments and codes that can be utilized during initial noting:

1. First order – descriptive comments,
2. Second order – linguistic comments, and
3. Third order – conceptual comments.

Each type of comment is described below, as they apply to and are used in the current study, along with examples of each from the transcripts analyzed.

Descriptive comments. Descriptive comments result from taking things at face value in an exploratory way, focusing on the objects that make up participants' perceptions, thoughts, and experiences (Smith et al., 2009). These comments are typically rudimentary in their level of analysis or interpretation. Only later do comments become richer, capturing the complex meaning of one's experience. The key features of descriptive comments are the objects of concern and experiential claims made by participants (Larkin, Watts, & Clifton, 2006). An examination of the transcript segments above in Figures 4.1, 4.2, and 4.3 demonstrate initial coding at the descriptive level. Examples are provided below in Table 4.1:

Table 4.1
Example Descriptive Comments During Initial Noting

Participant	Quote	Descriptive Comments
D-14-24-T	… like there was one time, toward the end where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.	Gave into the system
D-14-24-T	So I've billed now for copying papers, which is not good, but it fit the criteria of the organization	Conformed to company culture
P-14-19-F	It was just outside of my control. I didn't have all the information.	Lack of control System administrators withholding pertinent information
P-14-19-F	I mean, I mean, I did what I could.	I could only do so much
R-13-38-J	…but you do it anyways because you know you could get screwed by not doing it.	Moral abandonment Doing the right thing would jeopardize career
R-13-38-J	So you'd think, well, that's really not wrong, maybe I'm looking at it the wrong way, but deep down you have that, that feeling, no this is wrong. I know I'm doing it anyways, and I feel bad about it type of stress.	Going against core values Perspective confusion?

The descriptive comments in Table 4.1 represent basic descriptions of the participants' experiences or perspectives. From the short excerpts above, some initial assumptions can be made about the participants' objects of concern or their experiential claims. For example, participant D-14-24-T makes it clear that professional standards are an object of concern and conforming to company culture is a recurring experiential motif:

T: … like there was one time, toward the end, where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.

I: Uh huh.

T: Copying papers, so I've billed now for copying papers, which is not good, but it fit the criteria of the organization.

I: Uh huh.

T: So, so is that, is that right? I mean to their standards, yeah, I got money for them, this is part of the case conceptualization, this is talking to, um, you know, the principal, but it's stuff like that towards the end that makes you kind of think, I just have to settle or leave.

I: Ok

T: Um, the lunchroom stuff, I may have billed a couple of times for that. Hmm, but it was difficult to move from so conscientious to maybe too conscientious to realizing, I don't necessarily have to have these, these standards that I was trained to have these standards for.

I: Uh huh. Ok, yeah, so the, the profession or your professional roles was not at all what you expected it to be, or what you were trained to do with your clients.

T: Uh huh. Exactly.

Thus, standards is an identifiable object of concern, as it is explicitly stated more than once, suggesting his or her inability to provide care at a level or standard from which he or she was trained and believes to be correct is central to his or her understanding of and experience with moral distress. Additionally, the experiential claim that he or she had to conform to company culture and abandon one's own standards is evident, although it is not stated explicitly. Therefore, this participant's understanding of moral distress includes the object of concern (*standards*: a verifiable source of confusion and difficulty) and an experiential claim (that the difficulty was caused by giving into the company culture).

The descriptive comments for the transcript excerpt for participant P-14-19-F provides another example of a clear object of concern:

F: … it was just outside of my control. I didn't have all the information.

I: Mm, ok. Um, can you, can you talk a little bit more about, um, you just said it's outside of my control, um, I hope we're not beating a dead horse here, but could you talk a little bit more about that?

F: Yeah, I mean the parts that I didn't have control over were … um, you know, I mean … well I didn't have control over the, the decision that was made in the case …

I: Uh huh.

F: About how she would be handled. And I guess I didn't have control over, I mean, I wanted to help her, but, I didn't have the tools at my disposal to help her.

I: Ok.

F: I mean, I mean, I did what I could. I tried to comfort her in the hospital room …

I: Uh huh.

F: I, you know, I went and I even went and visited her. She, she was hold up in the room after the fact and I went to her dorm room and tried to coax her out at a picnic table and talk. I tried to work with her, um, because of the fear of men that she's having and the fear of leaving her room …

I: Uh huh.

F: But, I didn't have control over, I mean, she's skipping things, she has a scholarship … (pause)

From this expert and the descriptive comments, a lack of control emerged as an object of concern, which is explicitly stated several times. Therefore, it seems reasonable to view this participant's understanding of their experience of moral distress as centering, at least partially, on his or her perceived lack of control over their ability to intervene appropriately. While these examples demonstrate descriptive comments from very short excerpts and shouldn't be analyzed outside of the context of the participants' total experiences, they provide evidence that patterns and themes can begin to emerge relatively early in the analysis process. Descriptive comments, therefore, are important analytical tools that can help researchers engage in deeper levels of interpretation in subsequent stages of analysis.

It should be evident from the excerpts above that very little, if any, interpretation is included in the comments, as the goal at this point is to create simple exploratory notes that can be revisited and expanded upon with subsequent analysis. While IPA allows the researcher to transcend participants' terminology and conceptualizations in order to develop a theoretical framework or conceptual understanding (Larkin et al., 2006), descriptive comments typically are precursory to that goal. Interpretation at this level is speculative and usually takes the form of a

question, which represents the researcher's initial reactions to the participant's story. For example, the last descriptive comment in Table 4.1, "perspective confusion?" records the researcher's initial reaction to the participant's struggle to adopt an accurate perspective of the ethically challenging situation. Such a comment can be revisited in later phases of analysis in which the question may lead nowhere, may lead back to the data itself, or may lead the researcher to analyze the data at a more abstract level (Smith et al., 2009).

Linguistic comments. Linguistic comments are a form of noting that is conceptually separate from descriptive comments, although comments about participants' language also are descriptive in nature and can be annotated simultaneously with descriptive comments. As mentioned above, the prosaic and linguistic details of participants' stories were thought to have utility in the interpretation of distressful experiences. These details, including pauses, laughter, repetition, tonality, and articulation, are exactly the objects of focus when making linguistic comments (Smith et al., 2009). As such, linguistic comments and annotations were made during the initial noting process, but also were considered as additional analysis was conducted in order to consider the context of experiences and the ways in which participants presented their stories. Examples of linguistic comments and annotations are briefly provided below in Figures 4.4 and 4.5.

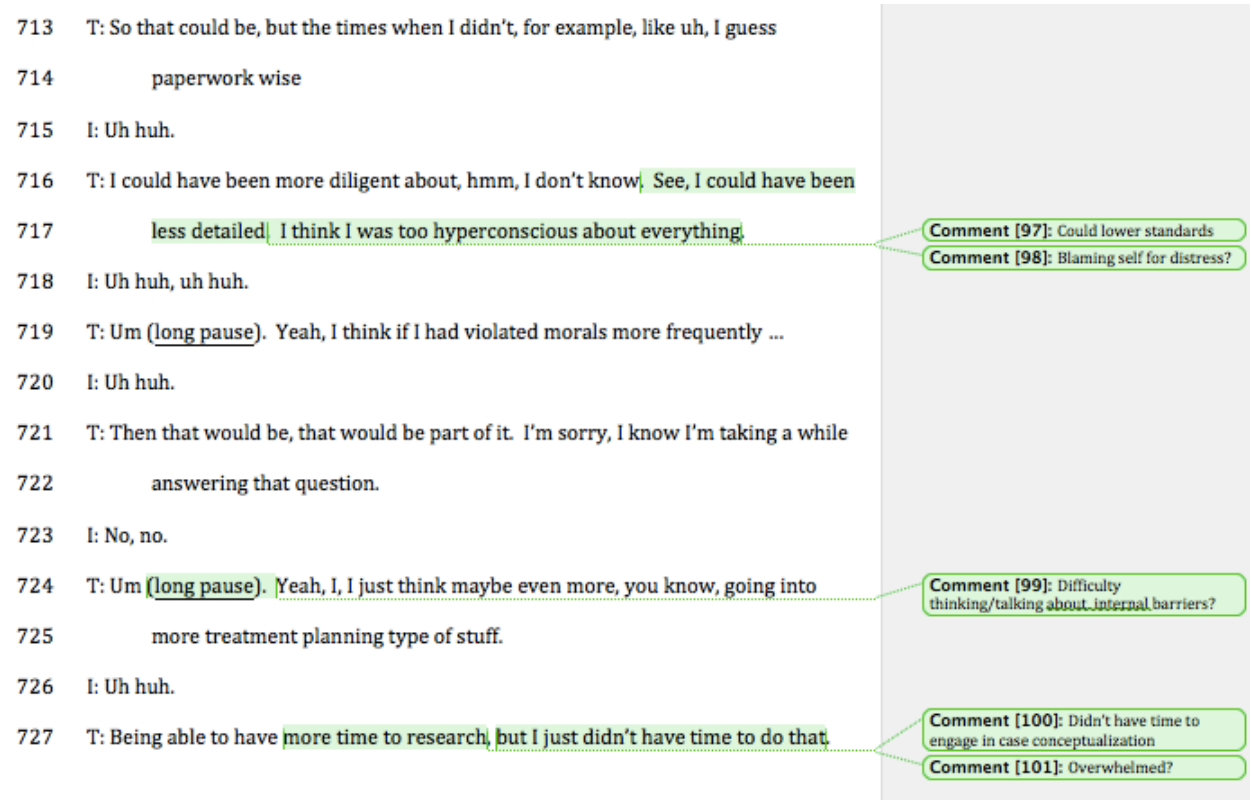


Figure 4.4. Example of linguistic annotations noting lengthy pauses in dialogue.

Figure 4.4 simply makes note of several linguistic anomalies, such as long pauses and an initial interpretation of those pauses. This portion of the interview immediately follows a shift in focus from the participant's experience of moral distress to the participant's perception of barriers that prevented him or her from engaging in moral action. The discussion begins with an internal reflection of personal qualities that might have made ethically challenging situations more difficult, which may represent an internal constraint to moral action. The long pauses noted in Figure 4.4 are characteristically different than the degree of fluency and flow of articulation recorded in the sections preceding the topic of potential barriers. As such, it seems evident that the participant is having some difficulty with the topic of barriers (particularly those internal in nature) and is thinking about those barriers in a meaningfully different way than previous topics. During initial noting, it is sufficient to identify these linguistic artifacts, without

interpretation; however, when such artifacts are contextually meaningful, such as their abrupt appearance in Figure 4.4, it is appropriate to make connections between language and content, which can take the form of rudimentary interpretation (Smith et al., 2009).

The example in Figure 4.5, taken from the same interview as the example in 4.4, provides two particularly interesting linguistic devices that offer insight about the participant's experience with moral distress. The first is a form of externalizing, in which the participant does not articulate their true feelings from their perspective directly, but rather acknowledges those feelings through a colleague's experience:

> T: But also, I mean I would hear other things like, I, I would, you know, one, I remember one coworker just, not sobbing, but she was crying like "I don't know how to do all this," and I was like yeah, I feel exactly like she does ....

Without further analysis, it is unclear exactly what the utility of the participant's externalization is, but framing the feeling of being overwhelmed as a quality introduced by others or attempting to creating a sense of universal discomfort, even to a small degree, provides information about the way in which the participant views moral distress or understands his or her experience of the phenomenon. Again, the purpose of commenting on unique or meaningful uses of language at the initial noting step is to make connections between language and content, which can provide further insight later. Regardless of the level of understanding, however, it is important to note the contextual relevance and potential utility of such linguistic devices.

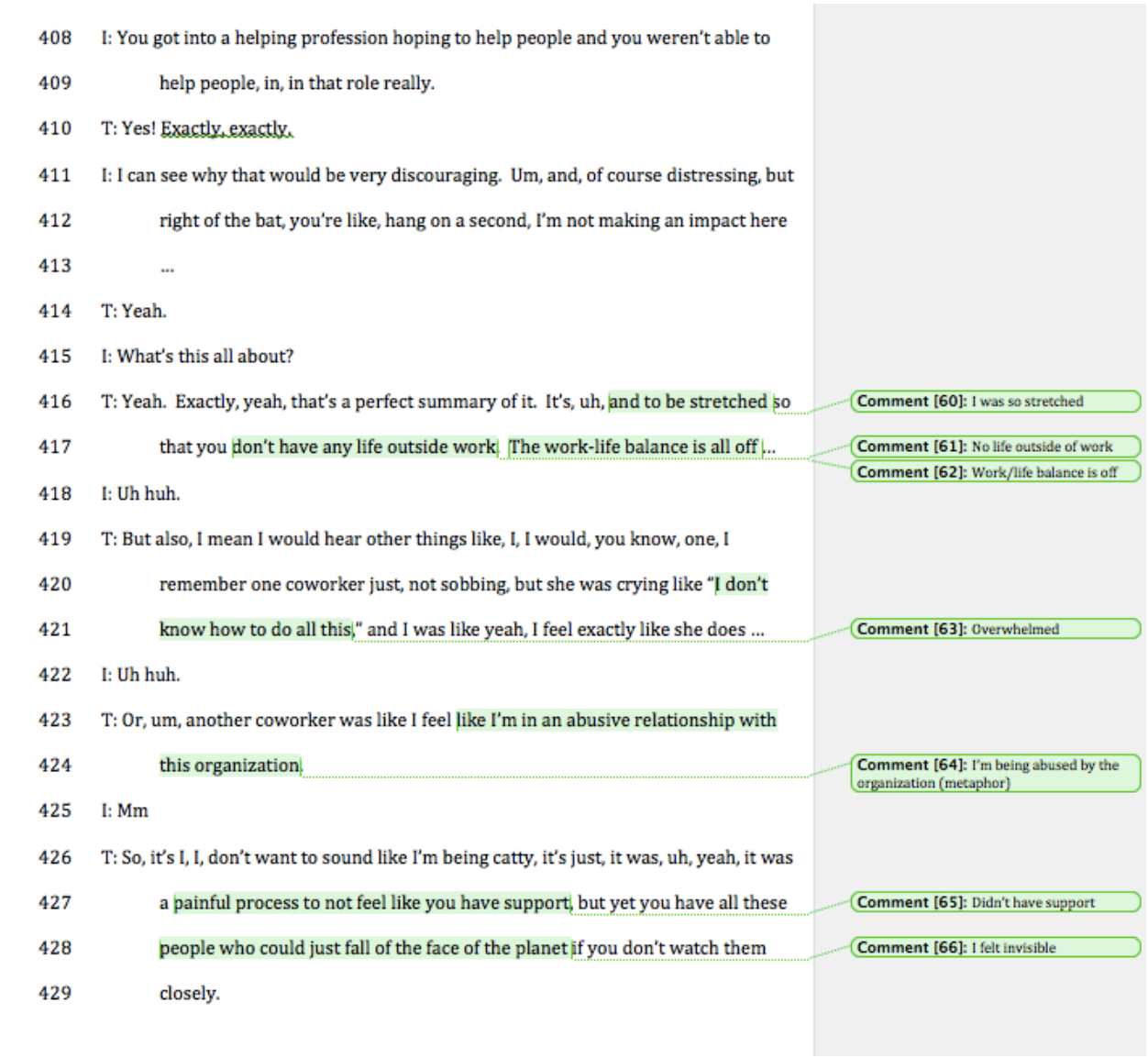


Figure 4.5. Example of linguistic comment noting participant's metaphor.

The second linguistic comment in Figure 4.5 is that of a metaphor, which Smith et al. (2009) suggested is a "particularly powerful component of the analysis here because it is a linguistic device which links descriptive notes … to conceptual notes" (p. 88). Although the metaphor is a derivation of another's experience, this participant's use of "abusive relationship" as a metaphor for describing the experience of overwhelming clinical responsibilities helps the

analyst conceptualize how moral distress unfolded, was experienced, and felt for this participant. Additionally, such an explicit proclamation provides an opportunity to explore more conceptual meanings, such as discomfort, uneasiness, and agony, for example (Smith et al., 2009). In this way, an exploration of underlying meaning may more completely elucidate the ways in which this participant uniquely experiences moral distress or, because he or she draws from others' experiences, shares experiential commonalities with others.

Conceptual comments. The third level of annotation is more interpretative in nature and draws on the initial hunches, reactions, and questions elicited during initial noting, as well as the researcher's knowledge and past experiences. Conceptual comments mark an analytic shift from a focus on the explicit claims of the participants, to the underlying meaning they portray in their descriptions through a process of "making manifest that which in some sense lies hidden" (Moran, 2000, p. 229. This process captures the Heideggerian perspective of phenomenonology as a methodological approach with the goal of letting "that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1962, p. 58) As such, the researcher becomes an analytical instrument, making interpretations that are grounded in the data but build off of logic, reason, personal experience, perceptions, and professional knowledge.

The role the researcher plays in the interpretative process cannot be understated, nor eliminated. Shinebourne (2011b), for example, notes, "every interpretation is already contextualized in previous experience and can never be presuppositionless" (p. 19). It is important to note the fine line between reasonable interpretations and unacceptable reliance on presuppositions without utility or self-awareness. Auebach and Silverstein (2003) provide clarification and caution:

> We think it justifiable, even inevitable, for a researcher to *use* his subjectivity in analyzing and interpreting data. However, it is not justifiable for him to *impose* his own subjectivity in an arbitrary manner, that is, in a way that is not grounded in the data. (p. 83)

It is clear that conceptually analyzing the available data is a complex and challenging process, and one that requires the analyst to engage in self-reflection in order to tease out biases from justifiable interpretations.

The conceptual analysis phase of the current study was conducted with caution, due to the researcher's knowledge of the phenomenon under investigation. Rather than making an array of interpretations at the conceptual level, many more questions were posed that alluded to interpretations and required further examination before they could be integrated into the researcher's understanding of the participants' experience. This process allowed for the interpretations to be temporarily shelved so they could be considered across the compendium of the participant's descriptions and claims. While this approach partially reflected the researchers novelty to the IPA process, it also allowed for interpretations to be well grounded in the data.

Examples of conceptual comments are provided in Figures 4.6, 4.7, and 4.8. An examination of Figure 4.6 reveals the analytical shift from description to conceptualization.

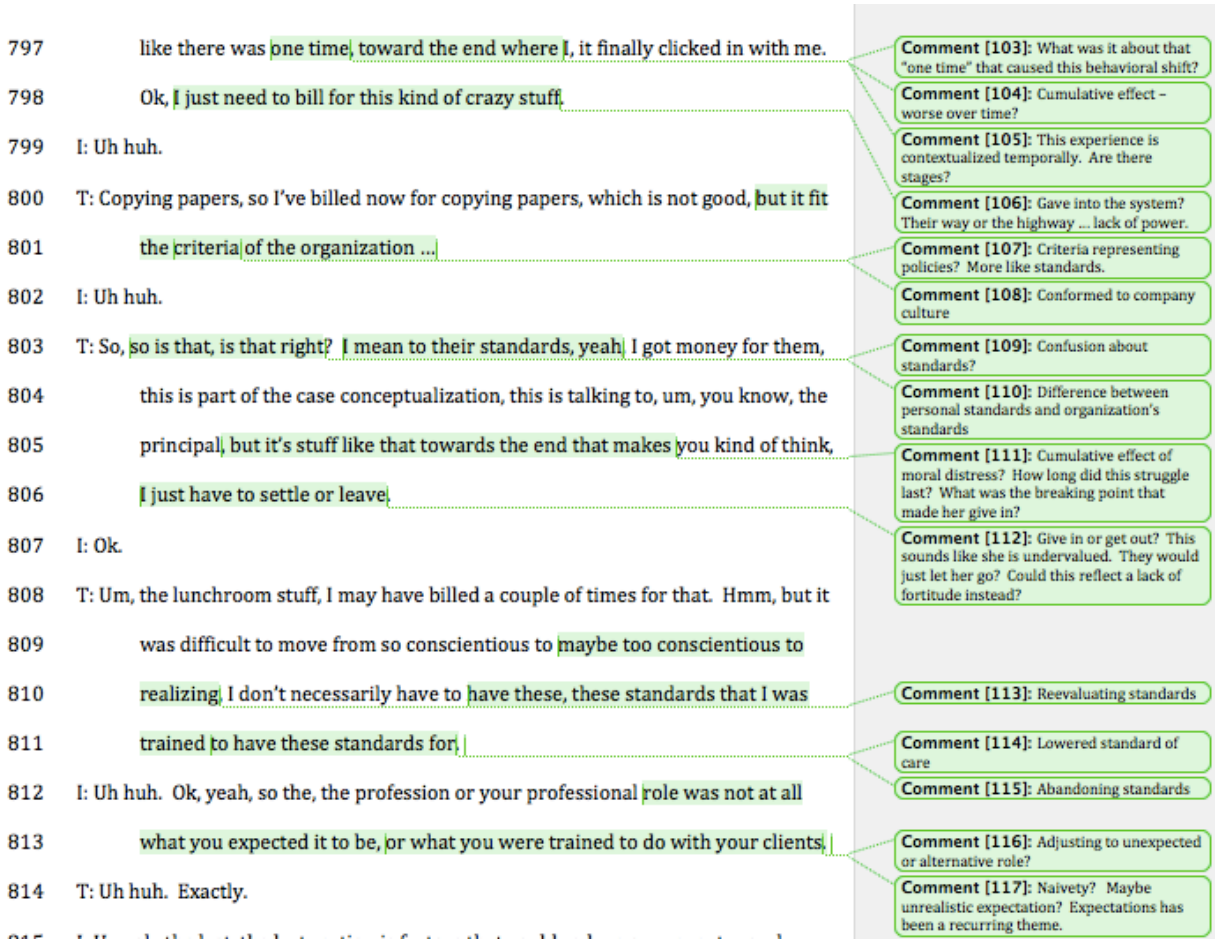


Figure 4.6. Example conceptual analysis of the interview transcript for participant D-14-24-T.

The first claim the participant made was:

> T: … like there was one time, toward the end where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.

Initial noting resulted in the comment "*Gave into the system*," which adequately described and synthesized this participant's experience, yet failed to capture contextual

cues that reveal the true nature of that experience, including how it unfolded over time and the possibility that the experience may have occurred in stages. As a result, The descriptive comment "*Gave into the system*" was reflected upon conceptually and enhanced to recognize that this participant seemed to have reached a breaking point over time, suggesting there might be a cumulative effect to the distress he or she experienced. Reviewing the participant's description again, and considering the time frame overwhich this experience occurred, a better understanding of what the participant may have gone through begins to emerge:

T: … like there was one time, toward the end where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.

The participant explicitly states there was an internal change toward the end of this experience, further suggesting a cumulative effect of the distress; however, that assertion also might suggest that the experience unfolded in a series of stages of levels of discomfort.

A second conceptual emergence that occurred in this excerpt was an understanding of why this behavioral shift (from resisting company culture to conforming to it) occurred. At face value, this participant was unable to do what he or she thought was right due to the company's unethical culture, suggesting the barriers to moral action were external in nature. Further analysis, however, also suggested that the participant may be struggling with internal barriers that are complicating the situation or exacerbating the distress. For example:

T: … it was difficult to move from so conscientious to maybe too conscientious to realizing, I don't necessarily have to have these, these standards that I was trained to have these standards for.

I: Uh huh. Ok, yeah, so the, the profession or your professional role was not at all what you expected it to be, or what you were trained to do with your clients.

I: Uh huh. Exactly.

In this exchange, the participant reveals that his or her high expectations and standards, and possibly naivety, may have created an internal barrier to moral action. That is, because their standards were too high, doing the right thing was unachievable, especially in the context of a company culture that had questionable standards. The company's ethical culture certainly restricted moral action, but his or her idealized view of their professional role, likewise, restricted them from doing what they believed to be correct. As a result, this participant was ultimately forced to abandon their high standards due to a combination of internal and external barriers.

Figure 4.7 also provides an example of a deeper understanding of the participant's experience resulting from a shift from description to conceptualization. This example draws on the interview in its entirety, but for the sake of brevity, is described in isolation. Figure 4.2 reflects the descriptive analysis of this excerpt, which clearly results in the realization that this participant felt a lack of power, which restricted the ability to the right thing. Further analysis, however, elucidated the participant's emotional connection with the client, which served as a second barrier to moral action. Just as the example in Figure 4.6, this example demonstrates both an external and internal barrier.

Figure 4.7. Example conceptual analysis of the interview transcript for participant P-14-19-F.

The external, and fairly obvious barrier, which emerged in this excerpt, was the participant's lack of power. Claims such as "outside of my control," "I didn't have control," "I didn't have the tools at my disposal to help her," and "I did what I could" clearly suggest the participant was not able to engage in what he or she believed to be the right course of action due to a real or perceived lack of power or control. Embedded within the overt experience of powerlessness resulting from external constraints, however, is the experience of powerlessness

due to the emotional connection made with the client. The following portion of the excerpt in Figure 4.7 will clarify this point:

F: About how she would be handled. And I guess I didn't have control over, I mean, I wanted to help her, but, I didn't have the tools at my disposal to help her.

I: Ok.

F: I mean, I mean, I did what I could. I tried to comfort her in the hospital room …

I: Uh huh.

F: I, you know, I went and I even went and visited her. She, she was up in the room after the fact and I went to her dorm room and tried to coax her out at a picnic table and talk. I tried to work with her, um, because of the fear of men that she's having and the fear of leaving her room …

I: Uh huh.

F: But, I didn't have control over, I mean, she's skipping things, she has a scholarship … (pause)

Initially, the exchange above seems like a reasonable level of concern and effort to put forth for a client that stopped coming to counseling, but in the context of this participant's disclosure throughout the interview, including an intense emotional connection with the client due to exceptional similarities between counselor and client, as well as past trauma that resurfaced while counseling the client, professional missteps become clear. For example, the participant begins to take on a parental role with the client, exaggerating his or her responsibilities and becoming overly concerned about the client. In this case, the participant knew he or she was

crossing boundaries, but was blinded by the emotional connection that was formed between counselor and client. Although the participant knew what the correct course of action was, their emotionality created a barrier that resulted in crossing ethical boundaries. Therefore, the powerlessness felt in this situation reflects both external restrictions (lack of control/authority) and internal restrictions (emotional entanglement/exaggerated responsibility).

The third example of conceptual analysis is presented in Figure 4.8. Previously, this excerpt was presented in Figure 4.3, demonstrating the initial noting, which mainly revealed the participant's fear of consequences and struggle with acting against his or her core values. Further analysis extends the researcher's understanding of these experiences within the context of the client's story.

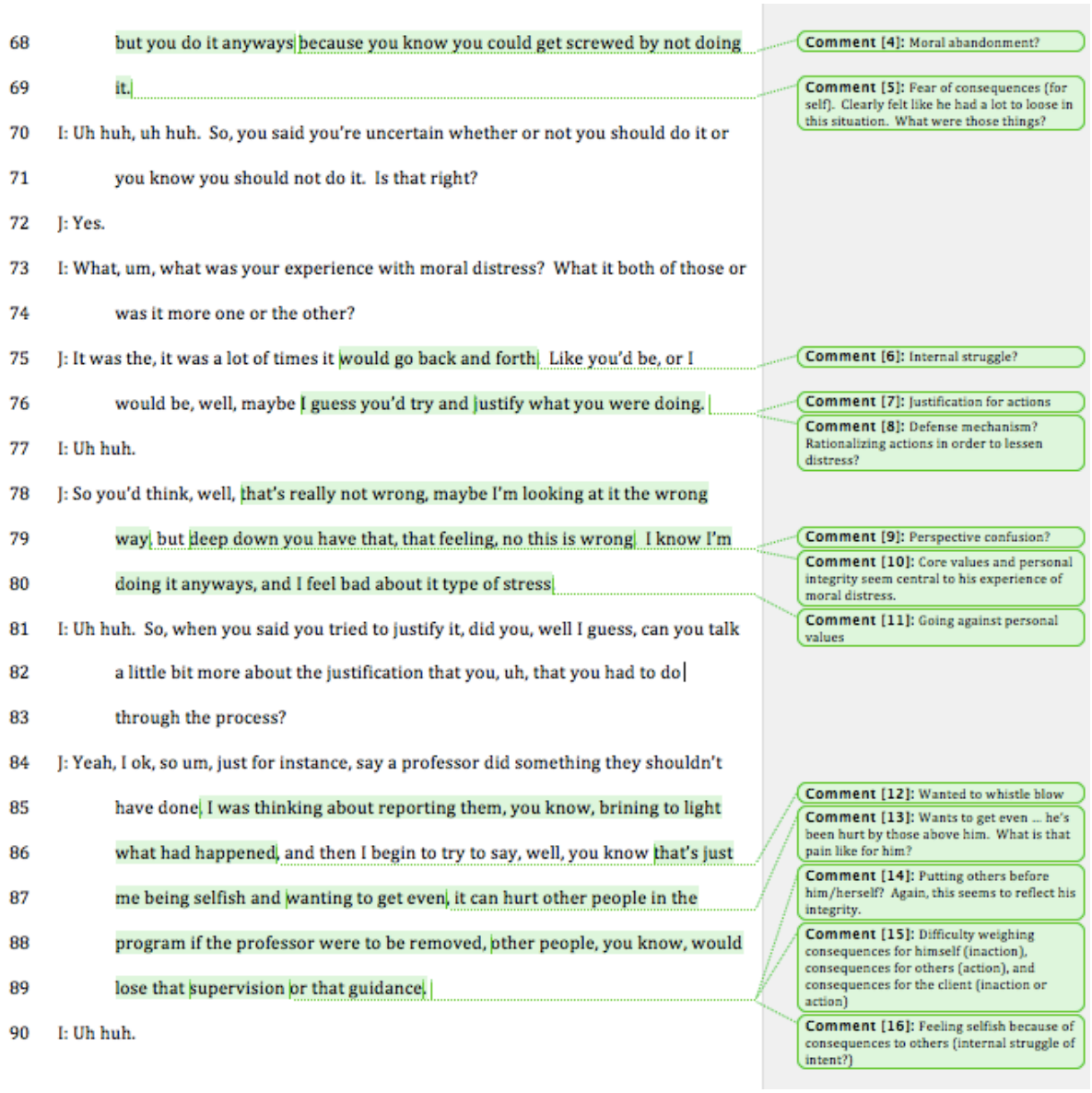


Figure 4.8. Example conceptual analysis of the interview transcript for participant R-13-38-J.

The main conceptual gain in Figure 4.8 is the extension of the participant's struggle with acting against core values to an understanding that threats to his or her integrity were a central component of the experience of moral distress. Later in this interview, the participant discloses:

J: Well, well growing up I was always taught to do what was right even if it was hard, um, if you've done something wrong own up to it, you know.

Revisiting the excerpt in Figure 4.8, it becomes clear that this participant's experience of moral distress was more than acting against values; it represented a fundamental challenge to his or her view of humanity, and personal integrity. The barriers this participant faced not only restricted him or her from doing the right thing in the context of their clinical work, but it also restricted them from acting in the way they understood self in relation to the world. Therefore, by moving beyond descriptive analysis, the researcher is able to understand the uniqueness of the participant's experience and connect the underlying meaning as an early theme in the analytic process.

The second conceptual gain from this excerpt is particularly relevant to the development of emergent themes, which is discussed in the next section. The first and last of the participant's quotes in Figure 4.8 demonstrate concern about the consequences of moral action:

J: … but you do it anyways because you know you could get screwed by not doing it.

J: Yeah, I ok, so um, just for instance, say a professor did something they shouldn't have done, I was thinking about reporting them, you know, bring to light what had happened, and then I begin to try to say, well, you know that's just me being selfish and wanting to get even, it can hurt other people in the program if the

> professor were to be removed, other people, you know, would lose that supervision or that guidance.

These two quotes demonstrate a variety of consequences beginning to emerge as barriers to moral action: those for self and those for others. While this may not be a profound development in understanding this client's experience, it does reveal an unexpected dynamic. Previous research has resulted in a clear acknowledgement that fear of consequences for self act as an internal barrier to moral action (Wilkinson, 1988; Tiedje, 2000; Wilson, Goettemoeller, Bevan, & McCord, 2013); however, to date, the fear of consequences for others has not been identified as a specific barrier. This finding is unexpected, yet not surprising, given the importance of integrity and humanity to this client. As Pendry (2007) pointed out, internal barriers stem from one's belief system, which appears to be particularly humanistic and selfless for this participant. As a result, a unique and deeply conceptual understanding of this participant's experience emerged, which otherwise might have been overlooked.

Table 4.2 provides a summary of conceptual comments that occurred during intial noting, which can be contrasted against the descriptive comments in Table 4.1 above.

Table 4.2
Summary of Conceptual Comments During Initial Noting

Participant	Quote	Conceptual Comments
D-14-24-T	… like there was one time, toward the end where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.	What was it about that "one time" that caused this behavioral shift? Cumulative effect – worse over time?
D-14-24-T	So I've billed now for copying papers, which is not good, but it fit the criteria of the organization	Lack of power
P-14-19-F	It was just outside of my control. I didn't have all the information.	Lack of control Not a valuable member of the clinical team
P-14-19-F	I mean, I mean, I did what I could.	Lack of power Unable to provide adequate care
R-13-38-J	…but you do it anyways because you know you could get screwed by not doing it.	Fear of consequences (for self)
R-13-38-J	So you'd think, well, that's really not wrong, maybe I'm looking at it the wrong way, but deep down you have that, that feeling, no this is wrong. I know I'm doing it anyways, and I feel bad about it type of stress.	Going against personal integrity seems central to experience of moral distress.

Qualtrics questionnaire data. Data collected by way of the Qualtrics questionnaire also were subjected to the data analysis procedureds described above; however, data organization was altered part way through analysis in order to make the data more manageable and to contextualize responses. The figures below will make clear the decision to change the analysis procedures.

The Qualtrics data was originally download by questionnaire item, with all participants' responses grouped together in the order in which they completed the questionnaire. Each response was transferred from an Excel document to a Word document in order to make the analysis procedures uniform across data. Figure 4.9 illustrates how the data for the second questionnaire prompt was downloaded and organized:

What factors, if any, contributed to your experience of moral distress?

1. A mismatch between my core values and the ethical/legal requirements for practice.
2. bureaucracies
3. confidentiality, my own personal sense of family and how I believe the family system model is important.
4. Factors contributing to my experience were my decision making models developed in through my belief system, the code of ethics, and universal law.
5. re the example given, knowing that regardless of which path I took, people would suffer. Even abused/neglected children often will choose to be with their abusive parent. Knowing that they will be removed (for their own good) , but also knowing that they will be traumatized no matter what.
6. Having to follow laws which were not helpful to my client. Feeling helpless. Being present at the client's distress and feeling responsible
7. Court requirements and protocol
8. Knowing what the company policy is and recognizing the needs of the families I was working with. It is that challenge of wondering which is the greater grievance: to follow standard protocol and deal with the knowledge that children will go to bed hungry, or to go against company policy to ensure that the children and families have some of their basic needs met.

Figure 4.9. Original data management for second Qualtrics questionnaire prompt.

Data were initially analyzed by questionnaire prompt, in an effort to more easily and accurately identify connections across participants' responses. However, analyzing responses in isolation by prompt removed the contextual cues and complexity associated with responses, which limited the amount of analysis that could be achieved. For example, when responses to the second prompt (What factors, if any, contributed to your

experience of moral distress?) were analyzed, the responses to the first prompt (Please briefly describe your experience of moral distress as it relates to your counseling experience.) were not included in the analysis. Because the factors that contributed to participants' moral distress were contextually dependent and specific, analysis without such information not only became difficult, but was inappropriate. This analytical problem would have become even more problematic as analysis became more interpreataive.

Figure 4.10 demonstrates the analytical limitations encountered by isolating responses by prompt. For example, the second participant identified bureaucracies as a factor that contributed to their moral distress; however, without placing this factor in the context of the participant's experience, very little can be understood about the way in which bureaucracies restricted moral action. After reviewing the participant's response to the first question, however, the participant's experience can be better understood and analyzed:

2: Knowing that children are homeless or have other needs, but can't find appropriate resources for them.

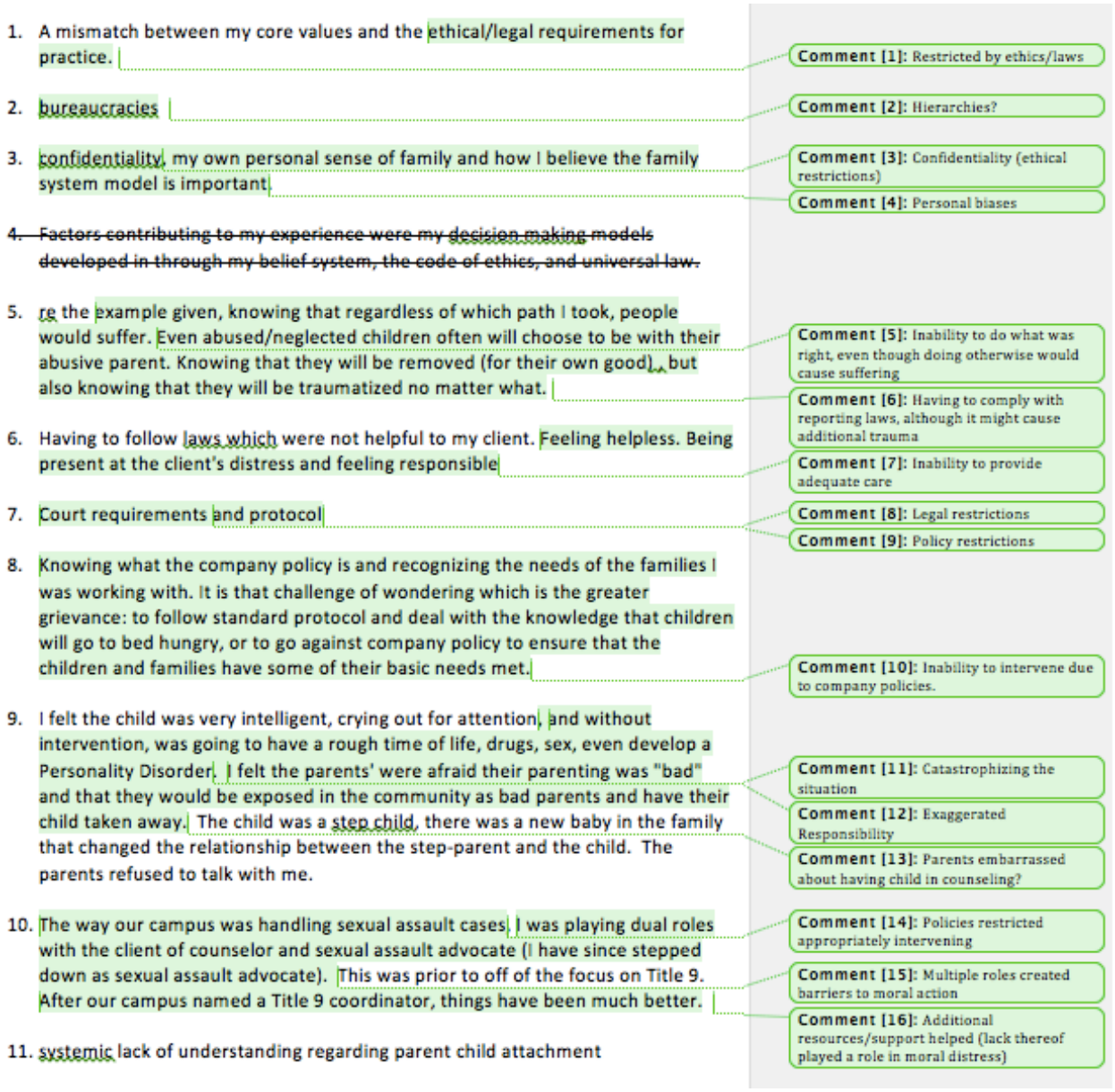


Figure 4.10. Initial organization and analysis of Qualtrics questionnaire data by prompt. The response with striked-through text indicates the participant's experience was not actually one or moral distress.

By placing "bureaucracies" in the participant's experiential context, it becomes clear bureaucratic restrictions prevented him or her from finding the resources that would benefit the client. Additionally, because the word "bureaucracies" was used as a

restricting factor, the participant may have been low in the hierarchy of power within the organization, which limited the decision-making authority he or she had about the scope of services provided.

This example may exaggerate the limitations the original data organization presented; however, it does make clear the contextual importance of the participants' responses in analysis and subsequent interpretation. As such, the individual paticipant's responses were organized together in order to increase contextual complexity and overcome the initial analytic limitations. Figure 4.11 depicts the altered data organization method.

Respondent 1

Experience:
Moral distress occurred because I was unable to carry out what I thought was best for a child due to restricting laws.

Factors:
A mismatch between my core values and the ethical/legal requirements for practice.

Barriers:
Feeling of powerlessness and an inability to act congruently.

Impact:
I felt guilty and frustrated with the restrictions and having to act in a way that was in conflict with my values and desire.

Figure 4.11. Alternate organization of Qualtrics data by participant.

As can be seen in Figure 4.11, each response can be viewed with the others, which allows for greater conceptual and contextual understanding of the participants' experience of moral distress. Because of this increase in organization and complexity,

analysis was much more appropriate and was likely to be more accurate. Examples of subsequent data analysis are provide below in Figure 4.12 and 4.13.

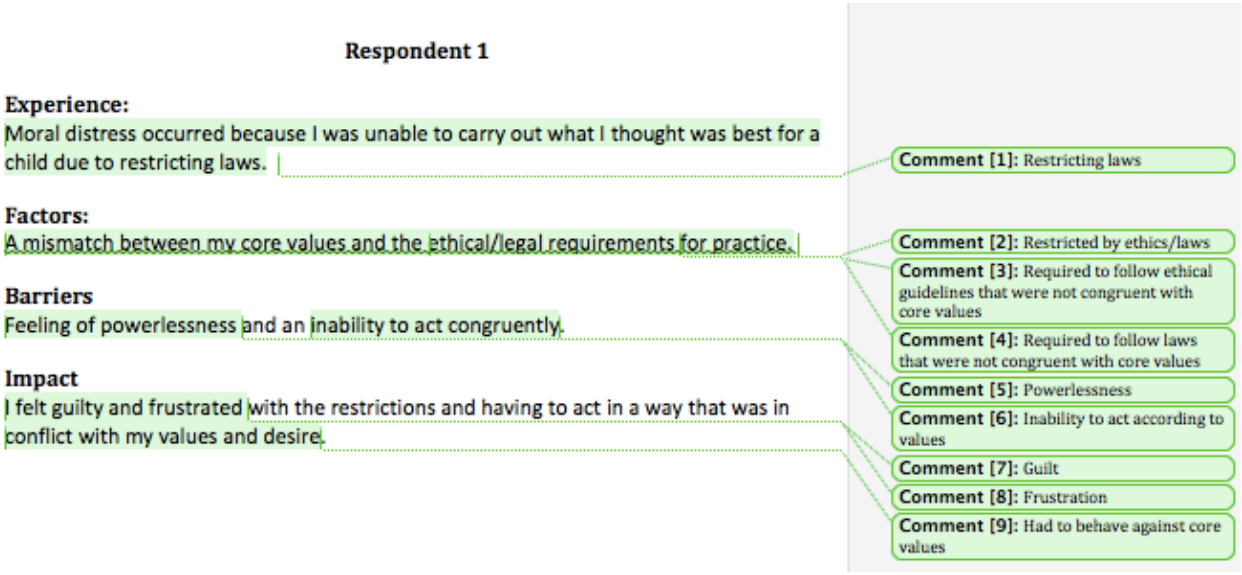


Figure 4.12. Analysis of Qualtrics data for Respondent 1, across responses.

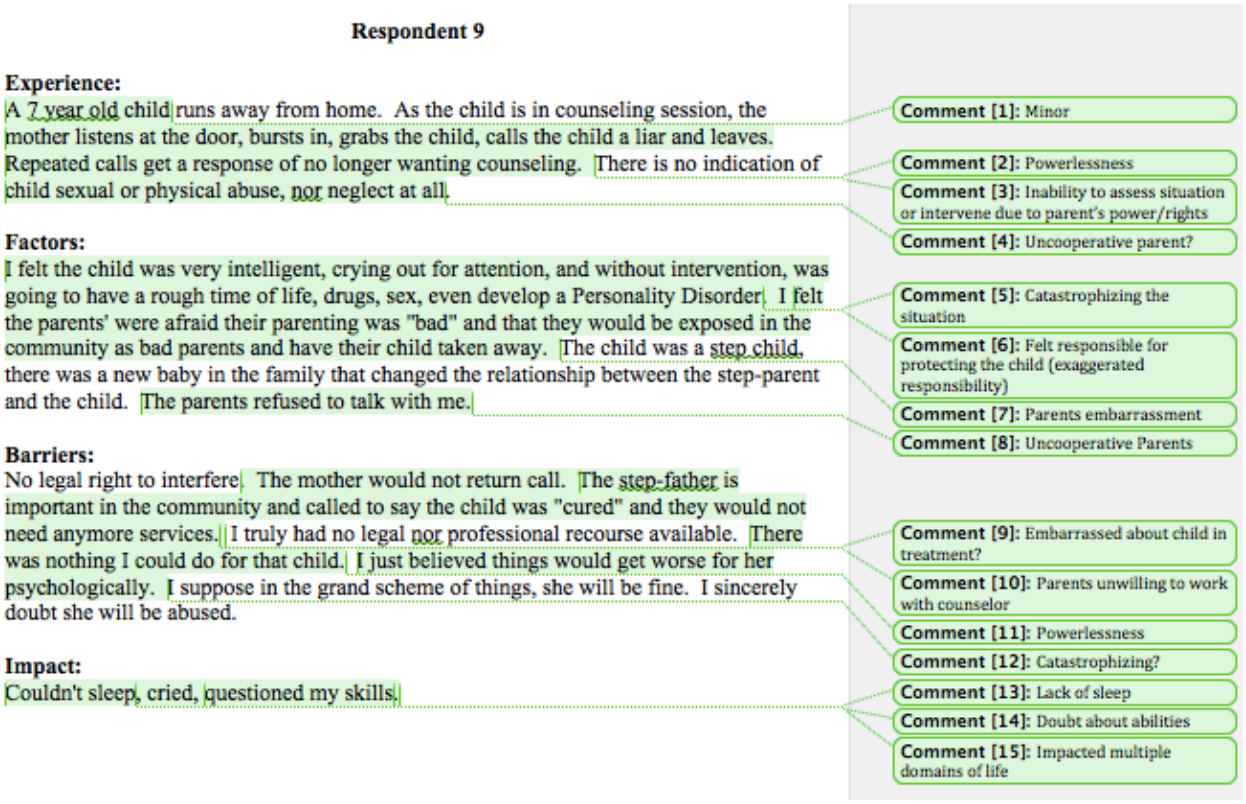


Figure 4.13. Analysis of Qualtrics data for Respondent 9, across responses.

Overview of writing initial notes. The examples above are provided to demonstrate the exploratory and complex nature of annotating transcripts during analysis. These examples are not meant to provide an exhaustive representation of the noting, commenting, and interpretation that occurred during analysis, but are intended to demonstrate the transformation and complexification that occurred over time during analysis. As Smith et al. (2009) noted, there is no right or wrong way to approach noting and initial analysis, and that the process of engaging with the data is almost equally as important as the annotation itself. The process described above represents a thorough, iterative, and reflective process of engaging with and analyzing the data, which was thought to be particularly appropriate due to the researcher's closeness to and familiarity with the phenomenon under investigation. As a result, the next steps in analysis build

out of the exploratory comments, which are very closely tied to the original data, yet are assumed to transcend the participants' understanding of their experiences as the previous analysis intertwined participants' understanding and researcher's self-understanding (Debesay et al., 2008).

Step 3: Transforming notes into emergent themes. The third step in the IPA procedure marked a shift from working with the original data collected from the research participants, to primarily working with the exploratory notes, comments, and interpretations that were obtained during the first two steps of analysis. Those exploratory annotations served as the platform from which emergent themes were subsequently built, and from which the initial item pool was developed. This step also marks a procedural shift from managing data to reducing data and "the volume of detail (the transcript and the initial notes) whilst maintaining complexity, in terms of mapping the interrelationships, connections and patterns between exploratory notes" (Smith et al., 2009, p. 91). If the exploratory annotations were done carefully and comprehensively, they will be fundamentally connected to the source material, more concisely capturing the overall meaning of the participants' experiences.

Identifying emergent themes from exploratory comments requires and acute focus of small sections of transcripts, while still considering the panorama of data, experience, and meaning. Additionally, it requires the analyst to reflect on and consider what was learned through the exploratory analysis (Smith et al., 2009). This process clearly represents understanding achieved via the circular hermeneutic process whereby "misunderstandings are *filtered out through the interplay of the whole and the parts*" (Debesay et al., 2008, p. 58). As it relates to the current study, the hermeneutic circle lead the researcher to gain an understanding of the participants' experiences by analyzing exploratory comments in relation to the original data,

in their respective parts and holistically. It should be noted, however, that the new understanding that emerged through this analytic process should not be regarded as a better understanding, but as a different way of understanding the phenomenon of interest (Gadamer, 1989). This step, as well as the remaining steps in IPA, therefore, are carried out in an attempt to achieve a lucid, clear understanding of something that appears unclear (Ramberg & Gjesdal, 2014).

Whereas the initial notes sometimes seemed somewhat loose and disconnected, the emergent themes should capture and reflect an understanding of what the participant is describing and experiencing. Smith et al. (2009) remind us that themes emerge through a "synergistic process of description and interpretation" (p. 92), therefore remaining closely connected to the data, but more concisely capturing its essence. As Pietkiewicz and Smith (2014) clarify, "the research aims to formulate a concise phrase at a slightly higher level of abstraction which may refer to a more psychological conceptualization" (p. 12).

Identifying emergent themes was conducted on in the margins of the transcripts themselves, similarly to the initial notes and comments seen in the examples above. Themes, however, were demarcated from initial notes by bolding them, as can be seen in Figure 4.14 below. This process of revisiting and reevaluating the same data in its original form aligns with a procedure described Debesay et al. (2008) in which a "*predraft* is continually revised as one gains a greater grasp of the text" (p. 59).

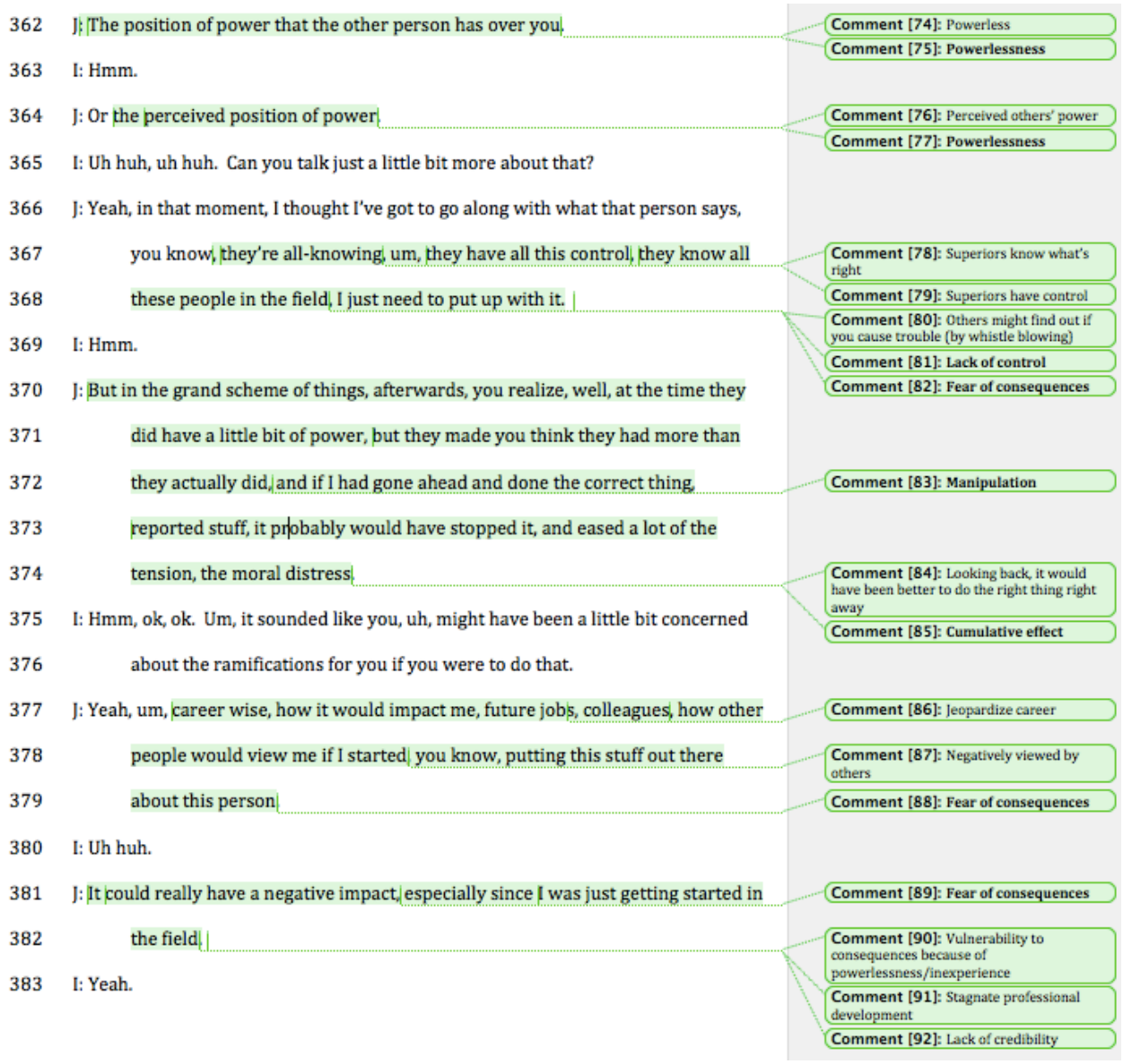


Figure 4.14. Example of how emergent themes were identified. Bolded words represent a theme.

The example in Figure 4.14 demonstrates the emergence of themes in the form of concise phrases that summarize meaning. In this example, several themes emerged: powerlessness, lack of control, manipulation, and fear of consequences. The emergence of powerlessness is not a surprise, as it was explicitly mentioned several times by the participant; however, powerlessness as a theme summarized the participant's feelings of repression, lack of credibility, and lack of

seniority. Lack of control, which later collapsed with powerlessness into an overarching theme and is described below, summarized the participant's feeling of an omnipotent superior, lack of authority, and lack of professional connection. Manipulation summarized the tactics the participant perceived his or her superior using to create the perceived sense of control or power. Finally, fear of consequences summarized the participant's fear that moral action would lead his or her superior to sabotage them, jeopardize their career, cause others to view him or her negatively, and stagnate their professional development. In each case, the emergent theme captured the meaning and exploratory notes in a concise and abstract way, increasing the understanding of the participant's experience.

Figure 4.15 and 4.16 provide additional examples of how themes emerged from the initial notes for both the Qualtrics participants' responses and the interviewed participants' transcripts.

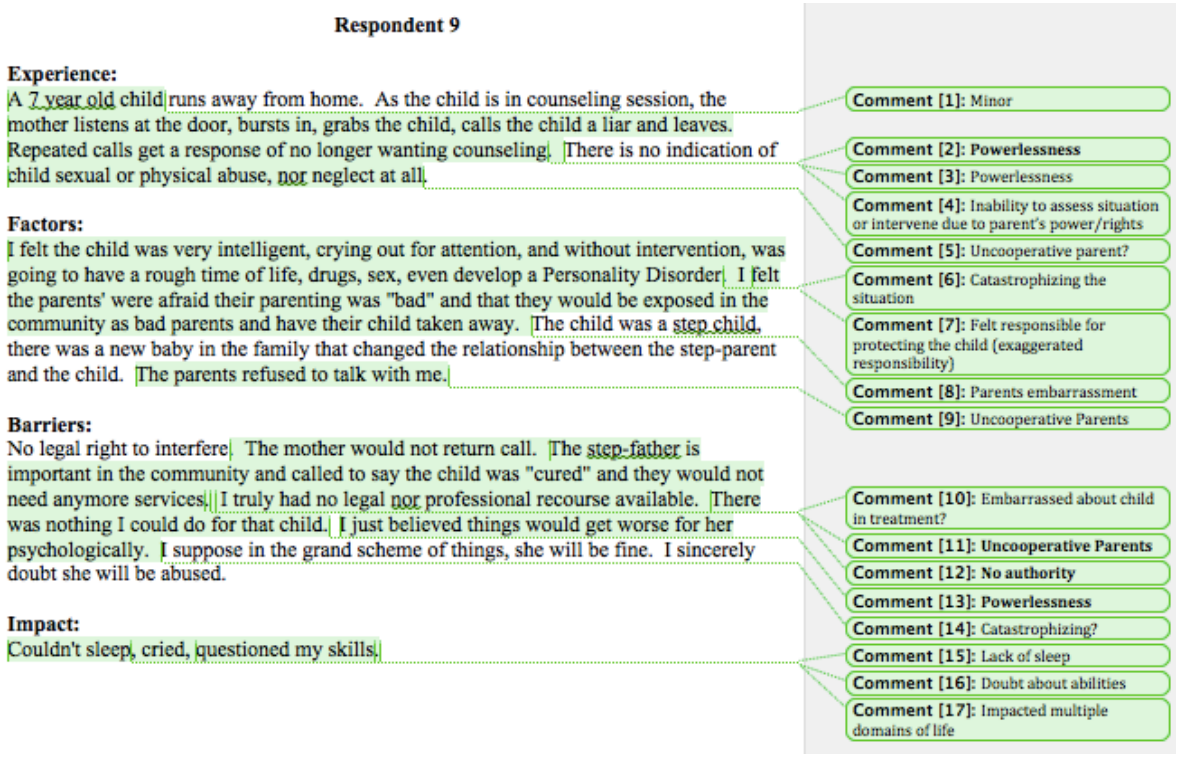


Figure 4.15. Example of emergent themes from Qualtrics data. Bolded words represent a theme.

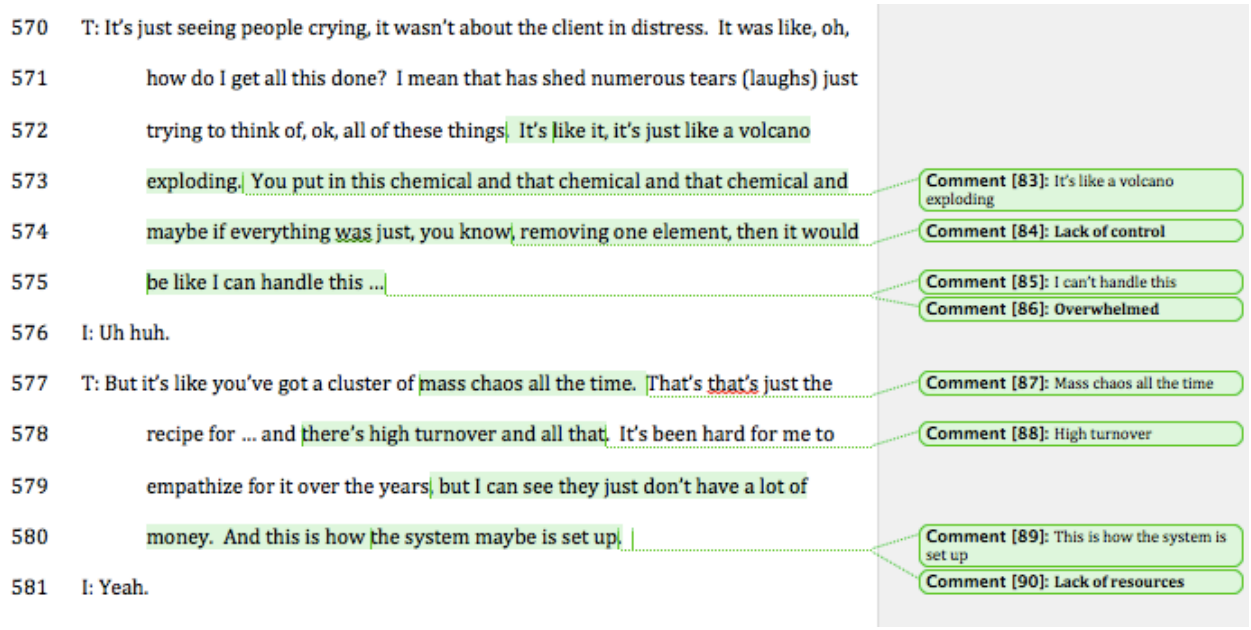


Figure 4.16. Example of emergent themes from transcript data. Bolded words represent a theme.

The example in Figure 4.16 demonstrates how three themes emerged in a relatively small exerpt of the interview. First, the participant is describing all of the things they have added to their schedule on a daily basis, through the metaphor of a volcano. While this type of description suggests the participant is overwhelmed (which it certainly does), the use of the metaphor and the description in the context of the rest of the interview, also suggests the participant has no control over his or her schedule or responsibilities. Just as a volcano erupts uncontrollably, so too, the chaos they experience at work develops uncontrollably.

The theme of being overwhelmed emerged quite obviously out of the same experiential description. It is clear that this participant had difficulty or was unable to handle everything they had to take on at their clinical position. This becomes even more clear when the entire transcript is considered, as the feeling of being overwhelmed permeated both work and personal life. For

example, this participant made the following statements indiciating the overwhelming experiences that contributed to their moral distress:

J: There's like 800 people with severe problems, uh, how do I help them out? How do I get all of this done?

J: Although you're only supposed to bill 25 hours a week, it, that's kind of not taking into consideration the types of, uh, you know, life happening situations where you'd have to go in and, uh, see how these students, and you get interruptions at your door, and the principal will stop and say, "Hey have you seen this person?" And so on and so on …

J: With the kids in the office, and some notecards and things like that, but um, it, it's really difficult to have that many people and do notes and then do case planning.

J: But can you see so-and-so and this one person said, oh I know this person, can you see this person? But then, there's no time to actually see these people because you have 800 interruptions throughout the day and the distress, uh, like there was one time, toward the end where I, it finally clicked in with me. Ok, I just need to bill for this kind of crazy stuff.

J: Um, of course, just not getting to socialize with friends, um, and then my kids who they, I'd remember these pictures where they'd go to, uh, hang out at places

and I'd be like, oh I'm not in these pictures because I'm doig my case notes on Saturday at four o'clock.

Finally, lack of resources emerged as a theme throughout this participant's interview. He or she explicitly described situations in which they wanted to do what they believed to be the right thing, but were unable to due to the organization's limited funds, lack of resources, constraints on time, or lack of support:

J: … they just didn't have enough time or resources, but, that', that's kind of the distress that I encountered and just being overworked, um, having so many stressful situations that you see fresh out …

J: But it's like you've got a cluster of mass chaos all the time. That's, that's just the recipe for … and there's high turnover and all that. It's been hard for me to empathize for it over the years, but I can see they just don't have a lot of money. And this is how the system maybe is set up.

Again, each of these themes concisely captures the participants' descriptions, experiences, and the exploratory notes. In some cases, the themes are directly tied to the participants' use of language, such as the them of powerlessness, which emerged from the excerpt in Figure 4.14; in other cases, themes reflect the researcher's interpretation of constructs or patterns not specifically alluded to by the participants. For example, the emergence of a cumulative effect of moral distress as a theme in the excerpt in Figure 4.14 reframes the way in which the participant talks about his or her experience over time. This second theme (cumulative effect) reflects the

qualities of an emerging theme that Smith et al. (2009) describe, in that it is a slightly more abstract or conceptual way of understanding the participant's description, and echoes theoretical models of moral distress based around an increasing, crescendo effect. As such, it is possible this theme may develop further with later stages of analysis.

The above examples are not intended to provide a complete or exhaustive list of the themes developed during this step of analysis. Rather, they are provided in an effort to demonstrate the ways in which the themes thoughtfully emerged from the original data, exploratory notes, and the researcher's simultaneous connection with and distance from the phenomenon of interest and the participants' experiences of it. Additionally, the specific quotes supplementing the figures are provided in order to illustrate the researcher's use of and involvement with the hermeneutic circle, in which specific parts of the data are related back to the sum of data, and vice versa.

Step 4: Clustering themes. The fourth step in the analytic process involves searching for connections across the emergent themes, clustering them together based on their conceptual similarities, and developing a descriptive label for each. As Pietkiewicz and Smith (2014) clarify, this process involves synthesizing the emergent themes and reducing data if themes do not correspond well with the developing structure or if there is inadequate evidence to support their existence. Additionally, this step typically is accompanied by the development of a graphical representation of the emerging thematic structure. Each of these components are described in detail as they pertain to one specific participant in order to thoroughly describe the analytic processes conducted during this step. This section concludes with a graphical representation of the themes developed before moving on to deeper levels of analysis connecting emergent themes and overall thematic structure to other particpants.

Because Smith et al. (2009) encourage innovation and creativity in this step, the researcher used Scapple, a mind-mapping software program for Macintosh, in order to extract emergent themes from the transcripts and organize them into a coherent thematic structure. Mind-mapping, or what Morgan and Guevara (2008) more appropriately refer to as concept-mapping, is a common form of analysis utilized in qualitative studies with the goal of producing network diagrams that connect conceptual themes in order to summarize their relationships. This process followed the procedures developed by Jones (1985), in which a concept map was created for each participant that summarized their way of thinking through the identification of conceptual similarities.

The first step involved recording both themes and supporting exploratory comments in a choronological list of when they occurred. Arranging the themes and notes this way allow the transcript to be deconstructed for two paradoxical reasons. First, it promoted a detailed focus of the de-contextualized meaning of participants' experiences, and second it assisted with the identification of interrelationships among experiences (Smith et al., 2009). That is, this type of arrangement allow the researcher to focus centrally on the specific meaning of the participants' experiences without the peripheral jargon used in everyday language, while highlighting conceptual and experiential similarities that linked themes across experiences. Figure 4.17 illustrates the way in which themes were initially organized in Scapple:

Figure 4.17. Chronological ordering of themes as the first step in clustering themes.

The next step involves charting or mapping the conceptual similarities between themes and codes in an effort for the analyst to make sense of how things fit together. This process is not done arbitrarily, and necessarily should take into account the research questions guiding the study. Additionally, just as subsequent steps of data analysis have included, this step makes use of the hermeneutic circle, requiring the analyst to return to the original transcripts in order to reevaluate the importance of some of the themes, as necessary (Smith et al., 2009). Ultimately, the goal is to connect themes in a way that produces a structure that highlights the most important and meaningful aspects of a participant's experience. As such, themes that do little to enhance the understanding of the participant's experience, have have a weak evidential base, or fail to fit within the emerging thematic structure, can be dropped in favor of more important or meaningful themes (Smith et al., 2009; Pietkiewics & Smith, 2014).

Themes were initially clustered in loose manner, making broad connections before becoming more specific and organized. Analysis at this stage was conducted using the methods of abstraction and contextualization. Abstraction involved putting like with like in order to arrive at an overarching theme and identifying a name that captures the essence of that theme (Smith et al., 2009). Contextualization, on the other hand, involved identifying the contextual or narrative elements that related to key events in the participants' stories. This allowed connections to be made across transcripts as they were deconstructed from the temporal moment in which they existed (Smith et al., 2009). In both cases, the connections were based on conceptual similarities, the particpant's use of language, and the researcher's knowledge of the contextual importance of the themes. Figures 4.18 and 4.19 provide examples of how the themes and codes from Figure 4.17 were reorganized into loose groups of conceptually-similar themes and codes, which formed an outline of the emerging structure.

Figure 4.18. Example of reorganized data identifying connections across themes.

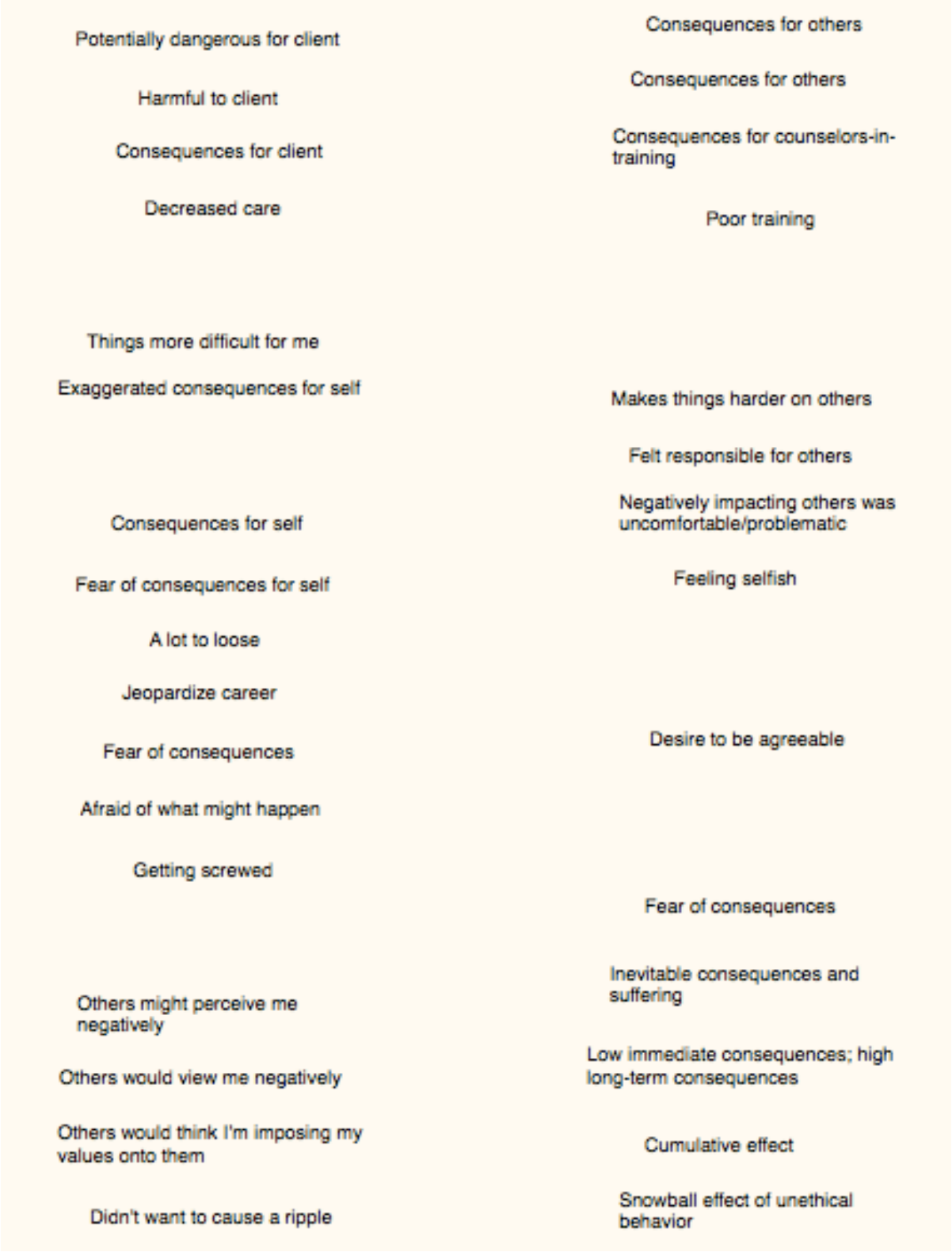


Figure 4.19. Example of reorganized data identifying connections across themes.

Figures 4.18 and 4.19 clearly demonstrate how the thematic structure for this participant's experiences were initially formed. Similar concepts were grouped together to form loose theme clusters, which helped create a higher level of organization and understanding of the participant's experiences.

Analysis continued by reanalyzing the theme clusters in both abstraction and contextualization in order to identify superordinate themes that captured the overall essence of each particular theme cluster. Again, similarities were reexamined and the contextual importance of the themes were reconsidered to help ensure the emergent themes were well grounded in the data and the participant's experience. Figure 3.20 illustrates how the initial clusters were reexamined and superordinate themes were developed for the initial clusters in Figure 3.19.

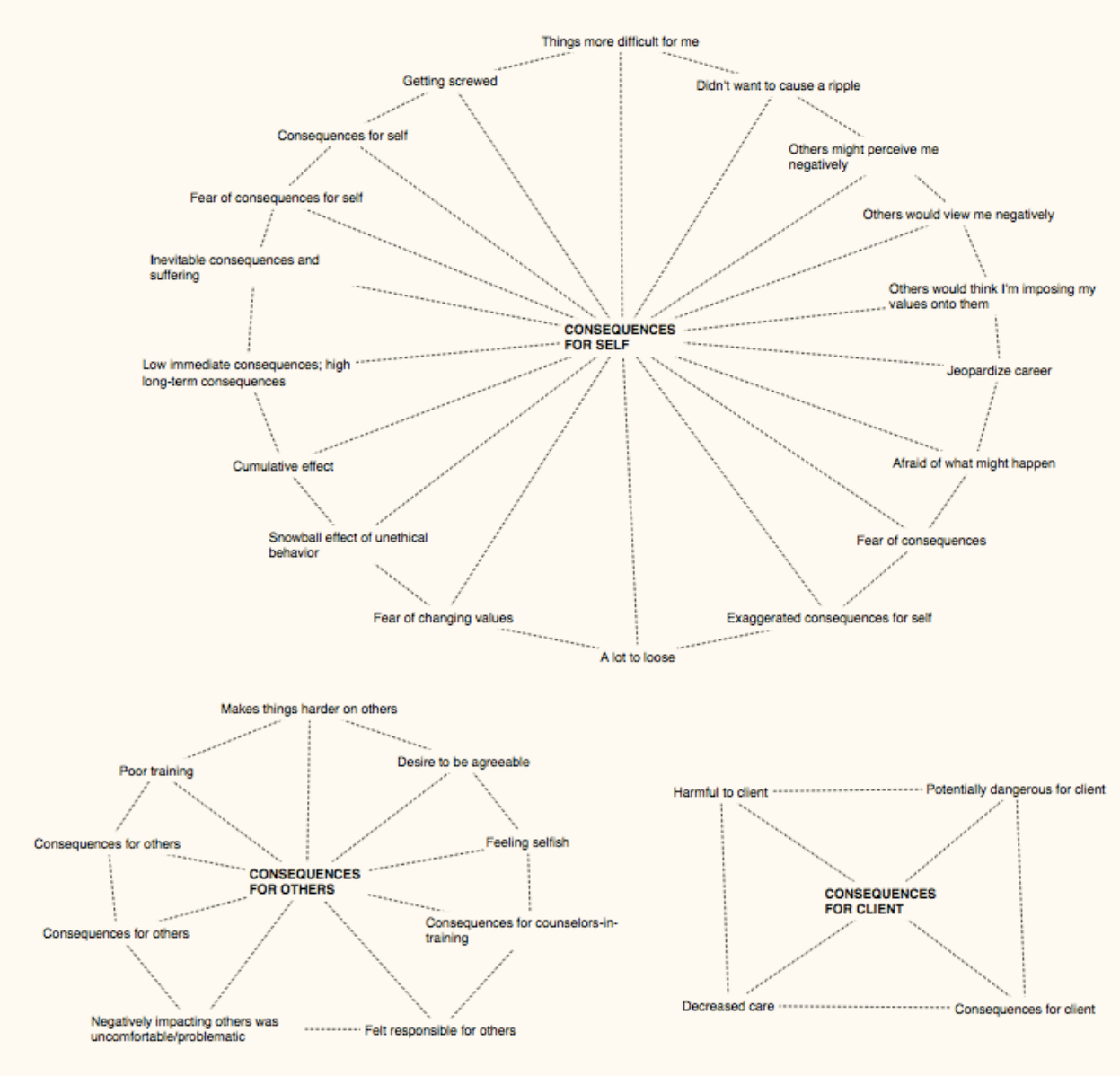


Figure 4.20. Identification of superordinate themes through abstraction and contextualization. Bold phrases indicate the superwordinate theme.

This process continued for all themes and comments for each participant. While the focus of analysis at this stage was to identify barriers to moral action and thematic domains from which moral distress occurred, in order to develop the item pool thematic structure of the MDSC-CA, it is important to note that other themes emerged. That is, themes relating to the

factors contributing to moral distress and the impact moral distress had on the participants emerged alongside the themes that more directly contributed to the development of the MDSC-CA. As these themes emerged, a third method of analysis was used to capture the unique experiences each participant articulated during their interviews, so not to prematurely discount themes that did not fit with the emerging structure.

Although the meaning of participants' experiences were fairly consistent across cases, the exploratory comments and themes that emerged during previous steps of analysis were examined for polarity. Searching for oppositional relationships still involves making connections across emergent themes; however, the focus is on differences, rather than similarities (Smith et al., 2009). This method did not prove to be as fruitful as other methods of analysis, but one important theme, positive outcomes, was identified. Because this theme does not apply to the research question being addressed at this stage of analysis, an example of how it was developed is briefly provided below. A more thorough discussion of this theme and its implications for the current study and understanding of participants' experiences is discussed in Chapter Seven.

Continuing with the data for the same participant as presented above, it became clear that the participant experienced positive outcomes due to their moral distress. Initially, these themes did not seem to fit with the overall thematic structure emerging from the data analysis, but by contrasting them against the set of negative consequences the participant clearly articulated, a new theme emerged that detailed the positive aspects of their experience. Figure 4.21 depicts the themes that emerged, which ultimately created the Positive Outcomes theme, which was not unique to this client alone.

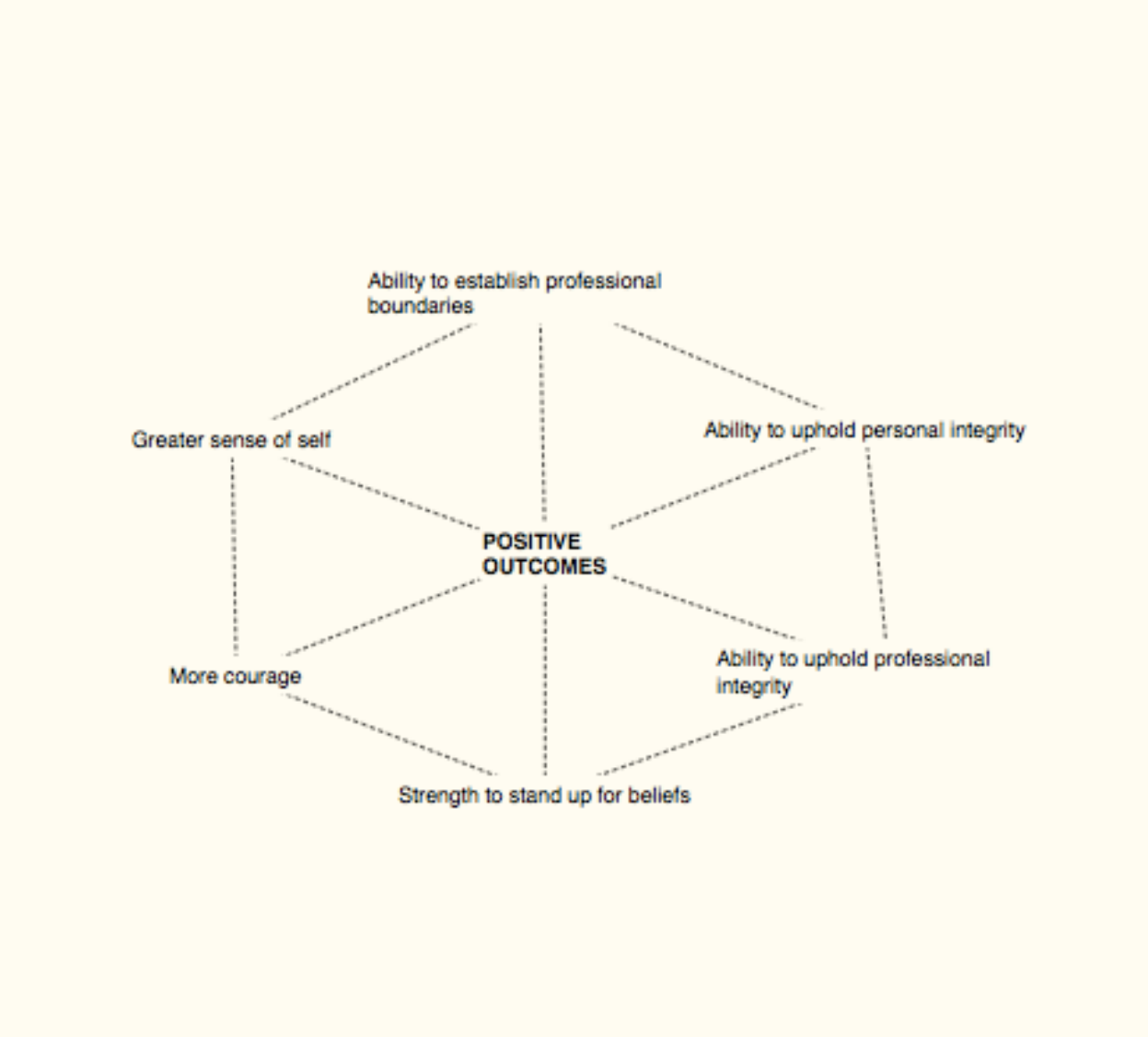


Figure 4.21. Positive Outcomes theme, which emerged from the data after analyzing for polarity.

The examples provided in this section follow the analysis of one participant's interview transcript and demonstrates how superordinate themes were identified from initial themes and exploratory comments. They do not, and are not intended to illustrate the full thematic structure that emerged throughout the current study. Rather, they are intended to demonstrate an abridged account of how data was transformed over time to arrive at a higher level of organization of data and understanding of the participants' experiences. The next step of analysis involves moving to

other cases, which will provide a few additional examples; however, since the steps remain the same for each participant, analyzed data will not be presented for all of the research participants.

Step 5: Repeating the process with new data. The next step involves moving to the next participant's transcript and repeating the process described above. Smith et al. (2009) pointed out that it is important to treat the new transcript on its own terms in order to capture the participant's unique experiences and meaning thereof. In keeping with IPA's idiographic commitment, the researcher engaged in a process of bracketing before moving to each new transcript in an attempt to put aside his repertoire of knowledge, the ideas already emerging from analysis, and beliefs about the data (Chan et al., 2013). Two strategies were used in an attempt to successfully bracket preconceptions, biases, and knowledge, to the extent that it is possible. First, the researcher reflected on the his knowledge about the phenomenon of interest and the already-completed interviews and transcript analyses. As Chan et al. (2013), noted this was done in an attempt to "awaken the researchers' own preconceptions" (p. 6). Bringing to awareness what had already been found and what was known allowed the researcher to become acutely aware of what he might bring to the analysis that would skew the findings away from what the participants truly mean.

The second strategy, also recommended by Chan et al. (2013), was adopting a not-knowing stance and approaching analysis with curiosity. Gade (2011) clarified that epistemic, rather than prudential, curiosity entails an "interest in phenomena for their own sake" (p. 49), which was particularly appropriate for the purposes of the current study. Similarly, Winslade and Hedtke (2011) note that curiosity honors the client's meaning, rather than imposing one's own meaning or interpretation. As such, a curious stance was taken in order to remove expectations, as much as possible, and analyze the data for their own sake. It was hoped that by

adopting a curious and not-knowning approach to analysis the interpretations are as close to what the participants actually experienced.

Following bracketing, each step described above was carried out for each transcript, one at a time. A graphical representation of theme clusters and superordinate themes was developed for each participant; however, for the sake of clarity and brevity, a summary of the themes identified for each participant can be found in Appendix S. An examination of Appendix S indicates that there was consistency and discontinuity in the themes that emerged through the analysis of each transcript, and in the way participants talked about their experiences. That is, while similar themes emerged across the cases, there were unique themes that emerged for each participant. This finding was noted due to its indication that analysis was conducted with a curious and not-knowning stance, as the participants' idiosyncratic experiences and meanings were identified as much as possible.

Stage D2: Domain Identification

This section describes the procedures used to analyze themes across all cases in order to develop the thematic domains and sub-themes, which were used to develop and structure the MDSC-CA.

Step 6: Looking for patterns across cases. Similar to the steps followed above for each individual transcript and corresponding set of themes, the identified themes and superordinate themes for each participant were analyzed and grouped in a master document, according to similarities and dissimilarities. The process was carried out in Scapple due to the program's mapping and organization features, which helped make the large amount of data manageable. Figures 4.22 and 4.23 show portions of the master document with all identified themes grouped

into meaningful clusters. Because of the size of the document, individual clusters are indecipherable; however, each is discussed in more detail below.

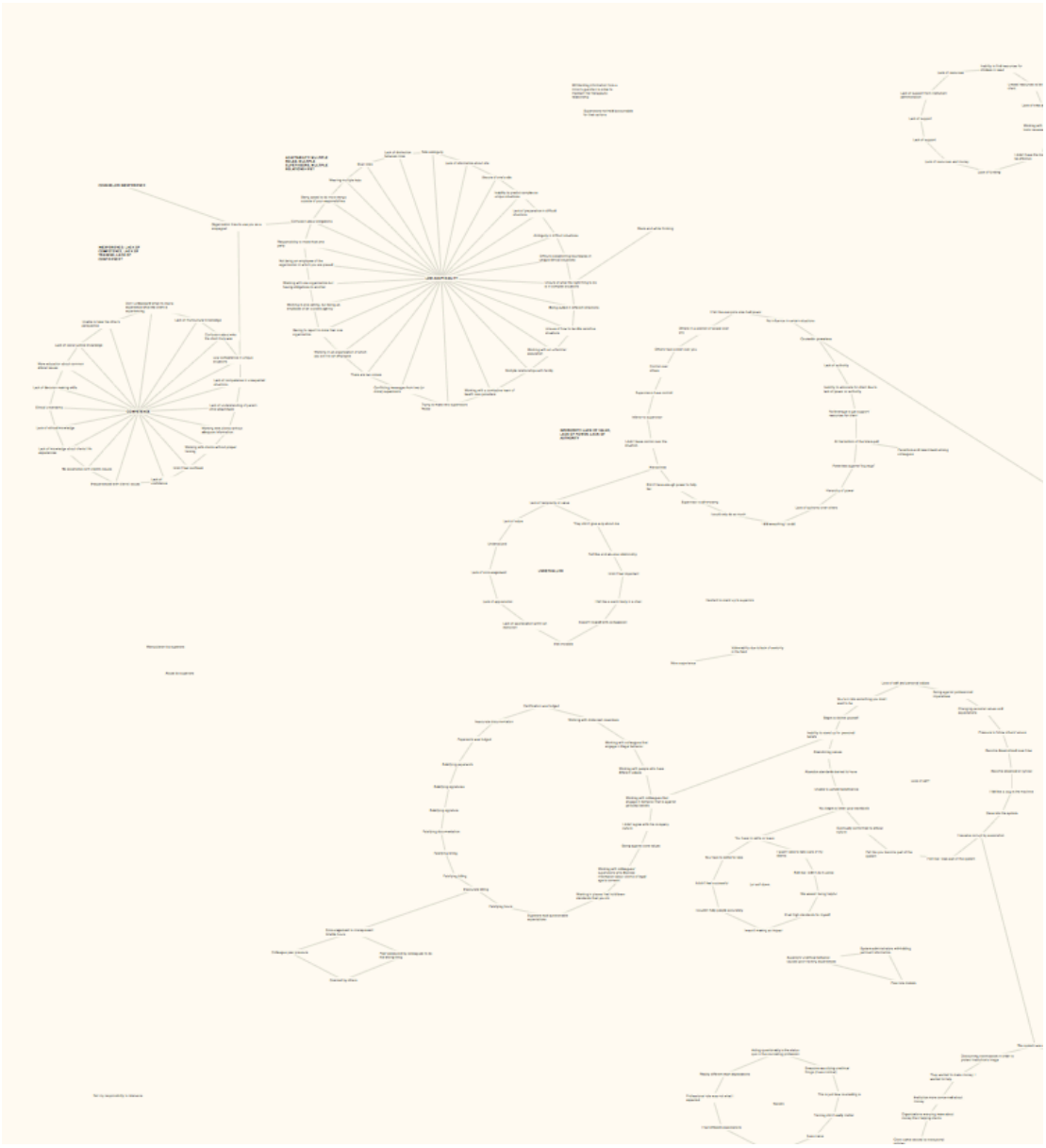


Figure 4.22. A portion of the master Scapple document containing all themes and clusters.

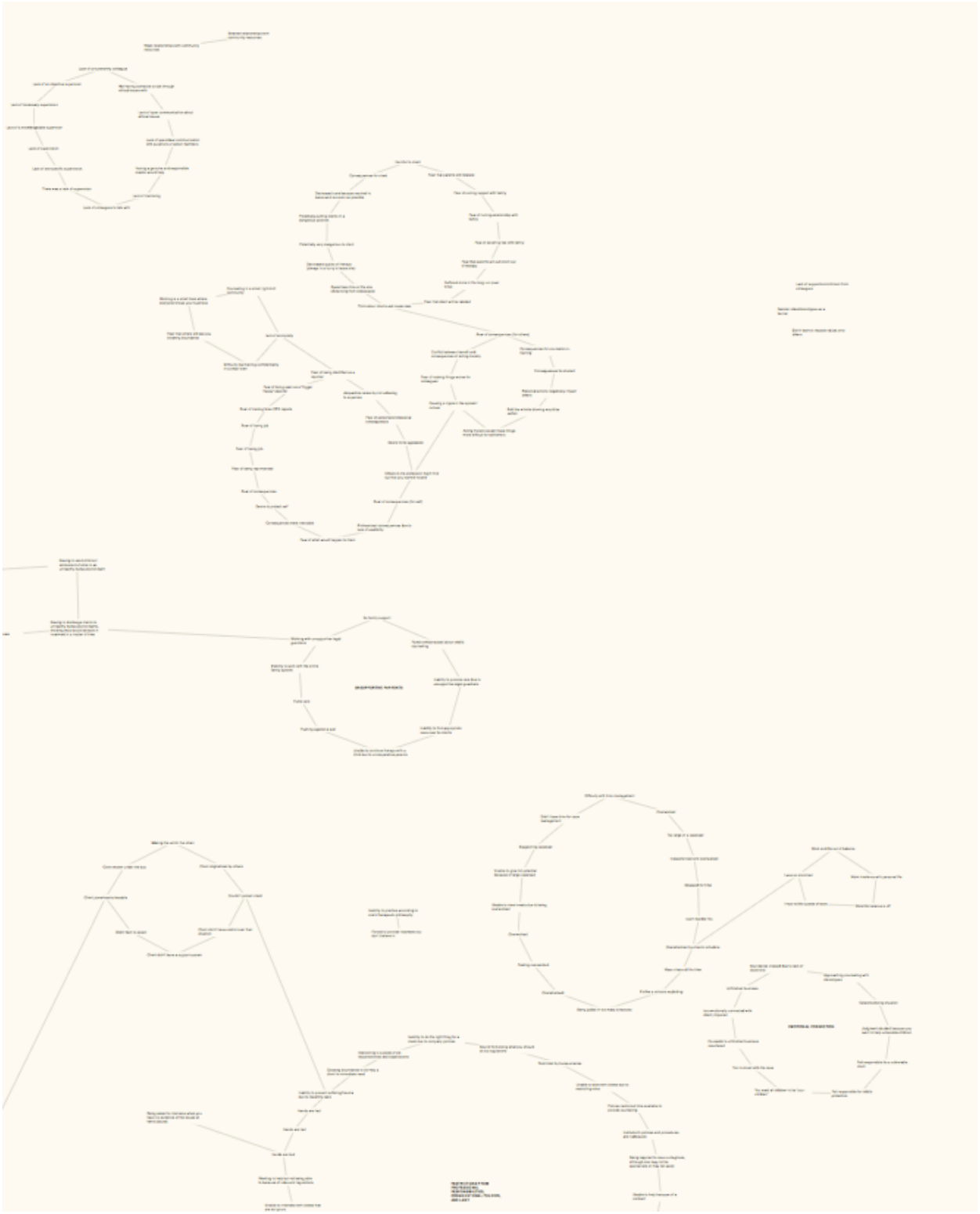


Figure 4.23. A portion of the master Scapple document containing all themes and clusters.

Although the individual themes and clusters cannot be identified in Figures 4.22 and 4.23, they do demonstrate the patterns of themes across participants. After all themes were transferred to the master Sapple document and clustered by connections made across participants, the master document was deconstructed by theme patterns to make the data more manageable. Additional analysis was conducted per the connections made in the master document in order to refine sub-themes and domains. Each process of analysis is described in detail below as they were conducted throughout the current study.

Institutional restrictions. The first themes to be reanalyzed were those representing restrictions to moral action. Initially, there was no distinction between different types of restrictions and all were grouped together according to their overall connections, as can be seen in Figure 4.24. Closer examination of the themes, however, revealed that sub-themes existed, which provided more conceptual clarity and resulted in a higher level of interpretation of the participants' experiences. Figure 4.25 demonstrates the sub-themes identified through reanalyzing the themes in this cluster.

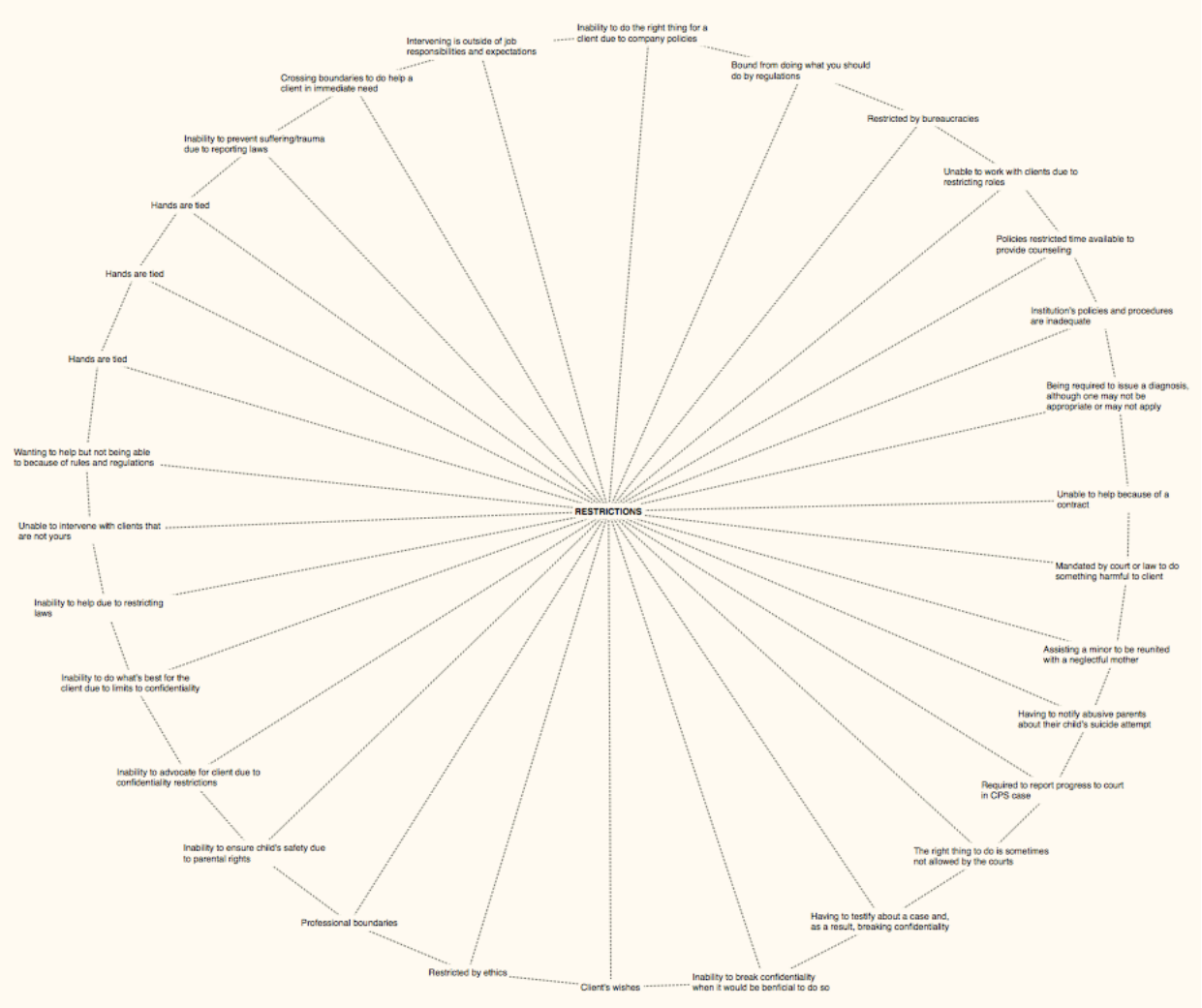


Figure 4.24. Overall identification of Restrictions theme.

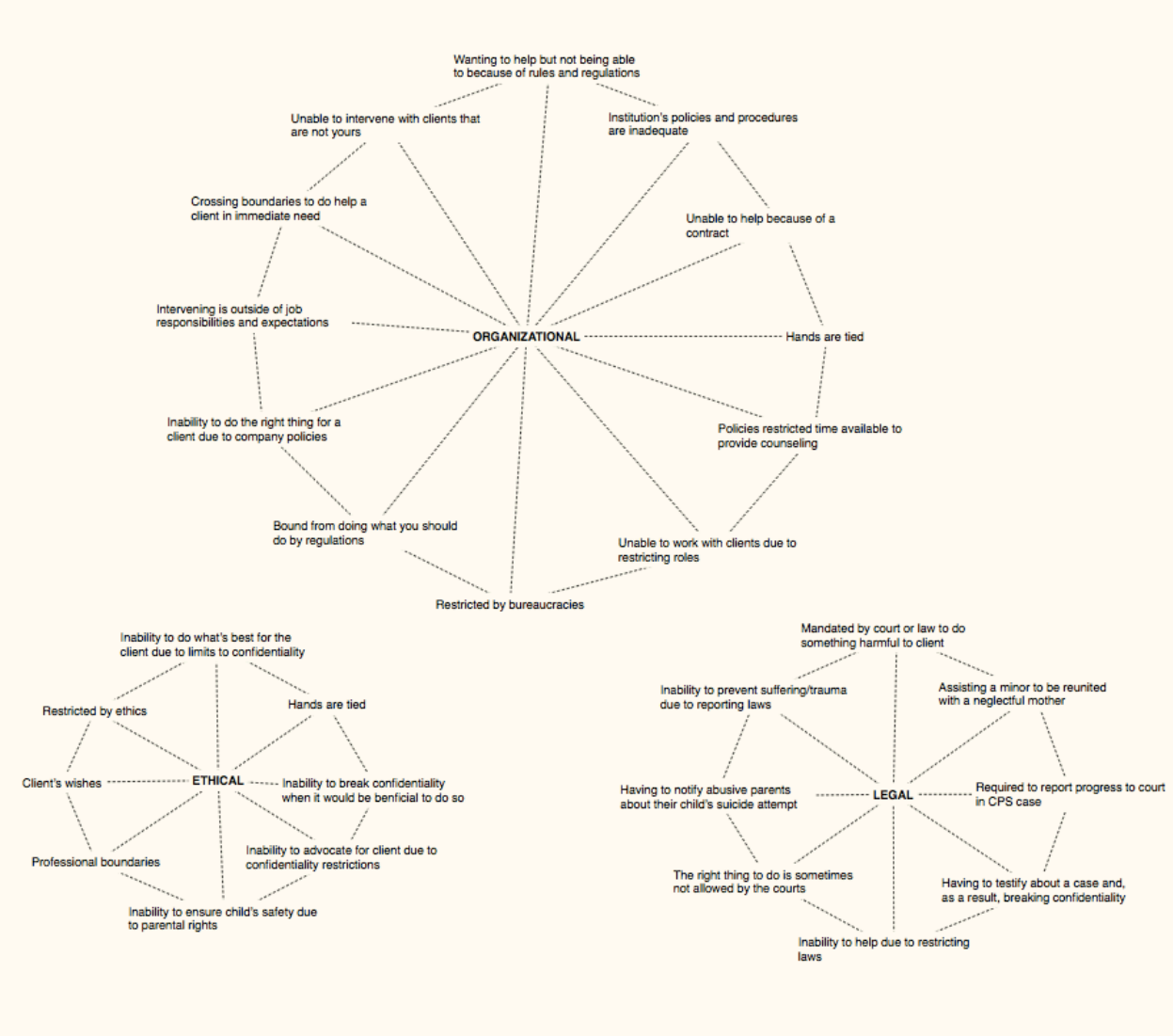


Figure 4.25. Identification of sub-themes within Restrictions theme.

Organizational restrictions. Situations in which the clinical organization or facility restricted moral action or influenced participants to do what they knew was wrong were described by several participants. For example, one participant described feeling like he or she did not have any choice but to cross boundaries because of insufficient policies:

F: Um, and I think maybe some boundaries got crossed. Like, and part of it wasn't my fault, 'cause the university doesn't have a great system, like how is this person going to get to the hospital? Or how are they going to get home?

Although this participant knew they were crossing professional boundaries, they felt like they had no other choice.

Conversely, several participants described situations in which the organization in which they worked had too many policies or policies that were too restrictive:

P: And as a mental health professional, like, yeah, that's what you want to do, that's what you should do, but at the same time when you have, um, you know, uh, job expectations or, you know, regulations, like, kind of bounding you from what you can do, and what you should and should not do, you know, if, uh, it's pretty tough.

Participant 8 who responded to the Qualtrics survey articulated the internal struggle that resulted from company policies, which created his or her moral distress:

8: Knowing what the company policy is and recognizing the needs of the families I was working with. It is that challenge of wondering which is the greater grievance: to follow standard protocol and deal with the knowledge that children will go to bed hungry, or to go against company policy to ensure that the children and families have some of their basic needs met.

When responding to the prompt about the barriers present that restricted moral action, the same participant (Participant 8) succinctly responded:

8: Company policy

Finally, a reflection of one's participant's account provided clarification about the experience he or she was having and the type of situation that was causing the moral distress:

I: But it sounds like you were kind of overall, one of the things that was most distressing to you was that it sounds like the, the client kind of came second to the institutional policies.

T: Exactly!

Each of these examples, regardless of whether the company policies were too undefined or restrictive, served as barriers to moral action for these participants. As a result, the overall meaning of their unique experiences emerged as Organizational restrictions.

Ethical restrictions. Ethical restrictions were also prominently described and identified as summative themes. Almost every participant mentioned at least one experience in which ethical guidelines restricted them from engaging in moral action. One participant who completed the Qualtrics survey pointed out the interal struggle that he or she grappled with during experiences of moral distress:

1: A mismatch between my core values and the ethical/legal requirements for practice.

Participant 3, who described their experience of moral distress vividly captured the struggle that resulted from ethical obligations:

3: I work in a college counseling center, and often times due to confines of confidentiality we cannot disclose information to family members. This is particularly diffiicult when we have information that could be helpful to the family or other helping persons and could be beneficial to our clients as well. A paritcular example is a client I was working with who had a severe eating disorder and who had been recieving treatment to our office and was connected with the local specialists, however she had not shared this information with her family. Her father called, was extremelhy concerned for his daughter's wellbeing and had no idea that she had been attending treatment. It was a struggle to not share that yes, his daughter was indeed being seen, as he was so stressed. That is just one example of many I have experienced while working as a mental health counselor.

In this example, it is almost painfully clear that the participant knew the ethical guidelines were preventing him or her from doing what they thought was in the best interest of their client.

Numerous examples of ethical restrictions were evidenced in both the Qualtrics and interview data. Although the experiences were context specific and varied by participant, the

meaning of these experiences and situations was explicit: ethical restrictions. Thus, an Ethical restrictions sub-theme emerged readily emerged from the data across participants.

Legal restrictions. Finally, the third type of restrictions that participants faced were those from the legal and court systems. Because the population of interest in the current study is counselors who work with children and adolescents, it is not surprising that requirements to testify in a case of abuse or neglect were the most commonly described situations in which laws prevented them from engaging in moral action. Several vague, yet explicit examples were provided by participants (Participant 1, Participant 6, and Participant 7) from the Qualtrics sample who described their experiences in the following way:

1: Moral distress occurred because I was unable to carry out what I thought was best for a child due to restricting laws.

6: Having to follow laws which were not helpful to my client.

7: I work with the court system. The right thing to do is sometimes not allowed by the courts which require different course of action.

Because these responses were from an open-ended survey, the researcher was unable to clarify the specific laws or situation that restricted moral action in these participants' experiences. Several participants shared such a restricting common experience, however, pointing out the conceptual similarities and indicating the meaningfulness of such experiences. Smith et al. (2009) suggest ignoring the lack of description or frequency in

participants' accounts as one isolated element of an experience still may provide insight into higher levels of understanding or important meaning.

With the above considerations in mind and the sub-themes that emerged through additional analysis, a three sub-theme structure appropriately represented the participant's descriptions of the ethical, legal, and organizational restrictions they experienced. Additionally, because each of these sub-themes corresponded to the restrictions of social institutions, the overall theme, or domain, was renamed Institutional Restrictions to more accurately capture the essence of the restrictions the participants encountered. Figure 4.26 depicts the final outcome of analysis for the restrictions themes, including the overall domain and the corresponding sub-themes.

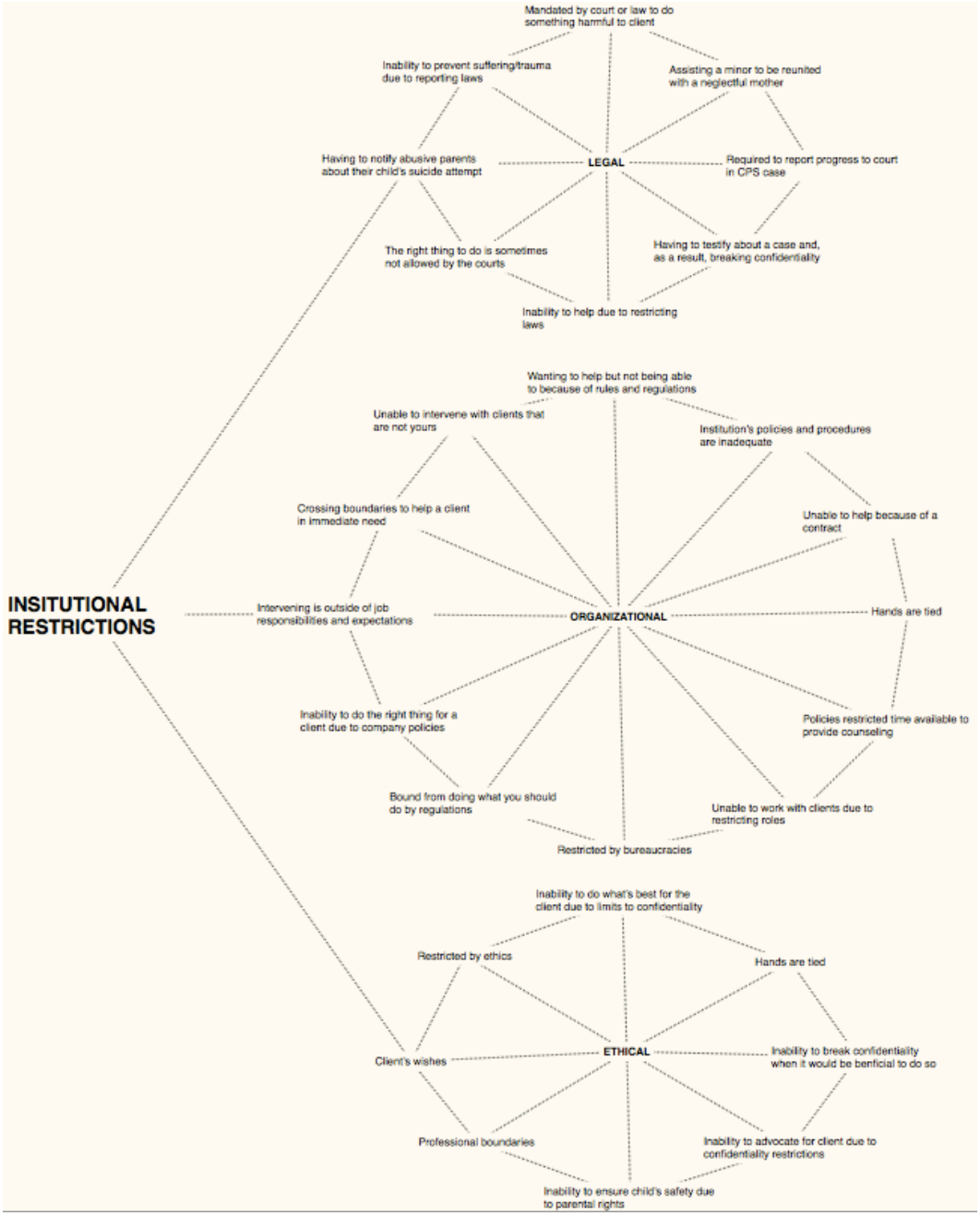


Figure 4.26. Institutional Restrictions domain and corresponding sub-theme structure indentified through analysis across participants.

Fear of consequences. The second pattern of themes identified were those representing the consequences participants feared would happen if they were to engage in moral action. It

was clear from the participants' accounts that they were afraid of the consequences they would experience, their clients would experience, or colleagues and interns would experience. Examples of each are provided below to illustrate the conceptual distinction between each.

Fear of consequences for self. The consequences participants revealed that they feared ranged widely from a fear of being accused:

K: And, and with that being a minor, what, you know, what do the parents need to know, not need to know and, uh, and being in contact with them, um, and, and part of that is difficult, too, because the parents are always interested in, well how long have you known? How long has this been going on?

I: Uh huh.

K: Uh, so they're accusatory not just toward the client, but also to me as well.

to a fear of losing one's job:

F: And a lot of people … I didn't perceive that I was getting support, and the only people I felt like I was getting support from were people outside of the university. And I felt like that could end up getting me in trouble with the university, right. When we went and confronted the chief, I felt like I might get in trouble because the chief kind of got threatened a little bit in that thing.

I: Hmm.

F: And, so I kind of thought I might lose my job.

I: Hmm, ok. So, oh, ok, you were afraid of the consequences if you were to, um, advocate a little bit more or stand up for yourself or for your client?

F: Yes.

to a fear of having one's career ruined or otherwise sabotaged by those in positions of power:

J: … when somebody's in a position of power over you, say a professor or a supervisor, at a practicum or internship site and they ask you to do questionable things or just expect you to do the questionable things they're doing, and you're either uncertain to whether you should do it or you know you shouldn't do it, but you do it anyways because you know you could get screwed by not doing it.

or

J: : Yeah, um, career wise, how it would impact me, future jobs, colleagues, how other people would view me if I started, you know, putting this stuff out there about this person.

I: Uh huh.

J: It could really have a negative impact, especially since I was just getting started in the field.

In all cases, participants described situations in which they did not do what they thought was right because of a fear that doing so would cause some sort of repercussion, which would impact

them negatively. As such, the sub-theme of fear of consequences for Self was identified to capture the overall meaning of each participants' idiosyncratic fear about consequences.

Fear of consequences for client. Similarly to the fear of consequences participants revealed above, they described situations in which they were afraid to do what was right because their clients would experience some sort of consequence. Most often, the fear of consequences for clients reflected participants' worry that moral action would result in the client's parents or guardians pulling them out of counseling, or it would ruin the rapport they had established with the client's family. One participant describes his or her reluctance to report a suspected case of abuse due to the destructive consequences that might result:

P: And so, um, you know, I, I think about that and the situation that I explained earlier with the little boy who's, uh, not verbal, you know, what if I had called and, you know, given that I, I have a relationship with the family, but I'm not obligated, you know, or he's not my client and what if I had called and they didn't find anything, but my name would have gotten out as the person who reported, then the relationship that I do have with the grandmother and trying to get her to sign off for services, it probably would have destroyed that, you know?

Another participant express his or her reluctance to disclose information to a client's parents because they might terminate counseling because they do not see the benefit:

K: Uh, for the, you know, for the therapy at this, and, you know, if we disclose too much and tell them everything, they're going to, you know, pull their

child out of counseling, or they're going to, you know, think it's not beneficial, and you know, I understand that.

Both participants' accounts above illustrate the ways in which their fear of what might happen to the client influences them to do what they know is not right. As a result, fear of consequences for Client emerged as a sub-theme, which captured the various situations in which participants experienced this type of constraint.

Fear of consequences for others. The last sub-theme that emerged within this domain was one that reflected participant's worry that their moral action would cause negative repercussions for other colleagues and peers. Participant 14 explained how they were afraid their moral action would cause turmoil in the organizational or clinical system in which they worked:

14: I thought it would cause a ripple in the "system," meaning the mental health system and those I worked with.

Another participant described a much more compelling argument about his or her concerns that their moral action would negatively impact colleagues and counselors-in-training. First, their feeling of guilt is described in the following way:

J: Yeah. And, I guess another thing that made it more interesting is that it wasn't just me, it was two other co-workers and students, well not just two, but several, but there were two in particular um, three or four, and what would happen is they might say well you're overreacting or are you sure you

really want to do this, you know almost try and talk me down. And then I'd feel like, well, you know almost guilty because it would jeopardize them too and it makes things harder on them, um, so I guess the whole colleague peer pressure …

I: Uh huh.

J: Came into play.

Second, he or she described how they began to perceive their desire to do the right thing as self-serving:

J: Yeah, I ok, so um, just for instance, say a professor did something they shouldn't have done, I was thinking about reporting them, you know, brining to light what had happened, and then I begin to try to say, well, you know that's just me being selfish and wanting to get even, it can hurt other people in the program if the professor were to be removed, other people, you know, would lose that supervision or that guidance.

And, further clarified that he or she could justify refraining from moral action as long as it did not cause harm to anyone else, suggesting an internal struggle of selfishness versus selflessness:

J: So, I mean I was following people that were making poor decisions and poor choices, and that was ok if it was just affecting me. I justified that, but then

> when I start bringing other people below me into it, and teaching them the same things that I know I shouldn't be taught or shouldn't be doing, it was really difficult then.

The accounts above are particularly descriptive and highlight the internal struggle of doing what he or she believes is correct or acting against one's judgment. In each case, the fear of repercussions clearly centered around the impact they would have on the participants' colleagues, which is qualitatively and patently different than the fear of the former two consequences. As such, a third sub-theme of fear of consequences for others (referred to as Others) emerged to contain the conceptual uniqueness, while capturing the shared meaning of these experiences.

Because the various types of consequences were accurately identified during previous steps of analysis, very little changed through reanalyzing the themes. As can be seen in Figures 4.27 and 4.28, the initial themes were Client, Self, and Others, which later became the sub-themes of the Fear of Consequences domain.

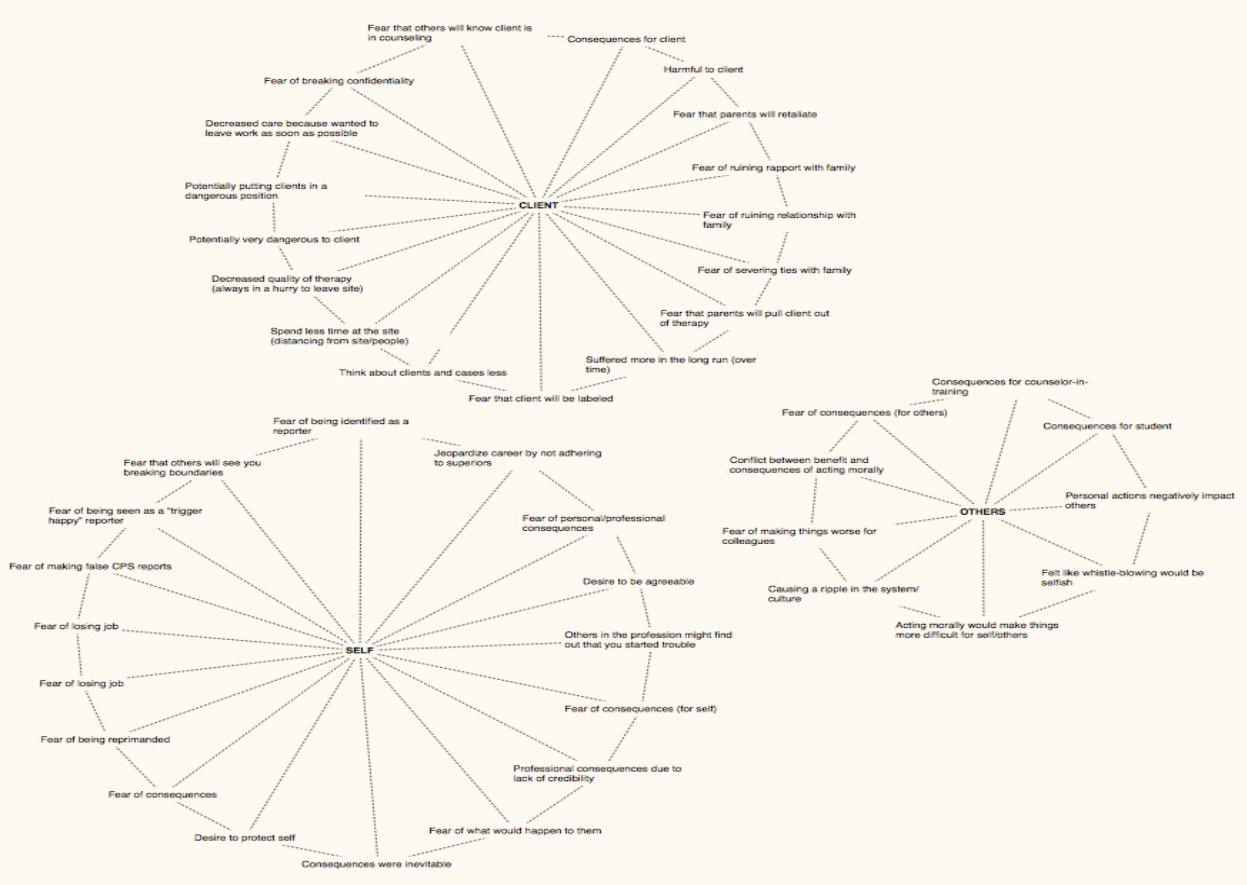


Figure 4.27. Initial themes representing various types of consequences identified across all cases.

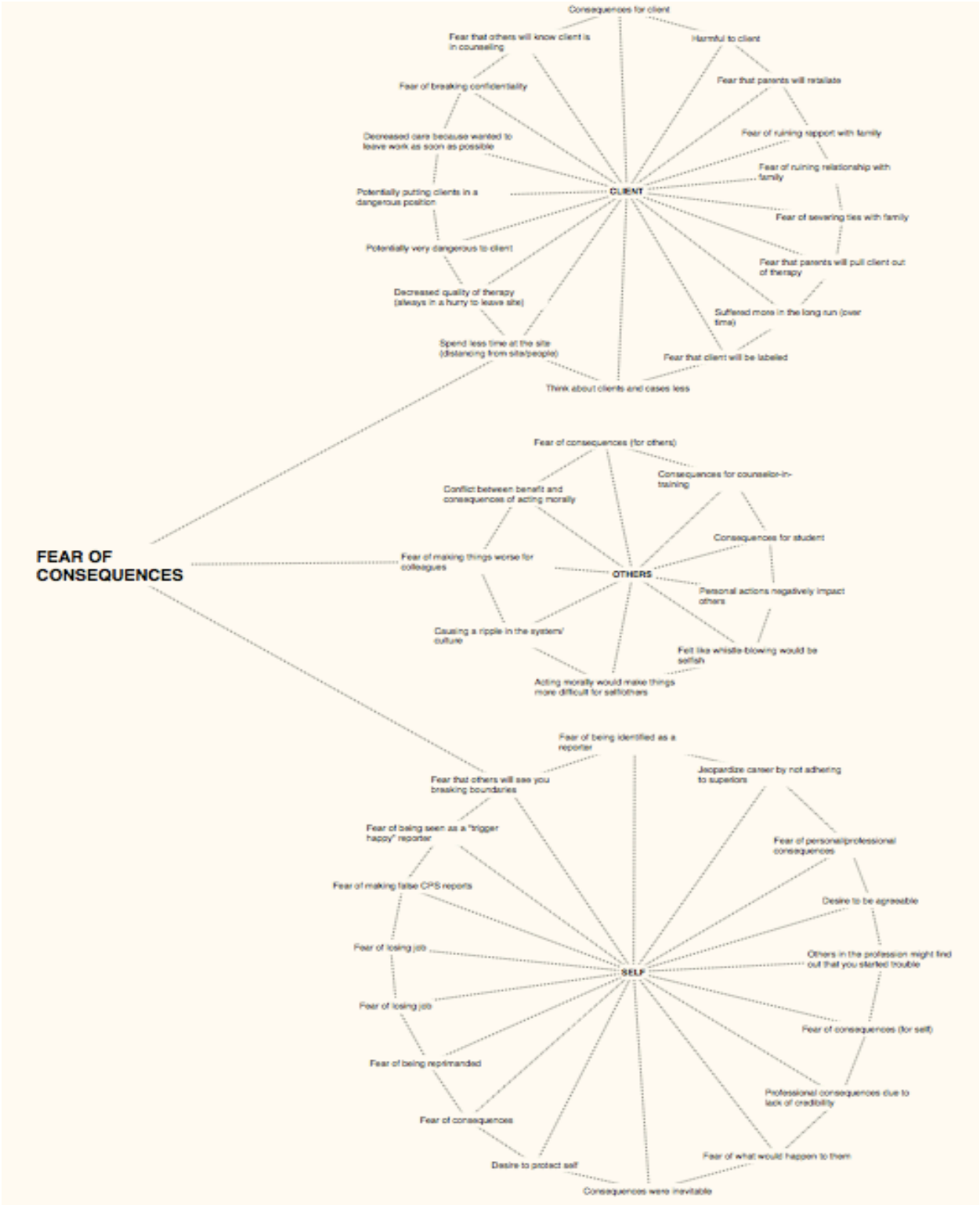


Figure 4.28. Fear of Consequences domain and corresponding sub-theme structure identified through analysis across participants.

Lack of support. The next themes that were reanalyzed were those representing a lack of support, in various forms. Initially, two themes were identified: Lack of Support and Unsupportive Parents, as can be seen in Figure 4.29 below.

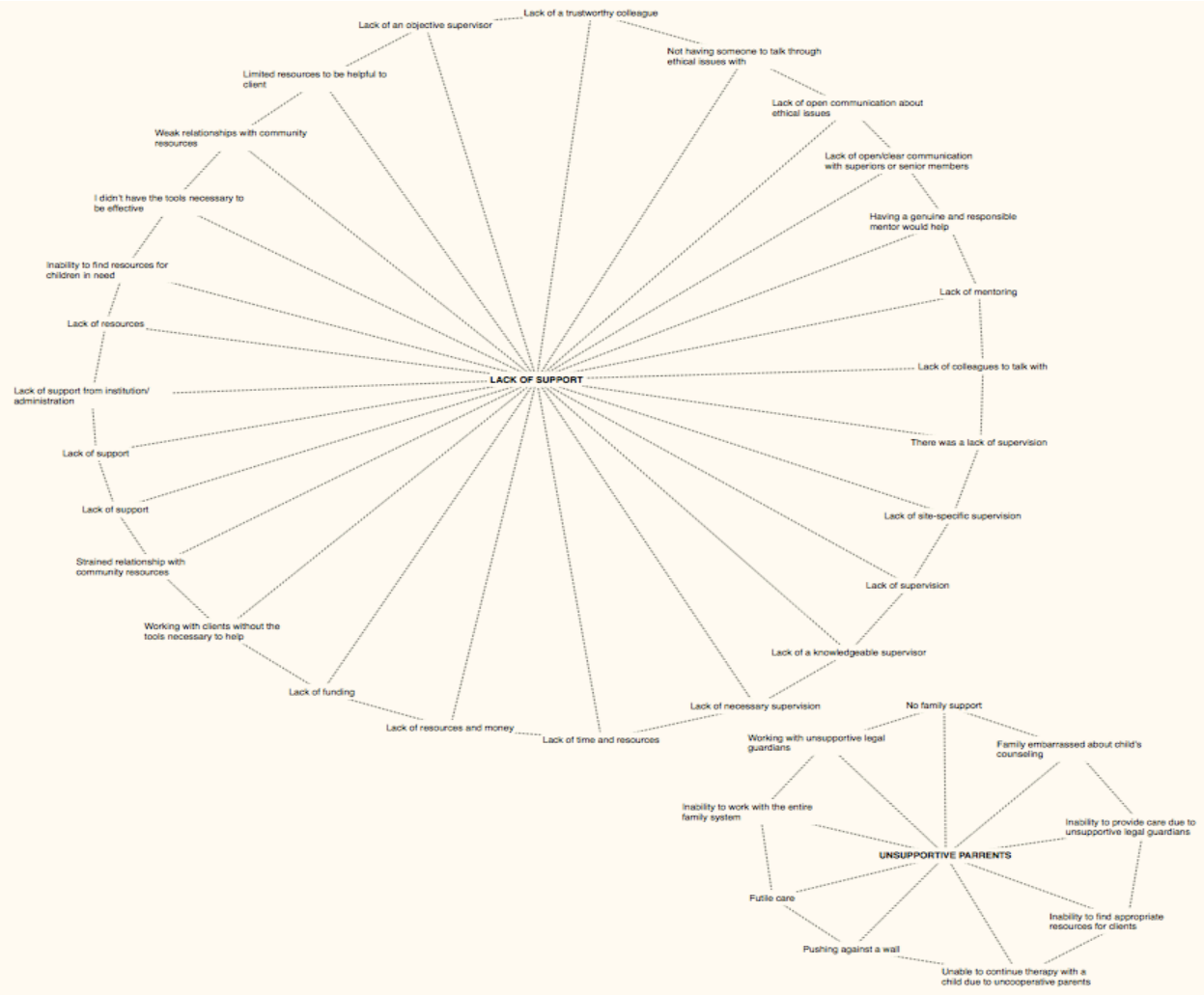


Figure 4.29. Initial themes representing a lack of support across participants.

Reanalysis of the Lack of Support theme indicated that participants had encountered a lack of two specific types of support. The first represented a lack of a supervisor, mentor, or colleague

to provide support or to openly discuss ethical issues with. In reflecting on their experience of moral distress, and thinking about what was missing in that situation and what could have help prevent it, one participant said:

> J: Uh, I mean, I might say peer support. If my other colleagues that were in the same position as me, if we had gotten together and all agreed that this is what we need to do, and even though I knew it was what I should do on my own, if I had had more support, then I mean, the distress would have been lower.

In Participant J's description above, he or she acknowledges that they know what they should have done, but because there was no support from other colleagues, doing the right thing felt like an uphill battle, which ultimately prevented them from engaging in moral action.

Similarly, another participant identified the lack of open communication with a supervisor as a contributing factor to his or her moral distress:

> P: You know, just having, you know, um, clear communication with a superior, and, um, having open communication and, you know, the expectation that, you know, if something happens I'm going to call you, and I think that we definitely have that with our community, um, you know, clinic. Like, our supervisors are always, you know, by the phone or cell phones and they said if there's an issue call us right away. So, just, having that communication line with your supervisor when you come across situations like this, you don't know what to do, you know, you

take advice from a, uh, a superior, someone with experience, someone who can help guide you through, you know, (inaudible) the process.

I: Mm, ok. Yeah, so you don't feel so alone in that, that process.

P: Right, and if you do try to figure it out on your own, that can be more distressing, you know?

In both of the examples above the lack of supportive colleagues or supervisors were a central factor in the participants' experience of moral distress. As such, these themes were grouped into a sub-theme called Lack of Consultation.

The second missing support was that of clinical resources. Most commonly, money, time, and clinical tools were cited as resources participants were lacking, which prevented them from engaging in moral action. Interestingly, however, a lack of resources stemmed from both the clinical organizations in which participants worked, as well as the families they worked with. For example, one participant comments on how he or she was unable to provide adequate services or promote positive changes due to their clients' familys' financial strains:

T: But, um, I just don't, I don't see how much is going to change when you have so many people, 'cause also the problem is, too, these people don't have resources where they can just go and have therapy for $100 an hour.

In this case, the counselor knew the client would benefit from additional services; however, a the family's lack of income to dispose on therapy prevented him or her from doing what they thought needed to be done.

More commonly, participants described situations in which the clinical facility in which they worked lacked the necessary resources to adequately provide for clients. As such, in order to capture the overall meaning of the participants' experiences with limited resources, the sub-theme Lack of Resources was identified.

Finally, participants described an inability to do what they thought was best for a client due to unsupportive legal guardians. Several scenarios in which parents were unsupportive were depicted, including embarrassment about having a child in counseling, one or more of the parents unwilling to be involved in the counseling process, and the perception that counseling was futile due to a client's toxic home environment. For example, Participant 9, responding to the Qualtrics prompt regarding the barriers that prevented moral action, described the way unsupportive parents restricted him or her from providing the services they thought were in the best interest of the client:

> 9: No legal right to interfere. The mother would not return call. The step-father is important in the community and called to say the child was "cured" and they would not need anymore services. I truly had no legal nor professional recourse available. There was nothing I could do for that child. I just believed things would get worse for her psychologically. I suppose in the grand scheme of things, she will be fine. I sincerely doubt she will be abused.

Another participant described a situation in which treatment of a child began to feel futile due to the client's home environment:

K: Uh, and so, I think, I think in that situation it was really a, uh, a battle … not a battle, uh, I, I think it was just an issue with the family, so I didn't have a lot of family support. So, uh, you know, even working with the client, I felt like they were going home to a situation that wasn't conducive to the things that we were working on in the school setting.

Again, in each case, these participants were faced with parents who were either uncooperative with the counselor or unsupportive of what the counselor thought was in the best interest of the client. Therefore, the sub-theme Unsupportive Parents emerged as an additional lack of support that was described across the participants. Figure 4.30 depicts the refinement of the Lack of Support theme.

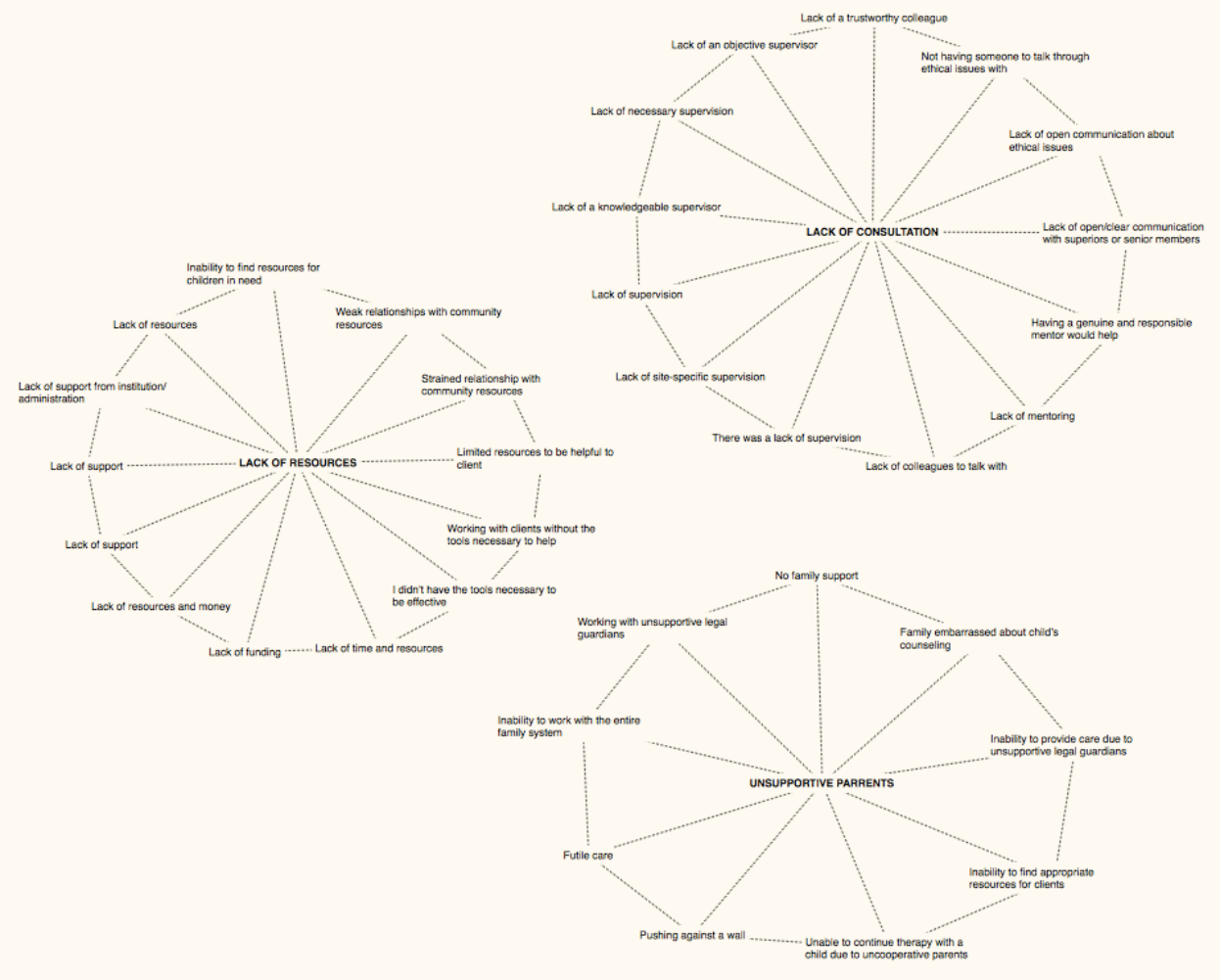


Figure 4.30. Refinement of the sub-themes representing a lack of support.

Because each of the sub-themes in Figure 4.30 indicate the lack of some type of support, which led to moral distress, the domain Lack of Support was developed. Figure 4.31 graphically depicts the Lack of Support domain and its accompanying sub-themes.

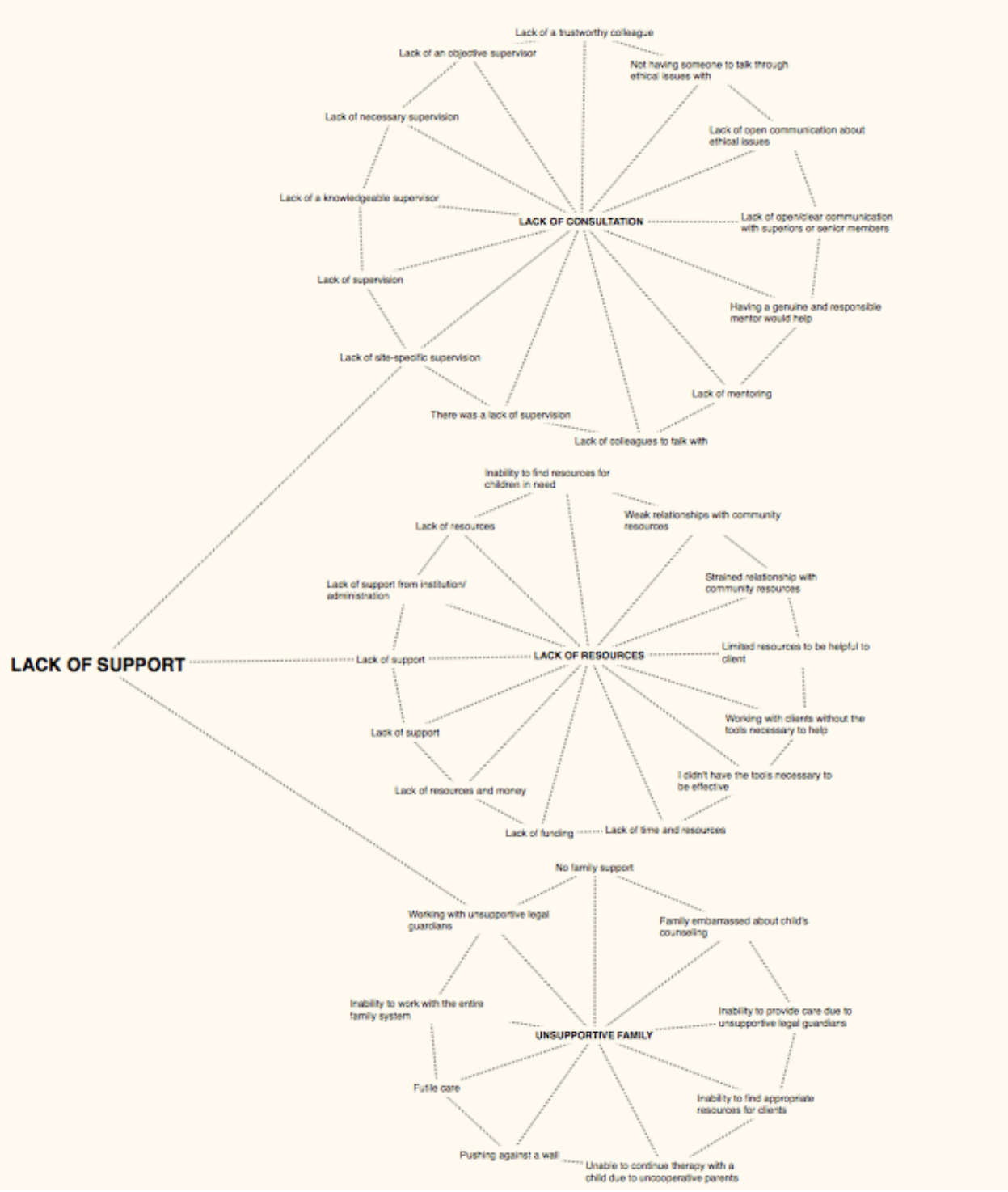


Figure 4.31. Lack of Support domain and corresponding sub-theme structure identified through analysis across participants.

Vulnerability. The next patterns of themes analyzed were those representing a feeling of powerlessness and being undervalued within an organization, which can be seen in Figure 4.32.

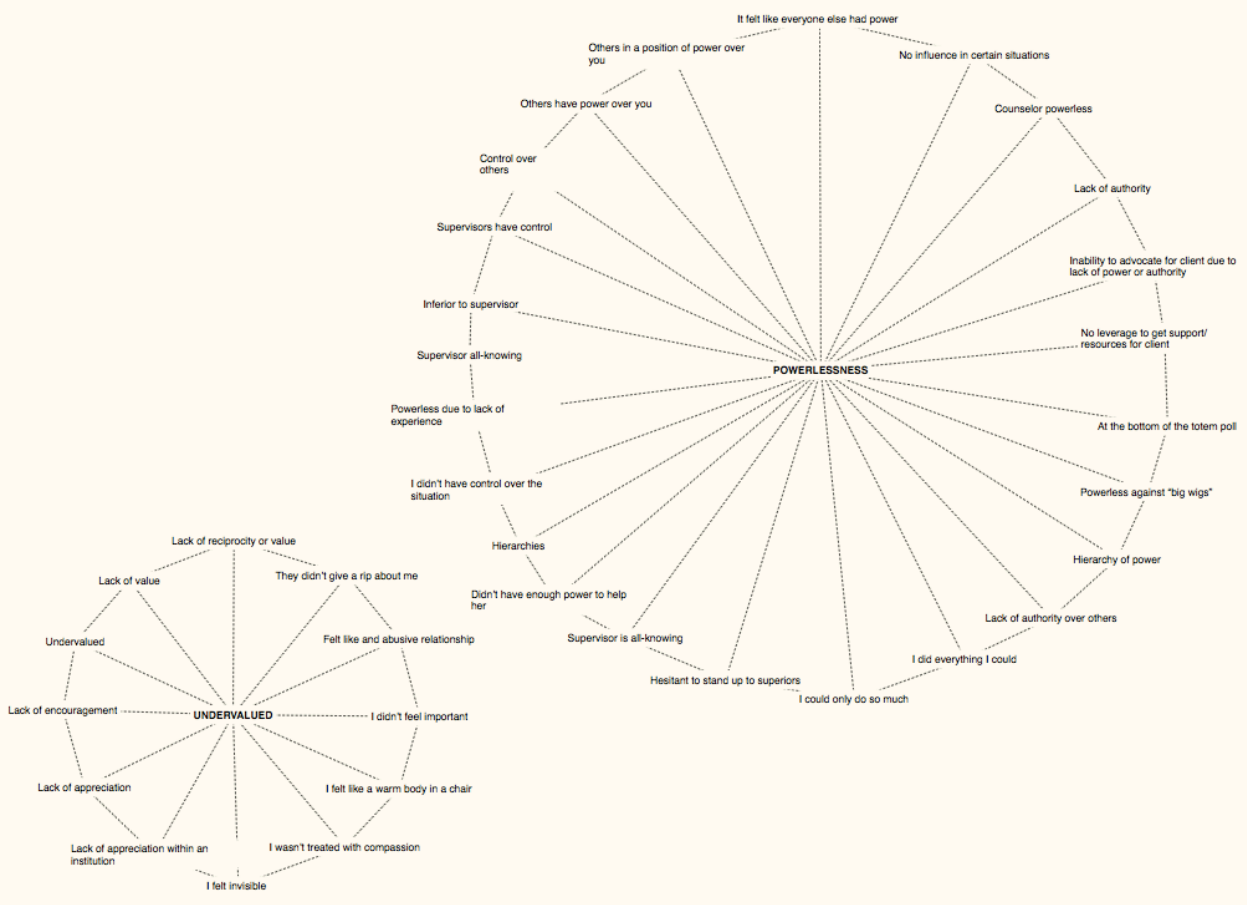


Figure 4.32. Initial themes of Powerlessness and Undervalued.

Further analysis of the Powerlessness theme indicated that two separate experiences comprised it. Participants experienced both a lack of power and a lack of authority, evidenced by the participants' use of language when describing such experiences and the context in which those experiences existed. As such, two sub-themes emerged from the original Powerlessness themes: Lack of Authority and Lack of Power. Additionally, the Undervalued theme was renamed Lack

of Value in order to better fit in with the thematic structure developing for this domain, which is presented in Figure 4.33.

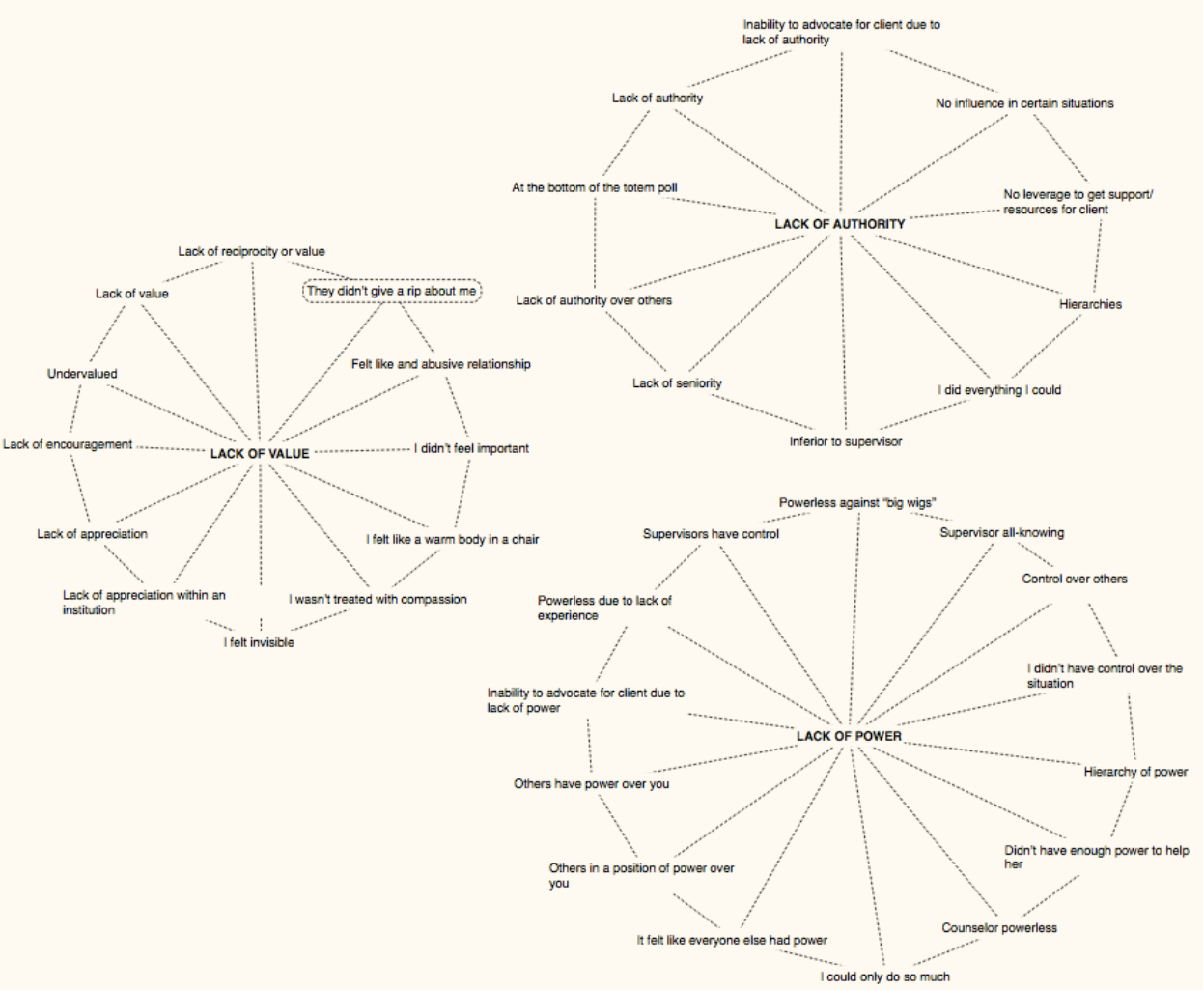


Figure 4.33. Refinement of the Powerlessness theme into the Lack of Authority and Lack of Power sub-themes.

Analysis continued by re-examining the sub-themes of Lack of Authority and Lack of Power, in content, concept, and context. Due to their undeniable conceptual similarities, and the context in which they were experienced, the two sub-themes were recombined into the Lack of

Authority sub-theme. The title Lack of Authority was selected as it concisely captured the overall meaning in the participants' descriptions in a variety of situations and interpersonal interactions. Table 4.3 clarifies this point with illustrative quotations from several participants. Each illustrative quotation describes a slightly different situation in which the counselor was unable to engage in moral action due to a lack of some type of power. Each of those experiences were distinct and unique, yet they all shared an underlying meaning that reflected their inability to make decisions.

Table 4.3
Lack of Authority Sub-Theme with Specific Illustrative Quotations Across Participants.

Sub-Theme	**Participant**	**Quotation**
Lack of Authority	R-13-38-J	Yeah, in that moment, I thought I've got to go along with what that person says, you know, they're all-knowing, um, they have all this control, they know all these people in the field.
	P-15-13-F	… like I still when I see him, just in the hallways I can't pull him, I can't work with him, I can't talk to him, you know, I can say hi and ask how he's doing but I can't say, you know, how are things going on at home, you know? That that's tough because, you know, I wonder if he's ok, but you know I can't really ask and I can't do anything, you know, so. Like, if I see something that's not right, or you know, whatever, I want to fix it, I want to, you know, do what needs to be done to help, help solve the problem. But when you feel like, um, your hands are tied … Or hurting my client that I was trying to protect, and I was helpless to help her. I couldn't do anyting to stop it …
	P-14-19-F	That person has authority. It's like she, she's a person with authority. She works with the Dean of Students office, and she has, you know, she has power over the police department, so she can advocate for them. If she calls, they're like, you know, ok this is like my boss … and they have to answer to her. But when I was calling, it was like I had to answer to whom I was talking to. The second part I think that was, that made it more difficult for me was that there, that there was a PR situation, and so, um, I was having to deal with like "big-wigs" on campus … like the biggest, top administrators a little bit, or I knew they were involved. Because they had power over me and I was, um, hesitant to, you know, kind of stand my ground …

D-14-24-T	I guess, uh, acquiring more wisdom and being in my current position where I have more control over things. … one of the supervisors wasn't my direct supervisor, but was part of leadership at that facility, leaned into our group of counselors and said, "Why aren't you enrolling your people in case management?" And it wasn't a, hey, let's talk about this, it was a punitive, what's wrong with you for not doing this?

Reflecting on the sub-themes and conducting the additional analysis described above resulted in an overall domain of Vulnerability, representing situations in which counselors faced restrictions to moral action due to a susceptibility to others' influence. The overall thematic structure for this domain can be seen in Figure 4.34.

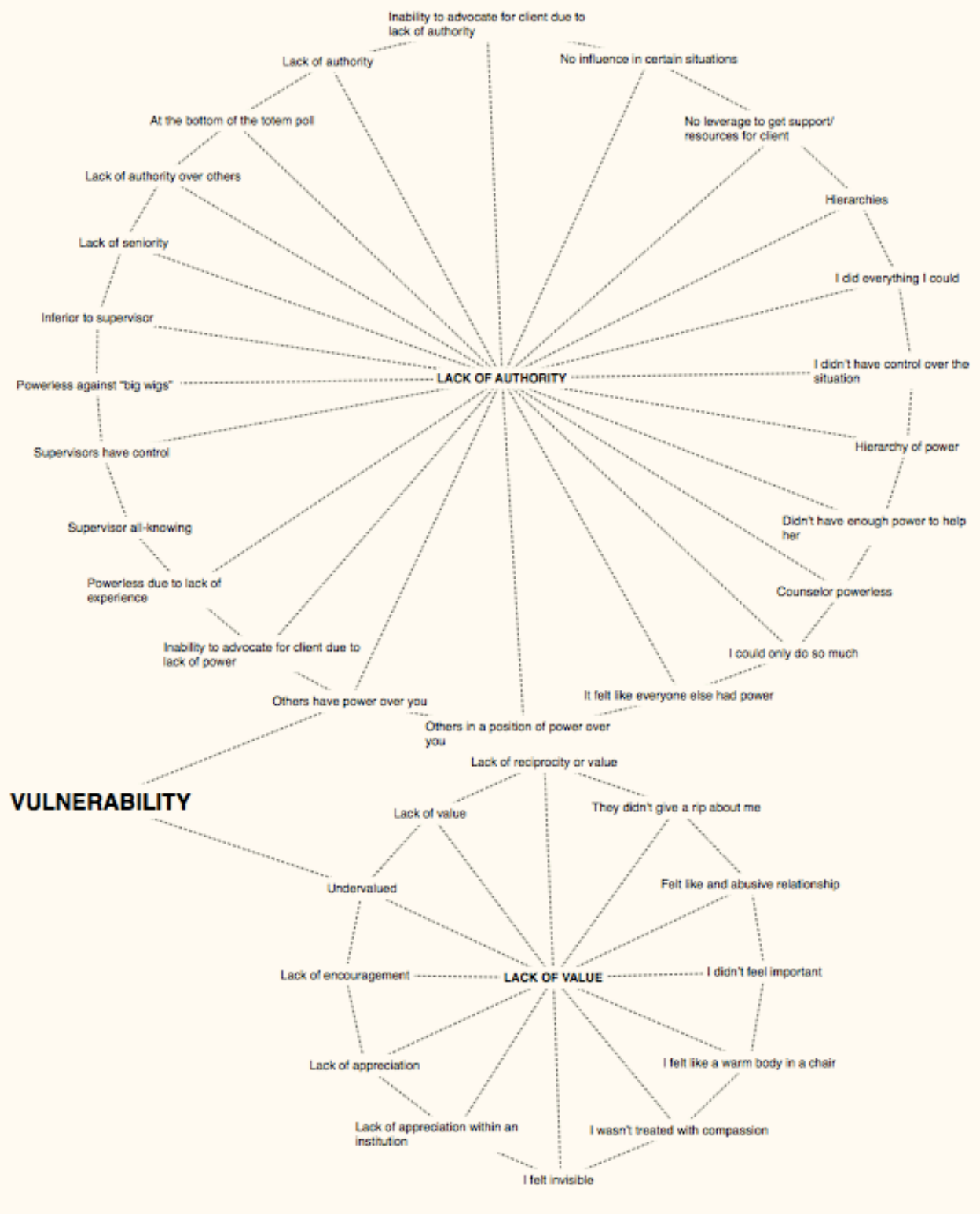


Figure 4.34. Vulnerability domain and corresponding sub-theme structure identified through analysis across participants.

Well-being. The next group of themes analyzed were those representing some aspect of the participants' well-being. Initially, the themes were identified as Overworked and Well-Being, as can be seen in Figure 4.35.

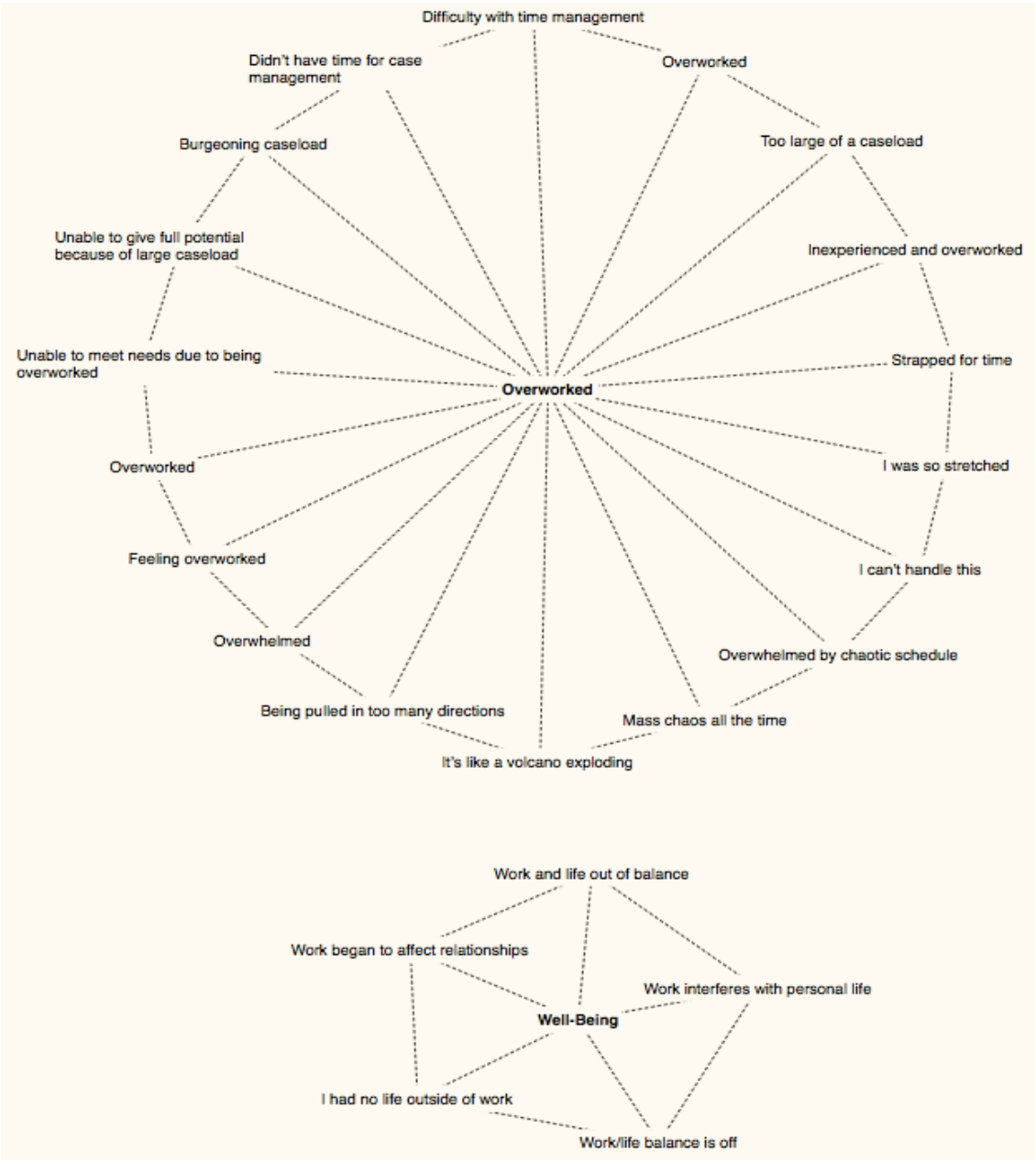


Figure 4.35. Initial themes of Overworked and Well-Being.

Subsequent analysis exploring the ways in which the participants' experiences impacted them resulted in the refinement of both themes to more accurately reflect the higher order concepts the participants shared. The Overworked theme became Work Life and the Well-Being theme became Personal Life, which better represented the ways in which participants' clinical responsibilities impacted their quality of life at work and outside of work. Several examples are provided below to clarify these points.

Work life. Well-being was impacted in a number of ways at work, which restricted the participants' ability to engage in moral action. Several participants described their experiences in the following ways:

K. I think, uh, you know, trying to do, well definitely trying to do what's right, uh, but at the same time, you know, uh, working with a, with a large caseload and things like that, so, um, I don't think that my full potential was given to each client at that time because I was, I was carrying such a caseload at that, at that point.

T: There's like 800 people with severe problems, uh, how do I help them out? How do I get all of this done?

T: Although you're only supposed to bill 25 hours a week, it, that's kind of not taking into consideration the types of, uh, you know, life happening situations where you'd have to go in and, uh, see how these students, and you get

interruptions at your door, and the principal will stop and say, "Hey have you seen this person?" And so on and so on …

J: So just trying to do your job and get out. But then you wind up not being able to do your job to the fullest because you're always in a hurry to leave.

In each of these cases, it is clear that participants' clinical responsibilities were impacting their work life well-being, which in turn restricted them from doing what was right or what was best for their clients.

Personal life. Similarly, participants described situations in which their clinical responsibilities impacted their lives outside of work, and put strains on personal relationships. Several examples are provided below to illustrate how clinical responsibilities impacted participants' well-being outside of work:

D. It's, uh, and to be stretched so that you don't have any life outside work. The work life balance is all off.

K: But I was out with my husband at the time and he was like, uh, and, and so and I had the kids with me, and I was like, oh, am I going to have to go to, go up, are you calling me out? Am I going to have to go up there? Because if so, I'm going to have to get everybody, we rode in one car to go home.

T. … but you know, it was pulling me out at nighttime with my babe, and you know, I, so it's just, um, maybe it was lack of, a little lack of sleep, because it kept you up, you know …

T. So, in the end it's just, figuring out this is, um, not how all places are and you know, this morally, yeah, it, it took a little while to, to decompress from it actually (laughs), because I, uh, it was just so stressful and took a toll on other areas, you know, just not being able to spend time with your kids.

Each of the examples above illustrate the ways in which participants' clinical responsibilities negatively impacted their personal life well-being, which ultimately created morally distressing situations for them. As a result, the domain Well-Being was developed in order to capture the meaning of both sub-themes, which is graphically depicted in Figure 4.36. Because the current study is based on the participants' subjective perceptions and understanding of their experiences, the subjective concept of well-being (National Academies of Science, 2013) seemed like the most appropriate domain name to both reflect the ways in which participants experienced and were impacted by clinical demands, and to capture the overall meaning of both sub-themes.

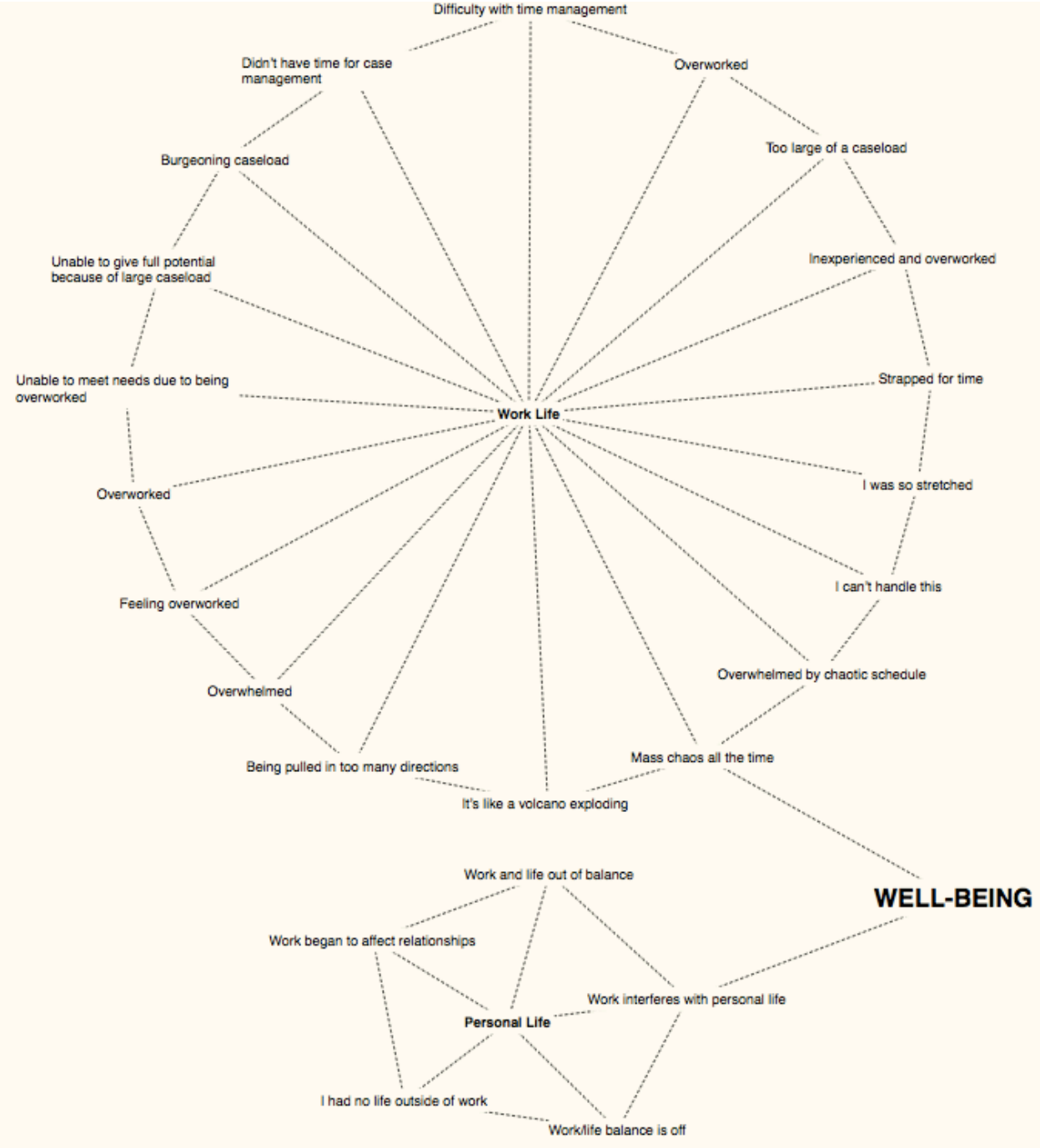


Figure 4.36. Well-Being domain and corresponding sub-theme structure identified through analysis across participants.

Adaptability. Following the development of the Well-Being domain, themes representing participants' low adaptability to complex, unique, and challenging situations were reanalyzed for connections across participants. Initially, all themes were grouped into one large superordinate theme called Low Adaptability, based on their overall connections, which can be seen in Figure 4.37 below.

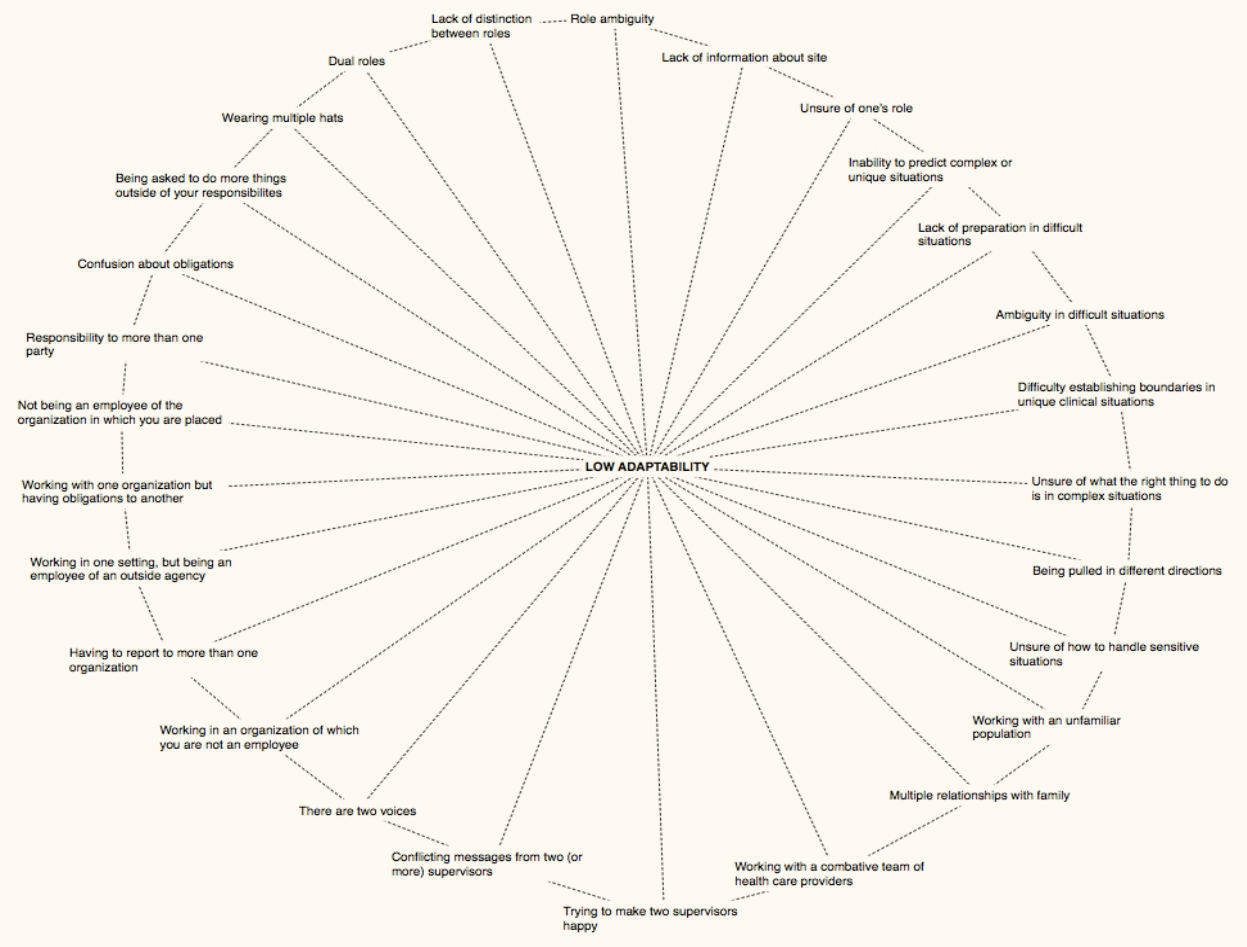


Figure 4.37. Initial connections across themes representing participants' low adaptability.

Reanalysis of themes comprising the Low Adaptability theme resulted in the identification of three sub-themes. The first represented situations in which counselors had difficulty adapting to

the multiple roles they assumed. Several examples of this kind of situation were described by participants, including conflicting clinical roles and conflicting organizational roles. One explicit and conscise example of the way in which multiple roles created situations that prevented moral action was described in the following way:

F: So, so boundaries were kind of getting crossed and I realized that from the fact that me being an advocate and me being a counselor is not good.

Regardless of the participant's specific experience, however, their inability to adapt to such situations impeded their ability to engage in moral action.

The second represented situations in which counselors' confusion about their clinical responsibility presented challenges to moral action. For example, one shared experience was difficult adapting to situations in which counselors provide services at an facility in which they are not an employee. Counselors in these situations found themselves unable to do what they thought was best for a client because intervening was outside the scope of their responsibility. One participant who was working in a school, but was an employee of and had a contract with a community mental health agency described how confusion about responsibilities created a barrier to finding or providing services for a student in need:

P: Um, now I worked with the family previously, and they were aware of me and they knew me and we had a good, um, I guess you could say therapeutic relationship (inaudible) and I knew the child from that situation. So, I think the school, who knew that I worked with the family before, thought that even though

I, he was not my client, they just wanted to find the services that maybe I was obligated to do something …

I: Uh huh.

P: But, per my job responsibilities, for my contract that I signed with community mental health, I cannot get involved with the child if I don't have release to obtain information about the child. And, like I said, I's a very sticky situation because, as the school counselor, all children are your children, you know.

What made this situation more difficult for Participant P was that he or she had previously been a school counselor and was familiar with responsibilities as a school counselor. Now that they were functioning from a community mental health facility in the school, his or her clinical responsibilities were blurred, creating confusion, further complicating situations in which they wanted to intervene, but could not.

Finally, the third sub-theme represented counselors' experiences of conflict among colleagues, which prevented them from doing what they thought was best for a client. A couple different examples were portrayed by participants, including situations in which they worked with a combative team of colleagues and those in which two or more supervisors were providing conflicting messages. One prominent, yet brief example of how conflicting messages from two supervisors created moral distress was described the following way:

T: And also, I guess the moral distress was I had one supervisor who was like you need to do this and the other was like you need to do that …

I: Uh huh.

T: And to, that's the stressful part. You have two different voices.

Figure 4.38 shows the initial development of the sub-theme structure that emerged with additional analysis.

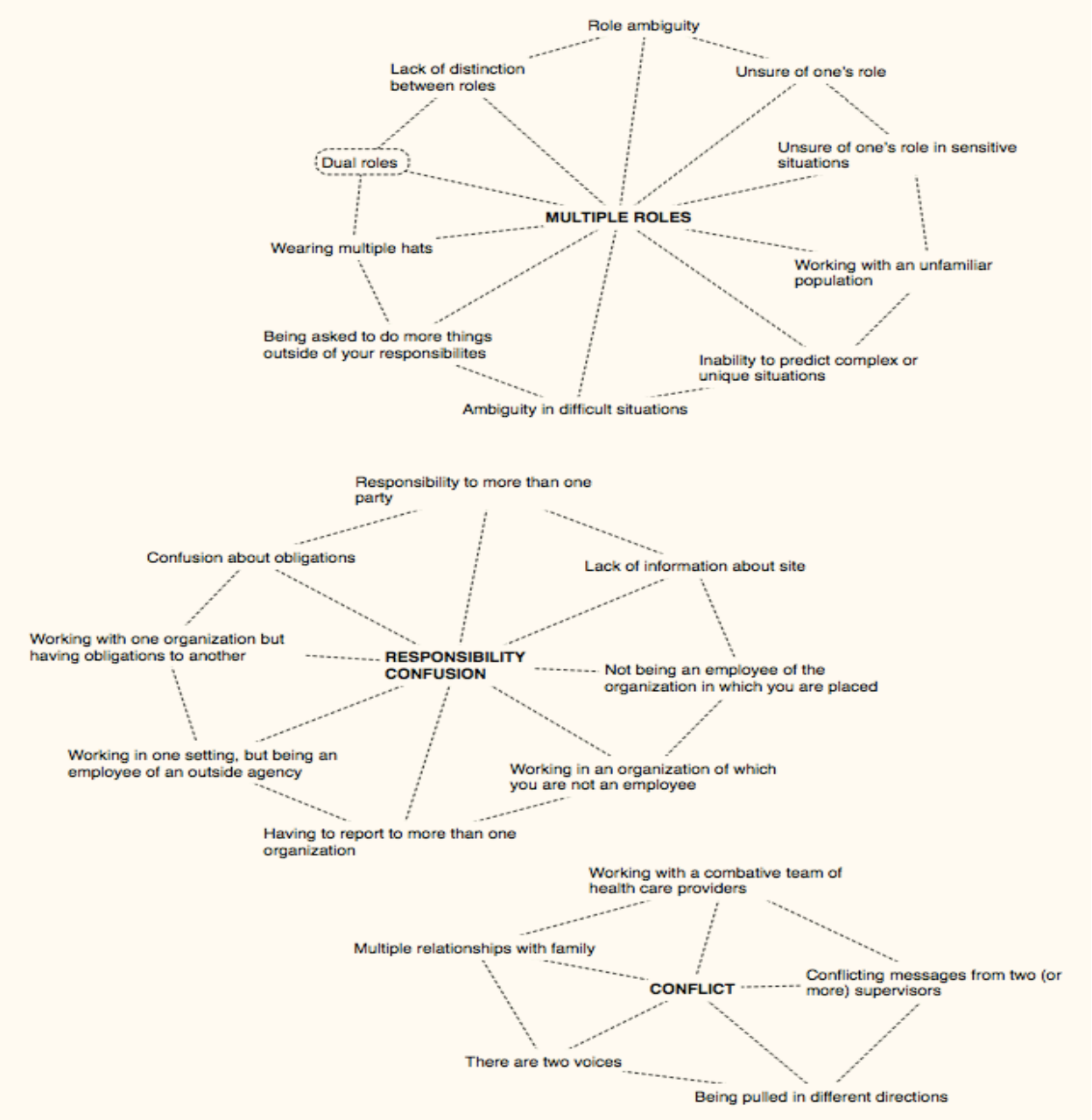


Figure 4.38. Initial sub-theme structure that emerged out of the Low Adaptability theme.

Continued analysis of the Multiple Roles and Responsibility Confusion sub-themes suggested the connections among them actually represented one overall type of experience in which counselors were unsure about their role in clinical situations or at their clinical site. Reviewing Participant P's experience above, because he or she assumed a new role (clinical mental health) their responsibilities changed. If he or she had remained in their original role (school counselor) the moral distress would have been eliminated, at least in the case described above. Therefore, because the clinical role changed, clinical responsibilities changed, which both contributed to their experience of moral distress.

The distinction between responsibilities and roles provided little, if any, additional conceptual clarity or insight about the participants' experiences. As such, the two sub-themes were merged to form a new sub-theme referred to as Role Confusion. Because one's responsibilities are dictated by the role they assume within an organization, a sub-theme consisting of both concepts resulted in a more parsimonious way to represent the overall meaning of ambiguity and confusion about one's role in an organization. That is, it seems that ambiguity about one's role would simultaneously include ambiguity about one's responsibilities.

Next, reanalysis of the Conflict sub-theme resulted in a better understanding of the type of conflict participants had experienced. In each case, the conflict stemmed from the counselors' relationships with others, including the client's family, colleagues, and supervisors. Therefore, the Conflict sub-theme was renamed Relationship Conflict to better capture the participants' experiences and underlying meaning thereof. Finally, the domain comprised by the two sub-themes was developed due to the overall meaning of the participants' experiences. In all cases, counselors had difficult adapting in new or ambiguous roles, confusing responsibilities, and

discordant relationships, which resulted in the development of the Adaptability domain. Figure 4.39 displays the final domain and sub-theme structure for Adaptability.

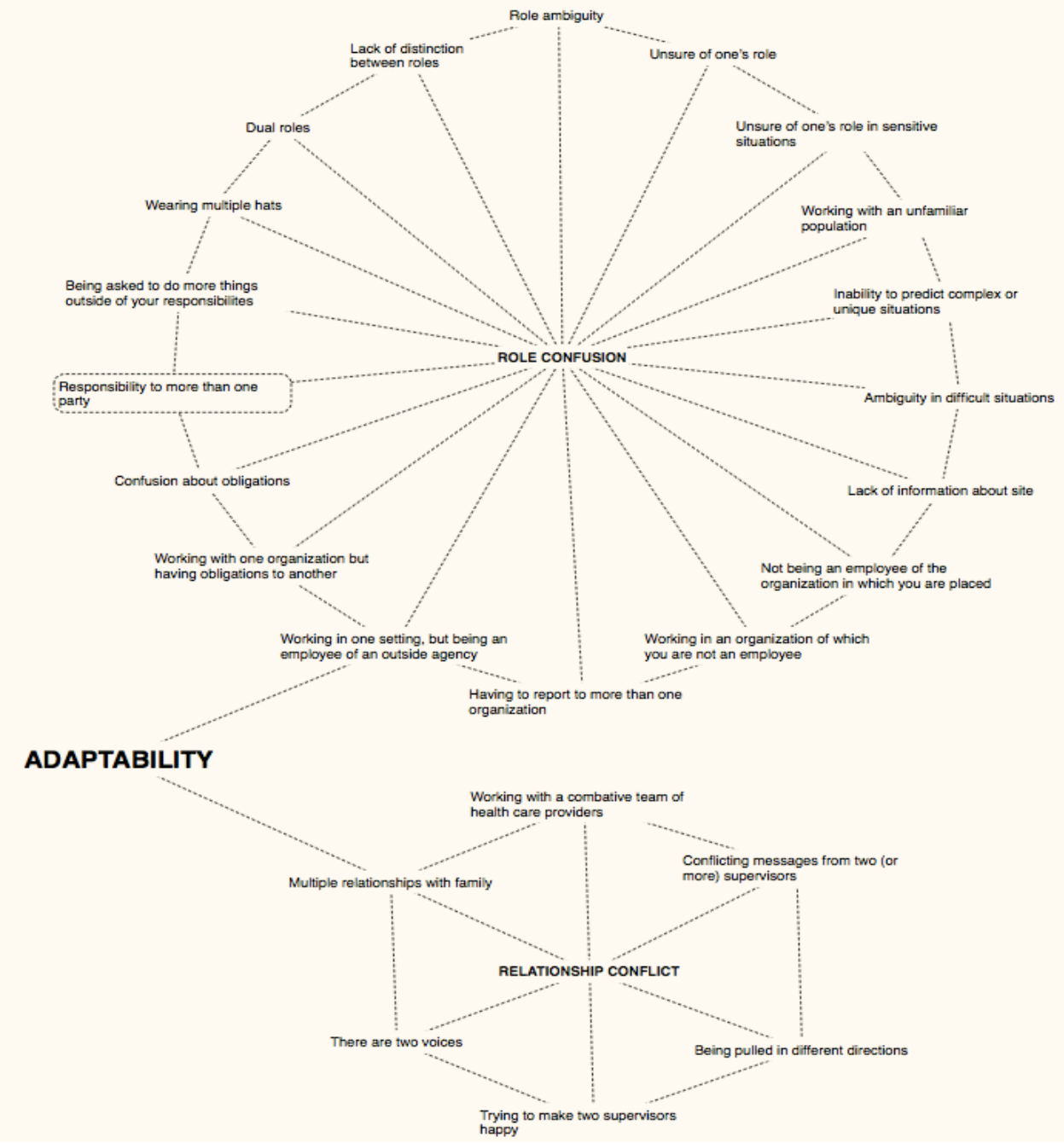


Figure 4.39. Adaptability domain and corresponding sub-theme structure identified through analysis across participants.

Inexperience. Following the development of the Adaptability domain and associated sub-themes, themes originally related to counselors' level of competence were reanalyzed. Initially, all themes were grouped together according to the connections across participants, as seen in Figure 4.40.

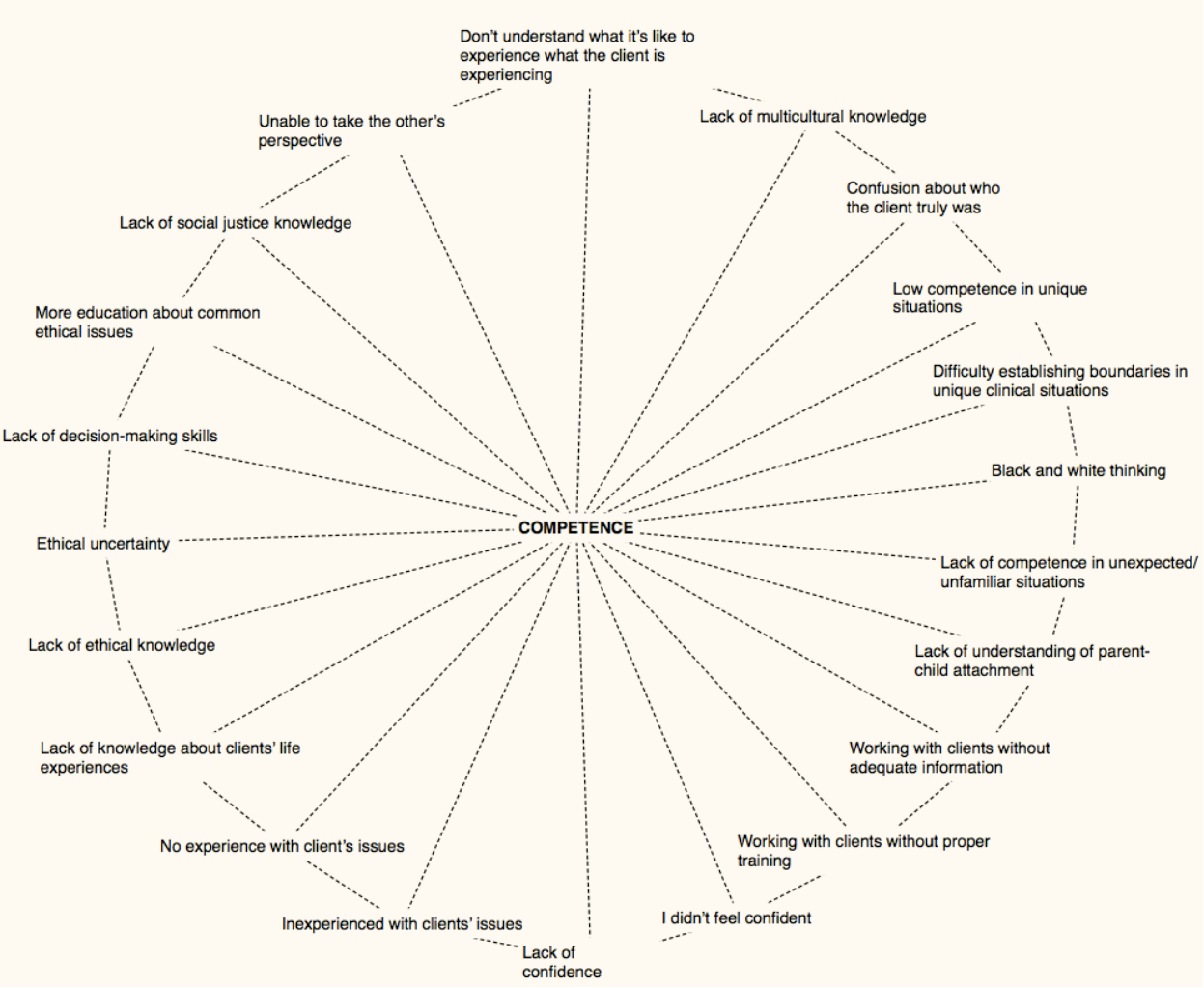


Figure 4.40. Initial connections across participants relating to counselor competence.

Each of the themes comprising the superordinate theme of Competence reflects an experience in which a counselor's competence, or lack thereof, created a barrier to engaging in moral action. Further analysis of the themes, however, revealed that there were several sub-themes reflecting higher levels of conceptualization and more accurately capturing the meaning across participants. The emergence of sub-themes was not surprising, given the complex and multidimensional nature of competence in mental health (Sommers-Flanagan, 2015). That is, while the Competence theme in Figure 4.40 reflects the connections made between participants' experiences and captured the overall meaning of those themes, it may be too comprehensive, discounting underlying conceptual elements that make up competence.

Further exploration of the themes that comprised the overall Competence theme resulted in the identification of several sub-themes, although the development of those themes went through several iterations. First, additional conceptual similarities were identified across themes and across cases, which represented individual dimensions of counselor competence. While this stage of analysis was not guided by a theory of competence development, the three sub-themes that subsequently emerged from additional data are documented in the counselor competence literature and depicted in Figure 4.41. The Lack of Understanding sub-theme captures the difficulties created by a lack of familiarity with the client's experience, or an inability to take their perspective. For example, one participant described his or her lack of understanding the following way:

K: … I mentioned earlier not being a parent, so I think that, that played a role, but, uh, in, in my thought process. And so, um, not fully understanding what it's like to have, uh, a child of that age, uh, you know, because it, it, it almost

> felt at times like being someone, you know, looking from the outside in and not fully comprehending the situation at hand, um, you know, because I didn't have a child of my own.

In this case, the participant's lack of understanding caused him or her to act in a way that they knew probably was not best for the client, but because he or she was unable to understand the parent's perspective, there was not another option.

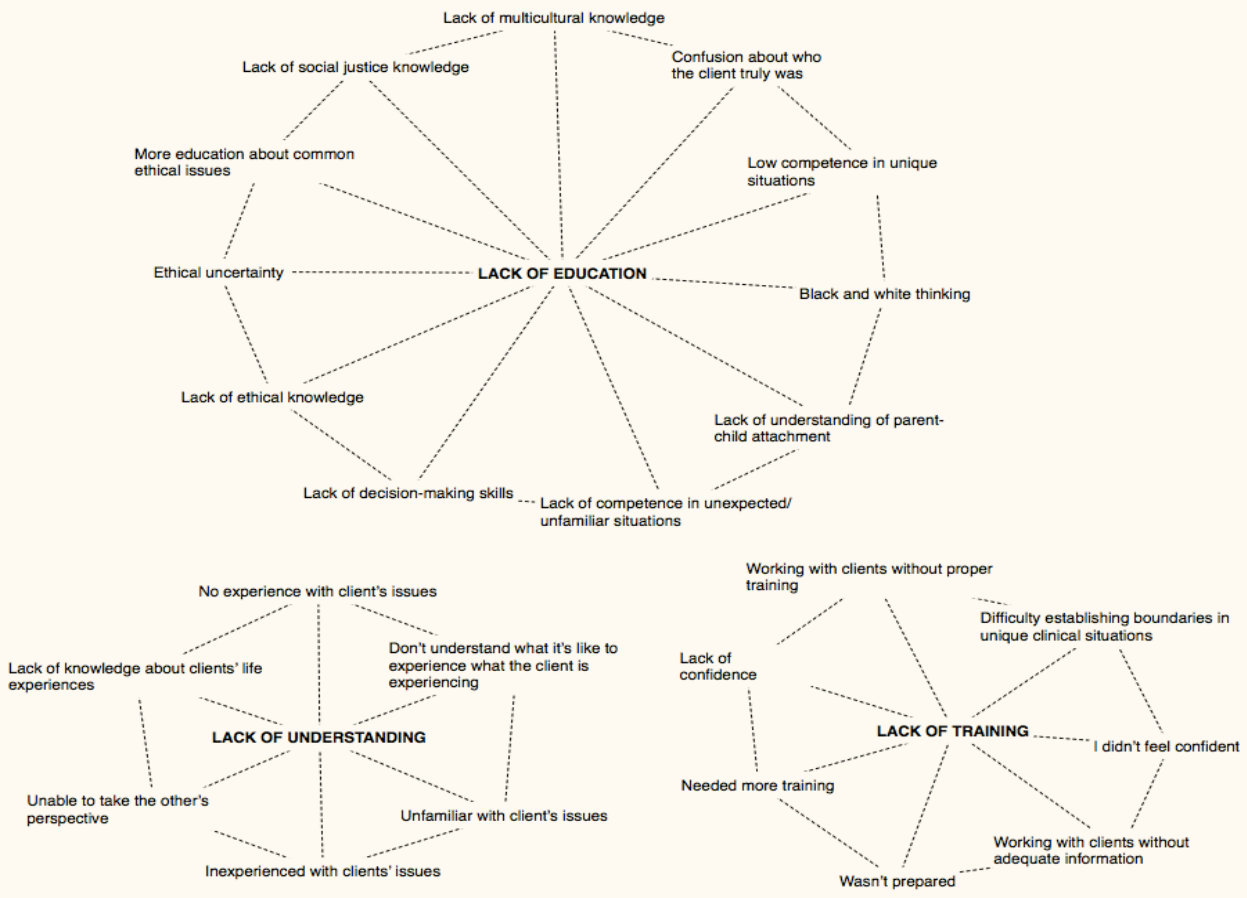


Figure 4.41. Initial sub-themes that emerged from the original superordinate theme of Competence.

The lack of understanding described by Participant K above closely resembles Roger's (1957) essential condition of empathic understanding in which the therapist or counselor "experiences an empathic understanding of the client's internal frame of reference" (p. 96). According to Rogers, empathic understanding is one of several counseling competencies that are required in order to affect change, regardless of therapeutic framework. As such, the emergence of Lack of Understanding as a sub-theme of Competence is theoretically appropriate and is grounded in the data, capturing the overall meaning of participants' experiences.

The other two emergent sub-themes, Lack of Education and Lack of Training certainly captured the difficulties participants experienced due to a professional deficit of some sort. Education and training are also documented in the counseling literature as core measures of learning outcomes and competence. For example, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) divides the eight core knowledge-based standards into learning objectives and skill components (Sommers-Flanagan, 2015), suggesting the importance of adequate education and training in becoming a competent counselor.

Lack of Education, as a sub-theme, represents situations in which participants knew they were not doing what was best for the client, but because they lacked the requisite knowledge to adequately meet their needs or handle their case, they had no other option but to behave in an unethical or professionally inappropriate way. Participant 12 concisely describes such an experience in the following way:

12: Wanted to help her. I was a new clinician and didn't know how to help. I knew driving her in my pov was not the best decision.

The above quote demonstrates the participant's lack of knowledge about ethical guidelines and proper ways to intervene. As a result, the counselor was left with only one option about how to handle the situation, one in which he or she knew they were crossing some sort of professional boundary. Other participants described situations in which a lack of ethical, social justice, or multicultural knowledge limited their ability to do what was best for a client, and resulted in questionable practices.

Very similarly, the sub-theme of Lack of Training emerged out of the Competence superordinate theme, which reflected experiences in which participants were unsure of how to or lacked confidence in providing appropriate services to a client. In this case, the counselor knew they were intervening in a way that was not in the best interest of the client, but lacked the requisite training to more appropriately intervene or provide services. Reflecting on their experience of moral distress and the factors that could have helped prevent it, one participant identified additional training with the population you are interested in or plan to work with:

> K: But I want to work with teens, so I think being able to work with that population, uh, that you're striving towards, uh, would be very beneficial. Uh, and if, if they could make it happen or have some of those site available for counselors coming in, because, um, I feel like if I had worked with that population beforehand, I would have been met with these issues and I would have been able to work with them within, while I was in school …

Another participant described the way in which a lack of training at the organizational level contributed to their experience of moral distress:

F: Yeah. The, the yeah, the university should have provided the training. And I, I had only been at the university for like three years, and there weren't very many situations in which it deserved, you know, I dealt with sexual assault, but lots of times it wasn't like an immediate … you know, it wasn't as intense as this situation and most of them didn't involve, well what we thought in the beginning was stranger rape.

I: Ok.

F: So, I mean now that I've had more training I know that, you know, all kinds of rapes are, are equally serious or whatever …

In Participant F's case, the lack of training he or she received at the organization in which they worked, resulted in an inability to intervene in ways that were in the best interest of the client and in crossing professional boundaries.

Although an identifiable and grounded thematic structured had emerged at this point of analysis, further analysis of the original themes and comments that comprised the newly formed sub-themes indicated the Lack of Understanding and Lack of Education were too specific to capture meaning across participants. That is, reanalysis of the original data from which Lack of Understanding emerged revealed that only one participant had expressed experiences reflecting a lack of understanding. Therefore, although the sub-theme captured the meaning of the experiences that participant had encountered, it did not reflect meaning across participants' experiences.

Smith et al. (2009) caution researchers from removing discounting a theme due to the relatively low frequency in which occurs in the data. Numeration, on the other hand, is only one factor that should guide the assessment of importance among emergent themes. One particularly

potent theme, which unlocks further meaning, yet is evidence only once in data, may still have substantial importance in developing an overall understanding of the meaning of participants' experiences and emergent themes. In light of their warning, the themes were once again reanalyzed, resulting in a third themtic structure change.

Lack of Understanding was merged with Lack of Education due to their conceptual similarities, the participants' experiences, and the meaning that permeated both sub-themes. Warren (2005) noted that empathic understanding is built upon educational components, such as multicultural training, reflective practices, and open and honest communication with others about social, cultural, and justice issues, at the very least, and among other things. Kornfeld (1992) pointed out the importance of experiential activities in the development of compassion and tolerance as components of empathy. Each of these foundational components often are built into counselor training programs in order to further prepare counselors to work in a pluralistic society (CACREP, 2009). Additionally, this participant explicitly indicated that their training program did not include enough multicultural and ethical education that would have been helpful in overcoming experiences of moral distress. A review of recommendations for remediating trainees with problems of professional competence issues (TPPC) surrounding diversity and multiculturalism also points to additional educational components, although training is also recommended (Rust, Raskin, & Hill, 2013). With these considerations in mind, merging the Lack of Understanding sub-theme with the Lack of Education sub-them seemed appropriate.

After merging the two sub-themes, a reevaluation of the overall meaning of the individual themes and comments comprising the newly formed sub-theme (Lack of Education) indicated the appropriateness of this structural change. That is, other experiences reflecting a lack of multicultural, social justice, and ethical knowledge displayed a clear connection with the

experiences formerly comprising the Lack of Understanding theme. Additionally, these experiences connected meaning across participants, which was more hermeneutically appropriate than the two previously separate sub-themes. The resulting two sub-theme structure is depicted in Figure 4.42.

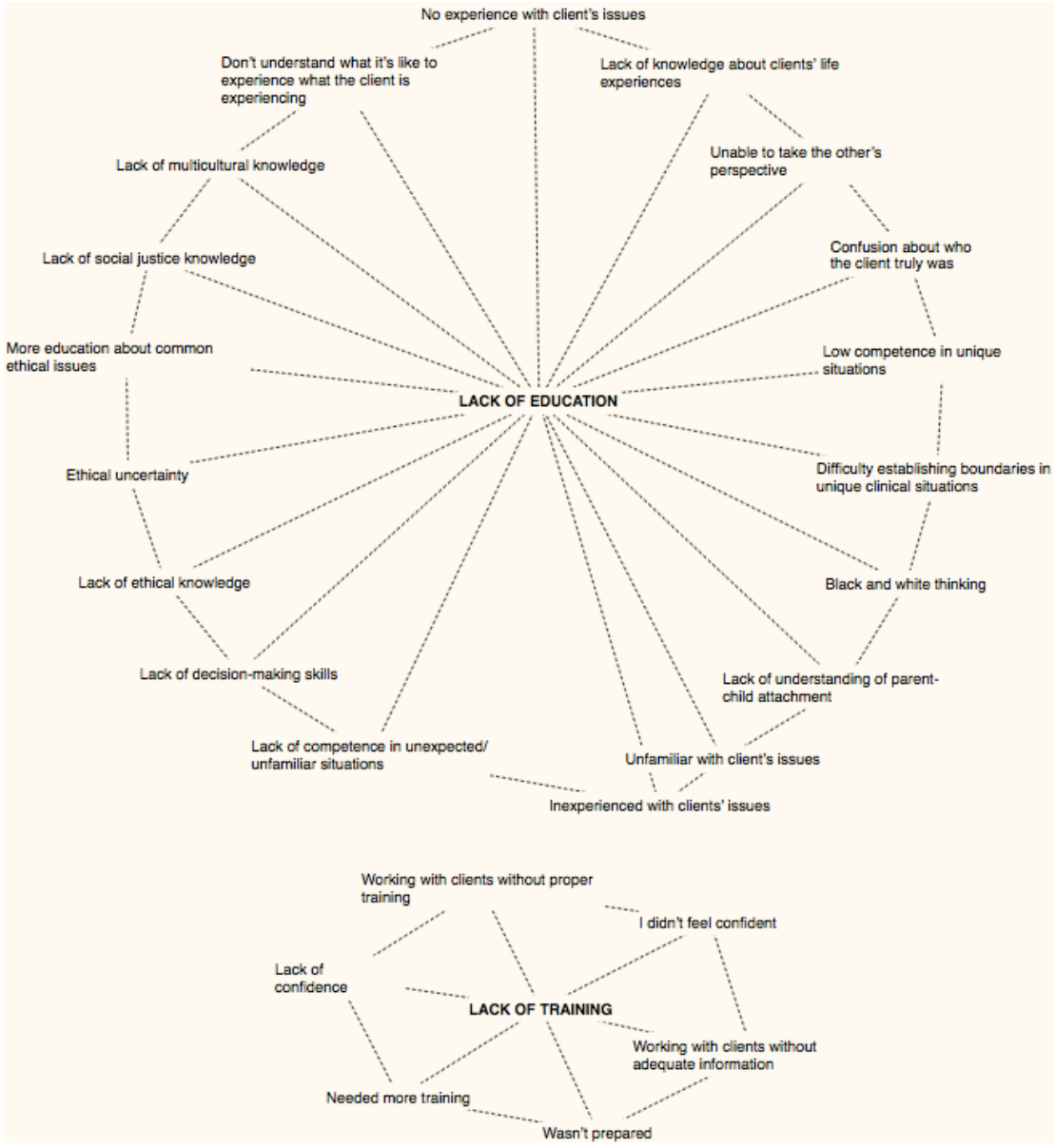


Figure 4.42. Two sub-theme structure, resultant from the collapse of Lack of Education and Lack of Understanding into the Lack of Education sub-theme.

Additional analysis of the sub-themes and the thematic structure did not lead to additional conceptual clarity, so the domain name Inexperience was chosen to completely capture the essence of the participants' meaning across sub-themes and across participants, depicted in Figure 4.43.

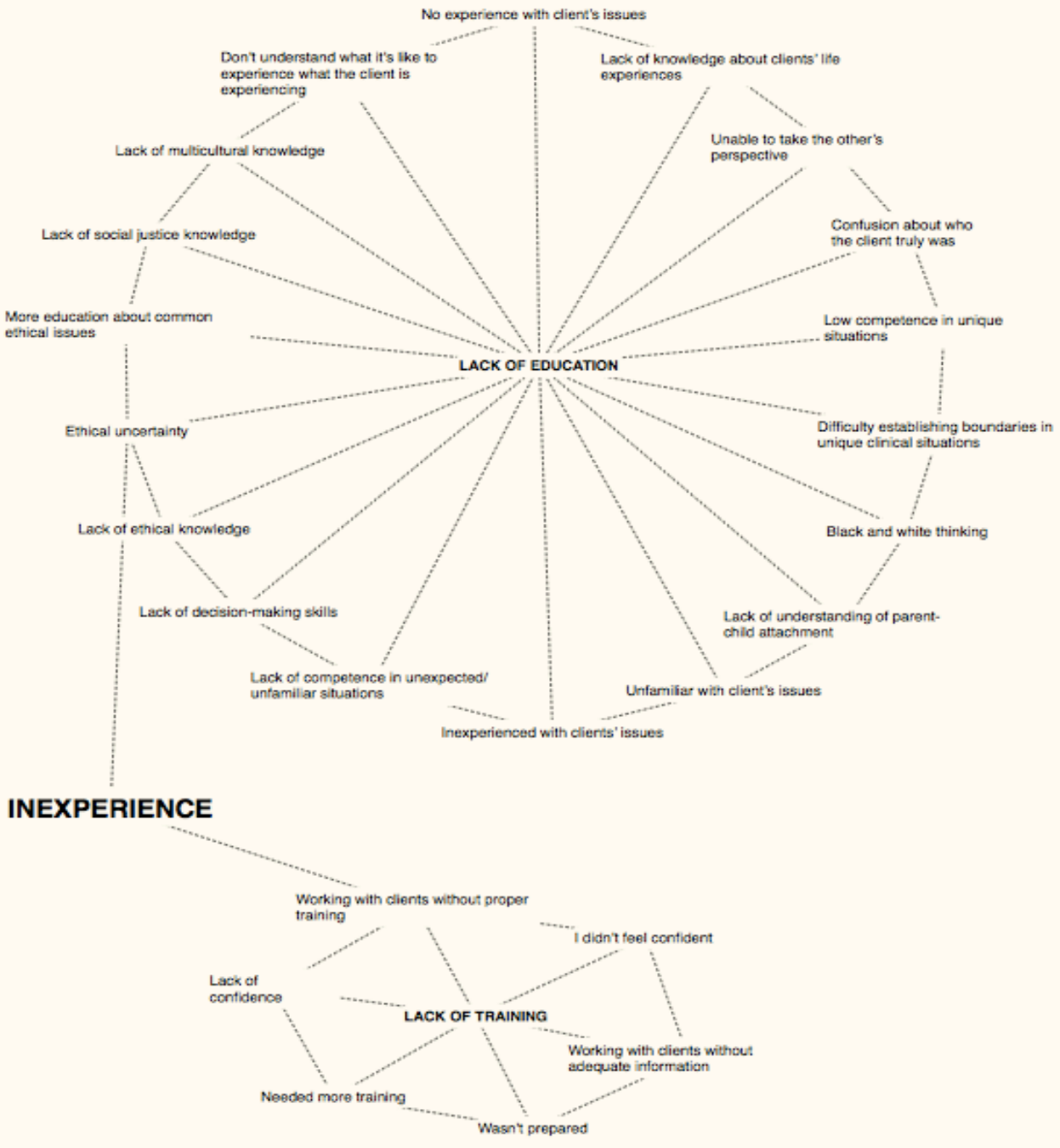


Figure 4.43. Final sub-theme structure and domain name for the Inexperience domain.

Lack of objectivity. Following the development of the Inexperience domain and associated sub-themes, the final themes, were reanalyzed. Initially, themes were grouped together according to their similarities, at a somewhat abstract level, as previous stages of

analysis had not completely made sense of their conceptual complexity. Initially, the theme clusters represented participants' impairment, idealization of what it meant to be a counselor or the counseling profession, and exaggerated responsibilities. Evidential support is provided for each cluster below. Figure 4.44 depicts the original conceptualization of the theme clusters and a detailed discussion of the additional analysis for each cluster follows.

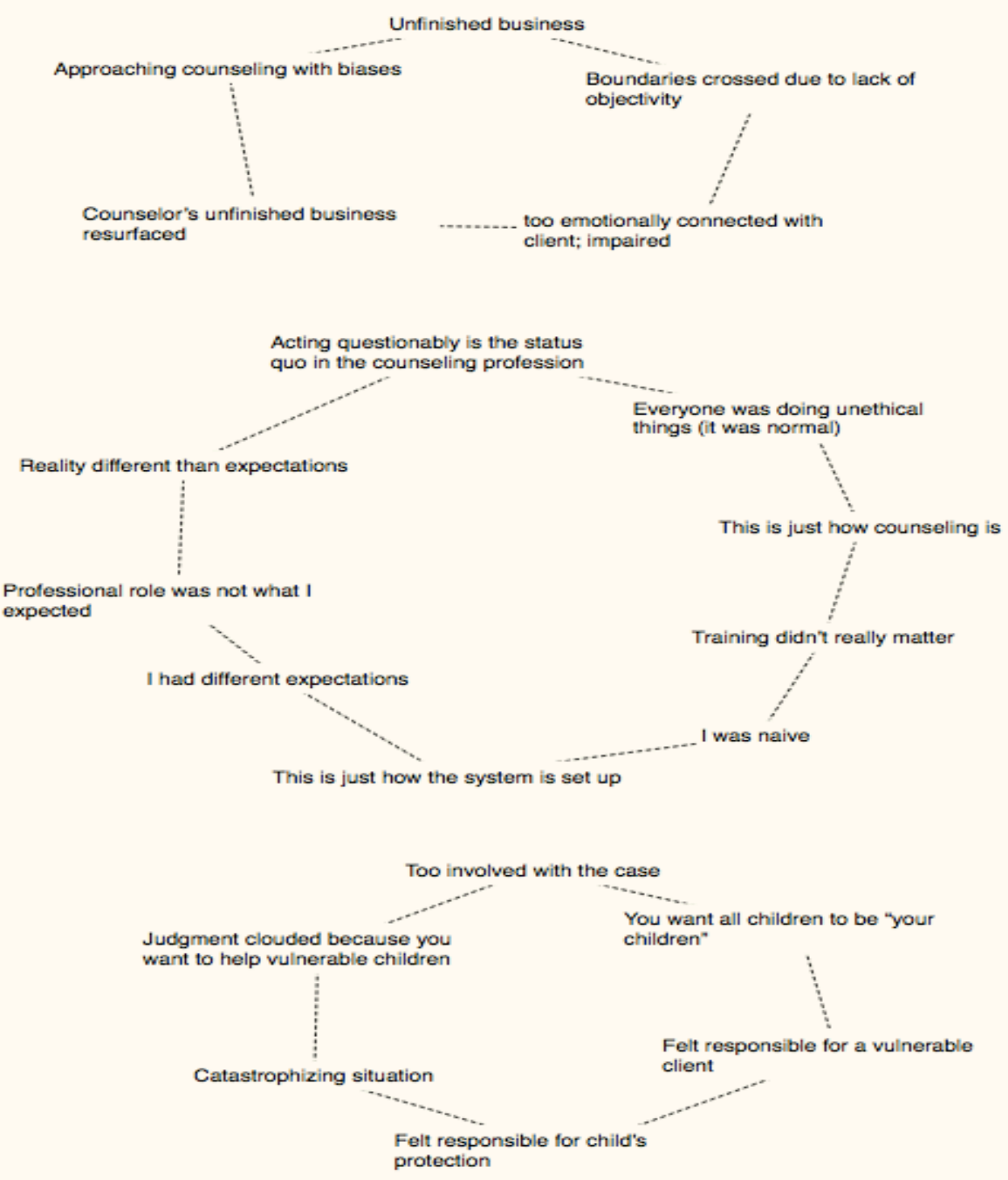


Figure 4.44. Initial clustering of themes ultimately comprising the Lack of Objectivity domain. Reanalysis resulted in further conceptualization and merging of clusters, based on shared meaning.

Impairment. The Impairment theme largely emerged from one participant's account of his or her experience; however, it was particularly meaningful to the participant and created a lasting impact on him or her, which further justified the inclusion of the theme. This participant was very similar to the client they were working with, which coupled with his or her previous trauma and emotional wounds, created an intense emotional bond that clouded objectivity. Throughout the interview, this participant described the ways in which this extreme level of emotionality prevented them from doing what was right, although they knew they were crossing ethical and professional boundaries. The emotional bond began from similarities between the client and the participant, which is illustrated in the excerpt from the transcript below, with some details changed and bracketed in order to protect the participant's identity, followed by additional Illustrative quotes, provided in Table 4.4.

F: And while we were there, um, she was so upset that I had been talking to her and I was trying to calm her down by asking her about her family and stuff. And while she was telling me about her family, she, it, it was just a little strange, she had a lot in common with my family, ok?

I: Mm.

F: There were [a lot of] kids in her family, you know, not common, and there were [a lot of] kids in my family.

I: Mm.

F: There [was an oddity] in the family, there [was an oddity] in my family, and she was the [birth order] girl and I was the [birth order] girl.

I: Hmm.

F: And, uh, you know, it was also bringing up some feelings for me because I've experienced some, you know, uh, I've been through lots of counseling for it, but it was bringing up some feelings in me and [inaudible] responses or what ever.

I: Uh huh.

F: So, anyway, so being there and, um, and so I was getting, anyway, so I was feeling of bonding with her and it was a little too much, because I was being, there were similarities and it was really intense.

From this excerpt, it seems clear this experience was particularly meaningful and potentially problematic (at this point of the interview) for the participant. He or she continually checks with the researcher after revealing more of their story and begins to have some difficulty articulating the story toward the end of the excerpt. Additional illustrative quotes are provided in Table 4.4 to further evidence the ways in which this experience resulted in moral distress.

Table 4.4
Impairment sub-theme with specific illustrative quotations.

Sub-Theme	Participant	Quotation
Impairment	P-14-19-F	And, uh, you know, it was also bring up some feelings for me because I've experienced some, you know, uh, I've been through lots of counseling for it, but it was brining up some feelings in me and [inaudible] responses or whatever. So, anyway, so being there and, um, and so I was getting, anyway, so I was feeling of bonding with her and it was a little too much, because I was being, there were similarities and it was really intense. … I think boundaries were getting crossed, and uh, and I think it led to me feeling more, I wasn't able to be objective. I had gotten too involved with the case … I was a little too, um, I wasn't able to be objective … because it go so intimate … … with that, I think, um, on, I had some, uh, some unfinished business, I had some issues I needed to work through in counseling. I've done a lot and I thought I was done with it, but clearly I wasn't. And, and I had to get in counseling for a while after that, because I wasn't, you now, it, it screwed me up.

It is evident from excerpt above and the quotes in Table 4.4 that this participant's previous experiences and intense emotional connection were preventing her from doing what she knew was right, which has been identified by others as traumatic countertransference (Corey, 1991). Boundaries were knowingly crossed, yet the bond, or emotional connection created with this client resulted in actions that carried out for self-serving purposes, rather than for best interest of the client. Due to the intensity of this experience and the lasting meaning it had for the participant, the sub-theme, originally called Impairment was identified.

Idealization. The second theme cluster that was reanalyzed was one that reflected participants' idealized view of themselves, colleagues, or the counseling profession. In these cases, participants were unable to do what they thought was best for clients because the standards they held were contextually unrealistic or the goals they strived for were contextually unattainable. The context-specific distinction is made here because to generalize beyond these participants' experiences is likely inappropriate. That is, the standards and goals these participants held may not have been unrealistic in other clinical contexts. Regardless, however, their experiences were genuine and depicted those of moral distress; thusly, they were included in analysis and subsequently identified as a sub-theme.

One participant described his or her realization that, despite their expectations about the profession, everyone was acting unethically. As a result, they began to assume those types of behaviors were just part of the counseling profession:

J. When you constantly see the person above you doing, doing the wrong thing, and you know it's wrong, you begin to think, well everybody else is doing it, this is just part of it

Another, who had a similar experience, reflected on their initial realization that their expectations or standards may have been too high:

T: Um, the first month, ok, so my, I realized this kind of the, the dissonance of I came in very naïve and they couldn't control that. I mean you can't control as a company what peoples ideas of it would be, but I came into it thinking, ok this is

where I grow as a counselor, this is where I get my stuff done, of course help people out. But coming in the first week was all about the training, ok check this box, check that box, this is the money, this is that, la la la, so I was like, ummmm, uh, can I ask you, like, REBT, do you like that?

This experience continued for this participant and resulted in a morally distressing situation where he or she was unable to provide the care or treatment they thought was best for the client. Initially, the barrier to moral action seemed to be a function of the standards, or lack thereof, held by the colleagues they worked with. This perception of apathy for clients also was generalized beyond the specific context in which they worked and extended to the entire field of counseling, described in the following way:

T: Um, I guess at the time I just thought, ok this is how counseling is (laughs)

I: Mm

T: So that, that frightened me a little bit. Ok, that's just how the field is.

Being forced to provide sub-standard care was scary and caused significant distress, met with sadness and frustration. After time, however, the constraints to moral action seemed to be internalized. That is, it was no longer that colleagues or the profession were holding them back; rather, it was their own high standards that restricted them from achieving a level of care they thought was best for the client, or that was congruent with their values. A short excerpt will provide clarity:

T: And I didn't think it was not value, I didn't feel like I was an unsuccessful person, but I couldn't help people accurately …

I: Uh huh, uh huh.

T: Um, according to my own standards. So, I think it's just being raised to, to try to be polite, work hard, be conscientious, help people …

I: Uh huh.

T: That's where I came from, I think.

I: You got into a helping profession hoping to help people and you weren't able to help people, in, in that role really.

T: Yes! Exactly, exactly.

I: I can see why that would be very discouraging. Um, ok, of course distressing, but right off the bay, you're like, hang on a second, I'm not making an impact here …

T: Yeah.

I: What's this all about?

T: Yeah. Exactly, yeah, that's a perfect summary of it.

The combination of her high standards and her naivety created a situation in which she expected more of the profession and more of herself, which made it difficult, if not impossible to meet those standards, at least in the current position they held. As a result, this participant began to realize that the training they had received and the standards they had internalized were unnecessary and, in fact, were causing the distress they were experiencing. Toward the end of the interview, when reflecting on what could have prevented this participant's moral distress, they responded after a long period of silence:

T: (Long pause) Yeah, I think that was the main thing. I could have, I could have relaxed my standards more.

The perception that she was responsible for the distress she encountered was a difficult thing to articulate and evidenced the lasting importance and meaning the experience had on her. As such, it also was included as a sub-theme, reflecting the ways in which unrealistically high optimism, standards, or expectations can create a morally distressing situation. This may be particularly true of novice counselors, as this participant acknowledged that she entered the counseling field naïvely, only to find that it would be impossible to live up to her standards.

Exaggerated responsibility. The final theme cluster that was reanalyzed was that of exaggerated responsibility. Themes in this cluster respresented situations in which participants knowingly engaged in behavior they knew was not the correct thing to do, owing to their feelings of responsibility for a client's protection or progress. In most cases, participants described desires to protect clients who were in dangerous environments, or were otherwise vulnerable, leading the counselor to cross professional boundaries. A few brief descriptions are below to illustrate the nature of moral distress experienced by these participants.

The first description was from a participant who knew his or her client was in a toxic home environment, but also had a relationship with the parent. As a result, he or she felt responsible for protecting the client, but also wanted to provide reports of positive progress to the parent. Therefore, ethical boundaries were crossed in an effort to create a more stable and healthy home environment for the client they counselor felt responsible for.

Interestingly, one of the Qualtrics participants provided a brief description of a situation in which vulnerable clients in a residential treatment facility were harming each other. Because he or she felt responsible for their clients, they knowlingly crossed professional or ethical boundaries in an effort to alleviate the harm they were experiencing. When reflecting on the factors that contributed to their moral distress, he or she simply wrote:

13: I felt responsible for the parties being injured.

Finally, another participant described his or her feeling of responsibility in protecting a client experiencing a traumatic situation:

F: Because I had been in the room with her when all that had happened and I had to go over to her apartment and talk to her on the … it felt very intimate and I felt overly protective.

Due to these participants' shared experience of responsibility to their clients, this theme cluster was originally identified as Exaggerated Responsibility. Figure 4.45 illustrates the resultant themeatic structure for the developing domain, at this point of analysis.

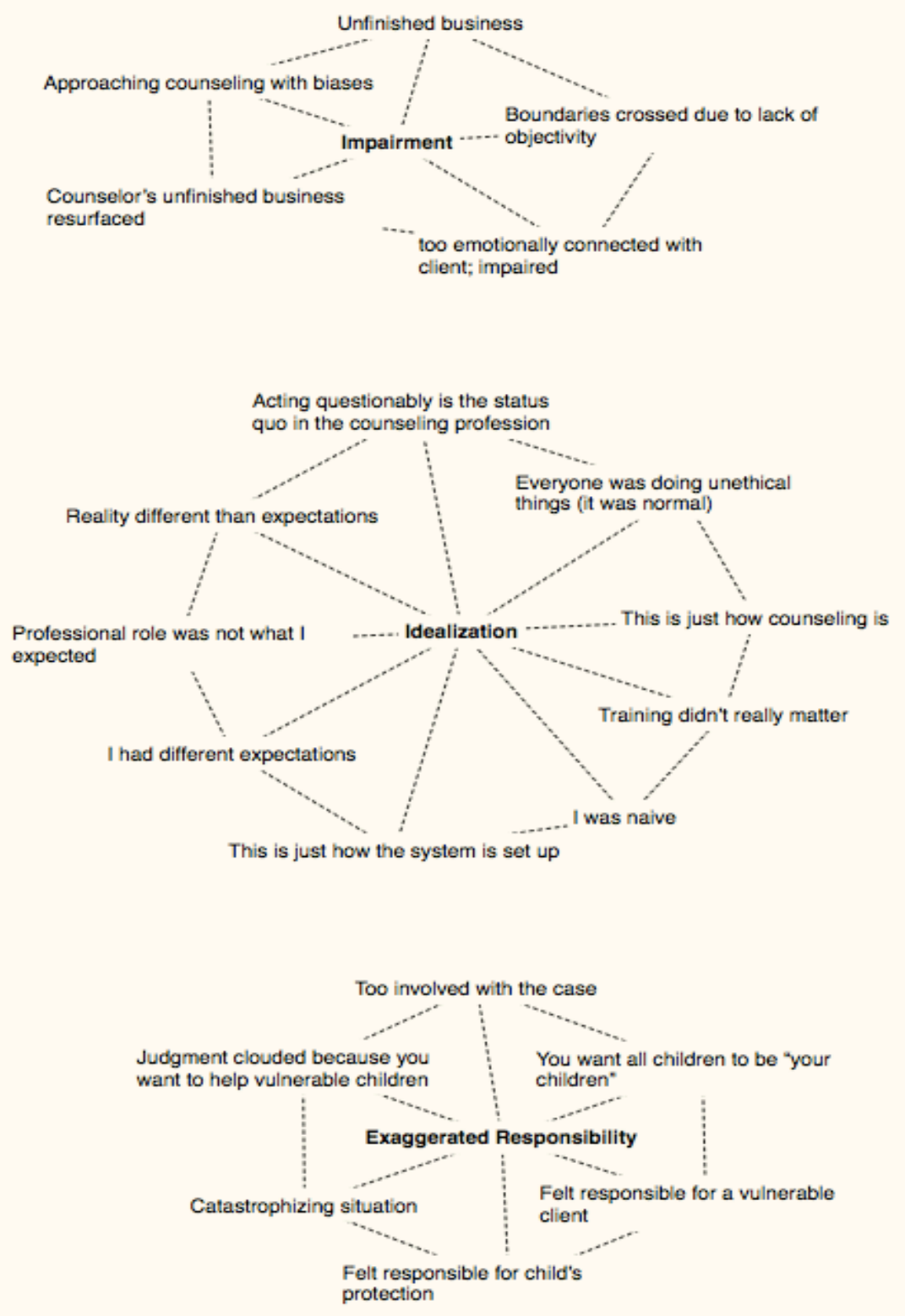


Figure 4.45. Initial theme structure for developing domain.

Additional analysis of the sub-themes highlighted the similarities in participants' experiences and the underlying meaning thereof. Specifically, the commonalities in the Impairment and Exaggerated Responsibilities sub-themes indicated a shared overall theme that linked the two more closely than originally thought. Most notably, participant T's feelings of responsibility in protecting her client resulted from the similarities, shared trauma, and intense emotional bond between counselor and client, which was ultimately captured in the Impairment sub-theme. Had that emotional bond not been created, it seemed clear that this participant would not have felt as responsible for her client, as she explicitly stated that there had been similar clients and cases before, but "nothing ever that intense." Therefore, Exaggerated Responsibility was viewed as part of the Impairment sub-theme.

Additional reflection on and consideration of the Impairment sub-theme resulted in a change of the sub-theme title from Impairment to Emotional Entanglement, for several reasons. First, a review of the context each original theme emerged from revealed that the overall meaning was more accurately an emotional bond that was created with the client and resulted in professional or ethical boundaries to be crossed for self-serving or protective reasons, or both. Therefore, the emotionality of these participants and its meaning was somewhat overlooked and even pathologized in a way. That is, definitions of impairment have varied widely over the last several decades and across professions (Sheffield, 1998), resulting in some misunderstandings about how impairment is manifested. In the past, impairment included burnout, mental illness, and chemical dependency (Stadler, Willing, Eberhage, & Ward, 1988), and alcohol problems, personality disorders, and adjustment disorders (Huprich & Rudd, 2004), among other things. The American Counseling Association's (ACA, 2014) definition for impairment is more vague, referring only to physical, mental, or emotional problems. Regardless of the definition, the term

impairment may be misleading and, in some cases, pathologize the counselor for an emotional connection, appropriate or otherwise.

Third, referring to counselors and other health professionals as impaired has become a contentious issue in the last decade (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004; Elman & Forrest, 2007). Because of the discrepancies above, impairment can be a misnomer, referring to a construct or characteristic irrelevant to the individual it refers to. Also, the term is used in the Americans with Disabilities Act (ADA, 1990), which can create additional confusion and create legal liability in misapplying the term to unintended or inappropriate situations (Falender, Collins, & Shafranske, 2009). As a result, the more appropriate term *professional competence problems* or *trainees with problems of professional competence* (TPPC) has been suggested and adopted by many (Schwartz-Mette, 2011; Veilleux, January, VanderVeen, Reddy, & Klonoff, 2012; Shen-Miller et al., 2015). As a result, the term impairment was deemed inappropriate and insensitive in its original use as a sub-theme title, and the title Emotional Entanglement was applied to more appropriately capture the meaning of the participants' experiences.

Examining the two sub-themes together, it appeared participants' emotions, expectations, or standards prevented them from objectively viewing themselves, their roles, or their responsibilities. As this shared meaning provided a link between the two sub-themes, the domain name Lack of Objectivity was identified to complete the domain and sub-theme structure, which can be seen in Figure 4.46.

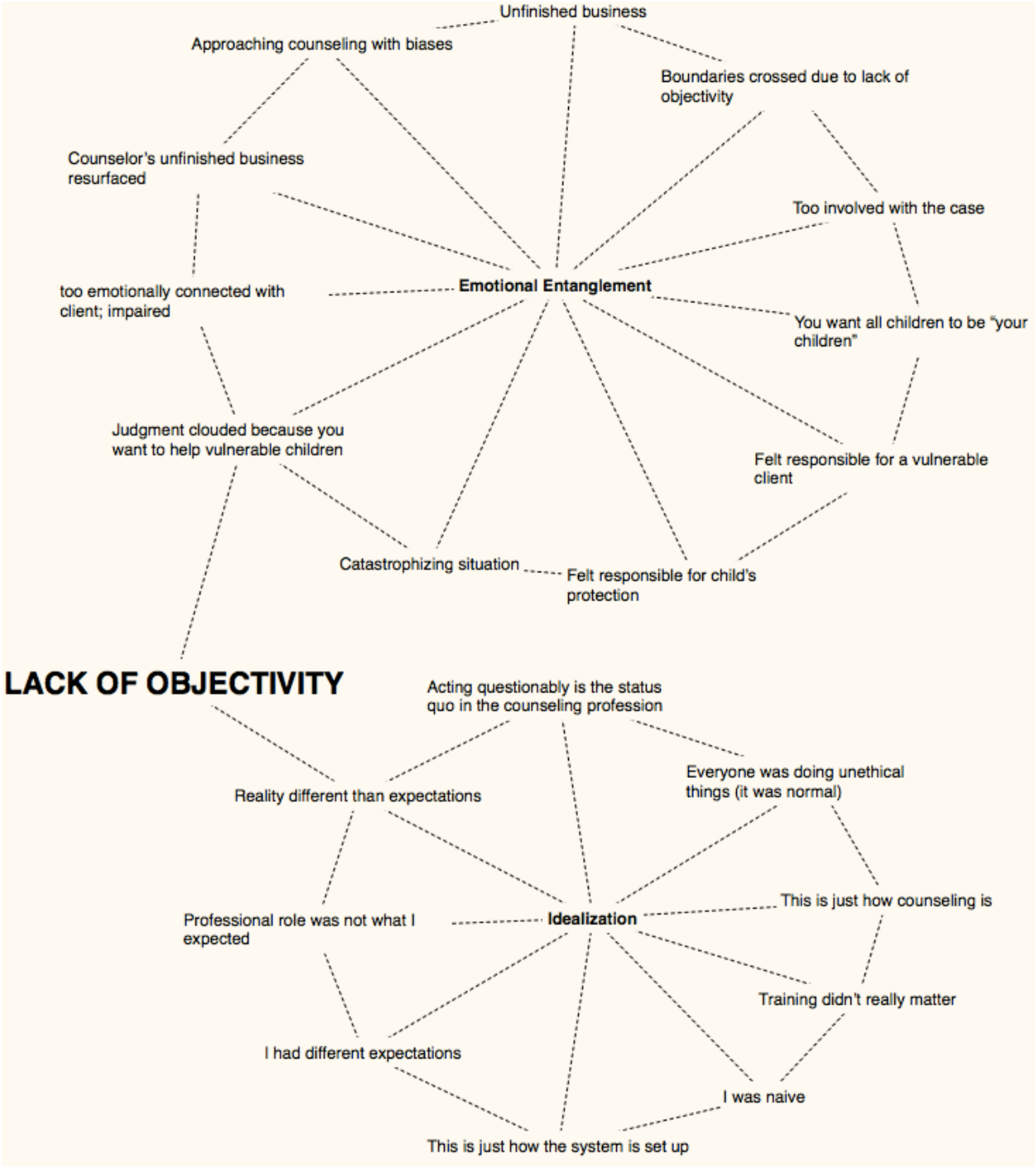
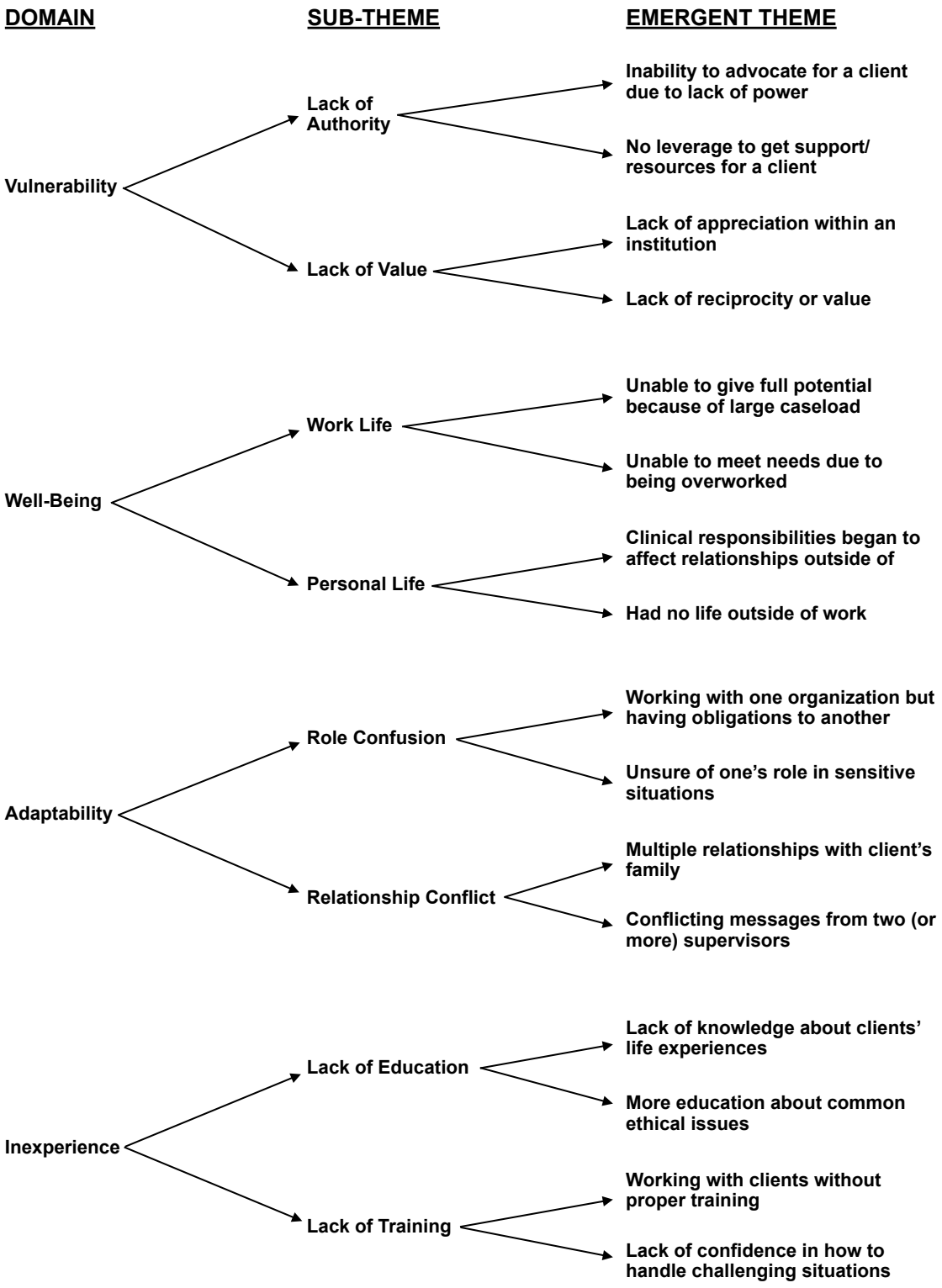


Figure 4.46. Final sub-theme structure and domain name for the Lack of Objectivity domain.

Summary of domain identification. The process of domain identification was time-consuming and complex, and involved many iterative steps, resulting in reanalyzing, reworking, and reconceptualizing in an effort to achieve as complete an understanding as possible of the meanings of participants' experiences. As mentioned at the beginning of this stage, three specific analytic techniques common to IPA research were used in data analysis, and specifically in looking for connections across emergent themes. First, abstraction, or "putting like with like and developing an new name for the cluster" (Smith et al., 2009, p. 96) was used to identify initial similarities at the conceptual, descriptive, and meaning levels. This process assisted with both the development of sub-themes and the domains of which they comprise. Second, contextualization, which involves identifying "the contextual or narrative themes within an analysis" (Smith et al., 2009, p. 98) was used to frame themes within the context from which they emerged. This process involved utilizing the hermeneutic circle, reading and re-reading original data, while examining the overall themes in order to more fully extract the meaning of participants' experiences. Finally, polarization was used to identify oppositional relationships between themes. By attending to differences, rather than similarities, some important connections were made that may not have been identified, had the researcher relied solely on abstraction to analyze the data.

Through these processes, an identifiable and coherent thematic structure was developed, which reflects interpretation of experience and meaning, while remaining well grounded in the original data. This structure, seen in Figure 4.47, laid a well-formed foundation from which to generate an initial item pool and construct the Moral Distress Scale for Counselors – Child and Adolescent Form. The next chapter briefly describes the methods and procedures used to accomplish those goals before moving to pilot testing and instrument modification.


DOMAIN
SUB-THEME
EMERGENT THEME
Institutional Restrictions
Legal
Inability to prevent suffering/ trauma due to reporting laws
Having to testify about a case and, as a result, breaking
Organizational
Wanting to help but not being able to because of rules and
Policies restricted time available to provide counseling
Ethical
Inability to advocate for a client due to confidentiality restrictions
Restricted by ethical obligations
Fear of Consequences
Client
Fear that client will be labeled
Fear that parents will pull client out of counseling
Others
Fear of making this worse for colleagues
Felt like whistle-blowing would be selfish
Self
Jeopardize career by not adhering to superiors
Fear of being seen as a "trigger happy" reporter
Lack of Support
Lack of Consultation
Lack of a knowledgeable supervisor
Not having someone to talk through ethical issues with
Lack of Resources
Weak relationships with community resources
Working with clients without the necessary tools to help
Unsupportive Family
Pushing against a wall with client's family
Family embarrassed about child's counseling


DOMAIN
SUB-THEME
EMERGENT THEME
Vulnerability
Lack of Authority
Inability to advocate for a client due to lack of power
No leverage to get support/ resources for a client
Lack of Value
Lack of appreciation within an institution
Lack of reciprocity or value
Well-Being
Work Life
Unable to give full potential because of large caseload
Unable to meet needs due to being overworked
Personal Life
Clinical responsibilities began to affect relationships outside of
Had no life outside of work
Adaptability
Role Confusion
Working with one organization but having obligations to another
Unsure of one's role in sensitive situations
Relationship Conflict
Multiple relationships with client's family
Conflicting messages from two (or more) supervisors
Inexperience
Lack of Education
Lack of knowledge about clients' life experiences
More education about common ethical issues
Lack of Training
Working with clients without proper training
Lack of confidence in how to handle challenging situations

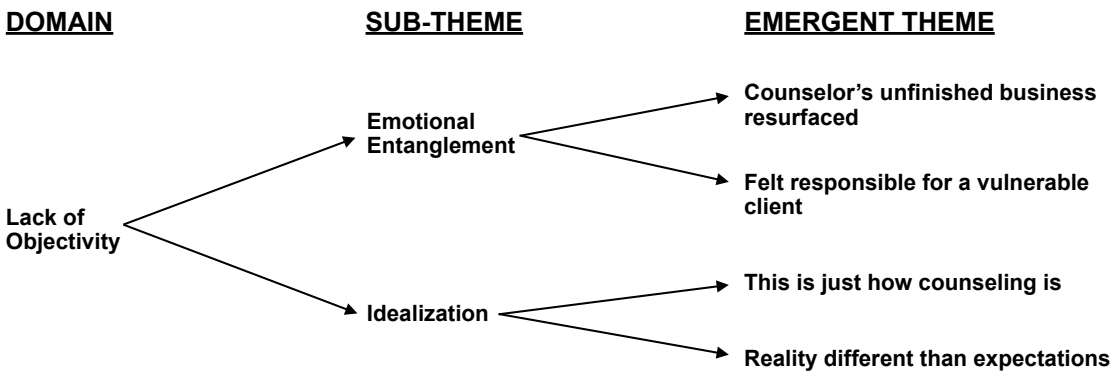


Figure 4.47. Summary of all domains and sub-themes identified through analysis across cases.

CHAPTER FIVE

RESULTS: ITEM GENERATION AND INSTRUMENT CONSTRUCTION

Instrument Construction

This chapter covers three stages: (D3) item generation and item selection; (D4) initial construction of the MDSC-CA; and (D5) pilot testing the MDSC-CA with two samples. The first two stages were informed by the scale development process identified by Hinkin (1998), although they were altered slightly in order to meet the goals of the current study. The first stage (D3) builds on the data analytic procedures described above in order to generate and select a pool of items, which were included on the initial instrument for pilot testing. During this stage, attention was given to the content validity of the instrument in an effort to ensure that the generated items actually measure what they are intended to measure, as least theoretically, at this point. The second stage (D4) involved designing and constructing the instrument, as it was used in pilot testing. Finally, the third stage (D5) briefly describes the pilot testing procedures and samples used, as a much more detailed description was included in Chapter Three.

Stage D3: Item Generation and Selection

Item generation can be accomplished in two ways. First, when a well-established theoretical foundation exists, it may, in and of itself, provide enough information needed to generate an initial set of items (Hinkin, 1998). This approach, "requires an understanding of the phenomenon to be investigated" (Hinkin, 1998, p. 106), in addition to a theoretical definition of the construct under examination. As such, the deductive approach to item generation cannot be used in the current study. Because this study involves the exploration of an abstract construct in

a new context, a neither an understanding of the phenomenon or a theoretical definition currently exists. For such situations, Hinkin identified an inductive item generation procedure, which will be used in the development of the MDSC-CA.

The inductive approach to item generation usually involves researchers asking a sample of respondents to provide detailed descriptions of their feelings, experiences, or behaviors associated with the phenomenon or construct of interest (Hinkin, 1998). Responses are then classified into separate domains or categories through the use of content analysis or a similar approach to qualitative data analysis and from these categories items are generated. Hinkin acknowledged the challenges in this method, as generating conceptually consistent items from the interpretation of respondents' descriptions is much more difficult than deriving items from theory and construct definition. This technique also makes instrument development vulnerable to extraneous content domains and inaccurate or inappropriate domain labeling (Schriesheim & Hinkin, 1990).

In light of the above warnings about the inductive item generation method used in the current study, several considerations need to be taken into account. DeVellis (2012) and Netemeyer et al. (2003) have identified several such considerations, which are relevant to the current study. First, theoretical assumptions about the concept of phenomenon to be measured should be considered. Careful thought should be given to the items generated and the ways in which they relate to one another to establish a content domain. DeVellis (2012) suggests that each item should be thought of as a test of the phenomenon of interest on its own.

Due to the complex and complicated challenges involved in item development through an inductive process, DeVellis (2012) encouraged creativity in the creation of new items. Domain sampling theory assumes that items chosen are from a theoretically infinite number of items

pertaining to the construct of interest (Kline, 1998); therefore considering other ways to word items to get at the same phenomenon is essential. Creative options should be exhausted, as the instrument will only be as good as the thought and effort put into generating the items that comprise it. Additionally, DeVellis noted that it is not good enough, or even appropriate, to group items simply based on a category; rather, the items should be grouped based on a theoretical concept, which they all have in common. Specifying categories is sometimes a helpful method in determining the concept that underlies a category. For example, rather than grouping items based on barriers, identifying the specific barriers and grouping items accordingly may more accurately represent the construct or category of constructs to be measured. A similar method was utilized in the previous chapter in order to identify sub-themes, which will partially guide item generation in this stage.

Netemeyer et al. (2003) suggested that thought should be given to the size of the initial item pool and the response format for the items. DeVellis (2012) pointed out there is no way to determine the number of items that should be included in an initial pool, but he recommended including considerably more than you anticipate including in the final scale. In fact, he points out that it is not uncommon to begin with three to four times more items than will remain in the final instrument. The general rule of thumb is to include as many items as possible, while still ensuring the instrument can feasibly be administered on a single occasion.

With the above recommendations and warnings in mind, the item generation process involved three components: (1) a review of the sub-theme-domain structure developed in the previous stages of data analysis in order to incorporated shared meaning and experience throughout the generated items; (2) a review of counseling literature pertaining to ethics and ethical dilemmas; and (3) a review of the moral distress literature, with special attention given to

previously developed instruments to measure moral distress among other health care providers. Using this three-component process allowed items to be grounded in the data collected in the current study, while identifying potential items that may be applicable to counselors beyond the sample included in the study. The third component was used in moderation, simply to take formatting and wording cues from reliable and valid items developed for other moral distress instruments. While the components are numerically arranged above, they were not conducted in a linear fashion. Rather, they were used as appropriate in the steps that follow, for the development of items for each sub-theme.

Item generation by sub-theme. Items were generated for one sub-theme at a time, in the order in which they were developed in previous analysis, for the sake of consistency. Item generation involved a process resembling the hermeneutic circle, in which the meaning extracted for sub-themes and their corresponding domain were tied back to the original data. In this way, the prevalent situations and experiences that led to feelings of moral distress could be used to inform each item. The goal of item generation was to capture the overall meaning of each sub-theme by including a combination of the experiences participants described, and the interpretations thereof. In most cases, this resulted in a diversity of items that were intended to comprise a composite meaning of participants' accounts. That is, the items were intended to capture the phenomenon in a variety of ways, just as participants alluded to the overall meaning of sub-themes in different ways. In other cases, when the experiences from which sub-theme meaning was derived were relatively homogeneous, the sub-theme items contained more conceptual repetition than diversity.

Conceptual redundancy can be considered both a strength and weakness of instruments, depending on its utility in capturing the overall sub-theme content or meaning. DeVellis (2012)

clarified this point by acknowledging that, while similar items might seem redundant, "the content that is common to the items will summate across items while their irrelevant idiosyncrasies will cancel out. Without redundancy, this would be impossible" (p. 78). DeVellis' endorsement for redundancy was incorporated into the item generation process for several sub-themes, but only when it was apparent that specific situations were particularly meaningful. Additionally, redundancy refers to the specific content of participants' experiences from which meaning was derived, which directly relate to the phenomenon of interest. Redundancy of grammar, item structure, and wording, which is much less desirable and utilitarian, was avoided.

An example of heterogeneous and homogeneous item generation for particular sub-themes is provided below. It both cases, the three components of item generation mentioned above are described in order to provide justification for the items themselves, demonstrate their ways in which they are grounded to the data, link them to counseling and mental health literature, and in some cases, inform their structure through previously developed instruments for measuring moral distress in other health care fields.

Heterogeneous item development: Legal restrictions. Sub-themes comprising the Institutional Restrictions domain were identified by the Legal, Organizational, and Ethical restrictions participants encountered. As such, the goal of item generation was to create items that represented situations in which counselors face institutionally established restrictions, which prevent them from engaging in moral action. The following section describes the process of generating items for the Legal sub-theme of the Institutional Restrictions domain to demonstrate how shared meaning was captured through a diversity of items.

Legal. Restrictions established by legal mandates were highly prevalent and revolved around two main issues. First, participants reported situations in which they had to break confidentiality due to requirements to testify in court about abuse or neglect. Second, participants described situations in which they were required to disclose information to parents or legal guardians, which was seen as a detriment to the client's progress or well-being. As a result, a plethora of data was available from which to generate items. Initially, the abundance of data was perceived as an advantage as many items could be generated for this sub-theme; however, later it became clear that capturing meaning that was not too specific to one participant or too repetitive was challenging. Therefore, the item pool for this sub-theme was large, and item generation went through several steps, ultimately resulting in an item sample that pertained to contextually specific and broad situations. The initial item pool is presented in Table 5.1, along with supporting evidence from the original data and from relevant literature.

Table 5.1
Initial Item Pool for the Legal Sub-Theme in the Institutional Restrictions Domain.

Item	Evidential Data	Evidential Literature
I was forced to break a client's confidentiality because I had to testify about his or her case in court.	My experiences of moral distress mostly have been related to decisions about parental rights versus child safety (reporting to children services/testifying in such cases) It revolved around having a professional relationship with both the parent and child, and having a requirement to report progress to the court in a CPS case. I work with the court system. The right thing to do is sometimes not allowed by the courts which require different course of action.	"Once school counselors have determined that a child may have been abused, they become informants. Often they continue or begin counseling relationships with victims or perpetrators. As school district employees, they must adhere to required procedures. School counselors usually become the liaisons who coordinate contacts between the victim and others. In some instances, they must testify in court" (Remley & Fry, 1993, para. 2). "When asked to testify by a governmental official, such as a social services worker, school counselors should cooperate fully" (Remley & Fry, 1993, para. 29). "Legislatures and licensing boards also have carved out numerous exceptions to confidentiality. Some of these exceptions, such as child abuse reporting, require that confidentiality be breached" (Younggren & Harris, 2008, p. 592).
I had to disclose information due to reporting laws, even though I did not think it was in the client's best interest.	Having to notify parents who were emotionally abusive about a minor's suicide attempt.	"Even when the law protects the confidentiality of adolescents' health information, legal limits apply, in addition to the clinical and ethnical limits that exist. Legal limits include any requirements to notify parents in specific circumstances, laws granting parents explicit access to minors' complete medical records, and legal obligations to warn intended victims of homicide and to take protective action in cases of suicidal ideation or attempts" (Goyal, 2015, p. 98).

I was required to report a case of suspected abuse, although I thought it would cause additional trauma.	Knowing that they will be removed (for their own good), but also knowing that they will be traumatized no matter what.	"Child abuse is a terrible experience for children; the process that follows a report, however, sometimes is more traumatic that the abuse itself" (Remley & Fry, 1993).
I had to follow laws that I thought were not helpful to a client.	Having to follow laws which were not helpful to my client.	"From an ethical perspective, minors should be able to expect confidentiality; however, parents and guardians have certain legal rights that limit the rights of minors" (Ledyard, 1998, para. 1).
I was unable to ensure a client's safety due to a guardian's legal rights.	My experiences of moral distress mostly have been related to decisions about parental rights versus child safety (reporting to children services/testifying is such cases). Having to notify parents who were emotionally abusive about a minor's suicide attempt. Having to assist a minor to be reunited with a neglectful mother.	None.
I knew what course of action I should take, but was unable to do so because of court requirements.	I work with the court system. The right thing to do is sometimes not allowed by the courts which require different course of action.	In situations when the client requests confidentiality or the counselor things confidentiality is in the best interest of the client, a judge's order takes precedence over a counselor's ethical code. Failing to abide by the judge's order may result in a charge of being in contempt of court (James & DeVaney, 1995).
I was required testify in a CPS case, which required a breach of	My experiences of moral distress mostly have been related to decisions about parental rights versus child safety (reporting to children services/testifying in such	"Legislatures and licensing boards also have carved out numerous exceptions to confidentiality. Some of these exceptions, such as child abuse reporting, require that confidentiality

confidentiality.	cases)	be breached" (Younggren & Harris, 2008, p. 592).
I was forced to follow laws that I knew were not in a client's best interest.	Having to follow laws which were not helpful to my client. Moral distress occurred because I was unable to carry out what I thought was best for a child due to restricting laws. No legal right to intervene. The mother would not return call. The step-father is important in the community and called to say the child was 'cured' and they would not need anymore services. I truly had no legal nor professional recourse available. There was nothing I could do for that child.	
I was forced to comply with laws that were not congruent with my core values.	A mismatch between my core values and the ethical/legal requirements for practice. Having to assist a minor to be reunited with a neglectful mother.	Mandatory reporting laws often are seen as unethical because they conflict with standards of confidentiality (Horton & Cruise, 2001). "Laws as well as our ethics admonish us to remember that parents have the right to be the guiding voice in their children's lives, especially in value-laden issues" (Stone, 2010, para. 6).

Note. Bolded items were selected for inclusion in the initial version of the MDSC-CA.

Table 5.1 demonstrates each of the components involved in item generation. First, a review of the original data from which the sub-themes emerged was conducted in order to ensure the items were grounded in the participants' experiences. In some cases, quotes from the Qualtrics questionnaire and interviews were the main source of insight and guidance for the development of items. For example, the item *I was forced to follow laws that I knew were not in a client's best interest* was generated directly from three main quotes:

> Having to follow laws which were not helpful to my client.
>
> Moral distress occurred because I was unable to carry out what I thought was best for a child due to restricting laws.
>
> No legal right to intervene. The mother would not return call. The step-father is important in the community and called to say the child was 'cured' and they would not need anymore services. I truly had no legal nor professional recourse available. There was nothing I could do for that child.

The three quotes above differ significantly in the amount of detail and information they portray about the respective participants' experiences. The shared meaning between them, however, pertains to legal restrictions to do what is in the best interest of the client. Therefore, an item with a broad conceptual quality was generated in order to capture that shared meaning and extend the applicability of the item to more than one participant.

Similarly, the item *I was unable to ensure a client's safety due to a guardian's legal rights* was developed from three quotes sharing a similar meaning:

> My experiences of moral distress mostly have been related to decisions about parental rights versus child safety (reporting to children services/testifying is such cases).

> Having to notify parents who were emotionally abusive about a minor's suicide attempt.
>
> Having to assist a minor to be reunited with a neglectful mother.

The first quote explicitly states that the participant's experience of moral distress stemmed a dilemma regarding legal rights and the safety of the client, while the second two describe more specific situations of the same capacity. As a result, the item was derived from the shared meaning that legal mandates restricted counselors from being able to ensure their client's safety.

In other cases, previous interpretation conducted in analytic stages, along with counseling literature informed the development of items. For example, the third item in Table 5.1, *I was required to report a case of suspected abuse, although I thought it would cause additional trauma,* was generated by an interpretation of the quote associated with it:

> Knowing that they will be removed (for their own good), but also knowing that they will be traumatized no matter what.

As discussed in Chapter Four, the meaning extracted from this quote indicated that the participant was required to follow a law that he or she knew would ultimately result in additional trauma for the client. That meaning, coupled with literature indicating the potentially traumatic nature of mandatory reporting of abuse, led to the development of an item that reflected ethical

dilemmas documented in the counseling literature, while remaining grounded in the data collected.

These processes were carried out as appropriate in order to generate an initial item pool for each domain and from which to construct the MDSC-CA. After the item pool was generated, the individual items were assessed for their appropriateness, mainly based on the degree to which they captured the sub-theme meaning and their specificity. Items that were thought to accurately reflect the sub-theme's meaning were selected for inclusion in the initial version of the MDSC-CA, while those considered too specific or less meaningful, were removed from the item pool. For example, the item *I was required testify in a CPS case, which required a breach of confidentiality* was ultimately deemed too context specific, as the item referred to a child protective services cases, excluding other cases in which a counselor might be subpoenaed to testify. Additionally, the less context specific, and therefore more applicable item *I was forced to break a client's confidentiality because I had to testify about his or her case in court* was thought to apply to a broader range of situations, and thus a broader range of counselors.

After careful consideration of each of the items, a final item sample was selected for the Legal restrictions sub-theme:

1. I was forced to break a client's confidentiality because I had to testify about his or her case in court.
2. I had to disclose information due to reporting laws, even though I did not think it was in the client's best interest.
3. I was required to report a case of suspected abuse, although I thought it would cause additional trauma.

4. I was unable to ensure a client's safety due to a guardian's legal rights.
5. I was forced to follow laws that I knew were not in a client's best interest.
6. I was forced to comply with laws that were not congruent with my core values.

A review of the themes and comments that informed the Legal restrictions sub-theme, shown in Table 5.2, also indicates the items chosen for inclusion on the MDSC-CA were representative of the participants'' experiences and the meaning interpreted from them. Once the items were considered satisfactory for a sub-theme, the items were generated for the next sub-theme, following similar procedures described above.

Table 5.2
Conceptual and Interpretative Relationships Between Items and Themes Comprising the Legal Sub-Theme.

Theme	**Item**
Required to report progress to court in CPS case	I was forced to break a client's confidentiality because I had to testify about his or her case in court.
Mandated by court or law to do something harmful to client	I had to disclose information due to reporting laws, even though I did not think it was in the client's best interest.
Inability to prevent suffering/trauma due to reporting laws	I was required to report a case of suspected abuse, although I thought it would cause additional trauma.
Having to notify abusive parents about their child's suicide attempt	I was unable to ensure a client's safety due to a guardian's legal rights.
Assisting a minor to be reunited with a neglectful mother	
Inability to help due to restricting laws	I was forced to follow laws that I knew were not in a client's best interest.
Unable to do the right thing because of court requirements	I was forced to comply with laws that were not congruent with my core values.

Homogeneous item development: Emotional Entanglement. Sub-themes comprising the Lack of Objectivity domain were identified by the emotional entanglement participants had with a client or the high expectations and standards participants for themselves, their colleagues, or the profession. As such, the goal of item generation was to create items that represented situations in which counselors were constrained from engaging in moral action due to clouded judgment. The following section describes the process of generating items for the Emotional

Entanglement sub-theme of the Lack of Objectivity domain to demonstrate how shared meaning was captured through homogeneous and somewhat redundant items.

Emotional Entanglement. Restrictions due to the emotional bonds participants established with their clients were highly meaningful and indelible; however, as mentioned in Chapter Four, this theme developed largely out of the experiences of one participant. Because these experiences were so meaningful and such a large component of their moral distress, it was included in sub-theme development, item generation, and instrument construction. As a result, many of them items generated to capture the meaning of this sub-theme were similar in content and the concept in which they reflected. As such, item generation was carefully considered in an effort to reveal the meaning in different ways, as suggested by DeVellis (2012). The initial item pool is presented in Table 5.3, along with supporting evidence from the original data and from relevant literature.

Table 5.3
Initial Item Pool for the Emotional Entanglement Sub-Theme in the Lack of Objectivity Domain.

Item	Evidential Data	Evidential Literature
I knew I had unfinished business that would impact my work with a client, but I continued counseling anyway.	It was also bringing up some feelings for me because I've experienced some, you know, uh, I've been through lots of counseling for it, but it was bring up some feelings in me and [inaudible] responses or whatever. … with that, I think, um, on, I had some, uh, some unfinished business, I had some issues I needed to work through in counseling. I've done a lot and I thought I was done with it, but clearly I wasn't.	"Over half (59.6%) of the respondents acknowledged having worked—either rarely or more often—when too distressed to be effective" (Pope, Tabachnick, & Keith-Spiegel, 1987, p. 1000). Emotional intelligence and emotional regulation have been linked to empathy (Miville, Carlozzi, Gushue, Schara, & Ueda, 2006).
I knowingly crossed boundaries because I felt responsible for a vulnerable client.	So the boundary crossing kind of made it more intense I did feel, and I had to, you know, talk that over with some other people in order to, to you know, let that feeling go down, but I did feel kind of responsible for her because she, she wasn't turning toward, she was very, very vulnerable …	Self-awareness impacts decision making processes and how successfully counselors balance the situational demands of complicated ethical dilemmas (Evans, Levitt, & Henning, 2012).
I was unable to adequately provide care for a client due to the biases I brought to the counseling relationship.	Um, you know, I think we definitely form ideas, uh, or stereotypes about how this parent's going to react this way and this parent's going to react that way, um, and so, uh, not really having a lot of that information, uh, from parents or getting that feedback from people, uh, I, I definitely think I was just unsure, uh, you know	Implicit assumptions, biases, and stereotypes about human nature and individuals have the potential to have powerful and detrimental influences on mental health counselors' behaviors (Abreu, 2001; Auger, 2004). World view discrepancies may lead to situations where counselors could neither understand a client's point of view nor respond to clients' concerns in a therapeutic way (Sue & Sue, 1999).

I was unable to remain objective due to the emotional bond I created with a client.	So I was feeling of bonding with her and it was a little too much, because I was being, there were similarities and it was really intense. I think boundaries were getting crossed, and uh, and I think it led to me feeling more, I wasn't able to be objective.	"Counselors who are unwell (stressed, distressed, or impaired) will not be able to offer the highest level of counseling services to their clients, and they are likely to begin experiencing a degradation of their quality of life in other domains as well (physical, social, emotional, spiritual, etc.)" (Lawson, 2007, p. 20).
I knew I was impaired, but continued counseling due to the emotional connection created between a client and me.	And, uh, you know, it was also bringing up some feelings for me because I've experienced some, you know, uh, I've been through lots of counseling for it, but it was bringing up some feelings in me and [inaudible] responses or what ever. So, anyway, so being there and, um, and so I was getting, anyway, so I was feeling of bonding with her and it was a little too much, because I was being, there were similarities and it was really intense.	Self-awareness impacts decision making processes and how successfully counselors balance the situational demands of complicated ethical dilemmas (Evans, Levitt, & Henning, 2012).
I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.	Well, I think the first thing about it was that maybe I had some unfinished business in working with [inaudible] me … Ok, yeah, with that, I think, um, one, I had some, uh, some unfinished business, I had some issues I needed to work through in counseling. I've done a lot and I thought I was done with it, but clearly I wasn't.	Emotional intelligence has been explored as one core characteristic of being a counselor and is correlated to counseling skills, attending to process, and dealing with clients in crisis (Martin, Easton, Wilson, Takemoto, & Sullivan, 2004).
I was unable to remain objective because I became too involved with a case.	A lack of confidence and I wasn't speaking clearly because, um, because … I guess because I had gotten too involved with the case.	Self-awareness impacts decision making processes and how successfully counselors balance the situational demands of complicated ethical dilemmas (Evans, Levitt, & Henning, 2012).

I knowingly crossed boundaries because of the intense emotional connection I had with a client.	I, I feel like I did get too personally involved, but part of that was because I had some personal issues I needed to work through a little more …	Self-awareness impacts decision making processes and how successfully counselors balance the situational demands of complicated ethical dilemmas (Evans, Levitt, & Henning, 2012).
I thought I would betray the colleagues I was close to by doing what I believed to be the right thing.	You still had that bond of you're on the same rung of the ladder, so you don't want to, almost like you're teammates so you don't want to cause problems with them.	None.

Note. Bolded items were selected for inclusion in the initial version of the MDSC-CA.

Table 5.3 demonstrates each of the components involved in item generation. First, a review of the original data from which the sub-themes emerged was conducted in order to ensure the items were grounded in the participants' experiences. In some cases, quotes from the Qualtrics questionnaire and interviews were the main source of insight and guidance for the development of items. For example, the item *I was unable to provide proper treatment for a client because my own emotional wounds resurfaced* was generated directly from two main quotes:

> Well, I think the first thing about it was that maybe I had some unfinished business in working with [inaudible] me …

> Ok, yeah, with that, I think, um, one, I had some, uh, some unfinished business, I had some issues I needed to work through in counseling. I've done a lot and I thought I was done with it, but clearly I wasn't.

The two quotes above are very similar in that they refer to a single experience in which the participant's previous traumatic experiences were reactivated in the counseling process. Although the quotes above do not make it perfectly clear, in the context of the original data, reflecting the participant's experiences, these unexpected emotional reactions cause him or her loose sight of what was best for their client. Therefore, an item reflecting the quality and meaning of that experience was generated in order to capture this participant's experience and hopefully that of others. Although the term *unfinished business* is common in mental health practice and literature, it had already been used in another item. Instead of repeating a term that could be ambiguous or confusing, this item was structured with the term *emotional wounds* in an effort to reduce the possibility of ambiguity as to its meaning, and hopefully making it more accessible and comprehendible for a larger group of raters. Including varying terms for a similar phenomenon or experience was also thought to provide information about the appropriateness of each, by comparing the representativeness and appropriateness ratings participants gave each item in the pilot test.

Similarly, the item *I knowingly crossed boundaries because of the intense emotional connection I had with a client* was developed from the corresponding quote in Table 5.3. The quote refers to an experience of an emotional bond that created a lack of objectivity. As a result, the item above was generated in order to reflect that meaning and the recognition that a lack of

self-awareness can contribute to the successfulness of decision making in clinical work (Evans, Levitt, & Henning, 2012). Generating the item in this was an attempt to capture the participant's experience while decontextualizing it so that it was applicable to other counselors who might have experienced a similar situation.

The last item in this sub-theme was generated from a different participant than the other items, yet still reflected an experience of emotional engagement with others. In this case, however, the emotional connection was with colleagues to whom the counselor felt loyal, which interfered with his or her ability to stand up for what they believed was right. In this sense, and in the sense that it shared meaning with the other items in the Emotional Entanglement sub-theme, it offered an alternative perspective to a similar situation, which may differentially capture the sub-theme meaning.

After the item pool was generated, the individual items were assessed for their appropriateness, mainly based on the degree to which they captured the sub-theme meaning and their specificity. Items that were thought to accurately reflect the sub-theme's meaning were selected for inclusion in the initial version of the MDSC-CA, while those considered too specific or less meaningful, were removed from the item pool. For example, the item *I knew I was impaired, but continued counseling due to the emotional connection created between a client and me* was ultimately deemed too less meaningful, due to the controversial view of the term *impaired*, as discussed in the previous chapter. Including such an item may detract from the purpose of the item and, therefore, lessen its appropriateness and the way in which it contributes to the sub-theme.

After careful consideration of each of the items, a final item sample was selected for the Emotional Entanglement sub-theme:

1. I knew I had unfinished business that would impact my work with a client, but I continued counseling anyway.
2. I was unable to remain objective due to the emotional bond I created with a client.
3. I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.
4. I became desensitized to ethical dilemmas because behaving unethically was common practice.
5. I knowingly crossed boundaries because of the intense emotional connection I had with a client.
6. I thought I would betray the colleagues I was close to by doing what I believed to be the right thing.

A review of the themes and comments that informed the Emotional Entanglement sub-theme, shown in Table 5.4, indicates the items chosen for inclusion on the MDSC-CA were representative of the participants'' experiences and the meaning interpreted from them. Once the items were considered satisfactory for a sub-theme, the items were generated for the next sub-theme, following similar procedures described above.

Table 5.4
Conceptual and Interpretative Relationships Between Items and Themes Comprising the Legal Sub-Theme.

Theme	**Item**
Unfinished business	I knew I had unfinished business that would impact my work with a client, but I continued counseling anyway.
Too involved with the case	I was unable to remain objective due to the emotional bond I created with a client.
Counselor's unfinished business resurfaced	I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.
	I became desensitized to ethical dilemmas because behaving unethically was common practice.*
Boundaries crossed due to lack of objectivity	I knowingly crossed boundaries because of the intense emotional connection I had with a client.
Too involved with the case	I thought I would betray the colleagues I was close to by doing what I believed to be the right thing.
Catastrophizing situation	

* Item was inaccurately classified during instrument construction; however, its inclusion in an inaccurate sub-them served a purpose during the inter-rater agreement analysis, discussed in Chapter Five.

The item generation procedures described above were carried out in order to generate items for each sub-theme. In all cases, a reflective, iterative process was used, which was connected to counseling and mental-health literature, when appropriate. The resultant item pool consisted of 106 items across sub-themes, which are briefly described below. The entire MDSC-

CA, in its original form can be found in Appendix R, which is the version that was used in the counselor and counselor educator pilot test.

Stage D4: Instrument Construction

The fourth stage of the dissertation phase included designing and constructing the MDSC-CA from the item pool generated in the previous stage, as well as selecting appropriate scaling procedures. Because Chapter Three included a thorough discussion of issues related to whether items should be dichotomous or multichotomous, rated on a Likert-type scale or multiple choice, positively or negatively worded, and instrument length, those considerations will not be review in their entirety here. Design and construction procedures are reviewed only as appropriate, before moving to a discussion of the initial evaluation of the constructed instrument.

Instrument length. The final item pool consisted of a total of 106 items across all sub-themes and domains. Although there are no absolute imperatives guiding instrument length, Hinkin (1998) provided the following guidelines for initial instrument length:

$$N = [(D * 4)(2)]$$

or

$$N = [(D * 6)(2)]$$

where:

N equals the number of items included in the initial item pool, and

D equals the number of identified domains.

The final thematic structure resulting from qualitative data analysis in Chapter Four consisted of eight domains, each of which had at least two sub-themes, but at most three, for a total of 19 sub-

themes. Therefore, an appropriate number of items predicted for inclusion in the initial item pool ranged from 48 to 96.

The initial pool was just beyond the upper bound of items recommended by Hinkin (1998); however, DeVellis (2012) suggested including considerably more items than you anticipate including in the final scale, while still ensuring the instrument can be administered on a single occasion. Hinkin pointed out that researchers should expect to remove approximately half of the items contained in the original pool following initial assessment and factor analysis. Therefore, the inclusion of more items than recommended was appropriate for the development of the MDSC-CA, especially considering items were intended to capture meaning across 19 sub-themes.

Instrument designs. Two separate versions of the pilot-test instrument were designed, each of which served distinct purposes. Each instrument was designed and presented to their respective participants in unique ways, as described below.

Layperson pilot tester instrument and procedures. The first version of the MDSC-CA, called the Layperson MDSC-CA, was a version presented as it is intended to be used in future studies with counselors who have experienced moral distress (see Appendix Q). This version included the instructions, items, and both the moral distress level and frequency rating scales, as described above. A Qualtrics link to this version was sent to the layperson pilot testers who were instructed to critically review all the instructions and items of the MDSC-CA, paying particular attention to issues of ambiguity, confusion, clarity, grammatical errors, typos, and instrument flow. Because these participants' attention was to be directed to those issues, they were not instructed to complete the instrument, in the sense that they would provide ratings for level and intensity of moral distress. Rather, items and response scales were presented in portable

document format (PDF; see Figure 5.1), preventing participants from responding to the items themselves, and ensuring they only responded to the non-validity questions, of which the pilot test was intended. Restricting their responses was accomplished in an attempt to minimize distraction from the issues on which they are to focus.

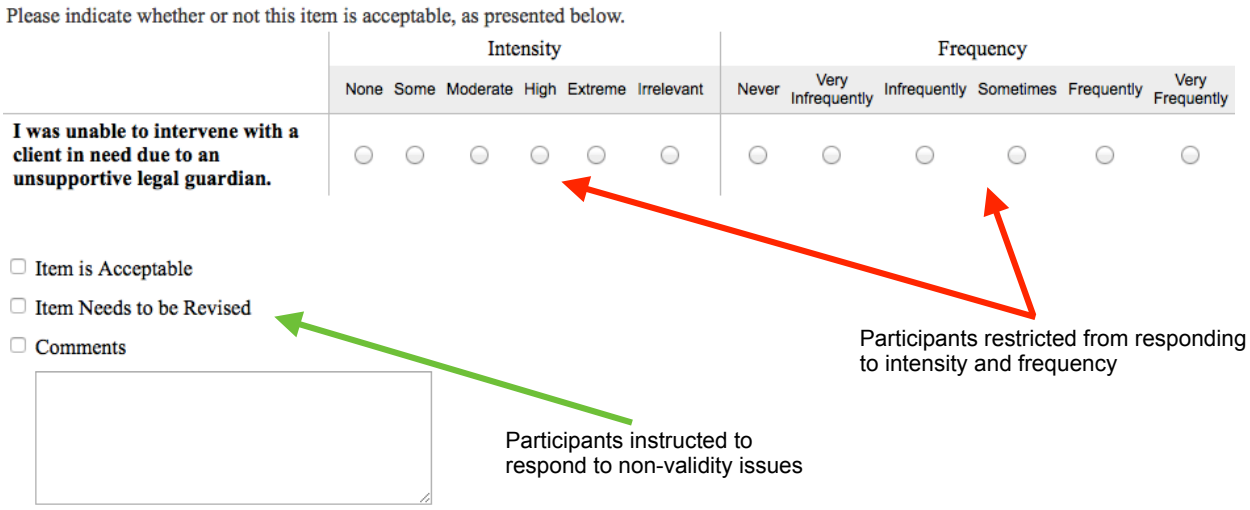


Figure 5.1. Example Layperson MDSC-CA item and response scales, as presented in Qualtrics.

This version of the instrument began with the instructions where participants were presented with the dichotomous ("Yes, the instructions are acceptable" / "No, the instructions are not acceptable") rating scale in order to indicate whether or not they believed the instructions were acceptable. Regardless of their response all participants were presented with a dialogue box in which they were able to provide feedback, comments, or suggestions.

All 106 items included on the initial MDSC-CA were presented to the layperson pilot testers and each included a response prompt relating to clarity, ambiguity, and so forth. The response prompt asked whether or not each particular item was acceptable, in terms of the issues

described above. Response options were dichotomous (e.g., "Item is Acceptable" / "Item Needs to be Revised") Again, regardless of response, participants were provided an opportunity to provide feedback for each item (see Figure 5.1). This procedure continued for all elements of the instrument. At the end of the instrument, after each element was rated, layperson pilot testers had an opportunity to provide overall feedback. If no overall feedback was provided, the pilot testers were instructed to simply submit their ratings by pressing the forward flow (arrow right) button at the bottom of the page. They were thanked for their time and feedback, and provided the researcher's contact information in the event they had questions or desired to add to or amend their ratings. Unless they contacted the researcher for those reasons, their participation in the current study was terminated.

Interviewed participants, counselor, and counselor educator instrument and procedures. The second version of the MDSC-CA, referred to as the Counselor MDSC-CA, included all of the same elements the first (layperson) version included, but were presented differently, and had a different rating scale, aside from that corresponding to the instructions (see Appendix R). This version of the instrument began with the instructions where participants were presented with the dichotomous ("Yes, the instructions are acceptable" / "No, the instructions are not acceptable") rating scale in order to indicate whether or not they believed the instructions were acceptable. Regardless of response, all participants were given an opportunity to provide feedback.

Following the instructions rating and optional comments, participants were taken to a section that included all items in the initial MDSC-CA item pool. Items were presented by construct domain and associated sub-themes in order to have these pilot testers, who were more familiar with counseling ethics and moral distress, rate the degree to which they believed the

individual items represented their respective sub-theme. In this case, testers were presented with a group of items under the sub-theme heading and were asked to rate each item individually using a three-response option Likert scale (e.g., "Not Representative," "Somewhat Representative," and "Clearly Representative") as recommended by Netemeyer, Bearden, and Sharma (2003). Each item also included the dichotomous rating scale the layperson pilot testers saw, giving these testers an opportunity to determine whether or not each item is acceptable or needs to be revised. An example sub-theme set is presented in Figure 5.2.

After all items were rated in terms of their representativeness to their respective sub-theme, these testers were presented with sub-themes in relation to their respective domain. Procedures for this section were identical to the item to sub-theme representativeness ratings above, in that each sub-theme was rated in terms of its representativeness to its associated domain. Again, these pilot testers rated sub-theme acceptability and had an opportunity to provide feedback for each sub-theme.

Just as the laypersons were restricted from actually completing the instrument, these pilot testers will be restricted from actually indicating their level and frequency of moral distress. This restriction was intended to minimize the possibility that they would distracted from the goals of this section, namely assessing face and content validity. At the end of the instrument, after each element was rated, these pilot testers had an opportunity to provide overall feedback. If no overall feedback was be provided, the pilot testers were instructed to submit their ratings by pressing the forward flow (arrow right) button at the bottom of the page. They were thanked for their time and feedback, and provided the researcher's contact information in the event that they had questions or desired to add to or amend their ratings. Unless they contacted the researcher for such reasons, their participation in the current study was terminated.

SUB-THEME: *Work Life*

The following items have been developed with the purpose of representing situations in which counselors are overwhelmed by their clinical responsibilities. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

	Item Representativeness			Item Acceptability	
	Not Representative	Somewhat Representative	Clearly Representative	Needs to be Revised	Acceptable
I was unable to meet the needs of a client because my caseload was too large.	○	○	○	○	○
I was overwhelmed by a chaotic schedule, which prevented me from fully attending to a client.	○	○	○	○	○
I was forced to provide inadequate treatment, owing to work overload.	○	○	○	○	○
The quality of care I was providing decreased because I was overwhelmed by my clinical responsibilities.	○	○	○	○	○
My attrition increased because I was frustrated with the low level of care I was forced to provide.	○	○	○	○	○
Despite not being able to keep my clients' stories straight, I maintained an unmanageably large caseload.	○	○	○	○	○
I started doing things I knew were not right because I was overworked and needed to make things easier on myself.	○	○	○	○	○
I felt like I was not doing a client justice because working too many hours exhausted me.	○	○	○	○	○

Figure 5.2. Example Counselor MDSC-CA sub-theme set and response scales, as presented in Qualtrics.

Instrument Development in Qualtrics. Both versions of the MDSC-CA were created in Qualtrics and distributed online for pilot testing. Qualtrics was chosen as the questionnaire development and distribution platform for several of the same reasons it was chosen for the questionnaire distributed during the pre-dissertation phase. First, Qualtrics increases accessibility to the MDSC-CA, as most anyone with a computer and an Internet connection is able to complete it. Similarly, this method increases ease of both distribution and participant completion, which can reduce threats to content validity (Netemeyer, Bearden, & Sharma, 2003). Second, Qualtrics and Internet distribution allows researchers to overcome the barriers associated with attempting to recruit participants from diverse geographical regions. Using other methods (e.g., paper and pencil, mail distribution) are much less efficient and would likely result in significantly higher financial costs to distribute the MDSC-CA. As a result, participants from all over the world can become potential participants, which can help increase sample size and participant variation. Additionally, the financial costs associated with the current study are minimal as a Qualtrics membership is provided to graduate students at The University of Mississippi and use of the Internet for instrument distribution is essentially free.

Lastly, because the pilot test procedures target particular participants, described below, exclusionary criteria can be established prior to allowing access to the MDSC-CA. While this measure does not and cannot guarantee only eligible target participants will complete the instrument, the complex item display, flow, and skip options direct those who do not meet the eligibility criteria to the end of the instrument, with an option to act as a participant. It is hoped that the appropriate applied Qualtrics options will discourage those who do not meet the eligibility criteria from completing the MDSC-CA during the pilot-testing phase.

Stage D5: Pilot Testing the MDSC-CA

Pilot testing was conducted over four weeks, which included participant recruitment and the participants' completion of their respective instrument. Recruitment procedures are described below for each group of participants.

Pilot tester recruitment. The MDSC-CA was pilot tested with laypersons, the participants who were interviewed in the pre-dissertation phase of this study and who volunteered to review the instrument, counselors who have experienced moral distress, those familiar with moral distress, and counseling ethics experts. Recruitment procedures varied according to type of pilot tester, but in all cases, pilot testers were emailed a Qualtrics link that directed them to the informed consent form for pilot testing and an initial version of the MDSC-CA that corresponded to their pilot tester classification.

Laypersons. Pilot testers considered laypersons consisted of family, friends, and acquaintances of the researcher. These participants were included to provide information about item clarity, conciseness, ambiguity, confusion, and difficulty, along with grammatical errors (Kline, 2005; Netemeyer et al., 2003). Some were recruited by telephone and some will be recruited by email, depending on the nature of the relationship between the researcher and the pilot tester. Closer friends and family were recruited by telephone, whereas acquaintances were recruited by email. In either case, however, all participants who were considered laypersons were emailed a recruitment announcement that provided information about the purpose of the study, their participation procedures, and a Qualtrics link to the layperson version of the MDSC-CA (see Appendix K). Prior to being able to access the MDSC-CA, participants were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix L). Participants were required to

give their informed consent before proceeding to the instrument itself. Although the layperson pilot testers did not provide information pertaining to instrument validity, they were able to provide valuable information pertaining to the instrument's construction and accessibility.

Interview participants. Those participants who were interviewed in the pre-dissertation phase and indicated interest in reviewing the developed instrument, were contacted via email and sent a pilot test announcement with the link to the Qualtrics version of the MDSC-CA (see Appendix M). Prior to being able to access the MDSC-CA, previously interviewed participants serving as pilot testers were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix N).

Target population and experts. Colleagues of the author and dissertation committee, who are counselors, counselor educators, ethics experts, and other professionals familiar with moral distress were recruited for pilot testing. Each potential pilot tester was emailed a recruitment announcement, which summarized the current study and provided information about the MDSC-CA (see Appendix O). Because moral distress is a new phenomenon in the context of counseling, the announcement was designed to target those who have considerable familiarity with counseling ethics, especially ethics pertaining to counseling children and/or adolescents, as the genesis of moral distress is understood be ethical complications (Jameton, 1984). Additionally, counselors or counselor educators who have experienced moral distress while working with children and/or adolescents were targeted as pilot testers. Prior to being able to access the MDSC-CA, pilot testers were presented with an informed consent form, which provided more in depth information about the pilot test goals, procedures, risks, benefits, and so forth (see Appendix P).

Pilot test sample size. Sample sizes varied considerably during different instrument development phases. During the pilot test phase, or what others refer to as the content validity pretest step (Hinkin, 1998), several researchers recommend that relatively small sample sizes, ranging from 20 (Gerbing & Anderson, 1988) to 65 (Schriesheim et al., 1993) are adequate for achieving this phase's goals, described above. Simms and Watson (2007), however, recommend using a larger pilot test sample (e.g., 100 participants) in situations where a convenience sample is available, such as undergraduate students. Because the current study was interested in obtaining a sample that is not particularly convenient to access, and because pilot test participants with substantial ethical knowledge or previous experience with moral distress were being targeted, the pilot test used in the current study was on the lower side of the above recommendations. Therefore, the target sample size was 15, consisting of each of the above pilot test participant groups, as an adequate sample to assess face and content validity.

Summary

Chapter Five provided a thorough description of instrument construction, including item generation, the construction of two versions of the MDSC-CA for use during pilot testing, and their development in Qualtrics. Additionally, pilot test recruitment and participation procedures were briefly described, as a more thorough description was provided in Chapter Three. Chapter Six describes the analysis of both the quantitative and qualitative data collected during pilot testing. Implications for instrument modification, in order to increase content and face validity are discussed, prior to carrying out instrument modification. The chapter concludes with a final, modified version of the MDSC-CA, based on pilot test data, which is intended to be used in future studies to assess its reliability and validity.

CHAPTER SIX

RESULTS: INSTRUMENT MODIFICATION

Chapter Six describes the analysis of both the qualitative and quantitative data collected during pilot testing, which informed instrument modification. Quantitative data, was analyzed using Fleiss' kappa in and proportions of agreeability order to determine the degree of inter-rater agreement about item representativeness and acceptability. Participants' feedback and comments about the instrument's items and sub-themes were analyzed in order to strengthen the instrument, in terms of validity and non-validity issues. The results of the qualitative and quantitative analyses were used to modify the instrument to arrive at a more parsimonious version that still represents the phenomenon of moral distress from a number of domains and which demonstrates acceptable face and content validity. Quantitative data analysis is described first; qualitative data of both the pilot test samples is then discussed in parallel with instrument modification, as the qualitative data was much more informative.

Stage D6: Analysis of Pilot Test Data

Following pilot testing, both Qualtrics instruments were closed and data were downloaded in three ways. First, data were downloaded as an Excel document in order to hand-calculate Feliss' kappa coefficient for inter-rater agreement of the representativeness of all MDSC-CA items. Second, data were downloaded in a Statistical Package for the Social Sciences (SPSS) document in order to analyze descriptive statistics and compute Fleiss' kappa coefficient for inter-rater agreement of the representativeness of MDSC-CA items by sub-theme and domain. SPSS was also used to compute Fleiss' kappa coefficient for the agreement of item

acceptability for both counselor and layperson participants. Third, data were downloaded as an initial report from Qualtrics, in order to visually inspect response frequencies and percentages, as well as demographic variables. The following sections describe data analysis and results through these three methods.

Fleiss' Kappa

The kappa statistic was originally introduced by Cohen (1960) as an index to measure the degree of agreement corrected for chance between two raters who assign a fixed number of subjects using a scale with a *k* categories. Since its introduction Cohen's kappa statistic has become the prominent index for measuring the agreement between raters at the nominal level, often referred to as the interobserver or inter-rater agreement (Falotico & Quatto, 2015; Fleiss, 1975; Viera & Garrett, 2005). The increase in popularity of Cohen's kappa over numerous other measures of inter-rater reliability is partly due to its ability to measure the degree of agreement between raters, beyond that expected by chance. Chance-corrected measures of reliability are extremely important, as Fleiss noted, because indices that fail to provide a measure of agreement as a "relative excess (or deficit) over the degree of agreement expected by chance along" (p. 658) result in very little information by themselves.

Despite the increased usage of Cohen's kappa, its utility and applicability are limited in several ways (Fleiss, 1971; Fleiss, Levin, & Paik, 2003). First, it is only appropriate for measuring the degree of agreement to cases where the number of raters is two. Second, its use depends on the same two raters assigning ratings for each subject. As a result, generalizations of Cohen's kappa are needed in situations when more than two raters are involved and when raters judging one subject are not necessarily the same raters judging others. In order to remedy these limitations, Fleiss proposed a generalized version of Scott's (1955) pi:

$$\pi = \frac{P_o - P_e}{1 - P_e},$$

which allowed the measurement of agreement among any fixed number of judges giving categorical ratings to a fixed number of subjects, or items.

The Fleiss' kappa statistic has become a well-known index for assessing the reliability of agreement between three or more raters and is flexible enough to handle large numbers of both raters and items (Falotico & Quatto, 2015). As the current study uses more than two raters to judge the representativeness and appropriateness of items on both the layperson version and counselor version of the MDSC-CA, and because the instrument being assessed contains a fairly large number of items (n=106), Fleiss' kappa statistics was used for initial inter-rater reliability for both groups of participants. A brief review of Fleiss' kappa and its algebraic foundations are described below, before an examination and interpretation of its use in the current study.

Algebraic foundations. The mathematical foundations and notation for Fleiss' kappa (κ) are described below and applied to the quantitative data collected from both the layperson and counselor versions of the MDSC-CA, as proposed by Fleiss (1971) and elaborated on by Randolph (2005). N represents the total number of items, n represents the number of ratings per item, and k represents the number of categories into which assignments were made. The subscript i, where $i = 1, \ldots, N$, represents the items, and the subscript j, where $j = 1, \ldots, k$, represents the categories of the rating scale.

Define n_{ij} as the number of raters who assigned the *i*th item to the *j*th category, and define

$$p_j = \frac{1}{Nn}\sum_{i=1}^{N} n_{ij}.$$

The quantity p_j is the proportion of all assignments that were to the *j*th category. Since $\Sigma_j n_{ij} = n$, therefore $\Sigma_j p_j = 1$.

Fleiss kappa calculations are based on the frequency of representativeness ratings on each item of the counselor version of the MDSC-CA where $k = 3$ categories (Not Representative, Somewhat Representative, and Clearly Representative), which were assigned to $N = 106$ items by $n = 10$ raters (see Table 6.1).

Table 6.1

Frequency of Representativeness Ratings per Category by Item on the Counselor MDSC-CA.

	Categories		
Items	Not Representative (j = 1)	Somewhat Representative (j = 2)	Clearly Representative (j = 3)
1	0	1	9
2	0	1	9
3	0	0	10
4	0	3	7
5	0	1	9
6	0	0	10
7	0	0	10
8	0	0	10
9	0	2	8
10	0	0	10
11	0	1	9
12	0	2	8
13	0	1	9
14	0	0	10
15	0	4	6
16	0	2	8
17	0	0	10
18	0	3	7
19	0	1	9
20	0	3	7
21	0	0	10
22	0	0	10
23	0	0	10
24	0	0	10
25	0	1	9
26	0	1	9
27	0	1	9
28	0	1	9
29	0	0	10
30	0	0	10
31	0	1	9
32	0	2	8
33	0	2	8
34	0	0	10

35	0	1	9
36	0	0	10
37	0	0	10
38	0	0	10
39	0	0	10
40	0	2	8
41	0	0	10
42	0	1	9
43	0	0	10
44	0	0	10
45	0	0	10
46	0	0	10
47	0	3	7
48	0	2	8
49	0	0	10
50	0	1	9
51	0	1	9
52	0	1	9
53	0	0	10
54	0	0	10
55	0	0	10
56	0	1	9
57	0	1	9
58	1	0	9
59	0	0	10
60	0	0	10
61	0	1	9
62	0	1	9
63	0	1	9
64	0	0	10
65	0	1	9
66	0	0	10
67	0	0	10
68	0	1	9
69	0	0	10
70	0	0	10
71	0	5	5
72	0	0	10
73	1	1	8
74	0	3	7
75	0	0	10
76	0	1	9
77	0	0	10

78	1	2	7
79	0	2	8
80	0	0	10
81	0	1	9
82	0	2	8
83	0	1	9
84	0	3	7
85	0	1	9
86	0	0	10
87	0	1	9
88	0	1	9
89	0	0	10
90	0	1	9
91	0	0	10
92	0	2	8
93	0	1	9
94	0	0	10
95	0	0	10
96	0	0	10
97	0	1	9
98	0	0	10
99	0	0	10
100	0	1	9
101	0	0	10
102	0	2	8
103	0	0	10
104	0	1	9
105	0	1	9
106	0	5	5

The degree of agreement among the *n* raters for the *i*th item may be indexed by the proportion of agreeing pairs out of all the *n* (*n* – 1) possible pairs of assignments. This proportion is

$$P_i = \frac{1}{n(n-1)}\left(\sum_{j=1}^{k} n_{ij^2} - n\right).$$

Thus, $P_1 = 0.8$; $P_2 = 0.8$; $P_3 = 1$; … $P_{106} = 0.4444444$.

The overall agreement may then be measured by the mean of the P_is,

$$\bar{\bar{P}} = \frac{1}{N}\sum_{i=1}^{N} P_i$$

$$= \frac{1}{Nn(n-1)}\left(\sum_{i=1}^{N}\sum_{j=1}^{k} n_{ij^2} - Nn\right).$$

For the data of Table 6.1,

$$\bar{\bar{P}} = 0.844863732$$

The value of $\bar{\bar{P}} = 0.844863732$ means if a MDSC-CA item was selected at random and rated by a randomly selected rater, and then rated a second time by another randomly selected rater, the second rating would agree with the first about 84% of the time.

Fleiss (1971) pointed out, however, that some degree of agreement is to be expected solely on the basis of chance. In fact, if raters made their ratings completely at random, one would expect the mean proportion of agreement to be

$$\bar{P}_e = \sum_{j=1}^{k} P_{j^2}.$$

For the data of Table 6.1,

$$\bar{P}_e = 0.002830189^2 + 0.086792453^2 + 0.910377358^2 = 0.836327875$$

The quantity $1 - \bar{P}_e$ measures the degree of agreement attainable over and above what would be predicted by chance. The degree of agreement actually attained in excess of chance is $P - \bar{P}_e$, so that a normalized measure of overall agreement, corrected for the amount expected by chance, is

$$\kappa = \frac{\bar{P} - \bar{P}_e}{1 - \bar{P}_e}.$$

For the data of Table 6.1,

$$\kappa = \frac{0.844863732 - 0.836327875}{1 - 0.836327875} = 0.0521521731.$$

The variance $Var_{(K)}$ is equal to

$$Var_K = \frac{2}{Nn(n-1)} \times \frac{\sum_j P_{j^2} - (2n-3)\left(\sum_j P_{j^2}\right)^2 + 2(n-2)\sum_j P_{j^3}}{\left(1 - \sum_j P_{j^2}\right)^2}$$

For the data of Table 6.1,

$$Var_K = 0.0001990921$$

Thus, the SE(κ) = 0.01411.

Under the hypothesis of no agreement beyond chance, K/SE(K) will be approximately distributed as a standard normal variate. In this case,

$$\frac{\kappa}{SE(\kappa)} = \frac{0.0521521731}{0.01411} = 1.25$$

The Fleiss' kappa analysis was conducted above to assess the degree that raters agreed on categorical ratings for each of the 106 items on the MDSC-CA. The resulting kappa (κ=0.05215), indicating the chance-corrected inter-rater agreement for representativeness assignments for all item on the MDSC-CA, revealed only slight agreement among participants (Landis & Koch, 1977), just above that expected by chance. Although the degree of agreement is very, the estimated kappa was not due to chance ($p < 0.001$). As such, it appears the degree to which participants agreed on the representativeness of items across the entire instrument is modest, at best, which is disappointing, as very little information is obtainable for instrument modification.

Lim, Palethorpe, and Rodger (2012) cautioned researchers against basing their entire judgment of an instrument or assessment tool on the kappa statistic. Although kappa can be a very robust indicator of degree of agreement between raters, it is also dependent on prevalence, which can make its interpretation dubious at times (Guggenmoos-Holzmann, 1996). In cases where the prevalence of giving a certain rating or ratings is very high, the influence of chance increases, which can result in lower kappa values (Helle et al., 2010). Falotico and Quatto (2015) clarify that in cases when there is strong agreement between raters, Fleiss' kappa statistic may behave inconsistently, resulting in lower values than would have been expected otherwise.

O'Leary et al., (2014) recently pointed out this type of paradox is particularly common with small, intentional samples, which represents the sample obtained for the current study.

In order to assess for and address this paradox, Fleiss' kappa was calculated for all items on the counselor version of the MDSC-CA, as well as all items per domain, and all items per sub-theme. These calculations were carried out with a modified SPSS macro written and provided by King (2015), as inter-rater agreement cannot be calculated with SPSS when there are more than two raters (Tang, Hu, Zhang, Wu, & He, 2015). The modified macro was able to provide both the Fleiss' kappa statistic and the proportion of rater agreement for all sets of item tested. Examining kappa in relation to the proportion of rater agreement was recommended by Lim et al. (2012), for decision-making regarding assessment tools, and was thought to be particularly relevant in this case, due to lack of variance in the ratings observed in Figure 6.1. Figure 6.2 summarizes further analysis of all items, domains, and sub-themes in order to gain more adequate information about the degree to agreement among raters.

Table 6.2

Inter-Rater Agreement Coefficient and Proportion of Agreement for the Representativeness of Items Comprising the Entire MDSC-CA, Each Domain, and Sub-Theme.

	N of Items	Proportion of Rater Agreement	Fleiss' Kappa
Instrument			
MDSC-CA (all items)	106	0.84486	0.05215**

	N of Items	Proportion of Rater Agreement	Fleiss' Kappa
Domain/Sub-theme			
Domain 1: Adaptability	10	0.85778	0.03382
1A. Role Confusion	5	0.78677	-0.01010
1B. Relationship Conflict	5	0.92889	0.07407
Domain 2: Fear of Consequences	17	0.80131	0.04296
2A. Client	6	0.72593	0.01333
2B. Others	4	0.71667	0.01876
2C. Self	7	0.91429	-0.04478
Domain 3: Inexperience	10	0.86889	-0.00700
3A. Lack of Education	6	0.81481	-0.02881
3B. Lack of Training	4	0.95000	-0.02564
Domain 4: Lack of Support	14	0.87302	0.04274
4A. Lack of Consultation	5	0.88889	0.01497
4B. Lack of Resources	5	0.90667	0.17258
4C. Unsupportive Family	4	0.81111	-0.04938
Domain 5: Institutional Restrictions	16	0.90000	-0.04661
5A. Legal	6	0.90000	-0.05263
5B. Organizational	5	0.88000	-0.04895
5C. Ethical	5	0.92000	-0.04167
Domain 6: Lack of Objectivity	12	0.77778	0.10163*
6A. Emotional Entanglement	6	0.81111	0.19622**
6B. Idealization	6	0.74444	0.01499

Domain/Sub-theme	*N* of Items	Proportion of Rater Agreement	Fleiss' Kappa
Domain 7: Well-Being	14	0.81587	-0.02293
7A. Work Life	8	0.79722	-0.01548
7B. Personal Life	6	0.84074	-0.04242
Domain 8: Vulnerability	13	0.86838	0.15033**
8A. Lack of Authority	8	0.95000	-0.02564
8B. Lack of Value	5	0.73778	0.11171*

* $p < 0.05$ ** $p < 0.01$

Table 6.2 reveals the Fleiss' kappa paradox, mentioned by Falotico and Quatto (2015), in which influential prevalence leads to a low kappa, despite high absolute agreement. The overall proportion of agreement for the entire instrument between raters is 0.84486, suggesting high inter-rater agreement; however, the Fleiss' kappa for the overall instrument 0.05215, which paradoxically indicates almost no inter-rater agreement. Additionally, among instrument domains, the proportion of agreement ranges from 0.77778 (Lack of Objectivity) to 0.90000 (Institutional Restrictions), while the Fleiss' kappas range from -0.00700 (Inexperience) to 0.15033 (Vulnerability). Finally, proportions of agreement among the sub-themes ranges from 0.71667 (Others) to 0.95000 (Lack of Training; Lack of Authority), while the Fleiss' kappas range from -0.01548 (Work Life) to 0.19622 (Emotional Entanglement). In all cases, the proportion of agreement between raters is relatively high to very high, yet the Fleiss' kappas indicate degrees of agreement slightly above chance to slightly below chance.

Fleiss' kappa coefficients were calculated to determine the degree of agreeability between participants on the acceptability of items, as presented on the counselor version of the MDSC-CA, which are displayed in Table 6.3. A similar statistical paradox occurred where the

proportion of agreement ranged from 0.82639 to 1.0000, while Fleiss' kappas indicated inter-rater agreement extremely close to that expected by chance (-0.01190 to 0.19817). Additionally, the Fleiss' kappa coefficient for the overall agreement for acceptability of the items on the layperson version of the MDSC-CA was computed, which revealed 76.3% of participants agreed about item acceptability, but the inter-rater agreeability coefficient was -.14260. Because all data demonstrated the kappa paradox described above, and thus were rendered useless in the interpretation of the quantitative data (Brooks et al., 2013), an alternative method of analysis was conducted.

Proportion of Inter-Rater Agreement

If the decision to retain or remove items was based solely on the Fleiss' kappa analysis, conducted in this stage, every item would be removed, as agreeability across all items, as well as the instrument as a whole, for both item representativeness and acceptability ranged from slightly below to slightly above that expected by chance alone. Again, however, Lim et al. (2012) cautioned against basing their entire judgment of an instrument or assessment on the kappa statistic. Therefore, due to its vulnerability to the prevalence limitation, interpretation of the kappa coefficient can be rendered useless in the presence of extremely high agreeability. Because it is evident that these limitations are characteristic of the analysis conducted for the qualitative data collected from pilot testing the MDSC-CA, two alternative approaches to item reduction were chosen, both of which guided instrument modification: (1) the proportion of inter-rater agreement and (2) qualitative feedback provided by pilot test participants. Inter-rater agreement proportions are shown in Tables 6.2 and 6.3, and qualitative data analysis is discussed below.

Table 6.3
Inter-Rater Agreement Coefficient and Proportion of Agreement for the Acceptability of Items Comprising the Entire MDSC-CA, Each Domain, and Sub-Theme.

	N of Items	Proportion of Rater Agreement	Fleiss' Kappa
Entire Instrument (MDSC-CA)	106	0.89602	0.05589

Domain/Subtheme	*N* of Items	Proportion of Rater Agreement	Fleiss' Kappa
Domain 1: Adaptability	10	0.95333	0.19817**
1A. Role Confusion	5	0.90667	0.17258**
1B. Relationship Conflict	5	1.00000	0.17258**
Domain 2: Fear of Consequences	17	0.89804	0.07917*
2A. Client	6	0.84444	0.13580*
2B. Others	4	0.90000	-0.05263
2C. Self	7	0.94286	-0.02941
Domain 3: Inexperience	10	0.90000	-0.05263
3A. Lack of Education	6	0.83333	-0.09091
3B. Lack of Training	4	1.00000	-0.09091
Domain 4: Lack of Support	14	0.90317	-0.01921
4A. Lack of Consultation	5	0.92000	-0.04167
4B. Lack of Resources	5	0.92889	0.07407
4C. Unsupportive Family	4	0.85000	-0.08108
Domain 5: Institutional Restrictions	16	0.89028	-0.03344
5A. Legal	6	0.84074	-0.04242
5B. Organizational	5	0.92000	-0.04167
5C. Ethical	5	0.84074	-0.04242
Domain 6: Lack of Objectivity	12	0.85185	0.03030
6A. Emotional Entanglement	6	0.82963	0.05350
6B. Idealization	6	0.87407	-0.01190

Domain/Subtheme	*N* of Items	Proportion of Rater Agreement	Fleiss' Kappa
Domain 7: Well-Being	14	0.87778	0.15590
7A. Work Life	8	0.81111	0.13651*
7B. Personal Life	6	0.96667	-0.01695
Domain 8: Vulnerability	13	0.90598	0.07730*
8A. Lack of Authority	8	0.95556	0.08832*
8B. Lack of Value	5	0.87778	0.15590**

* $p < 0.05$ ** $p < 0.01$

First, as Lim et al. (2012) recommended, carefully considering the proportion of agreement among participants is an appropriate place to start, in order to draw more accurate information about the degree of agreement. Second, because participants were solicited for feedback and comments about the items and the instrument as a whole, the analysis of qualitative data was conducted in order to glean a better understanding of the disagreement between participants. Together, items were modified or reduced based on overall agreement, informed by participants' disagreement about item conceptualization, resulting in a modified version of the MDSC-CA with acceptable face validity and strengthened content validity.

Stage D7: Instrument Modification and Assessment of Validity

Instrument modification refers to what Lichtenstein et al. (1993) call item purification. Item purification is a process of instrument modification that relies on the pilot test results in an effort to increase the validity of the measure. As Netemeyer et al. (2003) suggested, this process relied on the feedback provided by pilot testers. Such feedback will directly influence any

necessary alterations to item construction and wording, as well as the items to be retained for the initial version of the MDSC-CA.

The goal of this stage was to reduce the item pool to a more parsimonious group that is judged to have acceptable face and content validity. Preliminary establishment of face and content validity represent the culmination of the current study; however it is hoped that the initial version of the MDSC-CA will be valid enough to use in future studies to further test its psychometric properties and subsequently measure moral distress among counselors who have experienced the phenomenon while working with children and/or adolescents. Instrument modification included a review of both the quantitative and qualitative data for both the items themselves and the sub-themes of which they comprise. The items are discussed first, followed by the sub-themes.

The proportion of rater agreement for representativeness was used as a guide for additional analysis and instrument modification, in order to address sub-theme items with the most disagreement; however, acceptability was considered in conjunction with representativeness. All items of sub-themes in which the percentage of agreement among raters fell between 70 and 86 percent were initially assessed. In cases where the proportion of agreement for a domain was between 0.70 and 0.86, all sub-theme items comprising the domain were assessed, regardless of the proportion of agreement for the individual sub-themes. These guidelines were first used for analysis of the representativeness ratings, followed by the acceptability ratings for each version of the instrument. Representativeness was only judged by the participants who completed the counselor version of the MDSC-CA. As such, analysis began with that version of the instrument.

Counselor MDSC-CA Sub-Theme Items

A review of Table 6.2 reveals the Adaptability, Fear of Consequences, Lack of Objectivity, and Well-Being domains had agreeability proportions between 0.70 and 0.86, as did the Lack of Education, Unsupportive Family, and Lack of Value sub-themes. Therefore, items for the 12 sub-themes meeting the 0.70-0.86 agreeability criteria were initially analyzed based on the qualitative data pertaining to them and subsequently reanalyzed based on their conceptual consistency.

A discussion of the analysis and modification procedures for the items of the first three domains that met the analysis criteria above are described below. These procedures were ultimately conducted for each sub-theme in order to take into consideration all comments provided by participants and to obtain a more parsimonious instrument that still represents each domain of the phenomenon of interest.

Adaptability. The overall proportion of agreement among pilot test participants for the Adaptability domain was 0.856. Because this falls within the range of which the first analyses are to be completed, the items for both sub-themes, along with their associated data collected in the pilot test, were analyzed in an effort to obtain a more parsimonious subset of items.

Role confusion. The proportion of agreement for the items in the Role Confusion sub-theme was 0.78677, indicating a moderate level of agreement among the participants. Table 6.4 shows the frequency of ratings per representativeness and acceptability category for items in the Role Confusion sub-theme. Two items had a lower degree of agreement than the others, one with respect to acceptability and one to representativeness. Although 90% of the participants indicated the first item (*Because I assumed multiple roles, there was a conflict of interest that forced me to cross boundaries*) was representative of the Role Confusion domain, only 70%

thought it was acceptable in its current form. The three participants who indicated the item needed to be revised, expressed concern about the phrasing of the item. One pointed out the ambiguity about the term *roles*, which could mean organizational roles or roles in and outside of the organization. Additionally, two participants had issue with the word *forced*, which indicates the counselor has no control over his or her behaviors. Because 90% of participants agreed the item was representative of its domain, the item was revised, rather than removed.

Table 6.4.
Agreement per Rating Category for Items in the Role Confusion Sub-Theme.

Item	Needs to be Revised	Acceptable	Not Representative	Somewhat Representative	Clearly Representative
Because I assumed multiple roles, there was a conflict of interest that forced me to cross boundaries.	3	7	0	1	9
I was not able to intervene appropriately because I was not an employee of the organization in which I provided counseling.	0	10	0	1	9
I knew I should intervene, but I did not because I was unsure what my role was in the clinical situation.	0	10	0	0	10
I held more than one professional role, which interfered with my availability to meet with clients.	0	10	0	3	7
Aside from					

counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients.	0	10	0	1	9

First, the item was considered in the context of the original data, which indicated it was well-grounded as participants' expressed the challenges associated with varying organizational roles, which led them to cross professional boundaries. It was clear that participants thought they had no other option, due to their conflicting roles, and the phrasing of the question was structured based on previously designed scales to measure moral distress. For example, Eizenberg et al. (2009) developed the Moral Distress Questionnaire (MDQ) for clinical nurses, which included the following items:

> I was forced to provide care to the patient according to the physician's directions against my professional opinion.
>
> I was forced to keep a patient, who needed a treatment, waiting, due to lack of time.
>
> I was forced to deny an appropriate treatment from a patient due to budget cuts. (p. 892)

Because the word *forced* has been used in previously developed scales, and reflects the perceptions of participants, it seemed appropriate and accurate to structure the item under question similarly. It is clear, however, that pilot test participants disagreed about the use of the word *forced*, along with the ambiguity caused by the word roles. As a result, the item was revised as shown below:

Table 6.5
Original and Revised Item in the Role Confusion Sub-Theme.

Original Item	Revised Item
Because I assumed multiple roles, there was a conflict of interest that forced me to cross boundaries.	Because I assumed conflicting organizational roles, I was led to cross professional boundaries.

Participants had concerns about the last two items in the Role Confusion sub-theme, as well. The item (*I held more than one professional role, which interfered with my availability to meet with clients*) was rated "Not Representative" by three of the participants, two of whom clarified that they thought the item might be more representative of a theme involving workload or time management. Upon further reflection of the item and how it was developed, it did seem to more accurately represent a situation where the counselor is not able to meet with client, not due to role confusion, but rather due to role demands. As such, the item was removed from the sub-theme.

Finally, participants' feedback for the last item (*Aside from counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients*) reflected its similarity to the fourth item, in that multiple roles interfered with a counselor's ability to adequately meet clients' needs. Another participant indicated this item also seemed like it was more representative of a time management issue and might be a better fit with workload items. Reviewing this item in the context of the original data from which it was developed, as well as the theme it was purported to reflect, the item seemed acceptable in its current form. It also seemed conceptually consistent with other items in the theme, creating a composite of the overall theme.

Through this process of reanalysis, it became clear that the overall meaning this sub-theme was intended to capture might have been misinterpreted or mislabeled during original theme development. While the items are well-grounded in the data and reflect participants' experiences, each of those experiences and their associated items more accurately represent situations in which participants experienced conflict among roles, rather than confusion about their roles. In contrast to items in the Work Life sub-theme where participants may have experience too many roles or responsibilities, these items capture experiences where roles and responsibilities conflicted with each other. As a result, counselors were put in positions where they were unable to advocate for clients, or otherwise meet their needs. Therefore, this sub-theme was renamed Role Conflict, which more accurately captured the shared meaning of participants' experiences and still contributed to the Adaptability domain.

Item reduction was based on the above considerations in order to retain a more representative sample of items that reflected participants' experiences. Therefore, two of the five items were removed. The first was described above, which was more representative of the Work Life sub-theme. The second item removed was in direct conflict with the participants' ratings about representativeness. The only item all 10 participants unanimously agree was representative of the Role Confusion sub-theme was the third (*I knew I should intervene, but I did not because I was unsure what my role was in the clinical situation*). Despite the absolute agreement among participants, the item seemed to more accurately represent a situation in which the participant was truly confused about his or her role. By re-examining the participant's account of the experience, the participant's confusion was a result of a lack of education and/or training in the new role, which is captured in other sub-themes. The unanimous agreement for this item reflects its direct relationship to the sub-theme's title; however, the researcher's flaws

in earlier analysis rendered the agreement and the item useless. As such, it was removed from the sub-theme to increase conceptual clarity of the newly identified Role Conflict meaning. The final Role Conflict sub-theme is displayed in Table 6.6.

Table 6.6
Final Sub-Theme Resulting from Re-conceptualizing and Reducing the Role Conflict Sub-Theme.

Items
1. Because I assumed conflicting organizational roles, I was led to cross professional boundaries.
2. I was not able to intervene appropriately because I was not an employee of the organization in which I provided counseling.
3. Aside from counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients.

Relationship conflict. The second sub-theme in the Adaptability domain received much higher agreement (92%) than the Role Confusion sub-theme. In addition, no participants left feedback or comments about the items in the sub-theme, which limited its modification. As such, reanalysis began with the only item that did not receive unanimous agreement among the participants, in terms of both representativeness and acceptability (*I had multiple relationships with a supervisor, which impeded my ability to advocate for a client*). Because there was some disagreement about this item, it was removed from the sub-theme. Its removal was not thought to be to the detriment of the sub-theme, as it was the most situation-specific of the items and because the other items more accurately represented the overall meaning of the sub-theme.

Three of the items described similar situations in which the counselor received two messages from supervisors, resulting in an inability to do what he or she thought was right. In addition, two of the items described situations in which the counselor was unable to provide

adequate care or treatment for a client. In order to reduce this redundancy, the item *I did not provide adequate care for a client because of conflicting messages from two supervisors*, was removed. The last item in the sub-theme was reworded because the phrase *being pulled in different directions* is a colloquialism, which may cause confusion. The resulting Relationship Conflict sub-theme, now consisting of three items, is displayed in Table 6.7.

Table 6.7
Revised Relationship Conflict Sub-Theme.

Items
1. I was unable to do what I thought was best for the client because I had multiple relationships with the client's family.
2. I did something I thought was inappropriate due to conflicting messages from two supervisors.
3. I was not effective with a client because my supervisors were giving me conflicting recommendations.

Fear of consequences. The overall proportion of agreement among items comprising the Fear of Consequences domain was 0.80, which falls in the rage of interest. As such, the data corresponding to these items was analyzed, one sub-theme at a time.

Client. On one item received unanimous agreement among participants about its representativeness to the Client sub-theme. The other five items were judged as somewhat inadequate by at least one participant, with 40% of participants rating the fifth item (*I did not inform a legal guardian about a client's situation because I thought they would get upset about it*) as only somewhat representative. None of the participants left any feedback for the items, pertaining to representativeness or acceptability. As such, sub-theme modification and item reduction will partially be based on the proportion of agreement for items, as well as reanalysis of how items were generated and conceptualized.

The item that only received 60% of agreement about its representativeness of the sub-theme was removed. Aside from the participants' disagreement about the item, it also was somewhat ambiguous as the word *they* did not clarify who was being referenced in the item. Finally, the item was similar to the item above it, as they both referenced an experience in which the counselor refrained from informing a client's legal guardian about the client's situation, for similar reasons. Therefore, the item was easily removed in hopes of increasing sub-theme representativeness and conceptual clarity.

The other two items with the least amount of agreement among the participants, in terms of representativeness, were reviewed. One of those items (*I was afraid to intervene with a client because I thought he or she would be given an inappropriate diagnosis*) was similar to another in which the client did not provide appropriate interventions due to a fear that the client would be labeled. Therefore, the participant's judgment was accepted without question, as the item relating to fear of labeling was similar and was rated to be more representative. Although no comments were provided about the removed item, the lower proportion of representativeness it received may reflect the counseling profession's adoption of a wellness model, rather than the medical model (Kaplan et al., 2014). As such, the item may have been too context specific, as many counselors do not provide diagnoses for their clients.

The second item with a lower proportion of agreement between participants (*I thought doing the right thing would ruin the rapport I had established with a client's family*) was also reanalyzed, due to the lack of feedback from participants. Although the item does reflect a seeming legitimate constraint to moral action for counselors working with children and/or adolescents, its lack of representativeness was concerning. It is possible the item may be more representative of another domain, but it was removed from the instrument based on participants'

ratings. Also, it is possible the experience reflected in the removed item is still represented in another item (*I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client*) as it is broader and less specific.

The other three items received from 90-100% agreement in terms of their representativeness, and were thusly retained. A brief review of the acceptability ratings for the remaining items revealed that participants unanimously agreed each was acceptable as presented in the pilot test versions of the MDSC-CA. Therefore, the revised Client sub-theme is presented in Table 6.8.

Table 6.8
Revised Client Sub-Theme.

Items
1. I did not provide the appropriate interventions because I was afraid the client would be labeled.
2. I crossed professional boundaries because I thought to do otherwise would result in catastrophic consequence for the client.
3. I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client.

Others. The Others sub-theme received the lowest proportion of agreement, in terms of item representativeness (0.71667); however, 90% of participants agreed the items were acceptable as presented. Fortunately, several participants provided feedback about their disagreement of representativeness, which aided in sub-theme revision.

The first item's representativeness was unanimously agreed upon; however, one participant pointed out that the item (*I knew I needed to report the unethical actions of my supervisor, but I was afraid it would cause conflict among my colleagues*) seemed more representative of the relationship conflict sub-theme. The original conceptual distinction

between the Others and Relationship Conflict sub-themes was that Relationship Conflict represented experiences in which the conflict already existed, whereas the Others sub-theme represented experiences in which the counselor feared the conflict happening. A review of the context and themes from which the items were generated confirmed this conceptual and experiential distinction, which had significant meaning for participants. The fear that they would be the source of conflict for others was powerfully limiting and was meaningfully distinct from the conflict others created. Therefore, because of the high agreement about the representativeness of this item, it was retained.

The second item (*I should have reported the unethical actions of my supervisor but feared that doing so would leave the counselors-in-training without a supervisor*) had relatively high agreement, but the feedback pointed out the item may be too site-specific. It is true that this particular item was the result of one participant's experience, and reflects a situation that is not common to clinical sites. As such, it was removed from the instrument as its applicability may be quite limited.

The last item's representativeness (*Challenging the organization's unethical culture was not worth the turmoil it would cause*) was agreed upon by 70% of the participants. Two of the three who disagreed with the representativeness of the item left feedback about their views, which assisted with reanalysis and revisions. The first participant noted the item seemed related to the work environment theme. While the observation that this item relates to work environment is absolutely correct, there are distinct conceptual and meaningful differences between the two themes. Whereas the Work Life sub-theme represents situations in which the overwhelming workplace demands act as a barrier to moral action, the Others sub-theme represents situations in which the counselor worries about causing negative consequences for

colleagues. The second participant who left feedback expressed confusion about whether or not the consequences truly related to other or to the counselor. After moving on to the Self sub-theme, however, it became clear to this participant that the items reflected others as they added an addendum to their comment. That participant did recommend providing clarification about with whom the turmoil pertained.

Because one of the two dissenting participants changed their opinion after moving to the Self sub-theme and the other made linguistic connections to another sub-theme, but not conceptual connections, the sub-theme and three of its items were retained. The item about counselors-in-training was removed due to its specificity and lack of broad application. The other three items remained; however, the last item was revised to provide clarification about whom the turmoil pertained to. A final review of the acceptability ratings for the three remaining items revealed two of the items were unanimously rated as acceptable, while one participant indicated the last item needed to be revised. Due to the revisions to the last item just mentioned, it is assumed these issues were resolved through the revisions described. The final Others sub-theme is displayed in Table 6.9.

Table 6.9
Revised Others Sub-Theme.

Items
1. I knew I needed to report the unethical actions of my supervisor, but was afraid that it would cause conflict among my colleagues.
2. I thought it would be selfish to report a colleague's unethical behavior because it would cause problems for others.
3. Challenging the organization's unethical culture was not worth the turmoil it would cause among my colleagues.

Self. The proportion of agreement for the representativeness of items in the Self sub-theme was 0.91429; however, because it was included in the Fear of Consequences domain, which received 80% agreement overall, it was reviewed in the initial stage of instrument modification. Four of the seven items in this sub-theme received unanimous agreement, in terms of their representativeness; the other three received 90% agreement among the participants. The three items will less agreement were reviewed in an effort to arrive at a more parsimonious sub-theme and to address any overlooked conceptual and meaning components.

Based on the original data and the themes from which the three items came from, they were all determined to be conceptually appropriate and consistent, as they captured the meaning of the participants' experiences and were well grounded in the data. As a result, all three were removed from the sub-theme as the other four items were absolutely agreed upon by the participants. Additionally, the remaining items appear to have conceptual overlap with the removed items, and as such, may still be able to capture the meaning of the removed items. For example, the kept item (*I worried that standing up for what I believed was right would jeopardize my career*) overlaps with fears that doing the right thing would cause others to view the counselor negatively. Also, the remaining items pertained to what the counselor would lose if he or she stood up for what they believed, which was a large component of the fear of consequences for self sub-theme.

The resulting Self sub-theme was comprised of the four items participants unanimously agreed were representative of the sub-theme. A review of the acceptability ratings indicated all 10 participants approved of the items as they were presented on the pilot test versions of the MDSC-CA. The final Self sub-theme is presented in Table 6.10.

Table 6.10
Revised Self Sub-Theme.

Items
1. I did not stand up for what I believed was right because I thought doing so would cost me my job.
2. I followed directives I did not agree with because I thought I would be reprimanded if I did not.
3. I gave into pressure to do something I did not agree with because I believed I had a lot to lose if there were negative consequences.
4. I worried that standing up for what I believed was right would jeopardize my career.

Lack of Objectivity. The final domain discussed in this section is the Lack of Objectivity domain, which received the lowest proportion of agreement, in terms of representativeness, among the pilot test participants. The proportion of agreement among participants was 77.7% for the overall domain, whereas the Emotional Entanglement sub-theme received 81.1% agreement and the Idealization received 74.4% agreement. Acceptability ratings were higher (82.9-87.4%), but were still among the lowest for the entire instrument. As such, the items for each domain were carefully reviewed.

Emotional entanglement. The main source of disagreement among the items in this sub-theme related to one (*I became desensitized to ethical dilemmas because practicing unethically was common practice*) in particular. As briefly mentioned in Chapter Five, this item was mistakenly included in the Emotional Entanglement sub-theme; however, its inclusion had utility in determining the level of attention participants gave in completing the instrument. Due to the length of the instrument, there was a potential for participants to become fatigued by rating so many items. Over half of the participants caught the mistake and indicated the item was only somewhat representative of the sub-theme. Not surprisingly, based on the rest of the instrument, no participant rated it as clearly unrepresentative; that is, only three of the 106 items were given such a rating. Therefore, it was encouraging that more than half the participants questioned the

representativeness of the item. Due to its inappropriate inclusion in the sub-theme and the participants' agreement, the item was immediately removed.

The second most contested item in the Emotional Entanglement sub-theme (*I thought I would betray the colleagues I was close to by doing what I believed to be the right thing*) was ill-prepared and conceptualized. The item was derived from one participant's experience in which they made emotional connections with their colleagues and thought doing the right thing would result in betrayal or resentment. Because of the emotional component of the experience, it was interpreted as emotional entanglement, which might have been accurate, but the overall meaning was more accurately understood as fear of losing close colleagues or fear of being resented by close colleagues. As such it was also removed from the sub-theme, which was recommended by two participants, one of whom indicated the item was not representative of the sub-theme.

Of the remaining four items, only one was not unanimously agreed upon, in terms of representativeness. That item (*I knew I had unfinished business that would impact my work with a client, but I continued counseling anyway*) was not only rated as only somewhat representative by one participant, but it was also considered confusing and ambiguous by others. The term *unfinished business* may be a sort of counseling colloquialism that has multiple meanings or is simply confusing to some participants. Another participant mentioned that all counselors have unfinished business, which seemed to lessen the representativeness or meaningfulness of the item. While this participant was certainly correct, as mentioned in Chapter Five, a lack of awareness of one's emotional wounds or influences impacts counselors' decision making and their efficacy (Evans et al., 2012). Additionally, such counselors "will not be able to offer the highest level of counseling services to their clients" (Lawson, 2007, p. 20). As such, there is a distinction between being aware of one's unfinished business and a lack of awareness, which

negatively impacts clinical work. Regardless, the item was removed from the sub-theme due to its ambiguity, and because a clearer item with similar meaning is included (*I was unable to provide proper treatment for a client because my own emotional wounds resurfaced*) and was unanimously rated as representative.

The revised Emotional Entanglement sub-theme included three items, which all participants rated as both clearly representative and acceptable. As such, revision concluded and the final version of the sub-theme is presented in Table 6.11.

Table 6.11
Revised Emotional Entanglement Sub-Theme.

Items
1. I was unable to remain objective due to the emotional bond I created with a client.
2. I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.
3. I knowingly crossed boundaries because of the intense emotional connection I had with a client.

Idealization. The Idealization sub-theme represented situations in which the counselor held very high standards expectations for themselves and/or the counseling profession. This sub-theme had one of the lowest proportions of agreement, in terms of item representativeness, among participants (0.744), while acceptability agreement was relatively high (0.877). Due to the low agreement about item representativeness, this sub-theme received considerable thought in the modification process.

The first item (*I knowingly crossed boundaries because I thought it was my responsibility to protect a client*) and the fifth item (*I did not do what I believed was right because I realized the counseling profession has less integrity than I was led to believe*) were the two lowest agreed

upon (70%). Three participants rated the first item as somewhat representative, whereas two participants rated the fifth item somewhat representative and one rated it clearly unrepresentative. Because of the extreme representativeness rating of the fifth item, it was removed without hesitation. The first item, however, was examined more closely.

First, the participants' comments revealed that one thought the wording (*a client*) was a little odd. Another participant wondered if the item was more representative of the Emotional Entanglement sub-theme. This item was originally generated from participants' experiences of wanting to go above and beyond their responsibilities due to high standards, rather than having an emotional connection with their clients. The confusion was apparent, however, and therefore was removed to increase conceptual clarity. Surprisingly, the third item (*I went beyond my professional responsibilities because I felt responsible for a vulnerable client*), which shared meaning with the removed item about responsibility, received 90% agreement about its representativeness. Because the responsibility due to high standards theme was prominent, this item was retained, as participants rated it highly and it contributed to the overall meaning of the sub-theme.

The sixth item (*I lowered my professional standards because I discovered the counseling profession is not as responsible as I thought*) received 80% agreement about its representativeness; however, one participant pointed out that it was very similar to the fifth item, which was removed due to a rating of clearly unrepresentative. Due to the disagreement about the item and the conceptual and meaning similarities between this item and the removed item, it also was removed.

The remaining two items (*Because of my high standards, I never thought I was as effective as I should have been with a client; My inability to do what I thought was right reflected*

my unrealistically high standards for the profession) both were unanimously rated as clearly representative. Therefore, three items were retained for this theme. A review of their acceptability ratings indicated the second item needed to be revised. Two participants had issue with the inclusion of the word *never*, which was subsequently revised to provide additional clarity. The final revised Idealization sub-theme is seen in Table 6.12.

Table 6.12
Revised Idealization Sub-Theme.

Items
1. Because of my high standards, I was unable to be as effective as I wanted to be with a client.
2. I went beyond my professional responsibilities because I felt responsible for a vulnerable client.
3. My inability to do what I thought was right reflected my unrealistically high standards for the profession.

Summary of instrument modification based on the counselor MDSC-CA. The procedures described above were carried for all sub-theme items, regardless of the representativeness and acceptability agreement among participants; however, those with lower proportions were modified first. Modifications mainly were based on participants' ratings and feedback, but were also based on reviewing the original data, comments, and emergent themes. In rare cases, when the author believed the pilot test participants failed to grasp the meaning underlying the item or sub-theme, were their ratings overturned, as the goal was to create a parsimonious instrument that still captured the phenomenon of moral distress in a variety of ways that reflected its complexity.

Counselor MDSC-CA Sub-Themes

Once all items per sub-theme had been reviewed and modified as appropriate, analysis of the feedback pertaining to the degree to which sub-themes represented their respective domain and sub-theme acceptability was conducted. Most sub-themes were unanimously agreed upon for both representativeness and acceptability, so the sub-themes on which participants commented are described below.

Lack of objectivity. The lack of objectivity domain included two sub-themes: Emotional Entanglement and Idealization. Participants provided feedback for both, resulting in the title of one being modified to provide clarity about the meaning it was intended to capture.

Emotional entanglement. Two participants indicated the sub-theme title was somewhat ambiguous, as the individual or individuals to whom the counselor was emotionally entangled was not clarified. One participant recommended changing the title to Emotional Entanglement with Client to remedy the ambiguity. Including *with clients* did nothing to detract from the instrument and provided additional conceptual clarity, so the title was changed for the final version of the MDSC-CA.

Idealization. One participant wondered if this sub-theme could fall under either the Lack of Experience or Lack of Training sub-themes, since counselors with less experience may be more naïve about the appropriate standards to have for self and/or others. While the participant's feedback identified a potential overlap between sub-themes, the Lack of Education sub-theme more specifically represented situations in which counselors lacked the required competences to do what was best for their clients, whereas the Lack of Training sub-theme reflected situations in which counselors lacked the necessary training to do what they believed was right. Conversely, regardless of whether or not counselors had the appropriate education and training, Idealization

reflected situations in which a counselor's high standards made it seemingly impossible to do what they thought was right. These participants' experiences suggested that no amount of experience and/or training would allow them to reach their standards and, thus, achieve what they believed was best for their clients. As such, the Idealization title was kept for the final version of the instrument, although additional testing may, in fact, reveal an underlying factor not yet fully understood.

Vulnerability. The Vulnerability domain included the Lack of Authority and Lack of Value sub-themes. Participants provided feedback about both; however, the feedback about the Lack of Authority only pertained to a misplaced period at the end of the sub-theme title. Therefore, it is not included in the modification discussion below.

Lack of Value. One participant recommended changing the Lack of Value title to Mismatched Values or Incongruent Values. They further clarified that they thought the sub-theme reflected situations in which the counselors' values and the values of the clinical organization or colleagues were not congruent. The Lack of Value sub-theme more accurately reflected experiences where the counselor believed they were not a valued member of the clinical team, and therefore were unable to stand up for what they thought was right. Incongruent values, as described by the participant who left feedback, was included in other sub-themes, such as situations where the counselor was in a position where they felt like they had to follow laws or ethical imperatives that were not congruent with their core values. Because the feedback indicated a misunderstanding of the sub-theme, the Lack of Value sub-theme title was retained for the final version of the MDSC-CA.

Summary of sub-theme modification. Aside from the Emotional Entanglement sub-theme title change, all other sub-themes and their titles were kept as presented in the pilot test

versions of the MDSC-CA. With the representativeness issues addressed, the data collected from layperson participants was analyzed and appropriate modifications were made, which are described below.

Layperson MDSC-CA

The layperson version of the MDSC-CA was used to assess non-validity issues, such as clarity, ambiguity, and grammar. Rather than conducting the Fleiss' kappa coefficients for agreeability on item acceptability, each item was considered individually, based on participants' feedback. Appropriate modifications were made, which reflected the non-validity issues identified by participants, which mainly pertained to grammar and sentence structure. Of the five participants who completed the layperson version of the instrument, two rated every item as acceptable, whereas one indicated 57 of the 106 items needed to be revised. The remaining two participants indicated less than 10 items needed revision. As a result, only three of the participants' completed instruments were considered.

A review of the participants' feedback identified numerous grammatical and sentence structure recommendations, which strengthened the clarity of items. Additionally, one participant pointed out items that were not gender neutral and recommended removing he/she and his/her with they or their, respectively. At this point of instrument modification, only one item was included in the final version of the instrument that had gender specific pronouns, but their removal improved the instruments sensitivity and inclusivity.

In addition to the helpful suggestions, some comments recommended grammar or sentence structure changes that, while appropriate in other contexts, detracted from the meaning of the item. That is, in an effort to make items more concise, important conceptual elements were not emphasized or were removed altogether. Table 6.13 provides a brief summary of the

types of suggestions made by the participants in comparison to the original items, as well as those recommendations that were used and unused.

Table 6.13
Layperson Feedback About Item Acceptability and its use in Item Modification.

Used Recommendations

Original Item	Recommended Revision
1. I was unable to continue treatment with a client, due to a legal guardian's wishes.	1. Due to a legal guardian's wishes, I was unable to continue treatment with a client.
2. I was unable to do what I thought was best for a client due to the organization's policies.	2. Due to the organization's policies, I was unable to do what I thought was best for a client.
3. I was forced to break a client's confidentiality because I had to testify about his or her case in court.	3. I was forced to break a client's confidentiality because I had to testify about their case in court.
4. The organization had a lack of resources, which limited what I could do for a client.	4. The organization's lack of resources limited what I could do for a client.

Unused Recommendations

Original Item	Recommended Revision
1. I thought I let down a client because I did not have the appropriate training.	1. I was not effective for a client.
2. I wanted to do the right thing because I cared about the organization, but did not think the organization cared about me.	2. I wanted to do the right thing because I cared about the organization, but did not think the feeling was mutual.

Aside from the recommendations above, the layperson version of the instrument proved to be less meaningful than anticipated. This outcome mainly was a result of the level of attention and details the participants who completed the counselor version provided in their feedback. The

counselor participants had already identified many of the grammatical and clarity issues identified by the layperson participants. Additionally, a significant amount of instrument modification had already been completed, informed by the quantitative and qualitative data collected from the counselor version of the instrument, so many of the items that were ambiguous, confusing, or unclear had already been removed. As mentioned above, however, several important recommendations were provided by the layperson participants, which made the layperson pilot test worthwhile.

Summary of instrument modification and content validity.

Instrument modification successfully resulted in a parsimonious version of the MDSC-CA, which increased proportions of agreeability for both item representativeness and item acceptability. The improvement in inter-rater agreement from the unmodified version to the modified version for the entire instrument, as well as for each domain and sub-theme, serves as an initial estimate of content validity. Waltz, Strickland, and Lenz (2010) suggested an agreement percentage of 90% or above is considered acceptable at this stage of instrument development. The agreement proportions for item representativeness, provided in Table 6.14, indicate the overall instrument meets content validity acceptability (93.5%), seven of the eight domains are acceptable (90-100%), and 14 of the 19 sub-themes are in the acceptability range (90-100%), while the remaining items meet less conservative validity requirements (Obermiller & Spangenberg, 1998). Additionally, an index of content validity (CVI) was calculated for every item included on the modified version of the MDSC-CA. Beck and Gable (2001) suggest CVI percentages of 90% or above indicate acceptable content validity, which was achieved for 61 of the remaining 63 items. As a result, the modified version of the instrument appears to have acceptable content validity, based on the pilot test data and results.

Table 6.14

Proportion of Rater Agreeability for the Unmodified and Modified Versions of the MDSC-CA.

	Unmodified		Modified	
	N of Items	Proportion of Agreement	*N* of Items	Proportion of Agreement
Instrument				
MDSC-CA (all items)	106	0.84486	63	0.93545*
	N of Items	Proportion Agreement	*N* of Items	Proportion of Agreement
Domain/Sub-Theme				
Domain 1: Adaptability	10	0.85778	6	0.90000*
1A. Role Conflict	5	0.78677	3	0.80000
1B. Relationship Conflict	5	0.92889	3	1.00000*
Domain 2: Fear of Consequences	17	0.80131	10	0.89333
2A. Clients	6	0.72593	3	0.86667
2B. Others	4	0.71667	3	0.87778
2C. Self	7	0.91429	4	1.00000*
Domain 3: Inexperience	10	0.86889	6	0.96667*
3A. Lack of Education	6	0.81481	3	0.93333*
3B. Lack of Training	4	0.95000	3	1.00000*
Domain 4: Lack of Support	14	0.87302	10	0.96000*
4A. Lack of Consultation	5	0.88889	3	1.00000*
4B. Lack of Resources	5	0.90667	4	1.00000*
4C. Unsupportive Family	4	0.81111	3	0.86667
Domain 5: Institutional Restrictions	16	0.90000	10	0.94000*
5A. Legal	6	0.90000	4	0.90000*
5B. Organizational	5	0.88000	3	0.93333*
5C. Ethical	5	0.92000	3	1.00000*
Domain 6: Lack of Objectivity	12	0.77778	6	0.96667*
6A. Emotional Entanglement with Client	6	0.81111	3	1.00000*
6B. Idealization	6	0.74444	3	0.93333*

	Unmodified		Modified	
	N of Items	Proportion of Agreement	*N* of Items	Proportion of Agreement
Domain/Sub-Theme				
Domain 7: Well-Being	14	0.81587	7	0.91429*
7A. Work Life	8	0.79722	4	0.90000*
7B. Personal Life	6	0.84074	3	0.93333*
Domain 8: Vulnerability	13	0.86838	8	0.95000*
8A. Lack of Authority	8	0.95000	5	1.00000*
8B. Lack of Value	5	0.73778	3	0.86667

* Proportion of agreement indicates adequate content validity (Waltz, Strickland, & Lenz (2010).

Summary

This chapter thoroughly describes the analysis of pilot test results and the ways in which they informed instrument modification. Modification initially was conducted based on results of the counselor MDSC-CA, which resulted in a parsimonious version that still captured the meaning of each sub-theme and the participants' experiences. The representativeness of the entire instrument, as well as items in every domain and associated sub-theme were increased. The resulting instrument met acceptable content indices for seven of the eight domains and 14 of the 19 sub-themes. Additionally, the proportion of acceptability was increased for the items of every domain and sub-theme.

Subsequent analysis and modification was based on the results of the layperson MDSC-CA, which informed additional revisions of issues such as clarity, ambiguity, grammar, and inclusiveness. Layperson pilot test results were moderately helpful, as much of the participants' feedback had already been addressed in the counselor version of the MDSC-CA. Nevertheless,

several improvements to sentence structure and item sensitivity were achieved through the analysis of layperson qualitative data.

The instrument modification procedures achieved the goals of obtaining a parsimonious instrument that has acceptable face and content validity. Validity indices and inter-rater agreement proportions are provided above, while the final, modified version of the MDSC-CA can be found in Appendix T.

CHAPTER SEVEN

DISCUSSION

Researchers agree counselors have a responsibility to explore, assess, and maintain their health and well-being (Iliffe & Steed, 2000; Roscoe, 2009; Sexton, 1999; Wolf et al., 2014), an imperative also corroborated by the American Counseling Association (ACA; 2014). Similarly, Falender and Shafranske (2004) stated it is "essential for clinicians to develop and understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). The purpose of this study was to meet these professional imperatives by conducting an initial examination of an overlooked phenomenon that has the capacity to impact counselors personally, interpersonally, and professionally. Moral distress, a well-documented experience among other health care professionals, has been shown to be borne out of dynamics common to the counseling profession (Wilkinson, 1988), which may make counselors particularly vulnerable to a heretofore unrecognized threat to psychological and emotional equilibrium (Corley et al., 2001). Therefore, exploring this phenomenon among counselors in an effort to develop an instrument that might make possible the assessment and prevention of its effects, is a worthy pursuit.

This study was designed to gain an initial understanding of moral distress as experienced by counselors working with children and/or adolescents in order to develop an instrument to measure moral distress, which demonstrates initial face and content validity. Because previous research exploring moral distress among other health care professionals indicates those in helping professions are particularly likely to experience moral distress, and because the

phenomenological underpinnings of moral distress are prevalent in counseling (Jameton, 1984), the need for an instrument to address this overlooked phenomenon is necessary. The development of such an instrument can provide significant value to counselors and the counseling profession. Previous researchers suggest moral distress might act as an early warning sign to more serious psychological responses to distress, as well as problems within an organization (Austin, 2012; Somerville, 2000). Without a way to assess for such stressors, health counselors may undergo continual and unrecognized disturbances that lead to problems on personal, interpersonal, and organizational levels.

Counselors who work with children and/or adolescents may be even more vulnerable to the experiences and effects of moral distress, due to the unique challenges accompanying clinical work with those clients (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000). Unique situations regarding confidentiality, reporting abuse and neglect, working with clients' parents or guardians, and working in schools may cause morally distressing situations that counselors working with other clients would not encounter. Additionally, because children lack considerable control over their lives and the clinical treatment they receive, many decisions are made by important adults in their lives (Dugger, 2007). Working with clients who lack autonomy in making decisions about their treatment and well-being presents challenging situations in which counselors have very little, if any, control over the services they are able to provide. Therefore, the current study was limited to exploring moral distress among counselors working with children and/or adolescents, as their experiences might provide more robust data than other counselors.

Exploring an overlooked phenomenon that has the potential to cause detrimental consequences in multiple domains of life not only promotes the standards established for the

counseling profession, but also may generate an understanding of unrecognized factors that lead to distressing situations among counselors. As such, this study elucidated idiosyncrasies within the counseling profession that will provide insight about how to assess for and prevent moral distress, ultimately enhancing the efficacy of the profession and wellness of counselors.

Overview of the Study

This study sought to explore the experiences of counselors working with children and/or adolescents who have encountered moral distress in their clinical work. While an initial understanding of those experiences was an essential goal of the study, the ultimate goal was to develop and instrument to assess moral distress among such counselors. Qualitative methods were used to explore counselors' experiences and garner an understanding of their causes and consequences. Analysis of qualitative data informed the development of an instrument to assess moral distress among counselors, and both quantitative and qualitative methods were used to assess the instrument's initial validity.

An open-ended survey, distributed through Qualtrics, and semi-structured interviews were used to collect qualitative data about counselors' experiences of moral distress. Analysis of the data, using Interpretative Phenomenological Analysis (IPA) resulted in a thorough understanding of counselors' experiences. As a result, several themes were identified for the situations contributing to moral distress, the barriers preventing moral action, and the resultant consequences. Those themes directly informed the structure and development of items included on the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). The MDSC-CA was pilot tested with a professional and layperson sample in order to determine the representativeness and acceptability of the items comprising the scale. Finally, Fleiss' kappa coefficients, agreeability proportions, and additional qualitative analyses were conducted to

assess the inter-rater agreeability about the representativeness and acceptability of the scale items. Based on qualitative feedback and inter-rater agreement, a modified version of the MDSC-CA was developed that demonstrated improved representativeness and acceptability.

Summary of Results

Before summarizing the results, the research questions guiding the study are reiterated to provide structure for this section and to ensure the results contribute to the overall purpose of the study:

Research Question 1: What does the experience of moral distress look like for child and/or adolescent counselors?

Research Question 2: What factors, if any, contribute to moral distress among counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 3: What barriers, real or perceived, if any, exist that prevent child and/or adolescent counselors from engaging in moral action?

Research Question 4: What impact, if any, does moral distress have on counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 5: Are there thematic domains from which moral distress occurs for counselors who have experienced moral distress while working with children and/or adolescents?

Research Question 6: Can a Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) be constructed in order to measure moral distress among counselors who work with children and/or adolescents?

Research Question 7: If the MDSC-CA can be constructed, can its face and content validity be assessed through pilot testing?

Together, answers to these research questions provided an understanding of counselors' experiences of moral distress in their clinical work with children and/or adolescents, as well as justification for and validation of the developed instrument.

Research Question 1

The first research question guiding the current study asked what the experience of moral distress looks like for counselors working with children and/or adolescents. The use of open-ended surveys and semi-structured interviews to explore counselors' experiences of moral distress have provided a thorough understanding of the factors that lead to moral distress, how that distress is experienced, and the impact of that distress. As such, the dynamics surrounding a phenomenon previously unacknowledged of the counseling literature were elucidated. In order to adequately answer the first research question, however, the findings of this study are synthesized as they pertain to other questions research questions, which together, will provide an understanding of what moral distress looks like for child and/or adolescent counselors. That is, to garner a thorough understanding of the experience of moral distress, three elements must be explored: (1) the precursory ethical dilemma or ethically challenging situation; (2) the barrier to moral action; and (3) the consequences. We can view these as the ABCs of moral distress, which represent the second, third, fourth, and fifth research questions:

A. Antecedent (research question two)

B. Barrier (research question three and five)

C. Consequence (research question four)

While a large component of this study was to determine the barriers preventing moral distress among counselors, in which the thematic domains and sub-themes were derived from,

each of the elements were explored in both the surveys and interviews. Each element is briefly discussed below.

Research Question 2: Antecedents

The second research question pertains to the factors that contribute to moral distress while working with children and/or adolescents. Jameton (1984) and Wilkinson (1988) acknowledged the precursory factor required to experience moral distress is an ethical dilemma; however, the nature of the ethical dilemma varies considerably across the literature, depending on the context in which it happened. The same variation is true of the ethical dilemmas the participants described in their experiences of moral distress. Analysis of the qualitative data through the same procedures used to identify themes among barriers and constraints, however, led to the identification of themes in the ethical dilemmas, or antecedents the pilot test participants encountered.

A very common ethical dilemma across participants' experiences was the betrayal of clients by colleagues or the clinical organization itself. Betrayal included the organization worrying more about its image or the generation of money than the welfare of clients, colleagues providing deficient treatment, or other counselors breaking laws to protect themselves, rather than the client. Other dilemmas involved situations in which the client was "thrown under the bus" or blamed for their situation, as described by one of the interview participants. In each case, the client's well-being came second to others' self-interest. Often these situations were systematic and well established, which made them particularly troubling to participants in this study.

Another prevalent ethically challenging situation was when participants witnessed dishonesty among colleagues. Falsifying paperwork, documentation, billing, and clinical hours

were described by several participants, all of which created ethical dilemmas. Similarly, participants described situations in which they not only witnessed dishonesty but also were pressured to engage in the behaviors themselves. Peer pressure was a common theme among the antecedents, which put participants in situations where they had difficulty standing up for what they believed.

Other themes emerged, but in all cases, there was a mismatch in morals, values, standards, or beliefs between the participants and their colleagues or organizations. These situations directly reflect previous findings that moral distress arises out of an ethical dilemma due to differing values and morals, which can lead to profound emotional distress (Jameton, 1993). It is important to note, however, these types of discrepancies do not cause moral distress; rather, the barrier that prevents moral behavior is what truly causes the distress.

Research Question 3: Barriers

The third research question pertains to the barriers, real or perceived, that prevent counselors from engaging in moral action. The bulk of this study was geared toward identifying the contributing factors, or barriers, to moral distress. Both the open-ended survey and the interviews were conducted with the goal of identifying factors in the forefront of design and implementation. As such, numerous contributing factors were identified, some of which overlapped with previous findings among other health care professionals, and others seemed to be unique to the counselors working with children and/or adolescents. Together, these factors provide a clearer picture of how moral distress manifests itself and highlighted the need for continued exploration of the phenomenon among counselors.

Previous research examining moral distress has resulted in the classification of two types of barriers to moral action. External constraints are those that are typically outside the health

care professional's control and are presented by others. Jameton (1984) originally defined moral distress as occurring due to external constraints from the institution, administrators, the law, policies, and superiors, among others. Internal constraints, on the other hand, refer to internal personal factors and psychological responses to ethically challenging situations. Wilkinson (1988) was the first to describe internal constraints, such as socialization to follow orders, fear of losing one's job, a lack of confidence, and self-doubt. Of the eight domains identified in the current study, four were classified as external and four were classified as internal.

External constraints. One of the most evident factors contributing to moral distress among the study participants was the perceived lack of power to stand up for beliefs or otherwise do the right thing. Participants described feeling like they were at the bottom of the totem pole or hierarchy of power, were inferior to others, lacked authority or control, and had their hands tied by their lack of power or authority. This finding was not surprising, considering powerlessness is well-documented in the moral distress literature (Corley et al., 2001; Epstein & Hamric, 2009; McCarthy & Deady, 2008; Redman & Fry, 2000), and given the definition of moral distress as a phenomenon in which one is unable to overcome barriers to moral action. The very nature of moral distress necessitates the feeling of powerlessness to act according to one's moral resolve, or a sense of hopelessness in changing the ethical situation from which the distress originates (Corley et al., 2001).

Somewhat unique to the current study, a couple participants described their perceived lack of power more specifically as a lack of credibility. This finding was surprising, as a lack of power (Corley et al., 2001; McCarthy & Deady, 2008; Olson, 2002; Wilkinson, 1988) and authority (Hamric & Blackhall, 2007; Jameton, 1984; Nelson, 2009) have been identified in previous literature, whereas a lack of credibility was novel. This subtle distinction provides and

indication of how the experience of moral distress among child and adolescent counselors is contextually different from those in other health care fields, especially medical fields, in which moral distress originated. In the medical field, there is a clear distinction between the roles, responsibilities, and capabilities of physicians and nurses, which creates an evident, if not unspoken hierarchy of power (Jameton, 1993). Counselors, however, are on a more even playing field, where novice counselors and experienced counselors both practice in similar ways, provide similar services, and see similar clients (Porter, 2001). Credentials, experience, and expertise can make counselors distinct from one another, but the dividing lines are less defined and permeable. Therefore, the perception of credibility differences may underlie the experience of powerlessness for counselors (McCarthy & Deady, 2008).

Other external constraints, such as institutional barriers, well-being, and lack of resources are all well documented in the moral distress literature. For example, Kälvemark, Höglund, Hansson, Westerholm, and Arnetz (2004) provided an early thematic representation of external constraints within the health care system. The results of their study indicated that external constraints can be collapsed into four categories: (1) lack of resources; (2) rules and regulations; (3) conflicts of interest; and (4) lack of supporting structures. More recently, Shorideh et al. (2012) found institutional barriers and constraints could be grouped into six subthemes: (1) legal and organizational conditions; (2) medical supervision; (3) accountability; (4) ignoring and injustice to nurse; (5) large financial burden to the patient; and (6) forced cardiopulmonary resuscitation (CPR). The conceptual similarities between previously established external constraints and those identified in the current study are encouraging, as the basis of this study was the recognition of similarities between the two fields

The one external constraint most clearly unique to counseling was that of unsupportive family members. The uniqueness of this barrier to counselors working with children and/or adolescents is not surprising. As Dugger (2007) noted, children lack considerable control over their lives and are vulnerable to the consequences of the decisions made by important adults in their lives. Because parents and guardians often make decisions about their child's treatment, they have the power to prevent counselors from doing what the counselor believes is best for the client. Participants describing such an experience mainly depicted situations in which the parent or guardian suddenly, abruptly, or prematurely terminated counseling, even though the counselor believed counseling was necessary.

This type of barrier seemed to be particularly distressing to some participants, as there was absolutely nothing they could do to engage in moral action. Whereas a lack of power, authority, or credibility can be overcome with moral courage (Lachman, 2007a), a counselor is completely powerless and helpless in doing what they think is best for the client, unless there is evidence of abuse or neglect. These situations involved parents who were embarrassed or frustrated because their child was in counseling, leaving the counselor in a position where nothing could be done for the client.

In their comprehensive review of moral distress literature, Oh and Gastmans (2015) reported that one of the most intense experiences of moral distress for nurses was uncooperative patients and family members; however, the authors of the original article from which that finding was derived, more accurately described uncooperative parents as those who behaved inappropriately toward health care staff (DeKeyser Ganz & Berkovitz, 2012). In order to provide additional clarification about these types of behaviors, DeKeyser Ganz and Berkovitz (2012) reported their findings were consistent with previous studies identifying patient and

family verbal and physical abuse toward health care staff (Crilly, Chaboyer, & Creedy, 2004; Ganz, Wagner, & Toren, 2015; Wagner & Hendel, 2000; Wagner & Ronen, 1996). Therefore, while negative interpersonal experiences between clients/patients and their family may be a common factor in moral distress, the experiences described by the counselors in this study differ considerably from the experiences documented in previous nursing literature.

The conceptual similarities between previously established external constraints and those identified in the current study are encouraging, as the basis of this study was the recognition of a phenomenon borne out of dynamics common to counseling, yet heretofore overlooked in the counseling literature. These similarities suggest, while moral distress is context specific, very similar contextual dynamics exist between medical health care and mental health care, in terms of the institutional structures in which those professionals work. Therefore, the identification of themes documented in previous literature may mean the results of the current study provide an accurate initial look at essential features or root causes of moral distress (Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015) experienced by individuals in similar contextual dynamics.

The identification of unique external barrier themes is also encouraging. Because the nature of moral distress is context dependent (Wood, 2013), it should be expected that professionals in a different field who provide different services in different clinical settings to different clients would encounter unique barriers. Failure to identify such themes likely indicates a failure to capture idiosyncratic experiences among counselors working with children and adolescents. It is hoped that the inclusion of previously unidentified themes is an indication that participant's experiences and the underlying meanings were appropriately acknowledged and incorporated into the current study.

Internal constraints. Internal constraints differ from external constraints in that they stem from personal factors or characteristics, rather than from the perceived characteristics or qualities of others. The internal constraints identified in this study varied by participant, but well-defined themes emerged within and across participants' experiences. Most notably, participants described situations in which they were restricted from engaging in moral action due to their fear of consequences for themselves, others, and their clients. The fear of consequences theme was by far the most cited internal constraint to moral action and seemed to be quite powerful due to the detrimental nature of the consequences participants feared (e.g., loss of job, jeopardized career, and ruined relationships with colleagues).

Fear of consequences has been documented in previous moral distress literature (McCarthy & Deady, 2008); however, in previous studies, that fear mainly referred to the fear of being reprimanded or losing one's job. For the participants included in the current study, three distinct sub-themes emerged: (1) fear of consequences for self; (2) fear of consequences for a client; and (3) fear of consequences for others. Fear of consequences for self has been well established as a common barrier to moral action among other health care providers (Elpern et al., 2005; Hamric et al., 2012; Wendell, 1990; Wilkinson, 1988; Wilson et al., 2013); the fear of consequences for clients and others, however, seem to be unique to counselors. This barrier to moral action also is unique in and of itself. Participants described situations in which they were led to do what they knew was wrong, because doing otherwise would lead to negative consequences for a client. Examples include withholding information from a parent for fear that the parent will terminate counseling or failing to advocate for clients due to fear that the client would be labeled or blamed. In these situations, it seems that moral distress is a double-edged sword in that the counselor is destined to experience moral distress regardless of the action they

take. Failing to report caused moral distress due to the abandonment of values and integrity, whereas reporting may lead to harm or the removal of necessary interventions. This situation is different than any other described in moral distress literature, as further clarified in Figure. 7.1.

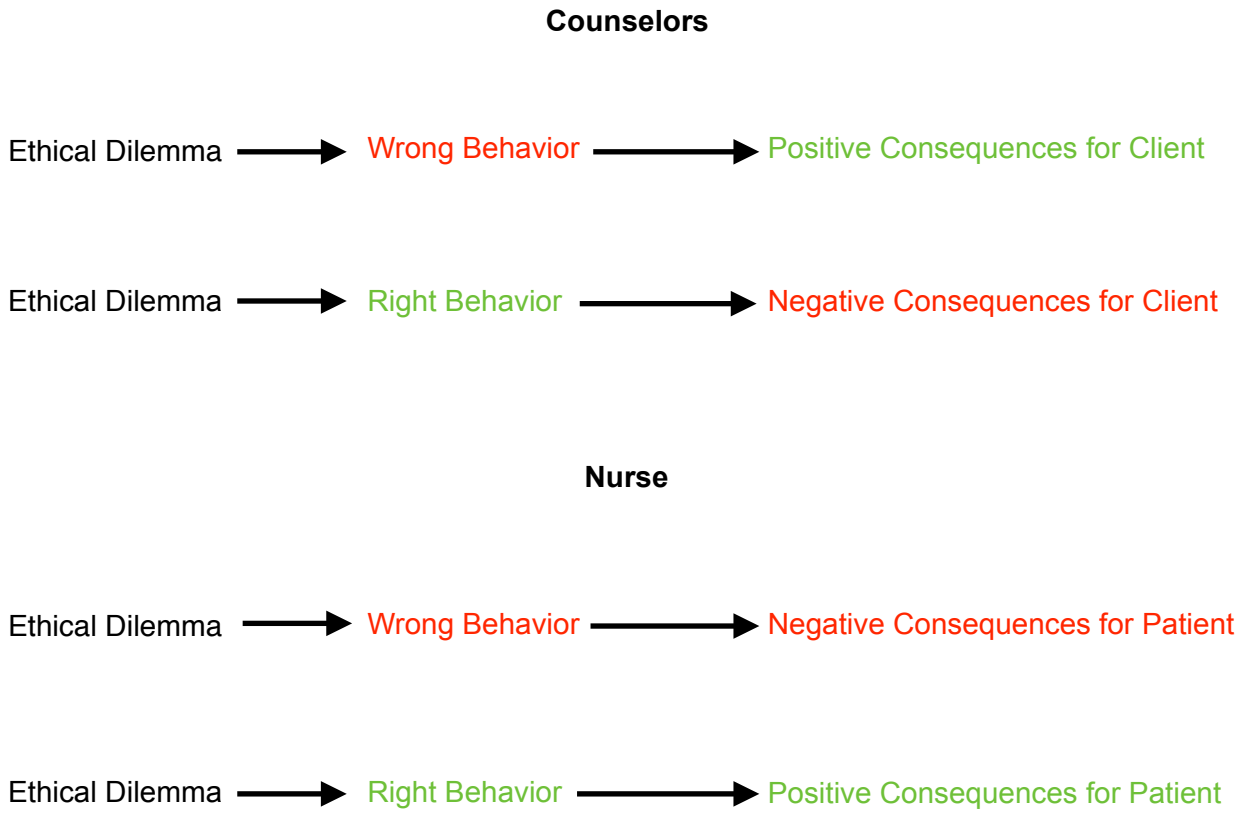


Figure 7.1. Morally distressing situations in which the fear for clients acts as a barrier to moral action for counselors and nurses.

In Figure 7.1 the red text indicates the negative aspects of morally distressing situations (e.g., doing what you believe is wrong, and negative consequences for client/patient). Previous literature on moral distress only describes situations in which doing the wrong thing leads to moral distress because it causes harm or other negative consequences to patients and doing the right thing reduces or removes moral distress as the negative consequences for patients are

eliminated. It is clear nurses are aware of and even anticipate the consequences resulting from clinical situations that lead to moral distress (Wiegand & Funk, 2012); however, those consequences themselves have not been described as barriers to moral distress. For counselors working with children and/or adolescents, however, doing the right thing may result in negative consequences, which would result in moral distress, and doing the wrong thing could prevent negative consequences for clients, yet still cause moral distress as the counselor was unable to do what they knew or believed was right. While this type of dilemma is not fully understood, it seems that it is the result of the lack of autonomy children and adolescents have in making decisions about their treatment as well as the stigma often associated with counseling. Regardless of the specific dynamics, working with children and adolescents has the capacity to create morally distressing situations that were previously unrecognized among other health care professionals.

The other emergent theme that has not been identified in previous literature is emotional entanglement, which appears to be unique to the counselors in the current study. Emotional entanglement was particularly interesting in that a counselor's emotional wounds from previous trauma resurfaced, which prevented them from doing what they believed was right. This finding is not altogether surprising, considering the intimate nature of counseling and the potential for trauma to enter one's clinical work; however similar dynamics also are characteristic of the nursing relationship, and researchers have identified and acknowledged the psychological effects of the difficult and intimate nature of the care they provide their patients. Empathy, or "a 'feeling into' or an imaginative entering into another person's affective world" (Lobchuk, 2006, p. 331) creates the potential for emotionally connecting with a client's traumatic material in such a way that can impact the health care provider's affective functioning (Pearlman & Saakvintne,

1995). While empathy is a necessary condition for counseling, it is not a core component of nursing (Gambles, Wilkinson, & Dissanayake, 2003). In fact, researchers have found that nurses' levels of empathy are likely to be too low to fully understand their patients' concerns (Renyolds et al., 2000). Additionally, rather than building alliances with patients, nurses often build connections with the multidisciplinary team in which they work for emotional support (Sinclair & Hamill, 2007). Therefore, it is plausible that nurses are less vulnerable to the emotional trauma, or vicarious traumatization (McCann & Pearlman, 1990), that seems to represent a barrier to moral action in the current study.

Because the emotional entanglement theme emerged from only one participant's experiences, it is difficult to draw implications from this finding, but it is possible that differences between the two professions lead counselors to be more vulnerable to emotional entanglement or nurses to be more resilient. There is evidence that the level of emotional intensity or connection with counselors' clients may be higher than that of nurses, but this theme will certainly be a focus of future research in order to gain a better understanding of its emergence in the current study.

Other internal constraints identified in the current study have been documented in previous moral distress literature. For example, lack of education (Wilson, Gottemoeller, Bevan, & McCord, 2013), lack of training (Burston & Tuckett, 2013), lack of confidence (Wilkinson, 1988), and unrealistically high expectations for oneself (Pendry, 2007) have all been identified as internal characteristics or qualities that present barriers to moral action among nurses. Again, the presence of previously and newly identified themes suggests common experiences associated with moral distress may have been appropriately identified among the participants in this study, while the idiosyncratic complexity of the those participants' clinical work was not overlooked.

Research Question 4: Consequences

The personal and professional affects moral distress can have on a health care worker permeate the moral distress literature and vary considerably in their severity, intensity, and chronicity. A review of the literature suggests personal consequences affect three domains of life: (1) emotional/psychological (Hanna, 2005; Laabs, 2007; McCarthy & Deady, 2008; Woods, 2013); (2) physical/physiological (Fry et al., 2002; Weissman, 2009); and (3) sleep disturbances (Foley et al., 2000; Unruh, 2010; Weissman, 2009; Woods, 2013). The current study found that participants experienced very similar negative ramifications from their moral distress, which were classified as personal, interpersonal, and professional.

The consequences comprising the personal theme included feelings of frustration, anxiety, sadness, resentment, exhaustion, self-criticism, self doubt, apathy, and dread. Several participants also described an inability to sleep and crying as a result of their moral distress. Participants described these consequences as relatively severe, causing significant distress; however, most participants indicated their moral distress left lasting effects that could last years after the experience. Only one participant experienced more severe psychological consequences, which have lasted for several years and required counseling to overcome, at least partially. During the interview with this participant, it was clear the consequences they experienced were still impacting them and the clinical work they are currently doing.

Interpersonal and professional consequences were discussed less frequently and did not vary as much as personal consequences. This finding is reflected in the literature, as previous findings report less interpersonal and professional consequences, and questions still remain about those previously identified (Tiedje, 2000; Wilson et al., 2013). The participants in this study described interpersonal consequences including reduced time with family and friends, strained

relationships with family and colleagues, and isolation. While these consequences are common among other professionals (Gutierrez, 2005), they allude to the powerful effect moral distress can have. That is, regardless of profession or context, it seems those who experience moral distress are likely to have personal relationships negatively impacted, in addition to the personal consequences mentioned above. The detrimental nature of moral distress also was demonstrated by several participants' inability to compartmentalize work and personal life in order to prevent negative consequences from permeating life outside of work. This also suggests the participants' coping mechanisms for dealing with their moral distress are less efficacious and adaptive than needed to successfully manage these difficult and distressing experiences.

Professional consequences, on the other hand, included increased attrition, distancing oneself from colleagues, hostility toward colleagues, looking for new employment, and leaving their position. Again, each of these consequences is documented in previous literature (Betty, 2006; Glissen et al., 2008; Winland-Brown et al., 2010), suggesting that, regardless of the situational or contextual elements, moral distress affects individuals in similar ways. Two of the professional effects, looking for new employment and leave one's job, replicate important findings in previous literature. Moral distress appears to lead to a breaking point, at which point people either contemplate leaving their job or quit altogether (Wilson et al., 2013). In the current study, three out of five participants (60%) contemplated leaving their job and two of the five (40%) participants actually left. These findings are consistent with previous research (Hamric & Blackhall, 2007; Winland-Brown, Chiarenza, & Dobrin, 2010), and could have important implications for the counseling profession. At this point it is unclear how prevalent moral distress is among counselors, but it is plausible that moral distress contributes to turnover and attrition among counselors.

This study provided an initial understanding of the ways in which moral distress impacts counselors working with children and/or adolescents. Among the participants, it is clear that moral distress causes significant distress that can affect several domains of life, which poses serious threats to counselors' well-being and the services they provide their clients. As Lawson (2007) reminds us, "Counselors who are unwell (stressed, distressed, or impaired) will not be able to offer the highest level of counseling services to their clients, and they are likely to begin experiencing a degradation of their quality of life in other domains as well (physical, social, emotional, spiritual, etc.)" (p. 20). Moral distress provides a cogent example of the ways in distress can impact a counselor's life, again, in multiple domains.

Research Question 5: Domains

The fifth research question pertains to whether or not thematic domains from which moral distress occurs exist among counselors working with children and/or adolescents. Again a bulk of this study was focused on the barriers preventing moral action, which resulted in a plethora of data from which to develop themes. Because Chapter Four discusses the development of thematic domains identified from participants in this study, only a brief summary of them is provided here.

Eight domains were identified, which included at least one sub-theme and at most three. As discussed in the barriers section above, four of the domains were comprised of external constraints and four of internal constraints. The thematic domains in the external classification included: (1) institutional restrictions; (2) lack of support; (3) vulnerability; and (4) well-being. Each represented constraints to moral action that were provided by someone other than the counselor, such as supervisors, the client's family, and workplace demands. The thematic domains in the internal classification included: (1) adaptability; (2) fear of consequences; (3)

inexperience; and (4) lack of objectivity. Each of these domains represented barriers that were a function of the counselor's personal characteristics, such as fears, previous experiences, and beliefs. A summary of the domains and their associated sub-themes is provided in Figure 7.2.

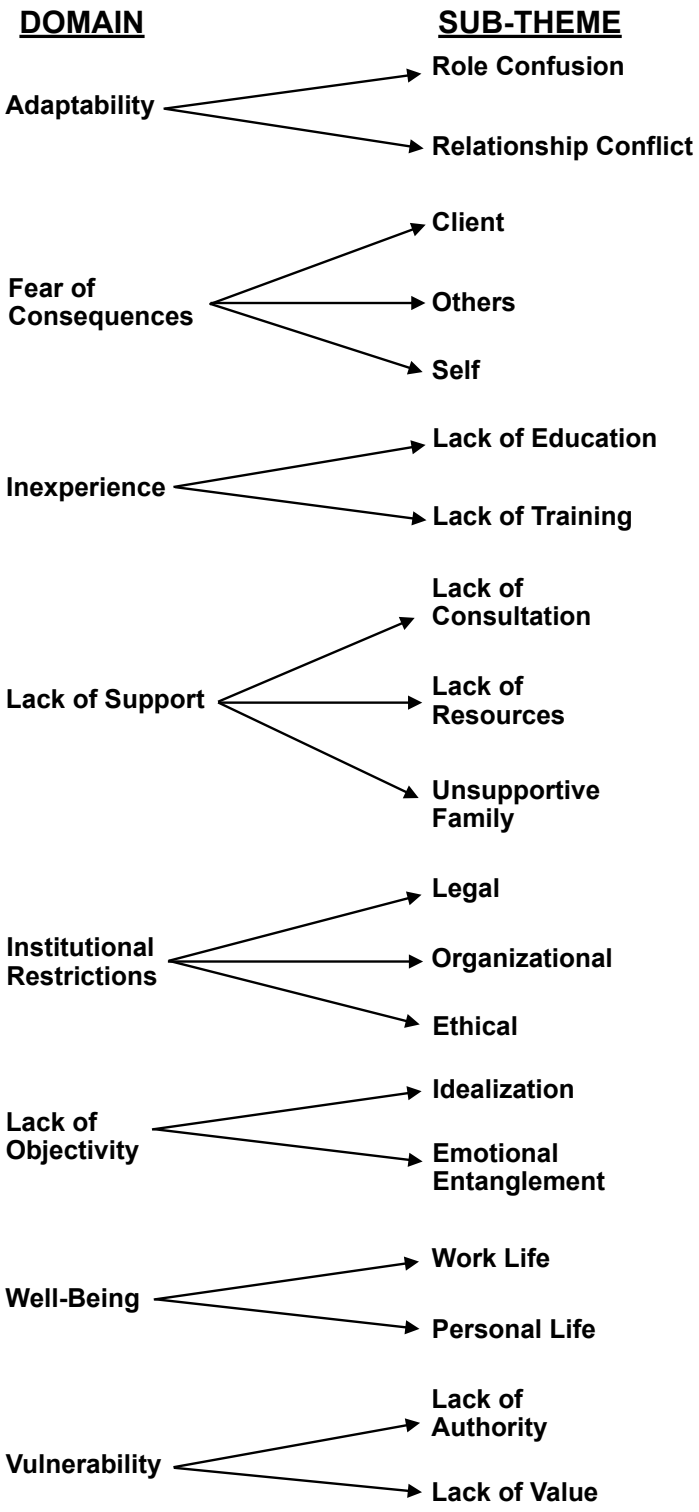


Figure 7.2. Summary of identified domains and associated sub-themes.

Research Question 1: Counselors' Experiences of Moral Distress.

By addressing the second, third, fourth, and fifth research questions, a better understanding of what moral distress looks like for counselors working with children and/or adolescents emerged. With a few exceptions, the experiences of the participants in the current study closely resemble experiences documented in the moral distress literature. Additionally, participants' moral distress was heavily dependent on the context in which one works. As such, a universal definition or view of moral distress among counselors, or even the participants in this study, is unattainable. Despite the variation across participants, however, their experiences can be better understood by reviewing the moral distress equation displayed in Table 7.1

Table 7.1
The Moral Distress Equation.

Moral Distress						
Moral Situation	+	Moral Decision About Right Action	+	Perceived Inability to Act	=	Painful Feelings and Psychological Disequilibrium

Note. Wilkinson (1988)

The moral distress equation (Wilkinson, 1988) provides a template from which to view individual experiences of moral distress, and can provide better insight about the participants in the current study. By inputting the each of the components described above, a participant's experience of moral distress can be understood from the original situation to the resulting consequences. Differences between nurses and the counselors in this study were described above, suggesting counselors working with children and/or adolescents do experience moral distress in ways unique to their profession.

The main difference between the health care professionals previously studied and the participants of the current study was the barriers that led to a perceived inability to act. Because of the unique situations counselors working with children and/or adolescents face, along with the level of intimacy created between counselor and client, the barriers, real or perceived, were markedly different. More specifically, the unique barriers were a function of an interpersonal or emotional connection with others, such as emotional entanglement or fear of consequences for others. Again, it is unclear exactly why these differences existed among the participants, but it is plausible to attribute them to the intimate and emotional nature of counseling, over and above that of nursing.

Regardless of the cause of the differences, the important finding is that there are differences. Previous research laid the foundation for an understanding of moral distress among counselors, but to apply previous findings or generalize themes among nurses to counselors ignores the idiosyncrasies of their experiences. Because moral distress is context specific and there is evidence that the contexts in which counselors working with children and/or adolescents practice uniquely contribute to moral distress, more research is needed in order to fully appreciate their experiences and gain a more complete understanding of moral distress among these mental health care professionals.

Research Question 6: Development of the MDSC-CA

The sixth research question pertained to whether or not an instrument to assess moral distress among counselors working with children and/or adolescents could be developed. The results of qualitative data analysis identified a thematic structure for the development of an instrument that assesses moral distress from a number of domains that can contribute to its experience. Additionally, the qualitative data informed the development of an item pool from

which to construct an initial version of the MDSC-CA. The generated items were analyzed and reanalyzed in the context of the original data, relevant counseling literature, and previous literature on the development of scales to measure moral distress among other health care professionals in order to obtain a pool of representative items and to increase face validity. The result was an initial version of the MDSC-CA with a large item pool from which to assess item representativeness and acceptability.

The initial MDSC-CA was pilot tested with two groups. First, a non-professional, or layperson sample, consisting of five friends and family was selected to assess non-validity issues such as grammar, difficulty, ambiguity, and clarity for each item, ultimately rating the acceptability of each item. A sample of 10 professionals, consisting of counselors, counselor educators, and those familiar with moral distress and counseling ethics, was selected to assess representativeness and acceptability of each item and sub-theme. Quantitative data pertaining to the participants' ratings were collected, along with qualitative data in the form of comments and feedback for items, sub-themes, and instrument instructions.

Analysis of both the quantitative and qualitative data resulted in a modified version of the MDSC-CA (see Appendix T). The modified version contained 63 items, which was a 40% reduction from the original item pool. Additionally, the instrument was improved in terms of both validity and non-validity issues, informed by participants' ratings and feedback. The result was a final version of the MDSC-CA that met several validity indices and had improved clarity, grammar, and conciseness. As such, an instrument to measure moral distress among counselors working with children and/or adolescents was constructed, although additional testing needs to be conducted in order to fully determine its validity and reliability before using it with a larger sample of counselors.

Research Question 7: Validity of the MDSC-CA

The validity of the instrument was based on participants' sub-theme representativeness ratings in order to establish face validity, and inter-rater agreement indices to determine content validity. Each was calculated for the initial version of the MDSC-CA in order to obtain initial information about validity and used to modify the instrument in ways that would increase validity of the items and the instrument as a whole.

The overall proportion of agreement for all items of the initial version was 84%. Inter-rater agreement for items in each domain ranged from 77% to 90%, and the items in each sub-theme ranged from 72% 95%. Analysis was conducted for items within every sub-theme, beginning with those that had the lowest inter-rater agreement and completing with those with the highest. Any item rated *clearly not representative* was removed and remaining items were analyzed based on pilot-test participants' feedback, the original data from which the items were derived, the meaning themes identified across participants, and counseling literature. In almost all cases, participants' feedback and ratings guided item reduction or revision. In the one case in which the participant misunderstood the Lack of Value sub-theme and its items, and therefore rated their representativeness low, the items were either revised or retained. Finally, items were revised in terms of the non-validity issues based on both the layperson and professional participants' acceptability ratings and feedback.

The final version of the MDSC-CA was again assessed by inter-rater agreeability among the remaining items, in order to determine whether or not an improvement in content validity was achieved. The inter-rater agreeability for all items on the final instrument increased from 84% to 93.5%, and inter-rater agreeability for the items in every domain and sub-theme also increased. The agreeability ratings for the overall instrument, seven of the eight domains, and 15

of the 19 sub-themes demonstrated acceptable content validity (Waltz et al., 2010). The only domain that did not meet the acceptability index was Fear of Consequences. Therefore, special attention should be given to that domain in subsequent instrument testing to determine whether or not the items comprising the domain are representative of their respective sub-themes and domain and whether or not they add to moral distress beyond the participants of this study. An index of content validity (CVI) also was calculated for every item included on the modified version of the MDSC-CA. The CVI assessed the percentage of participants that rated the retained items as *clearly representative.* Beck and Gable (2001) suggest CVI percentages of 90% or above indicate acceptable content validity, which was achieved for 61 of the 63 remaining items. Therefore, the modified version of the MDSC-CA appears to have acceptable content validity overall.

Face validity was assessed by participants' ratings of sub-theme representativeness in relation to their respective domain. Sub-theme representativeness provided an indication of the degree to which participants believed the instrument appeared to measure what it was intended to measure. Most sub-themes were unanimously agreed upon, in terms of representativeness to their domain, with only Emotional Entanglement, Idealization, and Unsupportive Family receiving ratings of *somewhat representative*. Two of the three sub-themes (Emotional Entanglement and Unsupportive Family) that received ratings of *somewhat representative* reflected participants' suggestions for sub-theme title changes. Therefore, their representativeness was not questioned. The third sub-theme (Idealization) that received a rating of *somewhat representative* was rated so because the participant wondered about its overlap with the Lack of Experience sub-theme. Despite the insightful response, the two sub-themes Idealization and Lack of Experience reflect clearly distinct experiences, despite surface

similarities, as discussed above. Therefore, the Idealization sub-theme was retained and considered to be mostly valid, as 90% of the participants rated it *clearly representative.*

Due to the inter-rater agreement proportions for item representativeness, as well as the inter-rater agreement pertaining to sub-theme representativeness, it appears the final version of the MDSC-CA demonstrates acceptable content and face validity overall. Additional testing is needed, however, to verify these results with a larger sample of counselors.

Implication for Counselors

This study demonstrated the presence of moral distress among counselors working with children and/or adolescents. Because this study represents the first exploration of the phenomenon in the context of counseling, many implications can be drawn from its results. Most importantly, the results provide an initial understanding of what the experience moral distress looks like for counselors, how it is encountered, and what impact it has on them. This understanding is important because moral distress has long been understood to be borne out of dynamics that directly overlap with the counseling profession (Austin et al., 2005), yet counselors' vulnerability to moral distress has gone unnoticed and unexamined. Therefore, counselors may be experiencing an unrecognized form of distress that has the potential to threaten well-being in multiple domains of life, and of which they are ill-prepared to manage or overcome.

The counseling profession has adopted a wellness orientation (Kaplan & Gladding, 2011; Wolf, Thompson, & Smith-Adcock, 2012) in which mind, body, and spirit are integrated to achieve a healthy balance (Meyers, Sweeney, & Witmer, 2000). Over the last decade, the importance of counselor wellness has been emphasized as a necessary component of counselor effectiveness (Wolf et al., 2012) and the ethical codes of the ACA (2014) require counselors to

"monitor themselves for signs of impairment" (p. 9). In 2005, the ACA proposed a continuum of wellness including well, stressed, distressed, and impaired. Therefore, the exploration and monitoring of moral distress as an index of wellness and impairment is appropriate and needed, as distress is a clear sign that a counselor's wellness is threatened.

Falender and Shafranske (2004) stated it is "essential for clinicians to develop and understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). This study has met these professional imperatives by providing evidence that moral distress is prevalent among counselors and poses serious threats to counselors' wellness and effectiveness with their clients. For the participants included in this study, moral distress arose out of dynamics common to counseling practice, impacted personal, interpersonal, and professional domains of life, and endured after the morally distressing experience was resolved, sometimes years. This initial exploration of such a detrimental phenomenon raises awareness to a previously unrecognized threat to counselors' health and wellness, which may lead to ways to monitor and prevent it in the future.

In addition to providing an understanding of moral distress among counselors, this study also identifies resources that may help counselors manage and overcome its effects. Each participant was asked to reflect on the factors missing that led to moral distress and those that might have prevented it. The most common element participants thought would have prevented their moral distress in the first place was having a colleague, mentor, or supervisor with whom to openly talk about ethical issues, and receive support from. This finding is not surprising, as others have found that, among those experiencing moral distress, those who regularly met with a supervisor were able to work through the distress and maintain ethical practice (Musto &

Schreiber, 2012). Dupre, Echterling, Meixner, Anderson, and Kielty (2014) reported crisis counselors indicated it was absolutely essential to have a supervisor to navigate and resolve those difficult situations. These findings reiterate the importance of supervision beyond counselor training and education, which some indicate is not a common practice (Remley, Benshoff, & Mowbray, 1987) or often is not available when counselors need it most (Benshoff, 1990).

The importance of clinical supervision or mentoring cannot be overstated; however, Borders and Usher (1992) found that, among a nationwide sample of counselors, those working in schools received little to no supervision. More recent studies have shown that school counselors want supervision, but most still do not receive it (Cook, Trepal, & Somody, 2012). Although counselors other than school counselors work with children and/or adolescent, these reports indicate that school counselors experiencing moral distress may not have at their disposal the single most effective resource for managing its effects. Supervision trends among other counselors are less clear, but among the participants included in this study, only two had a supervisor when experiencing moral distress.

The development of an instrument to assess moral distress among counselors working with children and/or adolescents provides a first step in elucidating the prevalence and impact of moral distress among such counselors. The ability to assess for moral distress would benefit all counselors, as moral distress can act as an "ethical canary" (Sommerville, 2000) indicating health professionals encountering moral distress may be on the verge more severe experiences, such as compassion fatigue or burnout. That is, assessing moral distress may lead to early detection and prevention of a detrimental phenomenon that counselors experience, is currently unrecognized, and has the potential to lead to more serious negative outcomes. As a result,

counselors may have an additional tool to monitor their health and wellness, which may ultimately lead to greater wellness among counselors, as well as ethical and effective practice.

Although considerable research needs to be conducted to fully understand and assess moral distress among counselors, this study has taken the first step in that direction. The initial understanding of moral distress among counselors working which children and/or adolescents has elucidated the common and unique ways in which those counselors experience moral distress. Additionally, the effects of moral distress have been identified and have suggested more research in this area is warranted. Finally, the development of an instrument to measure moral distress among counselors working with children and/or adolescents has initiated the endeavor to accurately assess and predict moral distress, in hopes to prevent it and other deleterious effects to counselor wellness.

Limitations

The researcher recognizes the following limitations of the study, which give caution to the implications drawn from the results. First, the sample used to collect initial qualitative data about moral distress among counselors working with children and/or adolescents was recruited from CESNET-L, an online listserv for counselors and counselor educators. Dr. Marty Jencius, the moderator of the listserv, cautions researchers that there is no demographic information for the population of subscribed users. Therefore, although demographic information was collected in an attempt to ensure participants were, in fact, counselors working with children and/or adolescents, there was no way to confirm the credentials and qualifications of the participants. The researcher established eligibility criteria and included exclusionary questions in the questionnaire in an attempt to restrict the respondents to those who had experienced moral distress while counseling children and/or adolescents; however, because participants were

protected by anonymity, those fabricating their qualifications could have gained access to the questionnaire and been included in the initial data collection. Therefore, questionnaire respondents' demographic information was self-reported and could not be substantiated or verified.

Second, the retrospective nature of the questionnaire and requirement of self-reported responses pose threats to the validity of the questionnaire used in the current study. As Connor, Barrett, Tugade, and Tennen (2007) warn, despite the pervasiveness of retrospective questionnaires in the social sciences, they rely on the assumption that respondents can accurately reflect on and report past experiences that may have happened over long intervals. Connor et al. suggest that this assumption is not warranted and may result in responses that are disproportionally influenced by the strongest, or most troubling, memories of such an experience. That is, because of the retrospective nature of the data collected in this study, participants' strongest experiences of moral distress are likely to be remembered and reported (Connor et al., 2007). As a result, levels of moral distress may be exaggerated, or otherwise disproportionate to participants' overall experience of moral distress.

A third limitation exists because the pre-dissertation interviewees were purposefully selected in order to include counselors who have experienced symptoms of moral distress in the context of their clinical experiences with children and/or adolescents. The exclusive inclusion of targeted counselors was necessary to gain an initial understanding of moral distress in counseling; at the same time, however, it may result in a sampling bias. As such, implications drawn from the interviews may not represent counselors at large, but rather over estimate the extent of moral distress and the situations that lead to its experience. Kitzinger and Barbour (1999) point out, however, that statistical representativeness is not the goal of most qualitative

research. Rather, sampling procedures used in qualitative research often have the goal of exploring the "common and unique manifestations of a target phenomenon across a broad range of phenomenally and/or demographically varied cases" (Sandelowski, 2000, pp. 337-338). Therefore, the questionnaire and interviews were purposefully chosen in order to help elucidate participants' unique and shared experiences, while still capturing diversity among participants.

Additionally, the sample size of both the questionnaire and the interviews may be a limitation to the current study. Guest et al. (2006), for example, acknowledge the infeasibility of achieving saturation in time-limited studies, which may inevitably lead to insufficient data collection. Therefore, because the current study was limited in the time it could be conducted, sample size was unavoidable limitation, and the study's methodology did not allow for the remediation of an inadequate sample size, which can limit the validity of the results obtained for instrument development. While sample sizes were modest, they were not outside the range of acceptability in qualitative studies (Creswell, 2014); however, larger sample sizes are needed in order to obtain more robust data and generalize the results beyond the current samples.

The researcher's knowledge of the phenomenon of interest may have been an additional limitation to this study. Having read about and studied moral distress to a great extent, the researcher had considerable knowledge of moral distress, which could have led the researcher to interpret the qualitative data "based on the researcher's prejudices and biases, without regard to the participants' experience (Auebach & Silverstein, 2003, p. 83). Because IPA involves a level of interpretation that is to extend beyond the participants' understanding of their experiences, the researcher was particularly vulnerable to interpret the data based on previous knowledge and biases. Bracketing procedures were carried out before data collection and analysis in an attempt

to reduce this limitation; however, it is likely that the data, interpretation, and results are not free of bias.

Finally, the validity of the instrument was established based on a purposeful sample of experts in counseling ethics and those familiar with moral distress. Although there are professional counselors who are familiar with moral distress, there are no known experts on the concept, as it pertains to counseling. Therefore, the current study is limited by the extent to which an instrument measuring moral distress among counselors can truly be validated.

Each of these limitations is acknowledged in the current study and should be taken into account when drawing implications from the results. Additionally, the limitations justify, if not require, additional research be conducted in order to gain a better understanding of moral distress among counselors working with children and/or adolescents. Better recruiting procedures, a larger sample, and collaborative data analysis will even more accurately capture the experience and meaning of moral distress among counselors. The results of this study, although limited, provide the foundation on which much more must be built in order to more thoroughly and effectively understand a phenomenon that may pose serious threats to counselor wellness.

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APPENDICES

APPENDIX A

QUALITATIVE PRE-DISSERTATION QUESTIONNAIRE

Have you experienced moral distress, as defined below, within the context of your counseling experience?

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

☐ Yes

☐ No

How many morally distressing experiences have you encountered?

☐ Only 1

☐ More than 1 but less than 5

☐ More than 5 but less than 10

☐ More than 10

Did your experience of moral distress occur while you were working with **children and adolescents**? By applying Siegel's (2013) definitions, children and adolescents, in this case, includes individuals roughly between the ages of two and twenty-four.

☐ Yes

☐ No

Please briefly describe your experience of moral distress as it relates to your counseling experience.

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

What factors, if any, contributed to your experience of moral distress?

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

What barriers, if any, were present that prevented you from engaging in moral action?

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

In what ways, if any, did your experience of moral distress impact you?

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

Gender

☐ Male

☐ Female

☐ Transgender

☐ Other

☐ Prefer not to disclose

Race/Ethnicity

☐ Asian or Pacific Islander

☐ Black or African American

☐ Hispanic or Latino

☐ Middle Eastern

☐ Native American

☐ White or European American

☐ Other

☐ Prefer not to disclose

Age **when you experienced moral distress**

☐ 18-29

☐ 30-39

☐ 40-49

☐ 50-59

☐ 60-69

☐ 70-79

☐ 80-89

☐ 90+

Current age

☐ 18-29

☐ 30-39

☐ 40-49

☐ 50-59

☐ 60-69

☐ 70-79

☐ 80-89

☐ 90+

Number of years of counseling experience, after completing your master's degree, **at the time when you experienced moral distress**

☐ 1-2

☐ 3-5

☐ 6-9

☐ 10-14

☐ 15-19

☐ 20-24

☐ 25-29

☐ 30+

Current years of counseling experience, after completing your master's degree

☐ 1-2

☐ 3-5

☐ 6-9

☐ 10-14

☐ 15-19

☐ 20-24

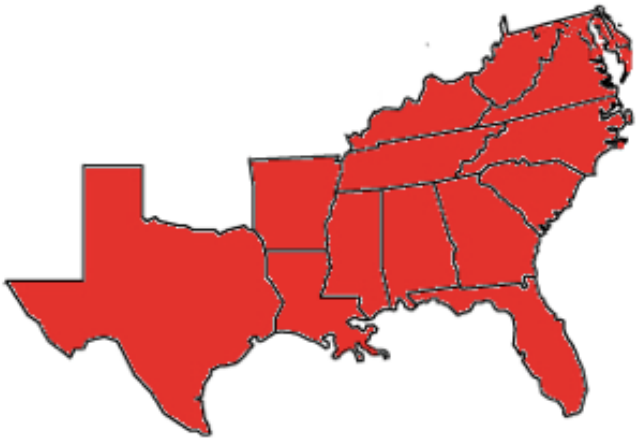
☐ 25-29

☐ 30+

Geographic location in which you experienced moral distress (if more than one location, please selected the region that reflects the most recent experience of moral distress)

☐

☐



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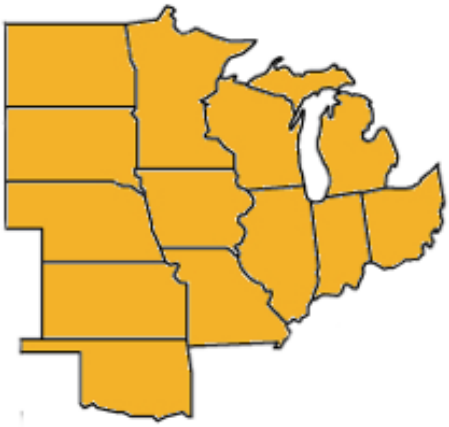

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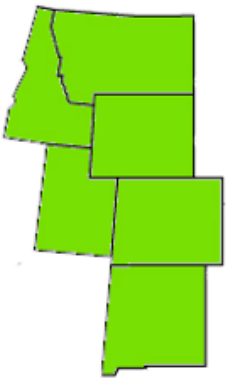

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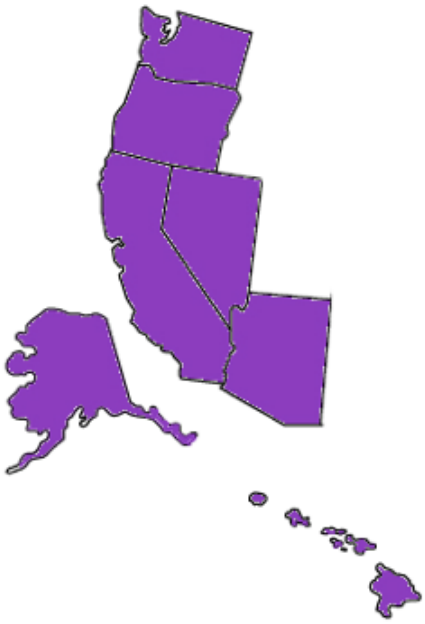
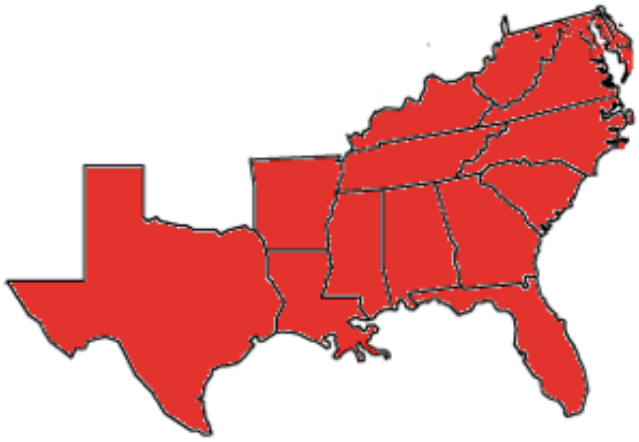


☐ I experienced moral distress outside of the United States (please specify)

Geographic location where you currently reside

☐

☐



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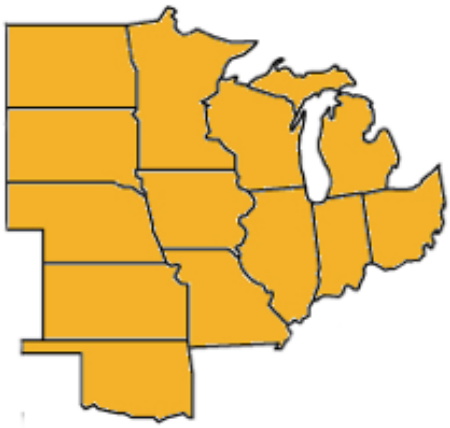

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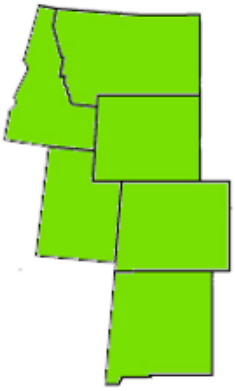

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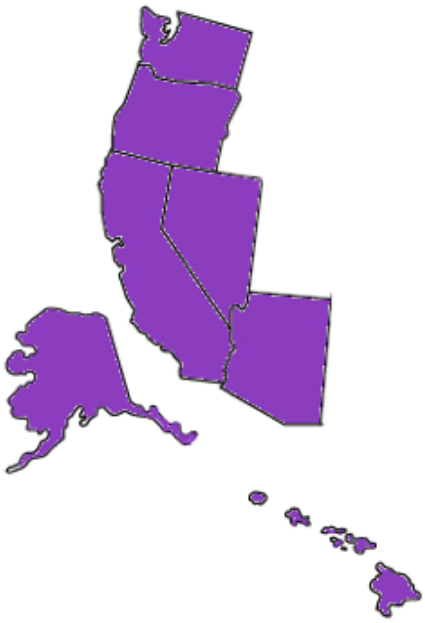

☐ I currently reside outside of the United States (please specify)

Clinical setting **in which you experienced moral distress**

☐ School (K-12)

☐ College

☐ Community

☐ Private Practice

☐ Medical

☐ Other (please specify)

Clinical setting in which you are currently counseling

☐ School (K-12)

☐ College

☐ Community

☐ Private Practice

☐ Medical

☐ Other (please specify)

☐ None

Did your experienced of moral distress lead you to leave your counseling position or the counseling profession?

☐ Yes

☐ No

Primary counseling specialty

☐ School

☐ Community

☐ Counselor Education and Supervision

☐ Mental Health

☐ Marriage, Couple, and Family

☐ Clinical Mental Health

☐ Student Affairs

☐ College

☐ Career

☐ Play Therapy

☐ Addictions Counseling

☐ Student Affairs and College

☐ Gerontological

☐ Trauma

☐ Other (please specify)

Would you like to be considered as a participant for an interview regarding your experiences of moral distress?

☐ Yes

☐ No

If you would like to be considered as a participant for an interview regarding your experiences of moral distress, please include your email address below.

If you choose to include your email address, only the principal investigator and research advisors will have access to it. Your email address will not be used for anything other than contact from the principal investigator. Providing your email address does not guarantee that you will be selected for an interview. Once the participants have been selected and contacted, the email addresses of the participants will be deleted from all data.

If you are interested in participating in an interview, however, would prefer that your responses to this questionnaire are not associated with your email address, you are welcome to email the principal investigator (Ian Turnage-Butterbaugh) at the following email address: isbutter@go.olemiss.edu. Thank you again for your consideration.

Email: (optional)

APPENDIX B

SEMI-STRUCTURED MORAL DISTRESS INTERVIEW PROTOCOL

Moral Distress Interview Guide

Introduction

- Greeting
- Recap of informed consent (each participant has …)
    - Indicated that they are 18 years of age or older
    - Indicated that they understand the purpose and procedures
    - Had a chance to ask questions and has received satisfactory answers
    - Agreed to have their comments audio recorded
    - Indicated that they understand the limits to confidentiality
    - Been informed that they can withdraw their participation at any time
        - Is this true of each participant in the focus group?
- Purpose of interview
    - Definition of moral distress
        - Moral distress is defined as the distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"
    - To learn about your experiences with moral distress and what it looks like in counseling.
    - To identify factors that contribute to moral distress among counselors
    - To understand situations or settings in which moral distress occurs

Experiences of Moral Distress

- Let's take a broad or overall look at your experience of moral distress.

- Would you tell me about the moral distress you experienced?
- What was that experience like for you?
- How did you know you were experiencing moral distress?
- In what ways, if any, did your experience of moral distress impact you?
- How severe was that moral distress to you?
- Where did the moral distress you experienced stem from?
    - Institutional policies?
    - Lack of resources?
    - Lack of time?
    - Personal ideals?
    - Hierarchical roles?
    - Insurance restrictions?

Factors Contributing to Moral Distress

- Let's talk specifically about the setting you were in when you experienced moral distress.
    - What clinical setting were you in when you experienced moral distress?
    - What was it about this setting that contributed to your experience of moral distress?
    - Would you describe the ethical climate of that setting or institution?
        - The shared perception of what is ethically correct behavior and how ethical issues should be handled.
    - Were there any interpersonal dynamics that contributed to your experienced of moral distress?
- Let's shift our focus to the clinical role you had in that setting.
    - In what ways did you contribute to your experience of moral distress, if at all?

- In what ways did your clinical role contribute to their experience of moral distress, if at all?

- Did others assume roles that made them less vulnerable to moral distress. If so, what were they?

- What other conditions or factors contributed to your experience or moral distress?

- What were the barriers that prevented you from engaging in moral action (real or perceived)?

- What was it about those barriers that prevented you from engaging in moral distress?

- What role do you think you might have played in your experience of moral distress, if any?

    - Lack of experience or expertise?

    - Personal ideals?

    - Frustration?

Factors that Could Reduce or Prevent Moral Distress

- What would have helped you overcome the experience of moral distress?

- What would you change about the counseling profession that could reduce moral distress for other counselors?

- Having gone through a morally distressing situation already, what advice would you give to another counselor experiencing moral distress?

- Having experienced moral distress, what would be different if you found yourself in a similar situation in the future?

Closing Comments

- What question did you expect me to ask about moral distress that I didn't ask?

- Is there anything else that we haven't talked about that would help me understand your experiences of moral distress?

- Thank participants for their time and participation.

APPENDIX C

PRE-DISSERTATION QUESTIONNAIRE INFORMED CONSENT FORM

Consent to Participate in a Free Response and Demographic Screening Questionnaire
Title: An Initial Exploration of Moral Distress Among Counselors Working With Children and Adolescents

Principal Investigator
Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
141 Guyton Hall
The University of Mississippi
(662) 380-3401

Research Advisor
Marilyn Snow, Ph.D.
School of Education
Counselor Education and Supervision
Insight Park, Suite 163
The University of Mississippi
(662) 915-1363

Research Advisor
Lori Wolff, Ph.D., J.D.
School of Education
Leadership and Counselor Education
139 Guyton Hall
The University of Mississippi
(662) 915-5791

Description
We are interested in exploring the experiences of counselors, regarding the phenomenon of moral distress and the factors that uniquely contribute to it. Moral distress is defined as:

***Distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"* (McCarthy & Deady, 2008, p. 254).**

The purpose of this study is to gain an initial understanding of counselors' conceptualizations of moral distress and the ways in which morally distressing situations arise in counselors' clinical work. Together, we are hoping to gain an initial understanding about the domains in which moral distress occurs in order to develop an instrument, which will be used to assess for moral distress within the context of counseling.

Procedure
If you agree to participate in this study, you be agreeing to complete a brief questionnaire that includes four free response questions, which provide you the opportunity to briefly describe your experience of moral distress. Additionally, there are several multiple choice and demographic questions, which will help determine criterion sampling and maximum variation. You will also have the option of being considered for an interview to explore your experiences with moral distress; however, completion of this survey does not require nor guarantee your participation in an interview. **Even if you do not intend to participate in an interview, your participation in this questionnaire is requested.** This informed consent form is for the free response and demographic questionnaire only. Participants selected for an interview will be provided an additional informed consent form regarding their participation in an interview. It is expected that the questionnaire will take approximately 10-15 minutes to complete. Selected interview participants will be provided an additional informed consent regarding their participation.

Eligibility Criteria
You are eligible for this study if you meet the following criteria:

- You have completed at least a master's degree in counseling,
- You have at least one year of supervised, post-master's degree, counseling experience,
- You have experience counseling children and/or adolescents (roughly between the ages of two and twenty-four; Siegel, 2013), and
- You have experienced moral distress, as defined above.

Risks and Benefits
Risks: There are no anticipated risks for completing the questions included in this study. As with any research, however, there is a possibility that you may be subjected to risks that have not yet been identified.

Benefits: Participation in this study will greatly increase the understanding of moral distress within the context of counseling. Your participation will aid in future endeavors to understand, assess for, and prevent moral distress and its consequences among counselors.

Cost and Payments
Costs: Aside from the time involved in your completion of the questionnaire, there are no costs for you to participate in this study.

Payments: The researchers are unable to provide payment for participating in this questionnaire. We hope that you will find the purpose of this study, along with its potential benefits, worth the brief amount of time it will take to complete this questionnaire.

Confidentiality
The only identifying information that the researchers will have access to is demographic information reported by the participants. The questionnaire has been anonymized so that IP addresses and locations are not identified or recorded. The questionnaire includes several items

related to your gender, ethnicity, age, years of experience, clinical setting, geographic area where you were practicing when you experienced moral distress, and counseling specialty or area of focus. Additionally, you will have an opportunity to briefly describe your experience of moral distress and the perceived barriers to moral action. Names of participants will not be collected, considered, or released. Therefore, the researchers believe that they have minimized the possibility that responding to the questions included in this questionnaire may reveal your identity.

Should you choose to provide your email address in order to be considered as an interview participant, the primary researcher will take steps to keep your information confidential. The principal investigator and research advisors will be the only individuals with access to your answers to the survey. All data collected will be stored on an encrypted hard drive that will be kept in a locked office on the campus of The University of Mississippi. Additionally, no identifying information will be linked to your responses or demographic information on any reports, presentations, or publications. If you participate in an interview, you will be given an arbitrary pseudonym during transcription of interviews and will, thereafter, be referred to solely by your pseudonym.

Some participants' responses may be reported in future presentations or publications. However, participant responses will only be connected to their given pseudonym and will not be tied to any identifying information in order protect your anonymity and to uphold confidentiality.

Voluntary Participation and Right to Withdraw
Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to participate in this study and wish to discontinue your participation at a later time, you have the right to drop out of the study at any time, without consequence. If you start the study and decide that you do not want to finish, you may exit the Qualtrics questionnaire to withdraw from participating in the study. If you would like to contact the researchers regarding your participation in the study or your right to withdraw, you are welcomed to do so in person, by letter, or by telephone, according to the contact information provided above.

The researchers may terminate your participation in the study without regard to your consent and for any reason, such as protecting your safety and protecting the integrity of the research data.

IRB Approval
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-134). If you have any questions, concerns, or reports regarding your rights as a participant of research, please contact the IRB at (662) 915-7482.

Statement of Consent
By selecting "I consent to participate in this questionnaire " below, you are confirming several things. You are confirming that you have read this form or have had it read to you, and you are confident that you understand this form, the research study, its risks and benefits, and your rights. You are also confirming that, if you had questions, you had the opportunity to raise them

and have received satisfactory answers. Finally, you confirm that you are at least 18 years old and you consent to participate in this questionnaire, which includes free response, multiple choice, and demographic questions.

You may print a copy of this consent form for your records.

☐ I consent to participate in this questionnaire

☐ I **do not** consent to participate in this questionnaire

APPENDIX D

INITIAL QUESTIONNAIRE RECRUITMENT ANNOUNCEMENT

Dear CESNET-L community,

We are writing to ask for your help in a pre-pilot study exploring moral distress among counselors. This study involves the completion of a brief questionnaire, which is part of an effort to learn about your thoughts and experiences concerning moral distress, as it pertains to your clinical work. Your participation and feedback are very important to us and will help us take the first steps in gaining an understanding of the nature of moral distress within the context of counseling.

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing" (*McCarthy & Deady, 2008, p. 254).**

Purpose:
The purpose of this study is to better understand how counselors experience moral distress and the conditions that contribute to morally distressing situations. Together, we hope to gain an initial understanding of the domains in which moral distress occurs in order to develop an instrument, which will be used to assess for moral distress within the context of counseling.

Procedure:
If you agree to participate in this study, you will be agreeing to complete a brief questionnaire that consists of four free response questions that allow you to briefly describe your experience of moral distress. Additionally, there are several multiple-choice and demographic questions, which will help us determine criterion sampling and maximum variation among participants. You will also have the option of being considered for a brief interview regarding your experiences of moral distress; however, completion of this questionnaire does not require nor guarantee your participation in an interview. **Even if you do not intend to participate in an interview, your participation in the questionnaire is requested.** Completion of this brief questionnaire is expected to take approximately 10-15 minutes of your time.

Eligibility Criteria:
You are eligible for this study if you fit in the following criteria:

- You have completed at least a Masters degree in counseling,
- You have at least one year of supervised, post-Masters degree, counseling experience
- You have experience counseling children and/or adolescents, and
- You have experienced moral distress, as defined above.

If you are interested in this study and willing to complete the brief questionnaire, please click the link below to be directed to the informed consent form and questionnaire. If you are not directed to the questionnaire immediately, you may cut and paste the link into your web browser. Before completing the questionnaire, you will be asked to review the informed consent form in its

entirety, including the purpose and procedures of the study, as well as your rights as a research participant.

Link to the questionnaire:

http://uofmississippi.qualtrics.com/SE/?SID=SV_8ekhuCLMmxSFJBz

IRB Approval:
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-134). If you have any questions, comments, or concerns regarding your rights as a participant of research, please contact The University of Mississippi's IRB at (662) 915-7482.

Please let us know if you have any questions, and please feel free to forward this email to anyone you know who works with children/adolescents and might be interested in sharing their experience of moral distress. Many thanks for your consideration of participating in this important study.

Sincerely,

Principal Investigator:
Ian Turnage-Butterbaugh, M.S.
Doctoral Candidate
Counselor Education and Supervision
isbutter@go.olemiss.edu

Research Advisors:
Marilyn Snow, Ph.D., LPC, NCC, RPT-S
Director, Child Advocacy and Play Therapy Institute
Associate Professor
Counselor Education and Supervision
mssnow@olemiss.edu

Lori Wolff, Ph.D., J.D.
Director of the Dr. Maxine Harper Center for Educational Research and Evaluation
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APPENDIX E

FIRST FOLLOW-UP QUESTIONNAIRE RECRUITMENT ANNOUNCEMENT

Moral Distress Demographic Questionnaire Recruitment Email (1 Week After)

Dear Counselors and Counselor Educators,

Last week a questionnaire seeking your feedback about moral distress was sent to you. Because of your role as a counselor, we are asking for your thoughts about and experiences with moral distress, as it pertains to your clinical work.

If you have already completed the online questionnaire, please accept our sincere thanks. Your feedback is very much appreciated and will help us gain an initial understanding of the nature of moral distress within the context of counseling. If you have not completed the questionnaire, we are hoping that you can take the time to complete it today. We are working to develop an instrument to assess for moral distress among counselors, which we hope will be of benefit to you and others in the field of counseling. By knowing your thoughts and experiences, we hope to build a stronger and more reliable instrument that will appropriately address the need to explore moral distress among counselors.

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

This study will help us better understand how counselors experience moral distress and the conditions that contribute to morally distressing situations. Together, we are hoping to gain an initial understanding about the domains in which moral distress occurs in order to develop an instrument that will be used to assess for moral distress within the context of counseling. The Institutional Review Board at The University of Mississippi has approved this study (IRB Protocol #15x-134).

This demographic screening questionnaire will help us determine criterion sampling and maximum variation among participants. If you decide to participate in the demographic questionnaire, you will have the option of being considered for a brief interview regarding your experiences of moral distress. Even if you do not intend to participate in an interview, your participation in the demographic questionnaire is requested. **This informed consent for is for the demographic questionnaire only, which is expected to take approximately ten (10) minutes to complete.** The selected interview participants will be provided an additional informed consent regarding their participation.

About your participation:

You are eligible for this study if you fit in the following criteria:

- You have completed at least a Masters degree in counseling,
- You have at least one year of supervised, post-Masters degree, counseling experience

- You have experience counseling children and/or adolescents, and
- You have experienced moral distress, as defined above.

About your participation:

Your participation in this study is voluntary. If you decide to participate in this study, you will be agreeing to complete a brief demographic questionnaire. Participation in the questionnaire does not guarantee participation in an interview. Selected candidates for participation in interviews will be contacted, via the optional email address provided in the demographic questionnaire, at a later date. Candidates will receive a second informed consent with a detailed description of the interview, its purpose, and procedures. You are not obligated to complete an interview if you provide your email address, and you are welcome to withdraw your consent to participate or dropout of the study at any time.

Compensation for your Time:

The researchers are unable to compensate you for participating in this demographic questionnaire. We realize that you are busy with your other commitments, however, **we hope**, **that you will find the study and potential benefits that accompany an initial investigation of moral distress among counselors important to your work**.

Confidentiality:

The researchers will take steps to keep all identifying information, including your email address if you decide to provide it, confidential. The principal investigator and research advisors will be the only individuals with access to your responses to this questionnaire. The results of this study may be reported in future presentations or publications, but at no time will any identifying information be associated with your responses.

If you are **willing to participate in this study**, **please click the link below to be directed to the informed consent form and demographic screening questionnaire. Before completing the questionnaire, you will be asked to review the purpose and procedures of this study and provide your informed consent.**

Please let us know if you have any questions. Many thanks for your consideration of participating in this important study.

Sincerely,

Principal Investigator:
Ian Turnage-Butterbaugh, M.S.
Doctoral Candidate
Counselor Education and Supervision
isbutter@go.olemiss.edu

Research Advisors:
Marilyn Snow, Ph.D., LPC, NCC, RPT-S

Director, Child Advocacy and Play Therapy Institute
Associate Professor
Counselor Education and Supervision
mssnow@olemiss.edu

Lori Wolff, Ph.D., J.D.
Director of the Dr. Maxine Harper Center for Educational Research and Evaluation
Professor of Leadership and Counselor Education
The University of Mississippi
lawolff@olemiss.edu

APPENDIX F

SECOND FOLLOW-UP QUESTIONNAIRE RECRUITMENT ANNOUNCEMENT

Moral Distress Demographic Questionnaire Recruitment Email (3 Weeks After)

Dear CESNET-L community,

Three weeks ago, a questionnaire seeking your feedback about moral distress was sent to you. Because of your role as a counselor, we are sending a **final request** for you to provide your thoughts and experiences concerning moral distress, as it pertains to your clinical work.

If you have already completed the online questionnaire, please accept our sincere thanks. Your time and feedback are very much appreciated and will help us gain an initial understanding of the nature of moral distress within the context of counseling.

If you have not completed the questionnaire, we are hoping that you can take the time to complete it today. We are working to develop an instrument to assess for moral distress among counselors, which we hope will be of benefit to you and others in the field of counseling. By knowing your thoughts and experiences, we hope to build a more valid and reliable instrument that will appropriately address the need to explore moral distress among counselors. **This questionnaire will remain available until midnight (PST) on Thursday, January 30, 2015**.

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing" (*****McCarthy & Deady, 2008, p. 254).**

Purpose:
The purpose of this study is to gain a better understanding of how counselors experience moral distress and the conditions that contribute to morally distressing situations. Together, we hope to gain an initial understanding of the domains in which moral distress occurs in order to develop an instrument, which will be used to assess for moral distress within the context of counseling.

Procedure:
If you agree to participate in this study, you will be agreeing to complete a brief questionnaire that consists of four free response questions that allow you to briefly describe your experience of moral distress. Additionally, there are several multiple-choice and demographic questions, which will help us determine criterion sampling and maximum variation among participants. You will also have the option of being considered for a brief interview regarding your experiences of moral distress; however, completion of this questionnaire does not require nor guarantee your participation in an interview. **Even if you do not intend to participate in an interview, your participation in the questionnaire is requested.** Completion of this brief questionnaire is expected to take approximately 10-15 minutes of your time.

Eligibility Criteria:

You are eligible for this study if you meet the following criteria:

- You have completed at least a master's degree in counseling,
- You have at least one year of supervised, post-master's degree, counseling experience,
- You have experience counseling children and/or adolescents (roughly between the ages of two and twenty-four; Siegel, 2013), and
- You have experienced moral distress, as defined above.

If you are interested in this study and willing to complete the brief questionnaire, please click the link below to be directed to the informed consent form and questionnaire. If you are not directed to the questionnaire immediately, you may copy and paste the link into your web browser. Before completing the questionnaire, you will be asked to review the informed consent form in its entirety, including the purpose and procedures of the study, as well as your rights as a research participant.

Link to the questionnaire:

http://uofmississippi.qualtrics.com/SE/?SID=SV_8ekhuCLMmxSFJBz

IRB Approval:
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-134). If you have any questions, comments, or concerns regarding your rights as a participant of research, please contact The University of Mississippi's IRB at (662) 915-7482.

Please let us know if you have any questions, and please feel free to forward this email to anyone you know who works with children/adolescents and might be interested in sharing their experience of moral distress. Again, many thanks for your consideration of participating in this important study.

Sincerely,

Principal Investigator:

Ian Turnage-Butterbaugh, M.S.
Doctoral Candidate
Counselor Education and Supervision
isbutter@go.olemiss.edu

Research Advisors:
Marilyn Snow, Ph.D., LPC, NCC, RPT-S
Director, Child Advocacy and Play Therapy Institute
Associate Professor
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Lori Wolff, Ph.D., J.D.
Director of the Dr. Maxine Harper Center for Educational Research and Evaluation
Professor of Leadership and Counselor Education
The University of Mississippi
lawolff@olemiss.edu

APPENDIX G

MORAL DISTRESS INTERVIEW REQUEST ANNOUNCEMENT

Dear Interested Research Participant,

Recently you indicated your interest in participating in an interview to explore your experience of moral distress in counseling. **I first want to extend my sincere appreciation for your interest in our study and willingness to participate in an interview. Thank you!**

I am contacting you to confirm your willingness to participate in one telephone or Skype interview. Each interview is expected to last a maximum of one hour of your time and will consist of questions regarding your experience of moral distress, along with the factors that contributed to and could have prevented the morally distressing situation(s). If you are willing to participate, the principal investigator, Ian Turnage-Butterbaugh, will contact you via telephone or Skype (based on your preference).

Purpose
The purpose of these interviews is to gain a clearer understanding of counselors' conceptualizations of moral distress and the ways in which morally distressing situations arise in counselors' clinical work. Together, we are hoping to gain an initial understanding about the domains in which moral distress occurs in order to develop an instrument, which will be used to assess for moral distress within the context of counseling

About your participation
If you agree to participate in an interview, please follow the link below, which will direct you to the informed consent form for this study. Before deciding whether or not you consent to participate in an interview, you are asked to please read the informed consent in its entirety. If you consent to participate, you will be asked to provide your contact information and availability for an interview. It is expected that this interview will take no longer than one hour of your time.

We realize that you are busy with other commitments, especially at this time of year; however, **we hope**, **that you will find this study and its potential benefits important to your work and the field of counseling**.

If you have any questions about your participation in this study, please do not hesitate to email the principal investigator at the email address provided below. Your questions, comments, and feedback are welcomed, and I will promptly respond to your inquiries.

Voluntary Participation and Right to Withdraw
Your participation in this study is completely voluntary and if you consent to participate, you are welcome to withdraw or drop out of the study at any time. If you decide to begin the interview and change your mind, you may end your participation at any time, for any reason, without consequence.

If you are willing to participate in an interview, **please click the link below to be directed to the informed consent.** You will be asked to review the purpose and procedures of the interview, including interview recording and storage procedures, the risks involved in participating, and the steps taken by the researchers to minimize those risks. You also will be asked to provide your informed consent to participate in an interview, and provide your email address, first name (or name in which you would like to be identified during the interview), telephone or Skype preference, respective contact information, and date(s) and time(s) available for an interview.

LINK TO INFORMED CONSENT AND CONTACT INFORMATION:

http://uofmississippi.qualtrics.com/SE/?SID=SV_5pUqKixTHdqN1eB

The Institutional Review Board (IRB) at The University of Mississippi has reviewed and approved this study (Protocol #15x-134). Again, please let us know if you have any questions.

Many thanks for your consideration to participate in this important study. I truly look forward to speaking with you soon.

Sincerely,

Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
The University of Mississippi
isbutter@go.olemiss.edu

APPENDIX H

MORAL DISTRESS INTERVIEW INFORMED CONSENT FORM

Informed Consent Form to Participate in an Interview Exploring Moral Distress
Title: An Initial Exploration of Moral Distress Among Counselors Working With Children and Adolescents

Principal Investigator
Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
141 Guyton Hall
The University of Mississippi
(662) 380-3401

Research Advisor
Marilyn Snow, Ph.D.
School of Education
Counselor Education and Supervision
Insight Park, Suite 163
The University of Mississippi
(662) 915-1363

Research Advisor
Lori Wolff, Ph.D., J.D.
School of Education
Leadership and Counselor Education
139 Guyton Hall
The University of Mississippi
(662) 915-5791

Description
Through interviews, we are interested in exploring the experiences of counselors, regarding the phenomenon of moral distress and the factors that uniquely contribute to it. Moral distress is defined as:

***Distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"* (McCarthy & Deady, 2008, p. 254).**

Purpose
The purpose of these interviews is to gain a clearer understanding of counselors' conceptualizations of moral distress and the ways in which morally distressing situations arise in counselors' clinical work. Together, we are hoping to gain an initial understanding about the domains in which moral distress occurs in order to develop an instrument, which will be used to

assess for moral distress within the context of counseling.

Procedure
After reading this informed consent form, please indicate whether or not you consent to participate in an interview. If you choose to consent, you will be asked whether you would prefer to be contacted by telephone or Skype, and to provide your respective telephone number or Skype contact name, your first name (or name you would like to be referred to as), and day(s)/time(s) you are available for an interview. A confirmation email will be sent to the email address provided confirming a date and time for your interview. At that scheduled date and time, and according to your preferences, you will be contacted by the principal investigator, Ian Turnage-Butterbaugh, via telephone or Skype. The interview is expected to last no more than one hour of your time. During that time, you will be asked questions that are grouped into three broad categories: (1) your experience of moral distress; (2) the factors that contributed to your experience of moral distress; and (3) potential factors that could have reduced or prevented your experience of moral distress. There are no right or wrong answers to these questions; we are genuinely interested in and value your perspective, as it will help us understand moral distress more completely.

The interview will be audio recorded and transcribed verbatim in order to capture the complexity and richness of participants' responses. During transcription, you will be assigned an arbitrary pseudonym; thereafter you will only be referred to by your pseudonym and it will be the only information associated with your responses. The principal investigator is the only person who will have access to your name prior to pseudonym assignment; however the principal investigator and research advisors will have access to your transcribed responses, as necessary.

Eligibility Criteria
You are eligible for this study if you meet the following criteria:

You have completed at least a master's degree in counseling, You have at least one year of supervised, post-master's degree, counseling experience You have experience counseling children and/or adolescents (roughly between the ages of two and twenty-four; Siegel, 2013), and You have experienced moral distress, as defined above.

Risks and Benefits
Risks: As mentioned above, your participation in this study will involve a telephone or Skype interview, during which the principal investigator will be able to see and/or hear you. As a result, your anonymity cannot be guaranteed; however steps will be taken to help ensure that your information, responses, and identity are protected. Steps to help ensure your anonymity and confidentiality after the interview are described below.

Benefits: Participation in this study will greatly increase the understanding of moral distress within the context of counseling. Your participation will aid in future endeavors to understand, assess for, and prevent moral distress and its consequences among counselors working with children and adolescents.

Cost and Payments
Costs: Aside from the time involved in your completion of the questionnaire, there are no costs for you to participate in this study.

Payments: The researchers are unable to provide payment for participating in an interview. We hope that you will find the purpose of this study, along with its potential benefits, worth your time, and we sincerely appreciate your contribution to our initial exploration of moral distress in counseling.

Confidentiality and Anonymity
Because this study involves interviews, we cannot ensure your anonymity. We will, however, take steps to ensure that your anonymity is upheld after the interview. Following the interview, audio recordings will be transcribed verbatim, during which time, you will be assigned an arbitrary pseudonym. Thereafter, you will be referred to solely as your pseudonym in an effort to conceal your identity. During and after analysis, no identifying information will be linked to or associated with your responses, in whole or in part. This includes, but is not limited to, future reports, presentations, and/or publications, which may result from this study.

The principal investigator and research advisors will also take steps to help ensure your confidentiality throughout the study. The interviews will be audio recorded; however, all audio files will be stored on an encrypted hard drive that will remain in a locked office. Aside from your first name (or name in which you would like to be referred), you are not required nor encouraged to provide any additional identifying information, unless you feel it is particularly significant to your experiences, and you disclose it voluntarily. In the event that you do provide identifying information, the principal investigator will do his best to protect your identity, to the fullest extent possible.

Due to these measures, we believe that we have minimized the possibility that participating in an interview will reveal your identity, connect you to your responses, or otherwise compromise your personal information, during and after the completion of this study.

Voluntary Participation and Right to Withdraw
Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to participate in this study and wish to discontinue your participation at a later time, you have the right to drop out of the study at any time, without consequence. If you start an interview and decide that you do not want to finish it, you can disconnect from the telephone or Skype call at any time, for any reason. If you would like to contact the researchers regarding your participation in the study or your right to withdraw, you are welcomed to do so in person, by letter, or by telephone, according to the contact information provided above.

The researchers may terminate your participation in the study without regard to your consent and for any reason, such as protecting your safety and protecting the integrity of the research data.

IRB Approval
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-134). If you have any

questions, comments, or concerns regarding your rights as a participant of research, please contact the IRB at (662) 915-7482.

Statement of Consent

By selecting "I consent to participate in this questionnaire " below, you are confirming several things. You are confirming that you have read this form or have had it read to you, and you are confident that you understand this form, the research study, its risks and benefits, and your rights. Additionally, you are confirming that you understand the interviews will be audio recorded and transcribed, and are satisfied with the steps that will be taken to protect your identity. You are also confirming that, if you had questions, you had the opportunity to raise them and have received satisfactory answers. Finally, you confirm that you are at least 18 years old and you consent to participate in this interview, which includes questions related to your experience of moral distress, the factors that contributed to it, and potential factors that could have prevented it.

You may print a copy of this consent form for your records.

☐ I consent to participate in an interview

☐ I **do not** consent to participate in an interview

APPENDIX I

QUALTRICS QUESTIONNAIRE FOR INTERVIEWEE CONTACT INFORMATION

1. Please provide your email address below so a confirmation email can be sent to you:

2. Please indicate whether you would prefer to be contacted by telephone or Skype:

   ☐ Telephone

   ☐ Skype

3. Please provide either your telephone number or Skype contact name (according to your preference above):

4. Please provide your first name (or the name in which you would like to be referred during the interview):

5. Please provide at least one day and time during which you are available for an interview. Interviews can be scheduled from 7:00 am to 10:00 pm (CST) any day of the week

	Time of Day (CST)															
	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00
Wednesday, February 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thursday, February 5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Friday, February 6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Saturday, February 7	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sunday, February 8	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Monday, February 9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuesday, February 10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wednesday, February 11	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thursday, February 12	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Friday, February 13	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

APPENDIX J

SEMI-STRUCTURED MORAL DISTRESS INTERVIEW PROTOCOL

Moral Distress Interview Guide

Introduction

- Greeting
- Recap of informed consent (each participant has …)
    - Indicated that they are 18 years of age or older
    - Indicated that they understand the purpose and procedures
    - Had a chance to ask questions and has received satisfactory answers
    - Agreed to have their comments audio recorded
    - Indicated that they understand the limits to confidentiality
    - Been informed that they can withdraw their participation at any time
        - Is this true of each participant in the focus group?
- Purpose of interview
    - Definition of moral distress
        - Moral distress is defined as the distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"
    - To learn about your experiences with moral distress and what it looks like in counseling.
    - To identify factors that contribute to moral distress among counselors
    - To understand situations or settings in which moral distress occurs

Experiences of Moral Distress

- Let's take a broad or overall look at your experience of moral distress.

- Would you tell me about the moral distress you experienced?
- What was that experience like for you?
- How did you know you were experiencing moral distress?
- In what ways, if any, did your experience of moral distress impact you?
- How severe was that moral distress to you?
- Where did the moral distress you experienced stem from?
    - Institutional policies?
    - Lack of resources?
    - Lack of time?
    - Personal ideals?
    - Hierarchical roles?
    - Insurance restrictions?

Factors Contributing to Moral Distress

- Let's talk specifically about the setting you were in when you experienced moral distress.
    - What clinical setting were you in when you experienced moral distress?
    - What was it about this setting that contributed to your experience of moral distress?
    - Would you describe the ethical climate of that setting or institution?
        - The shared perception of what is ethically correct behavior and how ethical issues should be handled.
    - Were there any interpersonal dynamics that contributed to your experienced of moral distress?
- Let's shift our focus to the clinical role you had in that setting.
    - In what ways did you contribute to your experience of moral distress, if at all?

- In what ways did your clinical role contribute to their experience of moral distress, if at all?

- Did others assume roles that made them less vulnerable to moral distress. If so, what were they?

- What other conditions or factors contributed to your experience or moral distress?

- What were the barriers that prevented you from engaging in moral action (real or perceived)?

- What was it about those barriers that prevented you from engaging in moral distress?

- What role do you think you might have played in your experience of moral distress, if any?

    - Lack of experience or expertise?

    - Personal ideals?

    - Frustration?

Factors that Could Reduce or Prevent Moral Distress

- What would have helped you overcome the experience of moral distress?

- What would you change about the counseling profession that could reduce moral distress for other counselors?

- Having gone through a morally distressing situation already, what advice would you give to another counselor experiencing moral distress?

- Having experienced moral distress, what would be different if you found yourself in a similar situation in the future?

Closing Comments

- What question did you expect me to ask about moral distress that I didn't ask?

- Is there anything else that we haven't talked about that would help me understand your experiences of moral distress?

- Thank participants for their time and participation.

APPENDIX K

POTENTIAL PILOT TESTER RECRUITMENT ANNOUNCEMENT

Dear Potential Pilot Tester,

I am happy to announce that the instrument development phase of my study is complete and the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) is ready to be pilot tested. I am contacting you to ask for your participation in the pilot-testing phase.

Purpose
The purpose of the pilot test is to obtain feedback pertaining to item clarity, difficulty, and ambiguity. Together, we are hoping to strengthen the instrument and make necessary modifications before more widespread distribution.

About your participation
If you agree to review the MDSC-CA, please follow the link below, which will direct you the informed consent form for this phase of my study. Before deciding whether or not you consent to participate in an interview, you are asked to please read the informed consent for in its entirety, which will provide you with information about the purpose of the study, the participation procedures, and any risks involved in your participation, along with the measures the researcher has taken to minimize those risks.

If you consent to participate as a pilot tester, you will be asked to complete the instrument with a critical eye. Following completion of the MDSC-CA, you will have an opportunity to provide any feedback, criticisms, and/or suggestions that might help strengthen the instrument.

Anonymity and Confidentiality
The Qualtrics version of the MDSC-CA has been anonymized, meaning that the researcher will not have access to your identifying information. This includes, but is not limited to, your name, location, professional affiliation, and IP address. Because I can provide anonymity, I can also provide confidentiality. None of your responses to the items on the MDSC-CA, nor the feedback and comments you provide, can be linked or associated to you in any way. Taking these measures is important to me in order to protect you and your information, and also to provide you with a safe and secure way to provide important feedback. I hope these measures will encourage you to respond genuinely and honestly, which is essential to the development and modification of the MDSC-CA.

If you have any questions or concerns about your participation in this study, please do not hesitate to email the researcher at the email address provided below. Your questions, comments, and feedback are welcomed, and I will promptly respond to your inquiries.

Voluntary Participation and Right to Withdraw
Your participation in this study is completely voluntary and if you consent to participate, you are welcome to withdraw or drop out of the study at any time. If you decide to begin taking the MDSC-CA and change your mind, you may end your participation at any time, for any reason,

without consequence.

If you are willing to participate as a pilot tester, **please click the link below to be directed to the brief informed consent form.** You will be asked to review the purpose and procedures of the pilot test, the risks involved in participating, and the measures taken by the researcher to minimize those risks. You also will be asked to provide your informed consent to participate as a pilot tester before you can access the MDSC-CA.

LINK TO INFORMED CONSENT FORM AND PILOT TEST SURVEY:

http://uofmississippi.qualtrics.com/SE/?SID=SV_cZ33T5eCl7iOadn

The Institutional Review Board (IRB) at The University of Mississippi has reviewed and approved this study (Protocol #15x-230). Again, please let me know if you have any questions.

Many thanks for your consideration to participate as a pilot tester in this important study.

Sincerely,

Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
The University of Mississippi
isbutter@go.olemiss.edu

APPENDIX L

LAYPERSON PILOT TEST SURVEY INFORMED CONSENT FORM

Consent to Participate in a Survey Assessing Non-Validity Issues of an Instrument Developed to Measure Moral Distress Among Counselors Working with Children and Adolescents

Title: Development and Initial Validation of an Instrument to Measure Moral Distress Among Counselors Working with Children and Adolescents

Principal Investigator
Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
141 Guyton Hall
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(662) 380-3401

Research Advisor
Lori Wolff, Ph.D., J.D.
School of Education
Leadership and Counselor Education
139 Guyton Hall
The University of Mississippi
(662) 915-5791

Description
We are in the process of developing an instrument to measure moral distress among counselors who work with children and adolescents. At this phase, we have identified several domains and sub-themes from which moral distress occurs, along with an initial item pool, all of which comprise the instrument. We are seeking pilot test participants to help assess non-validity issues of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Specifically, participants will be asked to assess the acceptability of instrument items as it pertains to issues such as item clarity, conciseness, and ambiguity. We would greatly appreciate your participation and feedback, which will help with the forthcoming instrument development and modification.

Moral distress is defined as:

Distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing" **(McCarthy & Deady, 2008, p. 254).**

The purpose of this survey is to assess non-validity issues of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Together, we are hoping to strengthen the validity of the instrument for future use in subsequent studies.

Procedure
If you agree to participate in this study, you are agreeing to complete a survey that asks you to assess the acceptability of the instructions for and items comprising the MDSC-CA. Specifically, you will be asked to assess non-validity issues, such as clarity, conciseness, ambiguity, and difficulty of both the instrument's instructions and items. Additionally, you will have the opportunity to provide feedback for each item, as well as the instrument as a whole.

Eligibility Criteria
You are eligible to complete this survey if you:

- can access the Qualtrics survey via the Internet, and
- are able to read at approximately a 10th grade reading level.

Risks and Benefits
Risks: There are no anticipated risks for completing the questions included in this study. This study does not ask or require you to divulge any personal information, aside from your feedback and comments, as described above. As with any research, however, there is a possibility that you may be subjected to risks that have not yet been identified.

Benefits: Participation in this study will greatly improve the clarity of the instrument, which will help with instrument accessibility in the future.

Cost and Payments
Costs: Aside from the time involved in your completion of the survey, there are no costs for you to participate in this study.

Payments: The researchers are unable to provide payment for participating in this study. We hope that you will find the purpose of this study, along with its potential benefits, worth the amount of time it will take to complete this survey.

Confidentiality
The researchers will not have access to any of your identifying information, unless you voluntarily and willingly provide such information in your responses. If you provide such identifying information, it will be removed from your responses prior to analysis and will not be collected, considered, or reported thereafter. The survey has been anonymized so that IP addresses and locations are not identified or recorded. Names of participants will not be collected, considered, or released; therefore, the researchers believe that they have minimized the possibility that responding to the questions and prompts included in this survey may reveal your identity.

The principal investigator and research advisor will be the only individuals with access to your answers to the survey. All data collected will be stored on an encrypted hard drive that can only

be accessed by the principal investigator. Additionally, no identifying information will be linked to your responses or demographic information on any reports, presentations, or publications.

Some participants' responses may be reported in future presentations or publications; however, because the survey is anonymized, participant responses will not be tied to any identifying information in order protect your anonymity and to ensure confidentiality.

Voluntary Participation and Right to Withdraw
Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to participate in this study and wish to discontinue your participation at a later time, you have the right to drop out of the study at any time, without consequence. If you start the survey and decide that you do not want to finish, you may exit the Qualtrics survey to withdraw from participating in the study. If you would like to contact the researchers regarding your participation in the study or your right to withdraw, you are welcomed to do so in person, by letter, or by telephone, according to the contact information provided above.

The researchers may terminate your participation in the study without regard to your consent and for any reason, such as protecting your safety and protecting the integrity of the research data.

IRB Approval
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-230). If you have any questions or concerns regarding your rights as a participant of research, please contact the IRB at (662) 915-7482.

Statement of Consent
By selecting "I consent to participate in this survey" below, you are confirming several things. You are confirming that you have read this form or have had it read to you, and you are confident that you understand this form, the research study, its risks and benefits, and your rights. You are also confirming that, if you had questions, you had the opportunity to raise them and have received satisfactory answers. Finally, you confirm that you are at least 18 years old and you consent to participate in this survey, which includes responding to dichotomous scales and free response questions.

You may print a copy of this consent form for your records.

☐ I consent to participate in this survey

☐ I **do not** consent to participate in this survey

APPENDIX M

PREVIOUS INTERVIEW PARTICIPANT PILOT TESTER RECRUITMENT ANNOUNCEMENT

Dear Moral Distress Interview Participant,

Recently you participated in an interview to explore your experience of moral distress in counseling with children and/or adolescents. **I first want to extend my sincere appreciation for your time and participation, as well as your willingness to review the initial version of our instrument. Thank you!**

I am happy to announce that the instrument development phase of my study is complete and the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) is ready to be pilot tested. Because you were instrumental in the development of the instrument, I would sincerely appreciate it if you would spend a few moments reviewing the instrument.

Purpose
The purpose of the pilot test is to assess non-validity and validity issues related to the developed instrument. Specifically, I am seeking your feedback about issues pertaining to item clarity, difficulty, and ambiguity, as well face validity and content validity. You will be asked to rate the appropriateness of the instructions, the representativeness of the items in relation to their content domains, and the acceptability of each item in its current form. Together, I am hoping to assess the strength of the instrument and make necessary modification before widespread distribution.

About your participation
If you agree to review the MDSC-CA, please follow the link below, which will direct you the brief informed consent form for this phase of my study. Before deciding whether or not you consent to participate in an interview, you are asked to please read the informed consent in its entirety. If you consent to participate as a pilot tester, you will be asked to complete the instrument with a critical eye. Following completion of the MDSC-CA, you will have an opportunity to provide any feedback, criticisms, and/or suggestions that might help increase the accessibility and validity of the instrument.

Anonymity and Confidentiality
The Qualtrics version of the MDSC-CA has been anonymized, meaning that the researcher will not have access to your identifying information. This includes, but is not limited to, your name, location, affiliation, and Internet Protocol address. Because I can provide anonymity, I can also provide confidentiality. None of your responses to the items on the MDSC-CA, nor the feedback and comments you provide, can be linked or associated to you. Taking these measures is important to me in order to protect you and your information, and also to provide you with a safe and secure way to provide important feedback. I hope these measures will encourage you to provide genuine and honest feedback, which is essential to the development and modification of the MDSC-CA.

If you have any questions or concerns about your participation in this study, please do not

hesitate to email the researcher at the email address provided below. Your questions, comments, and feedback are welcomed, and I will promptly respond to your inquiries.

Voluntary Participation and Right to Withdraw
Your participation in this study is completely voluntary and if you consent to participate, you are welcome to withdraw or drop out of the study at any time. If you decide to begin taking the MDSC-CA and change your mind, you may end your participation at any time, for any reason, without consequence.

If you are willing to participate as a pilot tester, **please click the link below to be directed to the brief informed consent form.** You will be asked to review the purpose and procedures of the pilot test, the risks involved in participating, and the measures taken by the researcher to minimize those risks. You also will be asked to provide your informed consent to participate as a pilot tester before you can access the MDSC-CA.

LINK TO INFORMED CONSENT FORM AND PILOT TEST SURVEY:

http://uofmississippi.qualtrics.com/SE/?SID=SV_0PAZfHWyllfyx0N

The Institutional Review Board (IRB) at The University of Mississippi has reviewed and approved this study (Protocol #15x-230). Again, please let me know if you have any questions.

Many thanks for your consideration to participate as a pilot tester in this important study.

Sincerely,

Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
The University of Mississippi
isbutter@go.olemiss.edu

APPENDIX N

PREVIOUS INTERVIEW PARTICIPANT PILOT TEST SURVEY INFORMED CONSENT FORM

Consent to Participate in a Survey Assessing Validity and Non-Validity Issues of an Instrument Developed to Measure Moral Distress Among Counselors Working with Children and Adolescents

Title: Development and Initial Validation of an Instrument to Measure Moral Distress Among Counselors Working with Children and Adolescents

Principal Investigator
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(662) 380-3401

Research Advisor
Lori Wolff, Ph.D., J.D.
School of Education
Leadership and Counselor Education
139 Guyton Hall
The University of Mississippi
(662) 915-5791

Description
We are in the process of developing an instrument to measure moral distress among counselors who work with children and adolescents. At this phase, we have identified several domains and sub-themes from which moral distress occurs, along with an initial item pool, each of which comprise the instrument. We are seeking pilot test participants to help establish the initial validity of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Additionally, participants will be asked to rate non-validity issues pertaining to the instructions and items included on the initial version of the developed instrument. We would greatly appreciate your participation and feedback, which will help with the forthcoming instrument modification.

Moral distress is defined as:

Distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing" **(McCarthy & Deady, 2008, p. 254).**

The purpose of this study is to assess the face validity, content validity, and non-validity issues of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Together, we are hoping to strengthen the validity of the instrument for future use in subsequent studies.

Procedure
If you agree to participate in this study, you are agreeing to complete a survey that asks you to rate the validity of items on the MDSC-CA. Specifically, you will be asked to rate the representativeness of each item as it pertains to its respective content domain. Additionally, you will be asked to consider the acceptability of each element, in terms of non-validity issues, such as clarity, conciseness, ambiguity, and difficulty of both the instrument's instructions and items. You will have the opportunity to provide feedback for each item and sub-theme, as well as the instrument as a whole. Finally, you will be asked to provide demographic information pertaining to personal and professional characteristics. Responding to demographic questions is completely optional and voluntary, as "Prefer not to disclose" and/or "Not applicable" responses are available for each question.

Eligibility Criteria
You are eligible to complete this survey if:

- you have experienced moral distress, as defined above, with children or adolescents (roughly between the ages of two and twenty-four; Siegel, 2013); or
- you are familiar with moral distress; or
- you are familiar with counseling ethics.

Risks and Benefits
Risks: There are no anticipated risks for responding to the questions included in this survey. This study does not ask or require you to divulge any personal information, aside from several optional demographic questions and your feedback, as described above. As with any research, however, there is a possibility that you may be subjected to risks that have not yet been identified.

Benefits: Participation in this study will greatly increase the understanding of moral distress within the context of counseling. Your participation will aid in future endeavors to understand, assess for, and prevent moral distress and its consequences among counselors.

Cost and Payments
Costs: Aside from the time involved in your completion of the survey, there are no costs for you to participate in this study.

Payments: The researchers are unable to provide payment for participating in this study. We hope that you will find the purpose of this study, along with its potential benefits, worth the amount of time it will take to complete this survey.

Confidentiality
The only identifying information the researchers will have access to are demographic variables

reported by the participants. The survey has been anonymized so that IP addresses and locations are not identified or recorded. The survey includes several items related to your gender, ethnicity, age, years of experience, clinical setting, geographic area where you were practicing when you experienced moral distress, and counseling specialty or area of focus. Names of participants will not be collected, considered, or released and demographic information will not be directly tied to or associated with any responses; therefore, the researchers believe that they have minimized the possibility that responding to the questions and prompts included in this survey may reveal your identity.

The principal investigator and research advisor will be the only individuals with access to your answers to the survey. All data collected will be stored on an encrypted hard drive that can only be accessed by the principal investigator. Additionally, no identifying information will be linked to your responses or demographic information on any reports, presentations, or publications.

Some participants' responses may be reported in future presentations or publications. However, because the survey is anonymized, participant responses will not be tied to any identifying information in order protect your anonymity and to ensure confidentiality.

Voluntary Participation and Right to Withdraw
Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to participate in this study and wish to discontinue your participation at a later time, you have the right to drop out of the study at any time, without consequence. If you start the survey and decide that you do not want to finish, you may exit the Qualtrics survey to withdraw from participating in the study. If you would like to contact the researchers regarding your participation in the study or your right to withdraw, you are welcomed to do so in person, by letter, or by telephone, according to the contact information provided above.

The researchers may terminate your participation in the study without regard to your consent and for any reason, such as protecting your safety and protecting the integrity of the research data.

IRB Approval
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-230). If you have any questions or concerns regarding your rights as a participant of research, please contact the IRB at (662) 915-7482.

Statement of Consent
By selecting "I consent to participate in this survey" below, you are confirming several things. You are confirming that you have read this form or have had it read to you, and you are confident that you understand this form, the research study, its risks and benefits, and your rights. You are also confirming that, if you had questions, you had the opportunity to raise them and have received satisfactory answers. Finally, you confirm that you are at least 18 years old and you consent to participate in this survey, which includes responding to dichotomous and polytomous scales, free response, and demographic questions.

You may print a copy of this consent form for your records.

☐ I consent to participate in this survey

☐ I **do not** consent to participate in

APPENDIX O

COUNSELOR, COUNSELOR EDUCATOR, AND EXPERT PILOT TESTER RECRUITMENT ANNOUNCEMENT

Dear Counselor, Counselor Educator, or Counseling Ethics Expert,

For the past several months, I have been working to develop an instrument to measure moral distress among counselors working with children and/or adolescents. I am pleased to announce that the instrument development phase of the study is complete and the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA) is ready to be pilot tested. I am contacting you to ask for your participation and feedback in this exciting pilot test phase.

Purpose
The purpose of the pilot test is to assess non-validity and validity issues related to the developed instrument. Specifically, I am seeking your feedback about issues pertaining to item clarity, difficulty, and ambiguity, as well face validity and content validity. You will be asked to rate the appropriateness of the instructions, the representativeness of the items in relation to their sub-themes, the representativeness of the sub-themes in relation to their respective domain, and the acceptability of each item in its current form. Together, I am hoping to assess the strength of the instrument and make necessary modification before widespread distribution.

Moral distress is defined as the ***distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing"*** **(McCarthy & Deady, 2008, p. 254).**

About your participation
If you agree to review the MDSC-CA, please follow the link below, which will direct you the informed consent form and pilot test survey. Before deciding whether or not you consent to participate in an interview, you are asked to please read the informed consent in its entirety. If you consent to participate as a pilot tester, you will be asked to review and rate the instrument elements with a critical eye. Following your ratings, you will have an opportunity to provide any feedback, criticisms, and/or suggestions that might help increase the accessibility and validity of the instrument. The final section includes several demographic variables, which will not be linked to or associated with your responses.

Eligibility Criteria
We are specifically seeking pilot testers who have experienced moral distress while working with children and/or adolescents, are familiar with moral distress, or consider themselves experts in counseling ethics. Therefore you are eligible to complete this survey if:

- you have experienced moral distress, as defined above, while working with children and/or adolescents (individuals roughly between the ages of two and twenty four; Siegel, 2013); or
- you are familiar with moral distress; or

- you are familiar with ethics relevant to counseling children and/or adolescents.

Anonymity and Confidentiality
The Qualtrics version of the MDSC-CA has been anonymized, meaning that the researcher will not have access to your identifying information. This includes, but is not limited to, your name, location, affiliation, and Internet Protocol address. Because I can provide anonymity, I can also provide confidentiality. None of your responses to the items on the MDSC-CA, nor the feedback and comments you provide, can or will be linked or associated to you in any way. Taking these measures is important to me in order to protect you and your information, and also to provide you with a safe and secure way to provide important feedback. I hope these measures will encourage you to provide genuine and honest feedback, which is essential to the development and modification of the MDSC-CA.
If you have any questions or concerns about your participation in this study, please do not hesitate to email the researcher at the email address provided below. Your questions, comments, and feedback are welcomed, and I will promptly respond to your inquiries.

Voluntary Participation and Right to Withdraw
Your participation in this study is completely voluntary and if you consent to participate, you are welcome to withdraw or drop out of the study at any time. If you decide to begin taking the MDSC-CA and change your mind, you may end your participation at any time, for any reason, without consequence.

If you are willing to participate as a pilot tester, **please click the link below to be directed to the brief informed consent form.** You will be asked to review the purpose and procedures of the pilot test, the risks involved in participating, and the measures taken by the researcher to minimize those risks. You also will be asked to provide your informed consent to participate as a pilot tester before you can access the MDSC-CA.

LINK TO INFORMED CONSENT FORM AND PILOT TEST SURVEY:

http://uofmississippi.qualtrics.com/SE/?SID=SV_0PAZfHWylIfyx0N

The Institutional Review Board (IRB) at The University of Mississippi has reviewed and approved this study (Protocol #15x-230). Again, please let me know if you have any questions.

Many thanks for your consideration to participate as a pilot tester in this important study.

Sincerely,

Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
The University of Mississippi
isbutter@go.olemiss.edu

APPENDIX P

COUNSLOR, COUNSELOR EDUCATOR, AND EXPERT PILOT TEST SURVEY INFORMED CONSENT FORM

Consent to Participate in a Survey Assessing Validity and Non-Validity Issues of an Instrument Developed to Measure Moral Distress Among Counselors Working with Children and Adolescents

Title: Development and Initial Validation of an Instrument to Measure Moral Distress Among Counselors Working with Children and Adolescents

Principal Investigator
Ian Turnage-Butterbaugh, M.S.
School of Education
Counselor Education and Supervision
141 Guyton Hall
The University of Mississippi
(662) 380-3401

Research Advisor
Lori Wolff, Ph.D., J.D.
School of Education
Leadership and Counselor Education
139 Guyton Hall
The University of Mississippi
(662) 915-5791

Description
We are in the process of developing an instrument to measure moral distress among counselors who work with children and adolescents. At this phase, we have identified several domains and sub-themes from which moral distress occurs, along with an initial item pool, each of which comprise the instrument. We are seeking pilot test participants to help establish the initial validity of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Additionally, participants will be asked to rate non-validity issues pertaining to the instructions and items included on the initial version of the developed instrument. We would greatly appreciate your participation and feedback, which will help with the forthcoming instrument modification.

Moral distress is defined as:

Distress that occurs when an individual makes a moral judgment about the right course of action to take but is unable to carry it out. "In short, they know what is the right thing to do, but are unable to do it; or they do what they believe is the wrong thing" **(McCarthy & Deady, 2008, p. 254).**

The purpose of this study is to assess the face validity, content validity, and non-validity issues of the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Together, we are hoping to strengthen the validity of the instrument for future use in subsequent studies.

Procedure
If you agree to participate in this study, you are agreeing to complete a survey that asks you to rate the validity of items on the MDSC-CA. Specifically, you will be asked to rate the representativeness of each item as it pertains to its respective content domain. Additionally, you will be asked to consider the acceptability of each element, in terms of non-validity issues, such as clarity, conciseness, ambiguity, and difficulty of both the instrument's instructions and items. You will have the opportunity to provide feedback for each item and sub-theme, as well as the instrument as a whole. Finally, you will be asked to provide demographic information pertaining to personal and professional characteristics. Responding to demographic questions is completely optional and voluntary, as "Prefer not to disclose" and/or "Not applicable" responses are available for each question.

Eligibility Criteria
You are eligible to complete this survey if:

- you have experienced moral distress, as defined above, with children or adolescents (roughly between the ages of two and twenty-four; Siegel, 2013); or
- you are familiar with moral distress; or
- you are familiar with counseling ethics.

Risks and Benefits
Risks: There are no anticipated risks for responding to the questions included in this survey. This study does not ask or require you to divulge any personal information, aside from several optional demographic questions and your feedback, as described above. As with any research, however, there is a possibility that you may be subjected to risks that have not yet been identified.

Benefits: Participation in this study will greatly increase the understanding of moral distress within the context of counseling. Your participation will aid in future endeavors to understand, assess for, and prevent moral distress and its consequences among counselors.

Cost and Payments
Costs: Aside from the time involved in your completion of the survey, there are no costs for you to participate in this study.

Payments: The researchers are unable to provide payment for participating in this study. We hope that you will find the purpose of this study, along with its potential benefits, worth the amount of time it will take to complete this survey.

Confidentiality
The only identifying information the researchers will have access to are demographic variables

reported by the participants. The survey has been anonymized so that IP addresses and locations are not identified or recorded. The survey includes several items related to your gender, ethnicity, age, years of experience, clinical setting, geographic area where you were practicing when you experienced moral distress, and counseling specialty or area of focus. Names of participants will not be collected, considered, or released and demographic information will not be directly tied to or associated with any responses; therefore, the researchers believe that they have minimized the possibility that responding to the questions and prompts included in this survey may reveal your identity.

The principal investigator and research advisor will be the only individuals with access to your answers to the survey. All data collected will be stored on an encrypted hard drive that can only be accessed by the principal investigator. Additionally, no identifying information will be linked to your responses or demographic information on any reports, presentations, or publications.

Some participants' responses may be reported in future presentations or publications. However, because the survey is anonymized, participant responses will not be tied to any identifying information in order protect your anonymity and to ensure confidentiality.

Voluntary Participation and Right to Withdraw
Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to participate in this study and wish to discontinue your participation at a later time, you have the right to drop out of the study at any time, without consequence. If you start the survey and decide that you do not want to finish, you may exit the Qualtrics survey to withdraw from participating in the study. If you would like to contact the researchers regarding your participation in the study or your right to withdraw, you are welcomed to do so in person, by letter, or by telephone, according to the contact information provided above.

The researchers may terminate your participation in the study without regard to your consent and for any reason, such as protecting your safety and protecting the integrity of the research data.

IRB Approval
The University of Mississippi's Institutional Review Board (IRB) has reviewed this study. The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies (Protocol #15x-230). If you have any questions or concerns regarding your rights as a participant of research, please contact the IRB at (662) 915-7482.

Statement of Consent
By selecting "I consent to participate in this survey" below, you are confirming several things. You are confirming that you have read this form or have had it read to you, and you are confident that you understand this form, the research study, its risks and benefits, and your rights. You are also confirming that, if you had questions, you had the opportunity to raise them and have received satisfactory answers. Finally, you confirm that you are at least 18 years old and you consent to participate in this survey, which includes responding to dichotomous and polytomous scales, free response, and demographic questions.

You may print a copy of this consent form for your records.

☐ I consent to participate in this survey

☐ I **do not** consent to participate in

APPENDIX Q

LAYPERSON MORAL DISTRESS SCALE FOR COUNSELORS – CHILD AND ADOLESCENT FORM

Instructions: Presented below are the instructions for the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Please review the instructions and indicate whether or not you believe the instructions are acceptable, considering clarity, difficulty, ambiguity, and grammar. Please provide any feedback that may help the author make the instructions more acceptable or understandable.

Moral Distress Scale for Counselors – Child and Adolescent Form Instructions		
The following items present situations you may have experienced while working with children and adolescents. Please indicate to what extent each situation has caused you to experience distress and how frequently you have experienced each situation in your clinical work. If you are not currently counseling, but have experienced distress associated with any of the items, please indicate the level to which such items caused you to experience distress and how frequently you experienced each situation. If you have not experienced a particular situation, mark your answer as "irrelevant."		
Item	Yes, the instructions are acceptable	No, the instructions are not acceptable
Do you believe the instructions are acceptable as presented above?	☐	☐
Comments:		

Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA)

The next section presents the initial item pool for the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Please review the items and indicate whether or not you believe each is acceptable by selecting either "Item is Acceptable" or "Item Needs to be Revised." Before making your selection, please consider:

- item clarity,
- conciseness,
- ambiguity,
- confusion,
- difficulty, and
- grammatical errors.

You are encouraged to leave any feedback in the comments section that may help with subsequent instrument development and modification.

Once you have rated all the items, you will have the opportunity to provide any final comments or overall impression prior to submitting your form. I sincerely thank you for your time and help with the initial validation stage of this instrument.

Item	Rating Scale						
1. Because I assumed multiple roles, there was a conflict of interest that forced me to cross boundaries.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
2. I thought doing the right thing would ruin the	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐

rapport I had established with a client's family.	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
3. I gave into pressure to do something I did not agree with because I believed I had a lot to lose if there were negative consequences.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
4. I was unable to do what was best for the client because I was not trained for a specific situation.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
5. I was not able to help a client because I could not find resources for him or her.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
6. I was forced to comply with laws that were not congruent with my core values.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
7. I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
8. I lowered my standards because I discovered the counseling profession is not as responsible as I thought it was.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
9. I believed I was not doing a client justice because working too many hours exhausted me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
10. I was forced to treat a client according to my supervisor's directions, against my judgment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
11. I was not treated with compassion, so I went along with things I did not agree with.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

12. I was not able to intervene appropriately because I was not an employee of the organization in which I provided counseling.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
13. I crossed professional boundaries because I thought to do otherwise would result in catastrophic consequences for the client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
14. I worried that standing up for what I believed was right would jeopardize my career.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
15. I thought I let down a client because I did not have the	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

appropriate training.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
16. I was unable to intervene with a client in need due to an unsupportive legal guardian.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
17. I was unable to intervene when needed, due to contractual obligations with my employer.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
18. I became desensitized to ethical dilemmas because behaving	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

unethically was common practice.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
19. I was unable to meet the needs of a client because my caseload was too large.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
20. I did not give my full potential to a client because work was interfering with my personal life.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
21. I felt powerless in situations in which I witnessed colleagues providing deficient treatment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
22. I wanted to do the right thing because I cared about the organization, but did not think the organization cared about me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
23. I knew I should intervene, but I did not because I was unsure what my role was in the clinical situation.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
24. I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

25. I did not do the right thing because I thought it would make my job more difficult.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
26. I knew I did not do what was best for a client, but was unsure of how to handle their sensitive case.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
27. I was unable to find appropriate resources for a client because he or she had no family support.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
28. I was forced to act against my wishes in an effort to	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

protect the image of the organization.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
29. I knowingly crossed boundaries because of the intense emotional connection I had with a client.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
30. I was overwhelmed by a chaotic schedule, which prevented me from fully attending to a client.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
31. I became frustrated with my responsibilities because they were cutting	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

into my personal time.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
32. Compared to my superiors, I lacked the credibility needed to stand up for what I believed to be right.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
33. I held more than one professional role, which interfered with my availability to meet with clients.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
34. I was reluctant to inform a legal guardian about a client's situation because I thought they would get upset about it.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
35. I did not stand up for what I believed because I did not want others to think I was imposing my values on them.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
36. I was not effective with a client because I was not confident about how to handle the situation.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
37. I was forced to discontinue treatment with a client due to a legal guardian's wishes.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

38. I was unable to do what I thought was best for a client due to the organization's policies.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
39. I thought I would betray the colleagues I was close to by doing what I believed to be the right thing.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
40. I was forced to provide inadequate treatment, owing to work overload.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
41. I became apathetic about my clinical	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

responsibilities because they were interfering with my personal life.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
42. When I tried to do what I believed was right, my superiors dismissed me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
43. Aside from counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
44. I was afraid to intervene with a client because I thought he or she would be given an inappropriate diagnosis.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	

	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
45. I knew I was not being helpful to a client, but I lacked the requisite knowledge to increase effectiveness.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
46. I was having difficulty working with a client but did not have a mentor to consult with.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
47. I thought I was providing futile treatment because of the client's toxic home environment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						

48. The organization's focus on paperwork interfered with my ability to provide counseling.	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
49. I knowingly crossed professional boundaries because I thought it was my responsibility to protect a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
50. The quality of care I was providing decreased because I was overwhelmed by my clinical responsibilities.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
51. I gave less time to my clients	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐

because my clinical responsibilities to them were taking up my free time.	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
52. My superiors were established professionals, so I thought it would be futile to stand up to them for what I believed was right.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
53. I was unable to do what I thought was best for a client because I had multiple relationships with the client's family.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
54. I knew I needed to report the unethical actions of my superior, but	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

was afraid it would cause conflict among my colleagues.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
55. I chose to work with a client despite a lack of pertinent multicultural knowledge.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
56. I was unable to openly discuss my ethical concerns with colleagues.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
57. I was forced to break a client's confidentiality because I had to testify about his or her case in court.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
58. I was forced to follow ethical imperatives that were not congruent with my core values.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
59. Because of my high standards, I never thought I was as effective as I should have been with a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
60. My attrition increased because I was frustrated with the level of care I was forced to provide.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

61. I was not fulfilling my clinical responsibilities because I always was in a hurry to leave my clinical site.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
62. I followed directions I did not agree with because I felt invisible within the system.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
63. I did not provide adequate care for a client because of conflicting messages from two supervisors.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
64. I should have reported the unethical actions of my	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

supervisor but feared that doing so would leave the counselors-in-training without a supervisor.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
65. I knew I was crossing a boundary with a client but was unsure about ethical guidelines for the situation.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
66. Because I did not have the mentorship I needed, I felt like I was becoming part of an unethical organization.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
67. I had to disclose information due to reporting laws, even	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

though I did not think it was in the client's best interest.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
68. I was unable to advocate for a client because doing so would require a breach of confidentiality .	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
69. I went beyond my professional responsibilities because I felt responsible for a vulnerable client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
70. Despite not being able to keep my clients' stories straight, I maintained an unmanageably large caseload.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
71. My clinical responsibilities kept me up at night, which made it difficult to give my full potential to my clients.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
72. I was reluctant to voice my concerns because I did not feel like a valuable member of the clinical team.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
73. I did something I thought was inappropriate due to conflicting messages from two supervisors.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

74. I thought it would be selfish to report a colleague's unethical behavior because it would cause problems for others.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
75. I was not able to meet a client's needs because I was newly out of school.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
76. I was being encouraged to do something I knew was wrong, but did not have a supervisor to support me through the process.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
77. I was required to report a case of suspected abuse,	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
		Very				Very	

although I thought it would cause additional trauma.	Never	Infrequently	Infrequently	Sometimes	Frequently	Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
78. My hands were tied by ethical obligations that conflicted with what was in a client's best interest.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
79. My inability to do what I thought was right reflected my unrealistically high standards for the profession.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
80. I started doing things I knew were not right because I was overworked and needed to make things easier on myself.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		

	☐				☐		
81. I was unable to advocate for a client due to the authority my superior(s) had over me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
82. I had multiple relationships with a supervisor, which impeded my ability to advocate for a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
83. Challenging the organization's unethical culture was not worth the turmoil it would cause.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

84. I knew I was not being effective with a client, but I did not have a trustworthy colleague to discuss the matter with.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
85. I was unable to ensure a client's safety due to a guardian's legal rights.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
86. I was unable to assist a client in need due to professional boundaries.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	
	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
87. A client was not being treated appropriately,	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

but I did not have the power to intervene.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
88. I did not stand up for what I believed was right because I thought doing so would cost me my job.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
89. I was unable to advocate for a client due to weak relationships with community resources.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
90. I knew I had unfinished business that would impact my work with a client, but I	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

continued counseling anyway.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
91. I went along with unethical practices because I did not think my superiors considered my feelings.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
92. I was not being effective because my supervisors were pulling me in different directions.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
93. I was unable to provide resources for a client because the organization had limited funds.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			

	☐				☐		
94. I was forced to follow laws that I knew were not in a client's best interest.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
95. I did not do what I believed was right because I realized the counseling profession has less integrity that I was led to believe.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
96. I thought the organizational system was corrupt, but I had no leverage to make changes.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

97. I did not provide the appropriate interventions because I was afraid the client would be labeled.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
98. I followed directives I did not agree with because I thought I would be reprimanded if I did not.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
99. I wanted to provide additional services for a client, but was not supported by the clinical organization.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
100. I was unable to remain objective due to the	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

emotional bond I created with a client.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
101. I thought I was providing inadequate treatment because I did not understand what a client was going through.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
102. The organization had a lack of resources, which limited what I could do for a client.	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently
	☐	☐	☐	☐	☐	☐
	Item is Acceptable			**Item Needs to be Revised**		
	☐			☐		
103. I did not do the right thing because I was afraid of what others would	Intensity					
	None	Some	Moderate	High	Extreme	Irrelevant
	☐	☐	☐	☐	☐	☐
	Frequency					
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently

think of me.	☐	☐	☐	☐	☐	☐	
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
104. The organization's policies limited the amount of time I was able to spend with a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
105. I knew I was crossing boundaries with a client, but was unsure of relevant state laws.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐
	Item is Acceptable			**Item Needs to be Revised**			
	☐			☐			
106. A client's wishes about treatment restricted me from doing what I thought was best for him or her.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently		Very Frequently
	☐	☐	☐	☐	☐		☐

	Item is Acceptable	Item Needs to be Revised
	☐	☐
Note. Instrument modification will be conducted based on participants' feedback, which may reduce the number of items, sub-themes, and domains.		

You have successfully rated each item in the initial item pool! If you have any final comments or overall impressions of the items, please feel free to leave them below. Once you are finished, you please click "Submit" below to submit your responses and exit the survey. Again, thank you for your time and help with this important study.
Comments:

APPENDIX R

COUNSELOR MORAL DISTRESS SCALE FOR COUNSELORS – CHILD AND ADOLESCENT FORM

Instructions: Presented below are the instructions for the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA). Please review the instructions and indicate whether or not you believe the instructions are acceptable, considering clarity, difficulty, ambiguity, and grammar. Please provide any feedback that may help the author make the instructions more acceptable or understandable.

Moral Distress Scale for Counselors – Child and Adolescent Form Instructions		
The following items present situations you may have experienced while working with children and adolescents. Please indicate to what extent each situation has caused you to experience distress and how frequently you have experienced each situation in your clinical work. If you are not currently counseling, but have experienced distress associated with any of the items, please indicate the level to which such items caused you to experience distress and how frequently you experienced each situation. If you have not experienced a particular situation, mark your answer as "irrelevant."		
Item	Yes, the instructions are acceptable	No, the instructions are not acceptable
Do you believe the instructions are acceptable as presented above?	☐	☐
	Feedback:	

The next section includes the initial item pool for the Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA), presented by ***Sub-Theme***. Each item reflects a situation associated with clinical work with children and adolescents. Please review the items and indicate:

- to what extent you believe each item is representative of its ***Sub-Theme***, and
- whether or not you believe each item is acceptable as presented in the next section.

Additionally, a comments section is included for each item. Please provide any feedback relating to item representativeness, clarity, conciseness, ambiguity, difficulty, and grammar, which may help with subsequent instrument development and modification.

The first two ***Sub-Themes*** comprise the **Adaptability** domain. Items for each ***Sub-Theme*** represent situations in which counselors are constrained from moral action due to unique, unfamiliar, or confusing interpersonal and professional dynamics.

DOMAIN

Adaptability

SUB-THEME

Role Confusion

The following items have been developed with the purpose of representing situations in which counselors experience confusion about their role(s). Please review the items and rate the extent to which you believe each item is, in fact, representative of its sub-theme. Please leave any comments in the space following each item.

Item			
1. Because I assumed multiple roles, there was a conflict of interest that forced me to cross boundaries.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐		Needs to be Revised ☐
2. I was not able to intervene appropriately because I was not an employee of the organization in which I provided counseling.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐		Needs to be Revised ☐
3. I knew I should intervene, but I did not because I was unsure what my role was in the clinical situation.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐		Needs to be Revised ☐
4. I held more than one professional role, which interfered with my availability to meet with clients.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐		Needs to be Revised ☐
5. Aside from counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐		Needs to be Revised ☐
SUB-THEME			
Relationship Conflict			

The following items have been developed with the purpose of representing situations in which counselors experience a conflict in one or more relationships. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments or feedback in the space below each item.

Item

1. I was unable to do what I thought was best for a client because I had multiple relationships with the client's family.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I did not provide adequate care for a client because of conflicting messages from two supervisors.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I did something I thought was inappropriate due to conflicting message from two supervisors.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I had multiple relationships with a supervisor, which impeded my ability to advocate for a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was not being effective because my supervisors were pulling me in different directions.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The next three ***Sub-Themes*** comprise the **Fear of Consequences** domain. Items for each ***Sub-Theme*** represent situations in which the counselors are constrained from moral action because they are afraid that acting according to their morals would result in negative consequences for themselves, their clients, or others.

DOMAIN

Fear of Consequences

SUB-THEME

Client

The following items have been developed with the purpose of representing situations in which counselors are afraid of the negative consequences their moral action would cause for a client. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item			
1. I did not provide the appropriate interventions because I was afraid the client would be labeled.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I thought doing the right thing would ruin the rapport I had established with a client's family.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I crossed professional boundaries because I thought to do otherwise would result in catastrophic consequences for the client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was reluctant to inform a legal guardian about a client's situation because I thought they would get upset about it.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I was afraid to intervene with a client because I thought he or she would be given an inappropriate diagnosis.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Others

The following items have been developed with the purpose of representing situations in which counselors are afraid of the negative consequences their moral action would cause for others. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I knew I needed to report the unethical actions of my superior, but was afraid it would cause conflict among my colleagues.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

2. I should have reported the unethical actions of my supervisor but feared that doing so would leave the counselors-in-training without a supervisor.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I thought it would be selfish to report a colleague's unethical behavior because it would cause problems for others.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. Challenging the organization's unethical culture was not worth the turmoil it would cause.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Self

The following items have been developed with the purpose of representing situations in which counselors are afraid of the negative consequences they would face if they engaged in moral action. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I did not stand up for what I believed was right because I thought doing so would cost me my job.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

2. I followed directives I did not agree with because I thought I would be reprimanded if I did not.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I gave into pressure to do something I did not agree with because I believed I had a lot to lose if there were negative consequences.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I worried that standing up for what I believed was right would jeopardize my career.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I did not do the right thing because I thought it would make my job more difficult.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I did not stand up for what I believed because I did not want others to think I was imposing my values on them.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
7. I did not do the right thing because I was afraid of what others would think of me.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The following ***Sub-Themes*** comprise the **Inexperience** domain. Items for each ***Sub-Theme*** represent situations in which counselors are constrained from moral action because of a deficit in education or training.

DOMAIN
Inexperience

SUB-THEME
Lack of Education

The following items have been developed with the purpose of representing situations in which counselors do not do what they believe is right because they lack required clinical competencies. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I knew I was not being helpful to a client, but I lacked the requisite knowledge to increase effectiveness.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I chose to work with a client despite a lack of pertinent multicultural knowledge.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I knew I was crossing a boundary with a client but was unsure about ethical guidelines for the situation.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

4. I was not able to meet a client's needs because I was newly out of school.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I thought I was providing inadequate treatment because I did not understand what a client was going through.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I knew I was crossing boundaries with a client, but was unsure of relevant state laws.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Lack of Training

The following items have been developed with the purpose of representing situations in which counselors do not do what they believe is right because they lack required clinical training. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was unable to do what was best for the client because I was not trained for a specific situation.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

2. I thought I let down a client because I did not have the appropriate training.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I knew I did not do what was best for a client, but was unsure how to handle their sensitive case.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I was not effective with a client because I was not confident about how to handle the situation.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The next three ***Sub-Themes*** comprise the **Lack of Support** domain. Items for each ***Sub-Theme*** represent situations in which the counselors are constrained from moral action because they lack the necessary support or resources to do so.

DOMAIN

Lack of Support

SUB-THEME

Lack of Consultation

The following items have been developed with the purpose of representing situations in which counselors are constrained from moral action due to the lack of professional support. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was having difficulty working with a client, but did not have a mentor to consult with.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was unable to openly discuss my ethical concerns with colleagues.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. Because I did not have the mentorship I needed, I felt like I was becoming part of an unethical organization.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I was being encouraged to do something I knew was wrong, but did not have a supervisor to support me through the process.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I knew I was not being effective with a client, but I did not have a trustworthy colleague to discuss the matter with.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Lack of Resources

The following items have been developed with the purpose of representing situations in which counselors are constrained from engaging in moral action due to a lack of necessary clinical resources. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was unable to advocate for a client due to weak relationships with community resources.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was unable to provide resources for a client because the organization had limited funds.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I wanted to provide additional services for a client, but was not supported by the clinical organization.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. The organization had a lack of resources, which limited what I could do for a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was not able to help a client because I could not find resources for him or her.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Unsupportive Family

The following items have been developed with the purpose of representing situations in which counselors are constrained from engaging in moral action due to a client's unsupportive family. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item			
1. I was unable to intervene with a client in need due to an unsupportive legal guardian.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was unable to find appropriate resources for a client because he or she had no family support.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I was forced to discontinue treatment with a client due to a legal guardian's wishes.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I thought I was providing futile treatment because of the client's toxic home environment.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The next three ***Sub-Themes*** comprise the **Institutional Restrictions** domain. Items for each ***Sub-Theme*** represent situations in which the counselors face institutionally-established restrictions, which constrict them from engaging in moral action.

DOMAIN

Institutional Restrictions

SUB-THEME

Legal

The following items have been developed with the purpose of representing situations in which counselors are constrained from moral action due to laws that restrict their clinical functions. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was forced to break a client's confidentiality because I had to testify about his or her case in court.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I had to disclose information due to reporting laws, even though I did not think it was in the client's best interest.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I was required to report a case of suspected abuse, although I thought it would cause additional trauma.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I was unable to ensure a client's safety due to a guardian's legal rights.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was forced to follow laws that I knew were not in a client's best interest.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I was forced to comply with laws that were not congruent with my core values.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Organizational

The following items have been developed with the purpose of representing situations in which counselors are constrained from engaging in moral action due to organizational limitations. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item			
1. I was unable to intervene when needed, due to contractual obligations with my employer.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was forced to act against my wishes in an effort to protect the image of the organization.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

3. I was unable to do what I thought was best for a client due to the organization's policies.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. The organization's focus on paperwork interfered with my ability to provide counseling.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. The organization's policies limited the amount of time I was able to spend with a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Ethical

The following items have been developed with the purpose of representing situations in which counselors are constrained from engaging in moral action due to ethical guidelines or obligations. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was forced to follow ethical imperatives that were not congruent with my core values.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was unable to advocate for a client because doing so would require a breach of confidentiality.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐	
3. A client's wishes about treatment restricted me from doing what I thought was best for him or her.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. My hands were tied by ethical obligations that conflicted with what was in a client's best interest.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was unable to assist a client in need due to professional boundaries.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The following ***Sub-Themes*** comprise the **Lack of Objectivity** domain. Items for each ***Sub-Theme*** represent situations in which counselors are constrained from moral action due to clouded judgment.

DOMAIN

Lack of Objectivity

SUB-THEME

Emotional Entanglement

The following items have been developed with the purpose of representing situations in which counselors' emotional involvement with a client interferes with their ability do the right thing. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I knew I had unfinished business that would impact my work with a client, but I continued counseling anyway.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was unable to remain objective due to the emotional bond I created with a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I was unable to provide proper treatment for a client because my own emotional wounds resurfaced.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I became desensitized to ethical dilemmas because behaving unethically was common practice.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I knowingly crossed boundaries because of the intense emotional connection I had with a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I thought I would betray the colleagues I was close to by doing what I believed to be the right thing.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐

SUB-THEME

Idealization

The Following items have been developed with the purpose of representing situations in which counselors held unrealistically high standards for themselves or the counseling profession. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments or feedback in the space below each item.

Item			
1. I knowingly crossed professional boundaries because I thought it was my responsibility to protect a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. Because of my high standards, I never thought I was as effective as I should have been with a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I went beyond my professional responsibilities because I felt responsible for a vulnerable client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. My inability to do what I thought was right reflected my unrealistically high standards for the profession.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

5. I did not do what I believed was right because I realized the counseling profession has less integrity that I was led to believe.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. I lowered my standards because I discovered the counseling profession is not as responsible as I thought it was.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The following ***Sub-Themes*** comprise the **Well-Being** domain. Items for each ***Sub-Theme*** represent situations in which counselors are constrained from moral action due to strains on work and personal life.

DOMAIN

Well-Being

SUB-THEME

Work Life

The following items have been developed with the purpose of representing situations in which counselors are overwhelmed by their clinical responsibilities. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was unable to meet the needs of a client because my caseload was too large.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was overwhelmed by a chaotic schedule, which prevented me from fully attending to a client.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I was forced to provide inadequate treatment, owing to work overload.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. The quality of care I was providing decreased because I was overwhelmed by my clinical responsibilities.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. My attrition increased because I was frustrated with the low level of care I was forced to provide.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. Despite not being able to keep my clients' stories straight, I maintained an unmanageably large caseload.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
7. I started doing things I knew were not right because I was overworked and needed to make things easier on myself.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

8. I believed I was not doing a client justice because working too many hours exhausted me.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME
Personal Life

The following items have been developed with the purpose of representing situations in which counselors' clinical responsibilities interfere with personal life. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments or feedback in the space below each item.

Item			
1. I did not give my full potential to a client because work was interfering with my personal life.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I became frustrated with my responsibilities because they were cutting into my personal time.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I became apathetic about my clinical responsibilities because they were interfering with my personal life.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I gave less time to my clients because my clinical responsibilities to them were taking up my free time.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐

Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was not fulfilling my clinical responsibilities because I was always in a hurry to leave my clinical site.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. My clinical responsibilities kept me up at night, which made it difficult to give my full potential to my clients.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

The following ***Sub-Themes*** comprise the **Vulnerability** domain. Items for each ***Sub-Theme*** represent situations in which counselors are constrained from moral action due to a lack of power, authority, or value.

DOMAIN

Vulnerability

SUB-THEME

Lack of Authority

The following items have been developed with the purpose of representing situations in which counselors do not have the authority or power to engage in moral action. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments in the space following each item.

Item

1. I was unable to advocate for a client due to the authority my superior(s) had over me.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

2. A client was not being treated appropriately, but I did not have the power to intervene.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I thought the organizational system was corrupt, but I had no leverage to make changes.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
4. I was forced to treat a client according to my supervisor's directions, against my judgment.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I felt powerless in situations in which I witnessed colleagues providing deficient treatment.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
6. Compared to my superiors, I lacked the credibility needed to stand up for what I believed to be right.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
7. When I tried to what I believed was right, my superiors dismissed me.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

8. My superiors were established professionals, so I thought it would be futile to stand up to them for what I believed was right.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
	Acceptable ☐	Needs to be Revised ☐	

SUB-THEME

Lack of Value

The following items have been developed with the purpose of representing situations in which counselors are unable to engage in moral action because they are undervalued. Please review the items and rate the extent to which you believe each item is, in fact, representative of its ***Sub-Theme***. Please leave any comments or feedback in the space below each item.

Item

1. I followed directions I did not agree with because I felt invisible within the system.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
2. I was reluctant to voice my concerns because I did not feel like a valuable member of the clinical team.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
3. I went along with unethical practices because I did not think my superiors considered my feelings.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	

4. I wanted to do the right thing because I cared about the organization, but did not think the organization cared about me.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
5. I was not treated with compassion, so I went along with things I did not agree with.	Not Representative ☐	Somewhat Representative ☐	Clearly Representative ☐
Comments:	Acceptable ☐	Needs to be Revised ☐	
Note. Instrument modification will be conducted based on participants' feedback, which may reduce the number of items, sub-themes, and domains.			

The next section includes only the **Domains** and the ***Sub-Themes***. Please review each ***Sub-Theme***, and indicate:

- whether or not you believe each ***Sub-Theme*** is representative of its **Domain**, and
- whether or not you believe each ***Sub-Theme*** is acceptable, as presented below.

Additionally, a comments section is included for each ***Sub-Theme***. Please provide any feedback relating to representativeness, clarity, conciseness, ambiguity, difficulty, and grammar, which may help with subsequent instrument development and modification.

Once you have rated all the ***Sub-Themes***, you will be asked to respond to several demographic questions, after which you will have the opportunity to provide any final comments or overall impressions prior to submitting your responses. Again, I sincerely thank you for your time and help with the initial validation stage of this instrument.

Please rate each ***Sub-Theme*** in terms of its representativeness to its **Domain** and its acceptability, as presented below.

DOMAIN

Adaptability

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors have difficulty adapting to potential professional and relationship dynamics. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments in the spaces below.

SUB-THEME

Role Confusion

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Acceptable	Need to be Revised
☐	☐

Comments:

Relationship Conflict

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Acceptable	Needs to be Revised
☐	☐

Comments:

DOMAIN

Fear of Consequences

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors a afraid of consequences for their clients, their colleagues, or themselves. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments in the spaces below.

SUB-THEME

Client

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Others

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Self

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

DOMAIN

Inexperience

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors lack pertinent education or training. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Lack of Education

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Lack of Training

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

DOMAIN

Lack of Support

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors lack several types of necessary support. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Lack of Consultation

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Lack of Resources

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Unsupportive Family

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

DOMAIN

Institutional Restrictions

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which the counselors face restrictions from a variety of institutions. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Legal

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Organizational

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Ethical

Not Representative	Somewhat Representative	Clearly Representative

☐	☐	☐

Comments:

DOMAIN

Lack of Objectivity

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors' judgment is impacted by previous experiences, biases, and expectations. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Emotional Entanglement

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Idealization

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

DOMAIN

Well-Being

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors' well-being is impacted by work and personal life. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Work Life

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Personal Life

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

DOMAIN

Vulnerability

The following ***Sub-Themes*** have been developed with the purpose of encapsulating situations in which counselors face the challenges that accompany a lack of power or value. Please briefly review the ***Sub-Themes*** and rate the extent to which you believe each is representative of its **Domain**. Please leave any comments or feedback in the spaces below.

SUB-THEME

Lack of Authority

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Lack of Value

Not Representative	Somewhat Representative	Clearly Representative
☐	☐	☐

Comments:

Thank you for rating the initial items and sub-themes identified for the MDSC-CA. If you have any overall comments, impressions, you are encouraged to leave them below. Specifically, please consider the extent to which you believe the instrument adequately assesses moral distress among counselors working with children and adolescents.

The final section includes several demographic questions. Once you have responded to each question, you may submit your responses and exit the survey by clicking the forward progression button on the bottom right.

Gender

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other
- ☐ Prefer not to disclose

Race/Ethnicity

- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern
- ☐ Native American
- ☐ White or European American
- ☐ Other
- ☐ Prefer not to disclose

Age when you experienced moral distress

- ☐ 18-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-69
- ☐ 70-79
- ☐ 80-89
- ☐ 90+
- ☐ Prefer not to disclose
- ☐ Not applicable

Current age

- ☐ 18-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-69
- ☐ 70-79
- ☐ 80-89
- ☐ 90+
- ☐ Prefer not to disclose

Number of years of counseling experience, after completing your master's degree, at the time when you experienced moral distress

- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10-14
- ☐ 15-19
- ☐ 20-24
- ☐ 25-29
- ☐ 30+
- ☐ Prefer not to disclose
- ☐ Not applicable

Current years of counseling experience, after completing your master's degree

- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10-14
- ☐ 15-19
- ☐ 20-24
- ☐ 25-29

☐ 30+

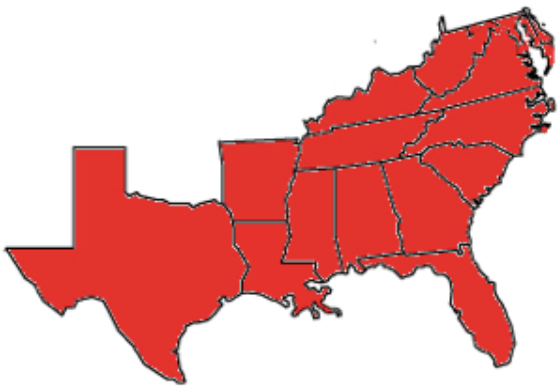
☐ Prefer not to disclose

☐ Not applicable

Geographic location in which you experienced moral distress (if more than one location, please select each applicable region)

☐

☐



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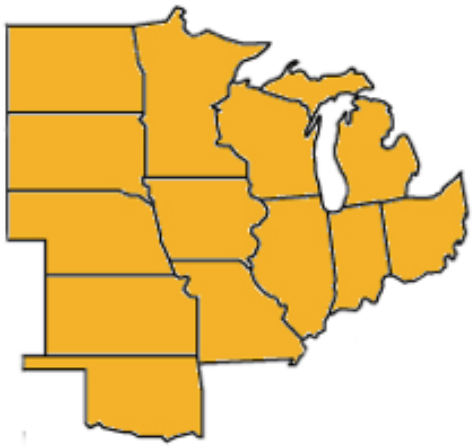

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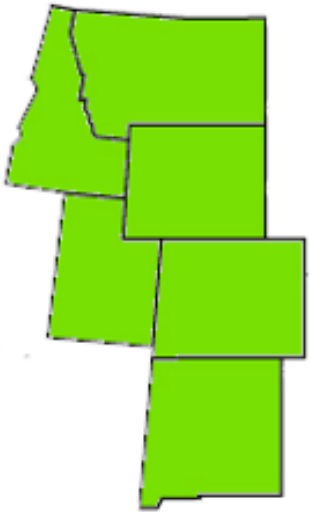

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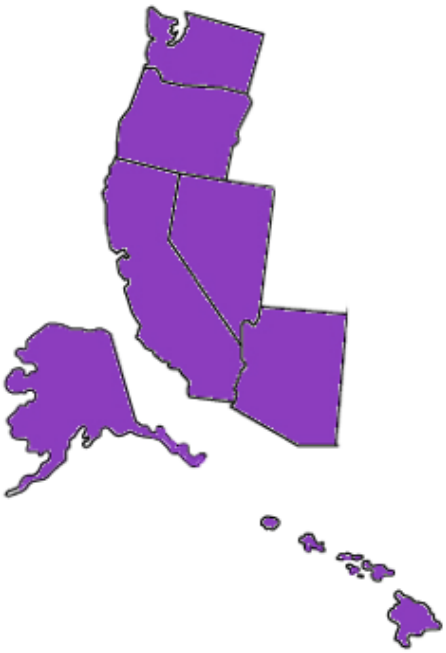


☐ I experienced moral distress outside of the United States (please specify)

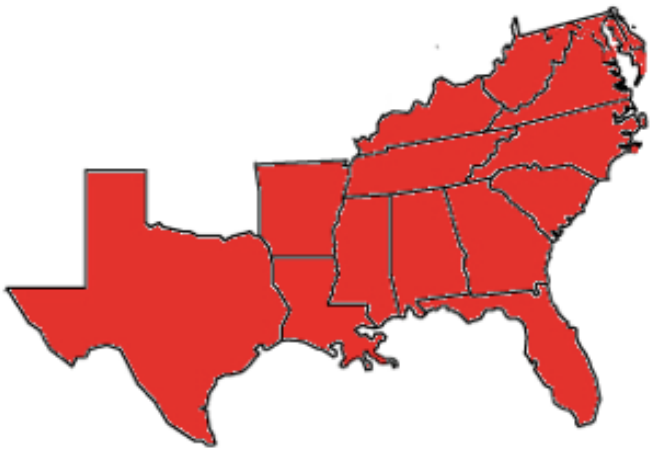
☐ Prefer not to disclose

☐ Not applicable

Geographic location where you currently reside

☐

☐



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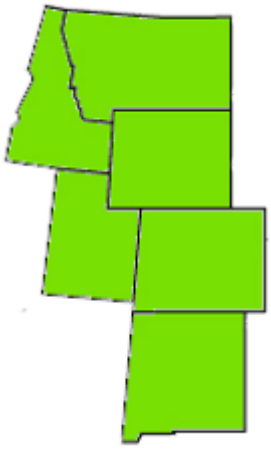

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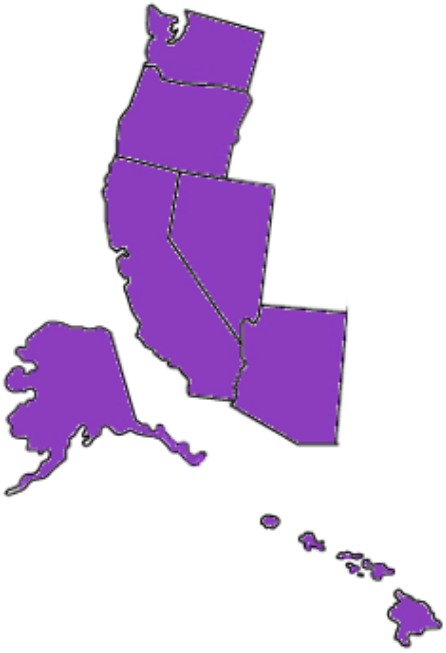

☐ I currently reside outside of the United States (please specify)

☐ Prefer not to disclose

☐ Not applicable

Clinical setting in which you experienced moral distress

- ☐ School (K-12)
- ☐ College
- ☐ Community
- ☐ Private Practice
- ☐ Medical
- ☐ Other (please specify)

- ☐ Prefer not to disclose
- ☐ Not applicable

Clinical setting in which you are currently counseling

- ☐ School (K-12)
- ☐ College
- ☐ Community
- ☐ Private Practice
- ☐ Medical
- ☐ Other (please specify)

- ☐ None
- ☐ Prefer not to disclose
- ☐ Not applicable

Primary counseling specialty

- [ ] School
- [ ] Community
- [ ] Counselor Education and Supervision
- [ ] Mental Health
- [ ] Marriage, Couple, and Family
- [ ] Clinical Mental Health
- [ ] Student Affairs
- [ ] College
- [ ] Career
- [ ] Play Therapy
- [ ] Addictions Counseling
- [ ] Student Affairs and College
- [ ] Gerontological
- [ ] Trauma
- [ ] Other (please specify)

- [ ] Prefer not to disclose
- [ ] Not applicable

Thank you for rating the initial items and sub-themes identified for the MDSC-CA. If you have any overall comments, impressions, you are encouraged to leave them below. Specifically, please consider the extent to which you believe the instrument adequately assesses moral distress among counselors working with children and adolescents.

APPENDIX S

SUMMARY OF INITIAL THEMES BY INTERVIEW PARTICIPANT

R-13-38-J

Powerlessness
- Others in a position of power over you (or perceived position of power)
- Control over others
- Hierarchy of power
- Vulnerability due to lack of seniority in the field

Consequences for self
- Detriment to your own career and future jobs (know others in the field)
- Fear of what would happen to them
- Getting screwed
- Things more difficult for me
- Others might perceive me negatively
- Jeopardize career
- Snowball effect of unethical behavior
- A lot to loose

Consequences for client
- Potentially very dangerous (to client)
- Decreased care
- Less time given to clients

Consequences for others
- Made things more difficult
- Poor training
- Consequences for counselors-in-training (lack of supervision)

Internal struggle
- Making things easier/standing up for beliefs
- Personal responsibility/personal role

Pressure
- Colleague peer pressure

Manipulation
- Supervisors manipulate you
- Make you think they have more power

Cumulative Effect
- Suffered more in the long run (over time)
- Low immediate consequences; high long-term consequences

Negative outcomes
- Spend less time at the site (distancing from site/people)
- Decreased quality of therapy (always in a hurry to leave site)
- Needed a better work-life ratio (needed to take care of self)

- Abandoning values (losing self)
- Dissociation from distress
- Became someone I didn't like (loss of self)

Positive Outcomes

- Greater sense of self
- More courage
- Ability to stand up for beliefs
- Ability to uphold integrity (personal/professional)

P-14-19-F

Multiple roles

- Dual roles
- More than one professional role
- Inability to advocate due to conflicting roles

Exaggerated responsibility

- Couldn't protect client
- Responsible for vulnerable client
- Catastrophic outcomes if not protected

Corruption

- The system was corrupt

Negative outcomes

- The world was spinning (I was dizzy/disoriented)
- I felt sick
- Questioning whether or not to quit job
- Felt like you become part of the system (it hurt)
- Wellness suffered (lack of sleep)

Powerlessness

- It felt like everyone else had power
- I could only do so much
- Counselor powerless
- Hands are tied (helplessness)
- Helplessness

Lack of authority

- Not included in decision making process

Emotionality

- Unfinished business (too emotionally connected with client; impaired)
- Too emotionally connected

Institutional restrictions

- Discounting victimization in order to protect institution's image
- Institution's policies and procedures are inadequate

Consequences for client

- Betrayal by the system

Lack of resources

- Working with clients without adequate information (about client)
- Working with clients without the tools necessary to help (lack of support)
- No support system in place to effectively work with clients (lack of support)

Lack of training

- Working with clients without proper training (inexperienced/incompetent)
- Didn't feel confident

Consequences for self

- Fear of losing job
- A lot to loose

Lack of education

D-14-24-T

Lack of support

- Futile care
- Lack of necessary supervision
- Lack of site-specific supervision

Powerlessness

- Forced to provide treatment you don't believe in

Pressure

- Encouraged to misrepresent billable hours

Overworked

- It's just like a volcano exploding
- Mass chaos
- Difficulty with time management
- Too large of a caseload
- Work-life balance out of sync (not being about to take care of self)
- Lack of time
- Overwhelming caseload

Lack of resources

- Lack of money
- Lack of resources
- Stretched for resources

Attrition

- Stressful enough to take some time off from work
- Contemplated leaving position

Negative consequences

- I just wanted to tear out all my hair
- I just can't take it
- I feel like I'm in an abusive relationship with this organization.
- It was a painful process.
- Emotionally taxing

Impact on work/life balance

- Interfered with other areas of life
- Takes a toll on other relationships

Institutional restrictions

- Organizations worrying more about money than helping clients
- Focus on paperwork, rather than counseling
- Client came second to institutional policies

Unethical culture

- Working with dishonest coworkers (falsifying signatures, billing, falsifying hours, etc.)

Relationship conflict

- Conflicting messages from two (or more) supervisors
- Trying to make two supervisors happy

High standards

- Working in places that hold lower standards than you do
- Higher expectations
- Different expectations

Lack of value

- Lack of reciprocity
- Not being valued
- I felt invisible
- Lack of appreciation
- I got forgotten in the process
- My feelings were not considered

Inexperienced

- Fresh out of school
- Lack of counselor development
- In experience with challenging situations

K-14-40-C

Unsupportive legal guardians

- Working with unsupportive legal guardians
- Having to send children/adolescents home to an unhealthy home environment
- Having to send children/adolescents home to family that thwarted therapeutic progress
- Inability to work with the entire family system (only with child, not parents)
- No family support

Adaptability

- Working in one setting, but being an employee of an outside agency (Office Space?)
- Having to answer to more than one organization

Relationship conflict

- Working with a combative team of health care providers

Inexperience

- Helping clients through life experiences that are completely unfamiliar to you or you have no knowledge of
- Looking from the outside in
- Ambiguity in difficult situations
- No experience with client's issues
- Confusion about who the client is

Lack of education

- Lack of competence
- Lack of ethical knowledge
- Lack of multicultural or social justice knowledge
- Unable to take the other's perspective
- Unsure what was right and wrong
- Lack of training

Overworked

- Burgeoning caseloads (inability to fully attend to clients)
- Unable to fully address issues because of large caseload
- Strapped for time
- Difficult to manage cases
- Confusing cases

Confidentiality

- Withholding information from a minor's guardian in order to maintain the therapeutic relationship
- Ambiguity about confidentiality

Lack of support

- Not having someone to talk through ethical issues with (supervision/consultation)
- Unable to advocate for clients
- Lack of open communication about ethical issues

Consequences for self

- Accused of withholding information for legal guardian
- Fear of being accused
- Fear of how others will view him

Consequences for client

- Guardian will pull client out of counseling
- Fear that parents will retaliate
- Fear that parents would pull client out of therapy

Balancing act

- Balancing what's best for client and guardians
- Right thing for parents and client

Relationship conflict

- Calm waters

Restrictions

- Legal responsibility to guardian
- Responsibility to school

Personal biases

- Approaching counseling with biases

P-15-13-F

Consequences for client
- Being required to issue a diagnosis, although one may not be appropriate or may not apply
- Fear that parent will pull client out of therapy
- Fear of making false reports (consequences for client)

Restrictions
- Wanting to help but not being able to because of rules and regulations
- Restricting expectations
- Intervening outside job responsibility
- Restricting organizational policies
- Organization doesn't respond to situations that require immediate action
- Inability to check in with clients due to restrictions

Consequences for self
- Fear of being identified as a reporter
- Fear of being seen as a "trigger happy" reporter

Powerlessness
- Hands are tied

Pressure
- Being asked to do things outside your responsibility
- Being asked to intervene without sufficient evidence

Manipulation
- Organization tries to use you as a scapegoat
-

Relationship conflict
- Multiple relationships with client's family

Consequences for others
- Fear of running relationship with family

Role confusion
- Role ambiguity
- Confusing responsibilities
- Confusion roles
- Lack of distinction in multiple roles

Lack of education
- Ethical uncertainty
- More competence in unique situations
- Confusion about obligations

Confidentiality

- Counseling in a small, tight-knit community
- People will know if you report abuse

Unethical culture

- Working in a setting that tries to play it safe with ethics
- Have their own best interest in mind, rather than the clients
- Setting/site ignores law in order to protect themselves
- Having own intentions in mind, rather than client's

Lack of experience

- Lack of experience in complex situations
- Unable to predict complex situations

Adaptability

- Inability to predict unique/complex situations
- Working in an organization of which you are not an employee

Dualistic thinking

- Black and white thinking
- Dualistic conceptualization

Lack of support

- Lack of supervision
- small/no professional network
- Lack of open/clear communication with superiors or senior members

APPENDIX T

MODIFIED MORAL DISTRESS SCALE FOR COUNSELORS – CHILD AND ADOLESCENT FORM

Moral Distress Scale for Counselors – Child and Adolescent Form (MDSC-CA)

The following items present situations you may have experienced while working with children and adolescents. Please indicate to what extent each situation has caused you to experience distress and how frequently you have experienced each situation in your clinical work. If you are not currently counseling, but have experienced distress associated with any of the items, please indicate the level and frequency to which such items caused you to experience distress. If you have not experienced a particular situation, mark your answer "irrelevant."

Item	Rating Scale						
Because I assumed conflicting organizational roles, I was led to cross professional boundaries.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was not able to intervene appropriately because I was not an employee of the organization in which I provided counseling.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
Aside from counseling, I had to fill other roles where I worked, which made it difficult to advocate for my clients.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to do what I	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

thought was best for a client because I had multiple relationships with the client's family.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I did something I thought was inappropriate due to conflicting message from two supervisors.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was not being effective because my supervisors were giving me conflicting recommendations.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I did not provide the appropriate interventions because I was afraid the client would be labeled.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I crossed professional boundaries because I thought to do otherwise would result in	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always

catastrophic consequences for the client.	☐	☐	☐	☐	☐	☐	☐
I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I knew I needed to report the unethical actions of my superior, but was afraid it would cause conflict among my colleagues.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I thought it would be selfish to report a colleague's unethical behavior because it would cause problems for others.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
Challenging the organization 's unethical culture was not worth the turmoil it would cause among my colleagues.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I did not	Intensity						

stand up for what I believed was right because I thought doing so would cost me my job.	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I followed directives I did not agree with because I thought I would be reprimanded if I did not.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I gave into pressure to do something I did not agree with because I believed I had a lot to lose if there were negative consequences.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I worried that standing up for what I believed was right would jeopardize my career.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I knew I was not being helpful to a client, but I lacked the requisite	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

knowledge to be more effective.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I chose to work with a client despite a lack of necessary multicultural knowledge.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I knew I was crossing a boundary with a client but was unsure about ethical guidelines for the situation.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to do what was best for the client because I was not trained for a specific situation.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I knew I did not do what was best for a client, but was unsure how to handle their sensitive case.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was not	Intensity						

effective with a client because I was not confident about how to handle the situation.	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was having difficulty working with a client, but did not have a mentor to consult with.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to openly discuss my ethical concerns with colleagues.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was being encouraged to do something I knew was wrong, but did not have a supervisor to support me through the process.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to advocate for a client due to weak relationships with community resources.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always

	☐	☐	☐	☐	☐	☐	☐

I was unable to provide resources for a client because the organization had limited funds.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐

I wanted to provide additional services for a client, but was not supported by the clinical organization .	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
The organization 's lack of resources limited what I could do for a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to find appropriate resources for a client because they had no family support.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
Due to a	Intensity						

legal guardian's wishes, I was unable to continue treatment with a client.	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I thought I was providing ineffective treatment because of the client's toxic home environment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was forced to break a client's confidentiality because I had to testify about their case in court.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I had to disclose information due to reporting laws, even though I did not think it was in the client's best interest.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was required to report a case of suspected abuse, although I	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

thought it would cause additional trauma.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was forced to comply with laws that were not congruent with my core values.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was forced to act against my wishes in an effort to protect the image of the organization .	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to do what I thought was best for a client due to the organization ’s policies.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
The organization ’s policies limited the amount of time I was able to spend with a	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always

client.	☐	☐	☐	☐	☐	☐	☐
I was unable to advocate for a client because doing so would require a breach of confidentiality.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
My hands were tied by ethical obligations that conflicted with what was in a client's best interest.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to assist a client in need due to professional boundaries.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to remain objective due to the emotional bond I created with a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable	Intensity						

to provide proper treatment for a client because my own emotional wounds resurfaced.	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I knowingly crossed boundaries because of the intense emotional connection I had with a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
Because of my high standards, I was unable to be as effective as I wanted to be with a client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I went beyond my professional responsibilities because I felt responsible for a vulnerable client.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
My inability to do what I thought was right reflected my unrealistically high	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

standards for the profession.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to meet the needs of a client because my caseload was too large.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I felt like I was not doing a client justice because working too many hours exhausted me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
The quality of care I was providing decreased because I was overwhelmed by my clinical responsibilities.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I started doing things I knew were not right because I was overworked and needed	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always

to make things easier on myself.	☐	☐	☐	☐	☐	☐	☐
I did not give my full attention to a client because work was interfering with my personal life.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I became frustrated with my counseling responsibilities because they were cutting into my personal time.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I gave less time to my clients because my clinical responsibilities to them were taking up my free time.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was unable to advocate for a client due to the authority my superior(s) had over me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
A client was not being	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant

treated appropriately, but I did not have the power to intervene.	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I thought the organizational system was corrupt, but I lacked the leverage to make changes.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I felt powerless in situations in which I witnessed colleagues providing deficient treatment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
Compared to my superiors, I lacked the credibility needed to stand up for what I believed to be right.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I was reluctant to voice my concerns because I did not feel like a valued	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						

member of the clinical team.	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I went along with unethical practices because I did not think my superiors considered my professional judgment.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐
I wanted to do the right thing because I cared about the organization, but did not think the organization cared about me.	Intensity						
	None	Some	Moderate	High	Extreme		Irrelevant
	☐	☐	☐	☐	☐		☐
	Frequency						
	Never	Very Infrequently	Infrequently	Sometimes	Frequently	Very Frequently	Always
	☐	☐	☐	☐	☐	☐	☐

CURRICULUM VIATE

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E D U C A T I O N

The University of Mississippi, Oxford, MS — 2011 – 2015; CACREP accredited, GPA: 3.94
Ph.D., Counselor Education and Supervision
Dissertation: Development and Validation of The Moral Distress Scale for Counselors – Child and Adolescent Form
Interests: Values in Counseling, Clinical Supervision, Schema-Informed Counselor Wellness, and Schema Therapy
Cognate Area: Quantitative Research Methods and Analytic Procedures
Recipient: Courtney Caldwell Memorial Scholarship; Dissertation Research Fellowship; Graduate Achievement Award in Leadership and Counselor Education

Avila University, Kansas City, MO — 2007 – 2009; APA accredited, GPA: 4.0
M.S., General Psychology
Thesis: From Self-Esteem to Self-Compassion: Reducing the Threat of Self-Relevant Implications of Future Failure
Emphasis: Cognitive Psychology
Recipient: Graduate Research and Teaching Assistantship

University of South Carolina - Upstate, Spartanburg, SC — 2005 – 2007; GPA: 3.53
B.S., Experimental Psychology
Thesis: Effects of Perfunctory and Informative Touch on Retail Customers' Purchasing Behavior
Emphasis: Personality Development, Social Psychology
Recipient: LIFE Scholarship

E M P L O Y M E N T

Wake Forest University, Winston-Salem, NC — Fall 2015; CACREP accredited, GPA
Supervision Practitioner Instructor

P U B L I C A T I O N S

Articles Submitted/Under Review

Mazahreh, L. G., Stoltz, K. B., Turnage-Butterbaugh, I. Wolff, L. A. (2015). Petra – Jordan's rose city: Assessing lifestyle with a Jordanian sample using the BASIS-A. Submitted to the *Journal of Individual Psychology.*

Peer-Reviewed Articles

Young, T. L., Turnage-Butterbaugh, I. Degges, S., & Mossing, S. (in-press). Wellness among undergraduate students on academic probation. *Journal of College Counseling.*

Young Gast, T. L., Michael, T., Eskridge, T., Hermann, K., & Turnage-Butterbuagh, I. (2014). Does a course in wellness education assist undergraduate students on academic probation in college success? *The Journal of College Orientation and Transition, 21*(2), 36-48.

Invited Books Chapters

Turnage-Butterbaugh, I. (2013). Nonsuicidal self-injury and treatment strategies for college students. In S. Degges-White & C. Borzumato-Gainey (Eds.), *College mental health counseling: A developmental approach.* New York: Springer.

Michael, T., Turnage-Butterbaugh, I. Reysen, R. H., Hudspeth, E., & Degges-White, S. (2012). When learning is "different": Readin', writin', 'rithmetic', and giftedness?. In S. Degges-White & B. R. Colon, (Eds.), *Counseling boys and young men*. New York: Springer.

RESEARCH IN PROGRESS

Development and Validation of the Moral Distress Scale for Counselors – Child and Adolescent Form

Establishing a Core Understanding of Moral Distress in the Context of Mental Health Counseling

Enhancing Clinical Supervision Through the use of Early Maladaptive Schemas: Raising Supervisee Awareness and Anticipating Problematic Events

Exploring Patterns of Interdisciplinary Research Among Counselor Educators: Implications for Collaboration and Professional Identity

An Exploration of Career Adaptability and the Applicability of the BASIS-A in Arabic Speaking Countries

Conceptualizing and Treating Survivors of Complex Trauma from an Integrative Perspective: Interpersonal Neurobiology, Attachment, Schema Therapy, and Person-Centered Treatment

FUNDED RESEARCH

CACREP Research Initiative for Graduate Students (CRIGS) Fellowship — January 2014 – December 2014

As one of two nationally selected CACREP Research Initiative for Graduate Students (CRIGS) Fellows for 2014, I work very closely with CACREP on a number of research initiatives that will contribute to the field of counseling in novel ways. I also have the opportunity to collaborate with another CRIGS Fellow in establishing a research agenda and working toward mutual research interests and professional aspirations. The fellowship is designed to provide support from CACREP, yet allow the autonomy to pursue unique research interests and continue to develop personally and professionally. Research endeavors are fully funded and supported by CACREP.

Implementing a Values-Based Wellness Program for Health Adults, Avila University, Kansas City, MO — 2007 – 2008

I assisted with a study investigating the benefits of a Mindfulness-Based Wellness program for healthy adult participants on a variety of psychological domains, including cognitive, social, physiological, and neurological. My main duties included helping plan and implement treatment programs, collecting data, and analyzing results in both qualitative and quantitative forms. In addition, I co-authored a manuscript that was presented in poster form at the 2008 Association for Psychological Sciences International Conference in Chicago, IL. The Menorah Medical Center in Overland Park, KS fully funded and supported this study, through the Menorah Legacy Foundation.

PREVIOUS RESEARCH

Enhancing Clinical Supervision: An Early Maladaptive Schema Approach The University of Mississippi — 2013 – Present

Critical events frequently arise in clinical supervision, especially with entry-level trainees. Early maladaptive schemas, or core cognitive and emotional patterns, stemming from toxic childhood experiences, may be an underlying factor in the personal and developmental challenges that novice counselors face during their training. Assessing for early maladaptive schemas may elucidate some of those underlying factors, which can help supervisors anticipate problematic events, tailor supervision to meet the unique needs of their supervisees, and help supervisees gain self- and other-awareness.

Ritualized Physical Torture Abuse: An Integrative Approach to Complex Trauma — 2014

This integrative case study incorporates interpersonal neurobiology, attachment, schema therapy, and person-centered treatment in an effort to provide a holistic conceptualization of the experience, needs, and treatment of survivors of ritualized physical torture abuse and complex trauma.

An Exploration of Career Adaptability in Arabic Speaking Countries — 2013 – 2014

A collaborative study exploring the factor structure and applicability of the BASIS-A among individuals living in Arabic speaking countries. The purpose of this study was to evaluate the psychometric properties of an Arabic version of the Basic Adlerian Scales for Interpersonal Success-Adult Form using a Jordanian sample. The sample included 330 Jordanian citizens in which Arabic is their native language. The results revealed three factors instead of the original five. The first factor included all items from the Belonging and Social Interest scale and nine items from the Wanting Recognition scale. All eight items of the Taking Charge scale, as well as one item from the Getting Along scale, constituted the second Factor. Finally, the third factor included seven items from the Being Cautious scale, two of the Getting Along items, and one item from the Wanting Recognition scale.

Interdisciplinary Research Study, The University of Mississippi — 2013

In order to promote and enhance interdisciplinary research endeavors at The University of Mississippi, the current beliefs, attitudes, motivations, and knowledge of faculty, research scientists, and graduate students concerning interdisciplinary research was investigated. A model was developed to conceptualize the current interdisciplinary research climate on campus and to propose steps to implement in order to enhance interdisciplinary research efforts. Factors

contributing to faculty, researcher, and student development outcomes were highlighted.

Wellness and Achievement Among Undergraduate Students on Academic Probation, The University of Mississippi — 2012
The purpose of this study was to explore the relationship between wellness and academic achievement. A pre- and post-test design, measuring the wellness of students on academic probation, was used in order to determine whether or not wellness is impacted by or contributes to academic achievement. The Five-Factor Wellness Evaluation of Lifestyle was used over the course of one semester with these students to further understand the unique characteristics of students whom are struggling academically.

Master's Thesis, Avila University, Kansas City, MO — 2009
I investigated the effects of intentionally substituting self-esteem with self-compassion on cognitive and social processes. The main purpose of the study was to further examine self-compassion as a unified construct, as well as dissecting the six components it encompasses, by evaluating correlations with self-defeating cognitive processes and their psychological consequences.

Undergraduate Thesis, USC - Upstate, Spartanburg, SC — 2006 – 2007
Previous research on spending and compliance were extended to a retail setting. The semester long study investigated the effects of a variety of tactile variables on retail customers' purchasing behaviors, in terms of average dollar sale (ADS), units per transaction (UPT), and average unit retail (AUR). Differences between experimental and control groups were analyzed, and the results were presented at a regional conference in Georgia.

P R E S E N T A T I O N S

International
Dean, D., Hunt, M., Butterbaugh, I. (2008, June). Mindfulness-based wellness: A pilot program on a university campus. Poster session presented at the annual meeting of the Association of Psychological Sciences, Chicago, IL.

National
Turnage-Butterbaugh, I. (2013, March). Wilderness therapy: Taking the scenic route to professionalism. Poster presented at the annual conference of the American Counseling Association, Cincinnati, OH.

Young, T., Michael, A., & Turnage-Butterbaugh, I. (2013, March). Are they really learning? Empirically based training in motivational interviewing. Poster presented at the annual conference of the American Counseling Association, Cincinnati, OH.

Regional
Turnage-Butterbaugh, I., & Bell, S. (2014, October). Raising supervisee self-awareness and enhancing supervision with an early maladaptive schema approach. Workshop given at the 2014 Southern Association for Counselor Education and Supervision, Birmingham, AL.

Butterbaugh, I. (2007, March). Effects of perfunctory and informative touch on retail customers' purchasing behavior. Paper presented at the annual meeting of the Georgia Undergraduate Research in Psychology Conference, Kennesaw, GA.

State

Turnage-Butterbaugh, I, & Bell, S. (2013, November). Getting to the core of supervision: Using early maladaptive schemas to enhance supervision. Workshop given at the 2013 Mississippi Counseling Association Conference in Jackson, MS.

Spruill, D., A., & Butterbaugh, I. (2011, November). Family system dynamics in school settings: Everything connected. Workshop given at the 2011 Mississippi Counseling Association Conference in Biloxi, MS.

Local

Butterbaugh, I. (2007, March). Effects of perfunctory and informative touch on retail customers' purchasing behavior. Poster presented at the annual undergraduate research seminar, Spartanburg, SC.

University

Stoltz, K., Turnage-Butterbaugh, I., Wolff, L., & Harper, M. (2013, April). Building a foundation for interdisciplinary research across university campuses. Paper and report presented for The University Research Board, Oxford, MS.

Turnage-Butterbaugh, I., Bell, S. (2012, November). Ethical Issues in using Technology in Clinical Supervision. Presentation given at the Annual Site Supervisor Training Workshop, Oxford, MS.

A C A D E M I C C O G N A T E A R E A

Quantitative Research Methods and Analytic Procedures

Due to my interest and experience in contributing to the counseling literature, I am currently completing a cognate in quantitative research methods and analytic procedures. Courses covering general linear modeling techniques, mixed method models, path models, structural equation models with latent variables, and estimating and testing indirect and conditional effects have been completed in the departments of Counselor Education and Pharmacy. Data analytic procedures have focused on questions about moderation and mediation, including multiple moderators, multiple mediators, moderated mediation, and mediated moderation.

T E A C H I N G

Instructor, The University of Mississippi, Oxford, MS — 2011 – 2012

Courses Taught

EDHE 101 - Academic Skills for College (Spring 2012)
EDHE 105 - Freshman Year Experience (Fall 2011)

C O - T E A C H I N G

Graduate Co-Instructor, The University of Mississippi, Oxford, MS — 2012 – 2015

Courses Co-Taught

Counseling Children and Adolescents, Section I (Spring 2014)
Counseling Children and Adolescents, Section II (Spring 2014)
Educational Statistics I (Fall 2013)
Educational Statistics II (Summer 2013)
Research in Counseling (Summer 2013)
Life Span Development (Summer 2013)
Group Procedures (Spring 2013)
Career Counseling (Fall 2012)
Life Span Development (Summer 2012)
Counseling Skills (Summer 2012)

Graduate Teaching Assistant, Avila University, Kansas City, MO — 2008 – 2009

As a Graduate Teaching Assistant, I helped design course objectives, helped teach an introductory psychology course for International students, planned, administered, and graded coursework, and led discussion of coursework application. In addition, I held office hours to help students with coursework, academic outcomes, and cultural integration.

G U E S T L E C T U R E S

Invited Guest Lecturer, The University of Mississippi, Oxford, MS — 2013

Lectures Taught

Assessment in Counseling I – Statistical Foundations for Clinical Assessment (Fall 2014)
Educational Statistics II – Multivariate Analysis of Variance Section (Summer 2013)
Educational Statistics II – Multivariate Analysis of Variance Section (Fall 2013)

P R O G R A M A S S E S S M E N T A N D D E V E L O P M E N T

Graduate Assistantship – Assistant Program Assessment Coordinator— 2012 – Present

As the departmental graduate assistant, I work with the Counselor Education faculty on a daily basis. I am responsible for assisting with program evaluation, CACREP assessment, evaluation, and reports, faculty searches, graduate student interviews, and several research initiatives department- and campus-wide. The recent focus of my assistantship has revolved around redeveloping the student assessment system for the Department of Counselor Education and Supervision and transitioning to an online assessment framework. I have been solely responsible for data collection and initial analyses on several research projects that are currently in progress. Additionally, I collaborate with faculty, staff, and administration in an effort to improve courses and programs for the department. I also host monthly information forums for prospective graduate students and act as a mentor for recently admitted and soon-to-graduate Master students.

C O U N S E L I N G E X P E R I E N C E

Doctoral Intern, University Counseling Center, The University of Mississippi, Oxford, MS — Fall 2011 – Spring 2013

As a Doctoral Intern at the University Counseling Center, I provided individual and couple counseling to students, faculty, and staff at the University of Mississippi.

Services Provided

Individual counseling
Couple counseling
On-call counseling
Crisis intervention
Crisis phone counseling
Triage intervention
Greek recruitment counseling

Additionally, I facilitated personal growth groups for Masters-level counseling students at the Oxford and Tupelo campuses of The University of Mississippi.

Mississippi Teacher Corps Counselor, University of Mississippi, Oxford, MS —2012 – 2013

As the Mississippi Teacher Corps Counselor, I provided individual and group counseling to teachers in the Mississippi Teacher Corps Program at the University of Mississippi.

Master's Internship, University Counseling Center, University of Mississippi, Oxford, MS — 2012

As a Graduate Intern at the University Counseling Center, I provided individual counseling to undergraduate and graduate students. Counseling experience included grief, substance abuse, self-esteem, body image, nonsuicidal self-injury, coping with trauma, anger, wellness, grades, college adjustment, and sexuality. Six hundred hours were completed during the semester-long internship.

Master's Practicum, Center for Excellence in Teaching and Learning, University of Mississippi, Oxford, MS — 2011

During my practicum, I counseled a caseload of twenty-eight clients in both group and individual settings. Counseling in both formats involved a wide variety of topics including time management, family problems, anxiety, depression, insecurities, coping with trauma, and grief. One hundred counseling hours were completed during the semester-long practicum.

Psychiatric Assistant, Millcreek of Pontotoc — 2009

As a psychiatric assistant, I managed a case load of five clients in a residential setting. My duties include monitoring and tracking patients' behavior, and intervening during crisis situations by implementing Therapeutic Crisis Intervention. In addition, I was responsible for implementing Cognitive Behavioral Therapy in order to reduce patients' level of stress, improve behaviors and level of functioning, and promote positive outcomes. I also acted as a mentor, promoting daily living skills, and collaborating with nurses and therapists to evaluate each patient's treatment plan.

SUPERVISION EXPERIENCE

University Internship Supervisor, Wake Forest University, Winston-Salem, NC — 2015

Masters-Level Counseling Students Supervised in the Following Courses
Clinical Mental Health Counseling Internship (Fall 2015)

Doctoral Supervisor, The University of Mississippi, Oxford, MS — 2012 – 2014

Masters-Level Counseling Students Supervised in the Following Courses
Internship in Counseling (Fall 2014)
Internship in Counseling (Summer 2014)
Internship in Counseling (Spring 2014)
Practicum in Counseling (Fall 2013)
Counseling Skills (Fall 2013)
Counseling Skills (Summer 2012)

SUPERVISOR TRAINING EXPERIENCE

Clinical Site Supervisor Trainer, The University of Mississippi, Oxford, MS — 2012 – 2014

I have served as a co-organizer for training workshops for the clinical site supervisors affiliated with the Department of Counselor Education. The focus of the training I provided was counselor trainee assessment and ethics in supervision. I also worked with the Department of Counselor Education in designing an online assessment program, in which site supervisors and faculty needed to be trained. These training workshops were provided in order to ensure supervision standards and ethics were being met, according to CACREP and ACA.

ADMINISTRATIVE EXPERIENCE

Admissions Counselor, The University of Mississippi, Oxford, MS — 2010 – 2011

As an admissions counselor, I worked with prospective students on admission requirements and the transition to college life. I was involved with many other offices of administration, such as the Office of the Bursar, Financial Aid, and the Registrar's Office. Additionally, I engaged with numerous academic offices in order to find resources for newly admitted high school and transfer students. As a result, I have an excellent understanding of how administrative and academic cultures function within a university setting and am familiar with ways in which to inform and advocate for students transitioning to college life.

SERVICE AND LEADERSHIP

Interdisciplinary Research Committee for the Creation of an Applied Statistics Certificate — Fall 2014 – Spring 2015

Graduate Student Representative on Counselor Education Hiring Committee — Fall 2014 – Spring 2015

Graduate Student Research Colloquium Coordinator — 2014 – 2015

Expert Reviewer – Survey Design and Research Methods for Institutional Review Board — July 2014

Co-Organizer of Site Supervisor Training for Assessment and Ethics in Supervision — Fall 2013 – Fall 2014

Graduate Student Council Senator for the Department of Leadership and Counselor Education — Fall 2013 – Spring 2014

Reviewer – Excellence in Counseling Grants, Chi Sigma Iota Review Committee, 2012 – 2014

Counselor Education and Supervision Information Forum Host, The University of Mississippi — 2012 – 2014

Co-Planner for the Association of Adult Development and Aging 2013 Conference — Spring 2013 – Summer 2013

Diversity Ally, The University of Mississippi — 2012 – 2015

President, Chi Sigma Iota, Epsilon Mu Chapter, The University of Mississippi, Oxford, MS — 2012 – 2014

Interdisciplinary Research Assistant for the University Review Board, The University of Mississippi, Oxford, MS — Fall 2012 – Spring 2013

Conference Co-Organizer for the Mississippi Association of Marriage and Family Therapy, Hattiesburg, MS — Fall 2012

GRANTS, FELLOWSHIPS, HONORS, & AWARDS

Awarded Outstanding Graduate Research Award in Leadership and Counselor Education Spring 2015

Awarded Graduate Achievement Award in Leadership and Counselor Education — Spring 2015

Awarded Dissertation Research Fellowship, The University of Mississippi — Spring 2015

CACREP Research Initiative for Graduate Students (CRIGS) Fellowship — Spring 2014 – Winter 2014

Awarded a Research Assistantship, The University of Mississippi— Summer 2014

Awarded Distinguished Leadership Award, Epsilon Mu Chapter of Chi Sigma Iota, University of Mississippi — 2012 – 2013

Selected as Graduate Student Council Senator for the Department of Leadership and Counselor Education, The University of Mississippi — 2013 – 2014

Awarded Student Development Grant, The University of Mississippi — 2013

Honored a Travel Award, The University of Mississippi — 2012; 2013; 2014

Awarded a Graduate Assistantship, The University of Mississippi — 2012 – 2015

Awarded the Courtney Caldwell Memorial Scholarship, The University of Mississippi — Summer 2012

Chancellor's List, University of South Carolina - Upstate — 2007

Gamma Beta Phi Society, University of South Carolina - Upstate — 2005 – 2007

President's List, University of South Carolina - Upstate — 2005 – 2007

President's List, Coastal Carolina — 2004

WORKSHOPS ATTENDED

CACREP Self-Study Workshop – Birmingham, AL — 2014

CONFERENCES ATTENDED

International

2009 Association of Psychological Sciences Conference. Chicago, IL

National

2013 American Counseling Association Conference. Cincinnati, OH

Regional

2014 Southern Association for Counselor Education and Supervision. Birmingham, AL

2007 Georgia Undergraduate Research in Psychology Conference. Kennesaw, GA

State

2013 Mississippi Counseling Association Conference. Jackson, MS

2012 Mississippi Association of Marriage and Family Therapy Conference. Hattiesburg, MS

2011 Mississippi Counseling Association Conference. Biloxi, MS

PROFESSIONAL MEMBERSHIPS

International Memberships
Chi Sigma Iota

National Memberships
American Counseling Association
American Mental Health Counselors Association
Association for Counselor Education and Supervision

Regional Memberships
Southern Association of Counselor Education and Supervision

State Memberships
Mississippi Counseling Association

TECHNOLOGICAL COMPETENCIES

Research Technology
SPSS
PROCESS
SAS
Qualtrics

Teaching Technology
BlackBoard
WebCT

PROFESSIONAL REFERENCES

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