Balancing Value Bracketing with the Integration of Moral Values in Psychotherapy: Evaluation of a Clinical Practice from the Perspective of Catholic Moral Theology

The Linacre Quarterly
2019, Vol. 86(2-3) 207-224
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DOI: 10.1177/0024363919856810
journals.sagepub.com/home/lqr

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Abstract

Value bracketing is a clinical practice proposed by graduate-level mental health counseling educators to help therapists-in-training learn how to avoid imposing their private values on clients as well as how to manage value conflicts with clients that emerge during the course of therapy. With value bracketing during professional work, a therapist does not refer to his or her private values so as not to influence a client's decision-making process. When some academic writers describe this practice, however, they risk overemphasizing the distinction made between a therapist's private values and the professional values that regulate his or her clinical work. This overemphasis is especially apparent in the assertion that a therapist's religious morality must be entirely separated from the ethics of professional practice. In contrast with this viewpoint, I maintain that a Catholic therapist can both avoid imposing values on clients while at the same time balance value bracketing with the integration of religious morality into professional work. I approach this integration in two ways. First, I approach therapy from the perspective of the intellectual tradition from which value bracketing originates (the tradition of qualitative research involving phenomenological interviewing). From this perspective, I agree that bracketing is methodologically necessary during the stage of clinical interviewing but not necessarily during the stage of treatment planning (when both therapist and client consent to seek particular treatment goals). Second, I outline moral criteria derived from the Catholic intellectual tradition that can help therapists exercise practical wisdom when discerning their professional involvement in how clients will apply treatment outcomes outside of the therapy.

Summary: The goal of the foregoing discussion has been to explore how therapists might balance the clinical practice of value bracketing with a supplemental practice of value integration. Ways were sought for Catholic therapists to adopt the practice of value bracketing without it requiring the professional affirmation (in thought, word, or deed) of client decisions and behaviors that contradict the therapist's private value system. An integration strategy to professional acculturation was explored where students and professionals seek to balance value bracketing with value integration. This balance is primarily to be located in the collaborative work of the therapist and the client when formulating a treatment plan together. At this stage of clinical work, a Catholic therapist consents to seek goals not only as a professional but also as a follower of Christ.

Keywords

Clinical practice guidelines, Ethics, Moral psychology, Philosophy of health care and ethics within the Aristotelian-Thomistic tradition, Psychotherapy, Value bracketing

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Value bracketing is a clinical practice proposed by graduate-level mental health counseling educators to help therapists-in-training learn how to avoid imposing their private values on clients as well as how to manage value conflicts with clients that emerge during the therapeutic process (Corey et al. 2015, 70; Herlihy and Corey 2014, 198; Hook et al. 2017, 173–78; Kocet and Herlihy 2014, 182; Remley and Herlihy 2015, 85). While this practice involves some clinical benefits, it also raises some concerns when evaluated from the perspective of Catholic moral theology. For example, does the practice of value bracketing require a Catholic therapist to aspire to be strictly value-free when conducting clinical work, to negate altogether his or her private values? Is it possible for a person entirely to separate private from professional values in order to compartmentalize the former and, if so, does this effort presuppose a dualistic anthropology (in other words, does this presuppose that a therapist's religious identity is a kind of second self that has nothing to do with his or her professional identity)?

In what follows, I examine how Catholic therapists might balance value bracketing with the integration of moral values in clinical work. I first consider the professional therapeutic context in which value bracketing is practiced. I recognize some benefits to the practice and I also raise some concerns. In light of studies in cross-cultural psychology, I then explore an integration approach to professional acculturation where Catholic students and professionals seek to balance value bracketing with value integration. There are two aspects to the integration approach under consideration.

The first aspect of the suggested integration approach involves examining in more detail the intellectual tradition from which value bracketing originates. This tradition involves the qualitative research method of phenomenological interviewing. In light of this tradition, I acknowledge that value bracketing is helpful during the therapeutic stage of clinical interviewing. Yet I also observe that bracketing in this sense need not be understood to apply in the same way at the therapeutic stage of treatment planning (when both the therapist and the client together consent to seek particular treatment goals). My primary focus in this regard is on the moral consent given by the Catholic therapist to the treatment plan, not the informed consent of the client.

The second aspect of the suggested integration approach under consideration involves exploring traditional moral criteria found in the Catholic intellectual tradition. Such criteria can assist Catholic

therapists to grow in practical wisdom in order to discern their moral involvement in the decisions of clients. These criteria include (1) discerning the various dimensions of a moral act, (2) assessing when a person has responsibility for unintended consequences, and (3) examining to what extent one is cooperating with the actions of others. I maintain that this twofold integration approach can assist a Catholic therapist who seeks to employ value bracketing so to avoid imposing values on clients but also not contradict the Catholic therapist's religious morality.

The Context of Therapist Value Bracketing

Psychotherapy in Contrast with Moral and Spiritual Development

When considering the moral responsibility of Catholic therapists with respect to their clients, Catholic moral theologians Benedict Ashley, Jean Deblois, and Kevin O'Rourke (2006) emphasize that therapists are foremost responsible to clients but not responsible for client decisions (p. 153). The authors indicate that the task of the therapist is distinct from assisting a client with moral development (Ashley, Deblois, and O'Rourke 2006, 152). In other words, according to these authors, it is not the task of the psychotherapist or mental health counselor to assist a client with obtaining moral freedom—the freedom from sin to which Paul alludes when proclaiming “Christ has set us free” (Gal. 5:1)—but rather with obtaining freedom from any psychological disturbance that impedes a client from the exercise of his or her autonomy. As such, the authors imply that a client's psychotherapeutic change is distinct from that client's moral development (Ashley, Deblois, and O'Rourke 2006, 154). The role of the therapist, they state, is not the same but only analogous to the role of “ethical and spiritual guides” (Ashley, Deblois, and O'Rourke 2006, 154; see also Brewster Smith 1978, 195). Due to this distinction, it may be necessary for mental health professionals to refer clients to clerics, spiritual directors, or religious leaders for spiritual and moral advice (Loving 1996, 359; Plante 2009, 66; 2016, 279; Vieten et al. 2013, 138; see also Pius XII 1953, §34–37).

The Impact of Values on the Therapeutic Relationship

Assuming that this account by Ashley, Deblois, and O'Rourke (2006) is correct, one must still ask: how

should a therapist understand his or her moral involvement in client decisions? Counseling ethicists Corey et al. (2015) observe that due to the different criteria that therapists and clients reference when making decisions, “value conflicts” can emerge during the therapeutic process (p. 72). By employing the language of “value” and “value system,” one has accepted at least implicitly what philosophical ethicists refer to as the fact/value (or is/ought) distinction (Ashley 2000, 15; Pojman and Fieser 2017, 212–31). This distinction is also called “Hume’s fork” after the eighteenth-century British philosopher David Hume (2005) who called attention to the difference between statements of fact and statements of moral obligation (p. 363; see also Gensler 2011, 38n, 45). Psychologist Alan Tjeltveit (1999) observes that the term “value” is used in many ways and argues that it should be defined in discussions of ethics in psychotherapy (pp. 83 and 104). In light of Hume’s fork, therefore, I use the term “value” at present to signify an ethical criterion that informs a person’s judgment concerning what *should* be desired or chosen (see also Tjeltveit 1999, 86; Illes, Ellemers, and Harinck 2014, 333). When a person is making a decision, a value provides that person with prescriptive or proscriptive guidance concerning which option is best (Beutler and Bergan 1991, 17).

A value system is intertwined with each person’s worldview (Ashley 2000, 15). Worldviews and value systems are present during psychotherapy and mental health counseling (Bergin 1980, 97; Gerig 2013, 51–52; Parrott 1999, 5). A client’s value system is operative, for example, when he or she makes a voluntary decision to pursue treatment. Different forms of psychotherapy and mental health counseling also involve affirmation of implicit values (e.g., rational beliefs should be preferred to irrational beliefs; Grayson 1982, 56; Remley and Herlihy 2015, 82). Further, there are basic “therapy values” to which a client must consent when entering a therapeutic relationship (such as valuing communication and receiving assistance; Ashley, Deblois, and O’Rourke 2006, 152). There are also values present when therapists and clients consent together to pursue certain treatment plan goals (regarding such goals, see Wiger and Solberg 2001, 105).

Client Autonomy

Ethical codes in the mental health fields recognize the roles that values play in the profession and the importance of therapists respecting client value systems. For example, the preamble of the 2014 Code of Ethics of the American Counseling Association

(ACA) outlines several “professional values” that provide “a conceptual basis” for six key ethical principles (ACA 2014, Preamble). The primary ethical principle is the principle of respecting a client’s autonomy. Client autonomy is defined as “the right to control the direction of one’s life” (ACA 2014, Preamble). One finds a similar affirmation of the right to “self-determination” in the Code of the American Psychological Association (yet with recognition that in some persons, the capacity for “autonomous decision-making” is impaired; American Psychological Association 2003, General Principles, Principle E).

Nonimposition of Therapist Private Values

In association with respecting a client’s autonomy, the ACA Code emphasizes that therapists must avoid influencing clients by imposing “personal values” upon them (ACA 2014, no. A.4.b). As defined by counseling ethicists Corey et al. (2015), “Value imposition refers to counselors directly attempting to influence a client to adopt their values, attitudes, beliefs, and behaviors. It is possible for mental health practitioners to do this either actively or passively” (p. 72). Some counseling theorists maintain that such value impositions are at worst coercive and at best paternalistic but in any event are always nonobservant of a client’s autonomy (Tarvydas, Vazquez-Ramos, and Estrada-Hernandez 2015, 227).

In clinical work, emphasis is to be placed on the client’s values not on the therapist’s private values. Psychologist Clara Hill (2014) explains that, “the goal of helping [as a therapist] is to encourage clients to explore and choose their own values” (p. 10; see also p. 411). In contrast with the client’s values, the therapist’s moral value system, according to counseling educators Theodore Remley Jr. and Barbara Herlihy (2015), is to be placed among private values (pp. 2–3), along with any associated “religious values” (Remley and Herlihy 2015, 85). These authors state that instead of referencing their private moral value systems, students who are entering the professional field should instead take up and “share certain *professional* values” that “are articulated in the code of ethics” (Remley and Herlihy 2015, 3, emphasis in original text; see also De Jong and Berg 2013, 256). As such, in this text, the authors entirely separate professional ethics from a student’s private religious morality (Remley and Herlihy 2015, 3).

Active and Passive Value Imposition

Ethicists Corey et al. (2015) indicate that when value imposition occurs actively and directly, such an imposition may entail “pressuring the client to choose a particular outcome” (p. 70). An example used by counseling educators Young and Cashwell (2011) is when a therapist proselytizes a client (p. 18). Remley and Herlihy (2015) give the example of a feminist therapist attempting to convert a female client to feminism when that client values religious subservience to her husband (p. 85). Hill (2014) gives the opposite example of a male therapist discouraging a female client from seeking a job because the male therapist believes that women should not work outside the home (p. 10). A further example Hill provides is of a therapist not allowing a client who has a terminal illness to explore the possibility of elective suicide should that client wish to do so (p. 411). Kurt and Piazza (2012) indicate that the role of the counselor in such a scenario is only to confirm that the client is exercising genuine autonomy when making the decision to seek elective suicide but not in any way to influence the client’s decision (p. 93).

In contrast with active value imposition, passive value imposition might be associated with a therapist responding to a client with greater affective warmth in relation to certain client behaviors or statements while not reacting in a similar way to other behaviors or statements (Hill 2014, 10). Describing these more subtle forms of value imposition, Remley and Herlihy (2015) maintain that such impositions can occur “through nonverbal responses, by focusing on some elements of a client’s story while not responding to others, and through the interventions [therapists] select” (p. 82, citing Francis and Dugger 2014, 132).

Value Conflicts between Therapists and Clients

When a client’s actions and decisions are at variance with the therapist’s beliefs and morality, a value conflict can emerge during the course of the therapeutic relationship (Corey et al. 2015, 72). This is not a value conflict in the sense of an interior struggle that a client may experience between conflicting desires or responsibilities but rather a conflict between the value system of the client and the private value system of the therapist (Ali, Allmon, and Cornick 2011, 41). Remley and Herlihy (2015) indicate that such conflicts can become a problem for the therapeutic process and hamper professional work (p. 82). As a result, the authors stress that “it is crucial” for therapists to explore how “they will manage the value

conflicts that inevitably will arise” (Remley and Herlihy 2015, 85). A therapist might be inclined to refer a client elsewhere when a value conflict emerges. Psychologists Hook et al. (2017), for example, recommend such referrals for a novice therapist who cannot therapeutically support a particular client’s values and who is not able to practice value bracketing effectively (pp. 173–74). The ACA Code (2014), however, rejects referral as an ethical option (no. A.11.b). Remley and Herlihy (2015) similarly maintain that a referral should occur only when there is a lack of professional competence in working with a client, not when there is a value conflict between the therapist and the client (p. 85).

Managing Value Conflicts: Therapist Value Bracketing

As distinct from making a referral, the clinical approach that counseling educators propose to assist therapists in managing value conflicts with clients involves learning how effectively to separate private values from values regulating professional work; *value bracketing* refers to this clinical practice (Remley and Herlihy 2015, 85). Some counseling ethicists describe this practice as protecting clients from counselor bias and from the imposition of the therapist’s private morality (Corey et al. 2015, 70). Describing the task of the mental health counselor, Herlihy and Corey (2014) assert that the counselor has an obligation to observe “appropriate boundaries” with clients and only to “provide a supportive environment” for clients to work through problems including ethical dilemmas (p. 204; on boundaries with clients, see also Holmes 2001, xvi). Value bracketing, these authors indicate, is a practice that enables therapists to stay focused on “the client’s agenda” and not their own (Herlihy and Corey 2014, 198).

Benefits of Therapist Value Bracketing

The clinical practice of value bracketing offers Catholic therapists several benefits when they encounter value conflicts with clients. First, using the language of Law Professor Elizabeth R. Schiltz (2010), one can affirm that there is a licit distinction to be made between the “private” domain of a person and the “public” or professional domain (p. 161). In many cases, the communication of a therapist’s private preferences to a client would lack professional propriety or relevance.

Further, a Catholic emphasis upon charity (Corby 2018), empathy, compassion, and justice toward others precludes the inclination to execute moral judgments upon the personhood of clients, a concern also maintained by some counseling ethicists (Corey et al. 2015, 72; Young and Cashwell 2011, 17). The *Catechism of the Catholic Church* (2000) indicates that it is ultimately the prerogative of Christ to judge a person in accordance with his or her deeds (no. 1861). This catechesis is consistent with biblical teachings (Matt. 7:1–5), especially statements made by Paul in reference to non-Christian persons (1 Cor. 5:12–13). With respect to traditional Catholic theological anthropology, one must make a distinction between persons and their actions. In other words, a therapist's moral discernment (carried out in light of the criteria of practical wisdom discussed below) pertains to judging actions rather than persons (Catholic Church 2000, no. 1749). In the same way, one may differentiate personal bias for or against others based on their inherent attributes (a practice that mental health workers should always avoid—see Boysen 2009) from the discernment of values regulating the choice of actions to be performed. Augustine sets the precedent in this regard when teaching that a Christian person should continue to love others without at the same time affirming the goodness of acts of sin (Augustine 1956, 46).

As a third point, it is reasonable when working in a pluralistic society that Catholic therapists professionally tolerate the *de facto* diversity (or relativity) of client value systems. In this respect, therapists might legitimately bracket moral issues pertaining to behaviors of a client that are not relevant to that client's treatment plan. This does not mean, however, that a therapist needs to affirm the *de iure* or objective truth of moral relativism. Such is a philosophical position with respect to which Ratzinger (1996), when serving as prefect for the Congregation for the Doctrine of the Faith, raised legitimate concerns (see also Ratzinger 2003, 117–19; Ratzinger 2006, 56).

Finally, respect for the personhood of clients requires respecting client decisions and autonomy (Ashley, Deblois, and O'Rourke 2006, 152). Pope John Paul II (1993b) recognized in the important moral encyclical, *Veritatis splendor*, that “a rightful autonomy is due to every man” (John Paul II 1993b, no. 38). The Pontiff maintains, however, that this autonomy does not extend to the creation of “values and moral norms” (John Paul II 1993b, no. 40). The ecclesial council Vatican II (1990) maintains in a similar way that the Church respects the autonomy of earthly realities and human societies as well as

recognizes the validity of methodological inquiry in the sciences, yet adds that scientific methodology should be exercised within the boundaries of “moral norms” (no. 36). With these observations made, one should note that bracketing moral judgments of clients differs from bracketing the therapist's private value system that would regulate *the therapist's* thoughts, words, and deeds, including affirmations communicated to clients during the course of therapy. It is when one considers value bracketing in this latter respect that certain concerns emerge.

Concerns with Value Bracketing

The Difficulty of Professional Value Neutrality

An initial concern one might examine with respect to value bracketing involves whether the practice requires therapists to attempt to work professionally in a value-free modality, adopting in relation to each client a perspective that exemplifies what philosopher Thomas Nagel (1989) refers to as “the centerless view” from nowhere (p. 60). Some authors indicate that they believe this to be a requirement of clinical practice. For example, Linde (2016), a member of the ACA ethics revision task force, states: “in counseling, it is important to leave our values and worldview at the door of the session and not allow how we see things to influence the way we view and work with our clients” (p. 21). Other authors, however, indicate that it is not possible to maintain total value neutrality in professional work (Miller 2001, 353; Titus 2017, 447; Young and Cashwell 2011, 16). For example, Hartwig Moorhead and Heller Levitt (2013) state, “Value neutrality in counseling is not only a past consideration but, in our opinion, a near impossibility” (p. 25). Philosopher and bioethicist James F. Drane (1982) argues that while value neutrality may remain an ideal for scientific psychotherapy and also for nonclinical psychological research, everyday clinical practice cannot ignore moral values (he refers to cases involving pedophilia or the “massive moral deficiencies” that can be present in cases of narcissism; pp. 18–19). The present issue, then, is not so much with attempting to work as a professional in an entirely value-free manner but rather to what extent a Catholic therapist can set aside his or her private value system and take on the client's value system as required in clinical work (Beutler, Machado, and Neufeldt 1994, 242; citing Propst et al. 1992, 94 and 102).

Self-Negation of a Therapist's Private Value System

Herlihy and Corey (2014) state that mental health practitioners are not asked to negate their private value systems in an absolute way, but only while carrying out the professional tasks associated with clinical work (pp. 197–98). Some thinkers describe value bracketing understood in this way as requiring a kind of “self-compartmentalization” on the part of the therapist (Shallcross 2010, 33). Hamilton (2013) refers to this process as an effort “to quarantine therapy from the danger of a therapist imposing [private values] on the client” (p. 486). In this way, some counseling ethicists emphasize that therapy must occur strictly and solely within the client’s value system (Corey et al. 2015, 73 and 81).

The result of these proposals is that a therapist cannot evaluate or regulate his or her professional activity in accordance with his or her own private values. In this respect, a therapist may feel professionally required to affirm the goodness of a client’s decision (e.g., to procure an abortion) even though interiorly the therapist is deeply opposed to such an action (regarding this particular kind of value conflict, see Millner and Hanks 2002; Corey et al. 2015, 70). The professional requirement to enter into such a state of self-contradiction can be interpreted as a kind of therapist self-negation. Writing from the perspective of Rogerian psychotherapy, for example, some authors refer to clinical work as involving a kind of self-sacrifice or self-emptying (*kenosis*) of the therapist vis-à-vis the client (Fruewirth 2013; see also Phil. 2:7). Yet does such a proposal adequately respect the personal dignity of the therapist?

A Dualistic Understanding of Therapist Personhood

Some psychologists have questioned whether therapists can entirely separate their professional and private values in order to compartmentalize them in the manner described above (Bergin, Payne, and Richards 1996, 313, citing Beutler, Machado, and Neufeldt 1994, 240). Should such a compartmentalization process be possible, one may also be concerned with whether the private value system of the therapist is receiving due respect. In other words, would not the professional structure of the therapeutic relationship, as self-defined by the community of professionals, require respecting the dignity of *both* the therapist and the client, and thus respecting the private moral value system of both parties?

To practice the aforementioned self-compartmentalization would involve a kind of psychological partitioning on the part of the therapist between the private and public (or professional) domains of the self, to the point of tacitly affirming a kind of dualism to the therapist’s personality. Such a dualism of the personality would need to be affirmed in order for a therapist to contradict his or her own core values during professional discourse. Should such a dualism be consistent with Catholic anthropology, the Apostolic council of Jerusalem, for example, would not have proscribed members of the early Church from eating food that had been offered to the idols of the civil cult (Acts 15:29). Some professionals may be comfortable embracing such a dualism. A genuine Catholic anthropology, however, will affirm the unity of a person in his or her thinking, speech, and actions (Moncher and Titus 2009, 25; Nordling and Scrofani 2009; see also the discussion of unified therapeutic presence in Brownell 2015, 91–92). Further, as clinical psychologist Philip Brownell (2015) observes, ethical consistency is an essential aspect of a person’s spirituality (p. 77). Would not the effort to discern ethical congruence between a therapist’s professional and private values contribute to the genuineness of the therapist’s personal character? Psychotherapist Carl Rogers (1957) maintains that such genuineness is to be found not when a therapist presents a “façade” to the client but rather when the therapist interacts with the client as an “integrated person” who “within the [therapeutic] relationship . . . is freely and deeply himself” (p. 97). From this interpersonal perspective, therefore, a Catholic therapist’s private value system cannot entirely be set aside or negated in order to participate in professional work.

Professional Acculturation Concerns

Aside from the philosophical problems associated with interpreting value bracketing as promoting a kind of dualism to the therapist’s personhood, one might also pause to consider the pedagogical effectiveness of value bracketing when it is proposed to students as the sole remedy for managing value conflicts with clients. Construing the ethical codes of a professional field to promote a kind of culture that students are expected to adopt, some mental health ethicists suggest understanding pedagogy as an acculturative process (Bashe et al. 2007; Handelsman, Gottlieb, and Knapp 2005; Sells and Hagedorn 2016, 272). Adopting categories from cross-cultural psychology to describe various acculturation approaches (Berry and Sam 1997, 296–99; Berry

2003, 24), these ethicists caution against a pedagogical approach where students are expected simply to assimilate to professional culture (Handelsman, Gottlieb, and Knapp 2005, 61). It is the process of acculturation by assimilation that is operative in pedagogy when value bracketing (interpreted as requiring a kind of total self-compartmentalization on the part of the student) is proposed as the sole remedy to navigate value conflicts with clients.

According to ethicists Handelsman, Gottlieb, and Knapp (2005), the assimilation approach to pedagogy in professional ethics can lead to student acculturation problems (p. 61). The authors state that such problems can involve a new therapist basing his or her ethical practice on a “shaky foundation” or making ethical decisions as guided by an empty legalism (Handelsman, Gottlieb, and Knapp 2005, 61). Psychologist John W. Berry (2003) observes that, “when acculturation experiences cause problems for acculturating individuals, it results in the phenomenon of acculturative stress” (p. 26). Berry writing elsewhere with cross-cultural psychologist David Sam (1997) states that such tension, stress, and related problems ultimately impede the process of personal acculturation or “adaptation to the new cultural context” (p. 299). What alternative acculturation strategy might help facilitate the education of students in the mental health fields by affirming the clinical benefits of value bracketing yet not requiring a total self-compartmentalization on the part of the therapist?

Developing an Integrative Balance to Value Bracketing

Balancing Value Bracketing with Value Integration

In order to facilitate adaptation to professional culture and prevent associated acculturative stress in students (as well as stress in established clinicians who encounter a culture change in their professional field), some ethicists point to the greater effectiveness of an integration approach to acculturation (Bashe et al. 2007, 61; Handelsman, Gottlieb, and Knapp 2005, 60–62). Berry (2003) maintains that, “when people have an interest in maintaining their original culture during daily interactions with other groups, they use the *integration* strategy” (p. 24). He explains that acculturation by way of integration “involves the selective adoption of new behaviors from the larger society and retention of valued features of one’s heritage culture” (Berry 2003, 31). Such a person, Berry states elsewhere, becomes “bi-cultural” (Berry and Sam 1997, 297). The

research of Berry (2003) emphasizes that acculturation by way of integration is ultimately more successful than that of assimilation (p. 33; see also Berry and Sam 1997, 318). He indicates that a professional field, however, would need to support such an integrative approach to student acculturation (Berry and Sam 1997, 318).

Approaching Value Integration

What might an acculturation strategy based on integration look like for a therapist who combines a Catholic value system (including a Catholic anthropological vision) with his or her professional work in psychotherapy or clinical mental health counseling? Integration as it is being discussed here must be understood in a way that is distinct from the integration of a client’s religion or spirituality into his or her treatment plan (for this, a therapist would need to acquire a spiritual competency; see, e.g., Brownell 2015; Shafranske and Sperry 2005; Young and Cashwell 2011, 15–19). Integration as considered here, rather, pertains to the intersection of a therapist’s private value system with his or her professional work.

Although counseling educators Kocet and Herlihy (2014) primarily stress the professional importance of value bracketing, they also state that bracketing as a clinical practice should be *balanced* with the integration of a therapist’s private values (p. 182). Unfortunately, Kocet and Herlihy do not explore what such an integration might entail. Even so, it is clear that *value integration* would serve as a kind of counterpoint, so to speak, to value bracketing; value integration would function as a supplemental clinical practice. Elsewhere, Herlihy and Corey (2014) describe the process of integration as an effort to reconcile one’s private value system with the value system of the counseling profession (p. 196). Some counseling educators indicate that such a reconciliation might require the evolution of a student’s private values into the values of the profession. Ametrano (2014), for example, explores guiding students through such a process of *value reconciliation*. In her discussion, it is evident that the process of value reconciliation involves students not only exploring but also challenging their private value systems (Ametrano 2014, 160). In contrast, a genuine integration approach would not seek to change a student’s value system but rather, as Sells and Hagedorn (2016) state, promote a strategy where students “integrate their personal identities with their professional identities” (p. 272). Without promising a perfect reconciliation, these authors assert that students should be guided to “walk within the tension”

of balancing their private value systems with the expectations of the profession (Sells and Hagedorn 2016, 273). Locating this balance (a mean between the excess of imposing private values on clients and the defect of therapist total self-negation) requires the exercise of a unique kind of *practical wisdom* (for a general discussion of the professional virtues of a therapist, see Fowers 2003, 425; Jordan and Meara 1999, 144; Meara, Schmidt, and Day 1996; Moncher and Titus 2009, 28; on the virtue of practical wisdom or prudence, see Catholic Church 2000, no. 1806; Mitchell 2015, 162). One possible way to achieve this balance is to consider therapist self-disclosure to clients.

Therapist Self-Disclosure and Client Informed Consent

Some thinkers indicate that a therapist can exercise practical wisdom to discern how appropriately to disclose his or her private values to clients while also maintaining a professional distance that is respectful of a client's autonomy (see, e.g., Holmes 1996, 268–69). Other ethicists in the field of mental health counseling, however, discourage any disclosure of a therapist's private values to clients. Corey et al. (2015), for example, maintain that such “values exposure” or therapist communication of value judgments “can determine the direction of counseling” and “control the process of therapy” (p. 79). These authors argue that such disclosures can jeopardize developing a therapeutic alliance with a client (Corey et al. 2015, 82). They state that therapist disclosures “can easily convey a judgmental attitude to clients about issues with which they may be struggling” (Corey et al. 2015, 70). Similarly, clinical psychologist Michael Kahn (1997) observes that too much therapist self-disclosure can risk missing the important therapeutic opportunity to explore why a client may be asking questions about the private values of the therapist (p. 149).

Conversely, Kahn (1997) also acknowledges that modest self-disclosure makes the therapeutic process more human and communication more bidirectional (p. 149). Similarly, psychologists Hook et al. (2017) state that the theoretical orientation of interpersonal psychotherapy supports a therapist's decision to engage in an open “collaborative values discussion” with a client (p. 175). Counseling educators Hagedorn and Hartwig Moorhead (2011) likewise observe that there are counseling theories that “encourage transparency” on the part of the mental health professional (p. 86). For example, Millner and Hanks (2002) maintain that it is appropriate for a clinician

to disclose his or her personal viewpoint to a client regarding the moral issue of abortion as long as the clinician does not interfere with the client's autonomy in making a decision whether or not to procure an abortion (p. 61).

The disclosure of the general value system of an agency is exemplified in the current ethics statement publicized by Catholic Charities USA (2007). Referring to the religious values of the agency, the code states, “the identity of the agency is clearly Catholic. As such, agencies adhere to the social and moral teachings of the Catholic Church” (Catholic Charities USA 2007, 1.13a). In connection with this affirmation of the agency's Catholic value system, the code then states, “the agency does not provide services contrary to teachings of the Church, such as abortion counseling” (Catholic Charities USA 2007, 1.13c; “abortion counseling” here might be interpreted as “abortion affirmative counseling”). This disclosure of agency values, so to speak, also affects how Catholic Charities understands the informed consent process (Catholic Charities USA 2007, 1.04d). The explicit communication of such pretherapy disclosures, according to psychotherapy ethicists Lewis and Epperson (1993), does not necessarily result in a disinclination on the part of clients to pursue therapy with explicitly Christian agencies (pp. 100–101; see also Beutler and Bergan 1991, 22). Further, in contrast with Corey et al. (2015), Bergin, Payne, and Richards (1996) maintain that consent and agreement between the therapist and the client regarding values contribute to the development of the therapeutic alliance (p. 313).

Implicit Value Integration

An approach to integration involving explicit therapist self-disclosure to clients may not greatly benefit Catholic therapists working in non-Catholic professional settings. Given the diversity of clients with whom a Catholic therapist might work as well as the diversity of professional settings, the insights of Siang-Yang Tan (1996) regarding *implicit integration* provide a helpful contribution to the current discussion. According to Tan, “The therapist practicing from an implicit integration model or perspective can still be a religious person who shows respect and caring for the client, while maintaining values, including religious values, that are consistent with the therapist's own religious convictions and beliefs” (p. 368; see also Walker, Gorsuch, and Tan 2004, 71; Plante 2009, 67; Pompeo and Heller Levitt 2014, 84). These remarks of Tan (1996) regarding implicit integration point directly to the kind of just balance

that can be sought between the values of the therapist and the values of the client. In this way, “implicit integration” is understood here not as a desire that therapists impose private moral values on clients nor seek to change a client’s value system, but rather a desire that therapists use practical wisdom with respect to each client in order to discern a balance between that client’s values and the Catholic therapist’s private moral values. A brief exploration of the historical background of value bracketing provides a context for understanding with more precision where this balance is to be located during the therapeutic process.

The Origin of Value Bracketing: Qualitative Research and Phenomenological Interviewing

Value bracketing as a professional practice can be traced to particular methodological recommendations found in qualitative research design. In this regard, counseling ethicists Kocet and Herlihy (2014) refer readers to a text authored by social science researchers Catherine Marshall and Gretchen Rossman (2011). Kocet and Herlihy (2014) state that they are adapting the understanding of bracketing presented by these authors for the application to the work of clinical mental health counselors (p. 182). Marshall and Rossman (2011) in turn follow the qualitative methodology proposed by education researcher Irving Seidman (2006) and consultant Michael Patton (1990). According to Patton, qualitative research design is influenced by two primary intellectual traditions, *ethnography* and *phenomenology* (p. 153; see also Creswell 2007). It is the latter tradition of phenomenology that is important for understanding the origin of clinical value bracketing. One might note that in the Catholic intellectual tradition, both Karol Wojtyla (John Paul II) and Edith Stein (St. Teresa Benedicta of the Cross) explored philosophical phenomenology and its methods as developed by the philosopher Edmund Husserl (for Wojtyla, see Wojtyla 1993, 210 and 226; see also Köchler 1982; Kupczak 2000, 7; Schmitz 1993; for Stein, see Stein 1989, 3–4; see also Brownell 2015, 22; for Husserl, see Husserl 2014, no. 32; see also Patton 1990, 69; Sokolowski 1999, 2–3).

Qualitative research design employs the presuppositions of philosophical phenomenology to develop an approach to interviewing research participants (Kvale 1983; Marshall and Rossman 2011, 148). Phenomenological interviewing in qualitative research is in this regard analogous to the clinical

interviewing that occurs between a therapist and a client (Sommers-Flanagan and Sommers-Flanagan 2009; Shea 2017). While there are variations in approach (see Smith and Shinebourne 2012, 74), here, I primarily draw upon the discussion of Marshall and Rossman (2011) who describe phenomenological interviewing as a process that aims to understand the *essential meaning* of any phenomenon under consideration (pp. 19–20 and 148; see also Kvale 1983, 184; Patton 1990, 69). For example, a researcher in psychology might seek to understand the essential meaning of “therapist empathy” by contrasting various experiential accounts offered by different therapists. According to Patton (1990), that there is such an essential meaning to be mutually experienced by different persons is the key philosophical assumption of phenomenological research (p. 70). If one applies this discussion analogously to clinical interviewing as Kocet and Herlihy (2014) suggest, then both the therapist and the client may have similar life experiences that enable them to understand the essential meaning of any clinical phenomenon under consideration (e.g., the phenomenon of addiction or depression—although the therapist’s experience of the phenomenon may be indirect by the way of study or work with previous clients).

At the initial stage of the phenomenological interview, qualitative researchers are asked to employ a research skill called *methodological bracketing* (Marshall and Rossman 2011, 148; see also Patton 1990, 408; Sokolowski 1999, 49–50; Wertz 2005, 168). Thus, just as phenomenological interviewing is analogous to clinical interviewing, so is methodological bracketing in research analogous to clinical value bracketing. According to Marshall and Rossman (2011), by the use of bracketing, researchers guard against presuppositions that the researchers might maintain regarding the phenomenon being described by the research participants (p. 159). Bracketing enables participants to disclose more information and so there is more research data to be collected (Creswell and Miller 2000, 127; Kvale 1983, 176).

The researcher’s comportment or interaction style with the participant is itself the realization of the phenomenological method (Kvale 1983, 178). The researcher chiefly employs open-ended questions in order that the participant might guide the interview, perhaps even leading the dialogue in an unexpected way (Smith and Osborn 2004, 233; Seidman 2006, 15 and 130). Researcher bracketing also benefits the research participant because the participant is able to reconstruct and consolidate his or her experience when reporting to the researcher; in this

way, the researcher is better able to understand *how the participant understands* the phenomenon under consideration (Seidman 2006, 24).

It is important to note in relation to the topic of clinical value bracketing that at a later synthetic stage of qualitative research, the researcher's judgment about the phenomenon is no longer bracketed (Marshall and Rossman 2011, 148). At this later synthetic stage, the researcher's private experience can also be *integrated* into the data. According to Marshall and Rossman (2011), "the primary advantage of phenomenological interviewing is that it permits an explicit focus on the researcher's personal experience *combined* with those of the interview partners" (p. 148, emphasis added). Due to the interpersonal nature of the phenomenological interview, the essential meaning of the phenomenon under consideration ultimately emerges out of the interaction between the interviewee and the interviewer, each party having a reciprocal influence on the other (Kvale 1983, 178). Bracketing therefore occurs not as an end unto itself but operates at an initial stage of the process of seeking understanding, a process where ultimately the researcher's experience is also integrated into the results. I proceed now to examine how this discussion of the origin of value bracketing contributes to discerning how therapist value bracketing might be balanced with the integration of the therapist's experience in clinical work.

Value Bracketing during the Therapeutic Stage of Clinical Interviewing

The foregoing discussion points to the importance of therapists bracketing cognitive presuppositions during clinical interviewing for the sake of acquiring a better understanding of clients.

This practice encourages a kind of cognitive caution on the part of the therapist during the clinical interview (Sommers-Flanagan and Sommers-Flanagan 2009, 24–31). Such caution is itself an exercise of practical wisdom. Bracketing a therapist's presuppositions involves bracketing not only expectations about a client's value system but also bracketing emotional responses to client disclosures. In order to bracket such emotional responses, therapists must engage in an ongoing process of developing self-awareness; this interior work requires clarifying private moral values (Corey et al. 2015, 71; Herlihy and Corey 2014, 198; see also Ali, Allmon, and Cornick 2011, 41; Bergin 1980, 101; Catholic Church 2000, no. 1779; Hagedorn and Hartwig Moorhead 2011, 72; Kelly and Strupp 1992, 39; Lyddon and Adamson 1992, 46; Pompeo and Levitt

2014, 82; Vieten et al. 2013, 136). In a similar way, psychologists Hook et al. (2017) state that novice therapists can experience "a lack of integrity" when practicing value bracketing because they may not yet be highly developed with respect to emotional self-regulation and client empathy (p. 174). Herlihy and Corey (2014) also recommend that therapists engage in value self-monitoring in order to discern how private values are interacting with and influencing professional work (p. 198). This awareness will assist therapists in discerning whether countertransference may be occurring during interaction with clients (countertransference occurs when a therapist confuses his or her own values and emotions with the values and emotions of the client; Hill 2014, 237; Kahn 1997, 143–44).

Value Integration during the Therapeutic Stage of Treatment Planning

Treatment planning occurs subsequent to clinical interviewing (Wiger and Solberg 2001, 105; De Jong and Berg 2013, 5). With treatment planning, objectives are considered that serve as measurable steps that might be taken to achieve more general client goals (Wiger and Solberg 2001, 105). Treatment planning, some counseling ethicists state, should be focused solely on the client's goals and not on goals that the therapist might prescribe for a client (the therapist's "agenda"; Corey et al. 2015, 84). Such prescriptions from the therapist would entail a form of active value imposition. When making this proposal, however, I assume that counseling ethicists would not want to be interpreted as stating that therapists should agree to pursue client proposed goals that are inconsistent with a client's assessment results, diagnosis, customary evidence-based treatment practices, or professional legal obligations. Yet, as discussed above, some counseling ethicists do indicate that therapists should consent to pursue treatment goals that contradict the therapist's private value system (Corey et al. 2015, 70, 73, and 81; Linde 2016, 21; Shallcross 2010, 33). This would occur, using the example from Hill (2014) mentioned above, should a Catholic therapist professionally affirm a terminally-ill client's choice to seek physician-assisted suicide in states where such procedures are legal, while privately believing that such a choice is immoral (p. 411; regarding the Catholic evaluation of physician-assisted suicide, see Catholic Church 2000, no. 2277). Hill's example leads one to consider the possibility that counseling ethicists might perceive the boundaries of civil legality as constituting the limits within which therapeutic

support is expected to be verbalized to clients by means of positive affirmations. Yet this leads not only back to the problems of moral relativism and personal dualism as discussed above but also to a reduction of mental health ethics to civil legalism (also mentioned above in relation to Handelsman, Gottlieb, and Knapp 2005, 61; regarding the distinction between the domain of the ethical and the domain of the legal, see Goligher 2017, 105).

Treatment objectives, counseling educator Linda Seligman (2004) writes, typically aim to improve a client's sense of well-being, reduce the impact of problematic symptoms, and improve a client's overall level of functioning (166, citing Wiger and Solberg 2001). Although therapists work with culturally diverse clients who have various presenting concerns, one can observe that in this remark by Seligman (2004), treatment goals and objectives are considered in a very general (transcultural) manner. If a therapist desires to avoid prescription and active value imposition upon a client, then all treatment goals must indeed originate in some way from the client. At the same time, the discernment and selection of treatment goals and objectives involves, according to counseling educators Reichenberg and Seligman (2016), "a collaborative process between the therapist and client" (p. 6; see also Sommers-Flanagan and Sommers-Flanagan 2009, 295–96).

If phenomenological interviewing in qualitative research is analogous to clinical interviewing, and if bracketing at the initial stage of qualitative research is analogous to value bracketing during clinical interviewing, then the synthetic stage of qualitative research described above can be understood as analogous to the collaborative stage of treatment planning during the course of therapy. In other words, the treatment goals under consideration can be construed as phenomena that both the therapist and the client experience together, common ends that unite their collaborative effort. When the essential meaning of treatment is grasped, the therapist and client work together to formulate a plan to pursue the goals in question. This moment of collaboration is the moment of integration, when therapist and client together experience the phenomenon of treatment not only in accordance with their respective roles as professional and client but also as unified persons.

In conjunction with the therapist's exercise of practical wisdom, the collaborative discernment of treatment goals should proceed in a way that is consistent with the client's proposals, assessment results, and evidence-based practices (Sommers-Flanagan and Sommers-Flanagan 2009, 297–98).

In this regard, I am led to ask Catholic therapists a key question: *when agreeing with a client to pursue a treatment plan, can Catholic therapists maintain a focus on general transcultural goals and objectives that contradict neither the value system of the client nor the value system of the therapist?* By "transcultural" here, I refer to general mental health goals that would be common to many clients, regardless of race, gender, ethnicity, or sexual orientation. Such general transcultural treatment goals would involve, for example, helping a client achieve psychological freedom from anxiety, depression, or fear (as discussed above in relation to Ashley, Deblois, and O'Rourke 2006, 152). The provision of other professional services (such as conducting standard mental health evaluations and assessments) would also occasion opportunities to maintain a similar general focus (on this point, see reference to the psychiatric evaluation of a patient who is seeking transgender reassignment surgery in Golder 2018, 126). This emphasis on pursuing general mental health goals that are common to the worldviews of both the therapist and the client will respect the client's autonomy to personalize the outcomes of therapy in relation to his or her value system, as well as respect the private value system of the therapist. This approach also allows for the treatment plan to remain open to the possibility that a client might choose to apply the treatment outcomes outside of therapy in a manner that is genuinely conducive to that client's moral and spiritual health. On this point, John Paul II (1993a) states, "*no genuine therapy or treatment for psychic disturbances can ever conflict with the moral obligation of the patient to pursue the truth and to grow in virtue*" (emphasis in original text). However, it will remain the client's choice whether to apply treatment outcomes in such a way so to grow in genuine virtue in this regard.

Pursuit of common treatment goals does not mean that a therapist needs to disclose to the client the therapist's private feelings, reflections, or experiences concerning such goals (see De Jong and Berg 2013, 37). Further, as stated above, all treatment goals would originate from the client. With respect to the goals that are collaboratively selected as the focal points of treatment, the therapist and the client would both value the treatment goal under consideration and both persons would give free consent to pursue it. When giving such mutual consent to pursue common treatment goals, the therapist and the client realize together what philosopher Hans Georg Gadamer (1989) describes as the "communicative agreement" that must be present in any genuine dialogue (p. 111; see also Serres 2012, 226).

Discerning Therapist Moral Cooperation in Client Applications

Resources from the Catholic Intellectual Tradition

As a closing concern, a therapist might desire to explore situations where he or she foresees that work with a client (even when pursuing general transcul-tural goals) enables a client to apply treatment out-comes in a way that contradicts the therapist's private moral value system. This might occur, for example, when a client discloses that his therapeutic growth in self-confidence will allow him to pursue an adulterous affair with a coworker. The virtue of practical wisdom enables therapists to have foresight regarding client applications (Aquinas 1981, II-II, q. 49, a. 6; for a general overview of practical wisdom in relation to psychotherapy, see Titus 2013). Fowers and Davidov (2006) emphasize how the virtue of practical wisdom can assist therapists in discerning what should be focused upon when communicating with a client as well as in discerning when it is most appropriate to introduce topics in a way that will best help a client (p. 591; see also Fowers 2003, 423; Catholic Charities USA 2007, 1.08c footnote 4). Certain discernment criteria developed in the Catho-lic intellectual tradition can assist therapists who desire to grow in practical wisdom and evaluate their moral involvement in the decisions of clients. To the extent that such criteria can be utilized in the profes-sional discernment of a therapist, they contribute to an integration strategy for professional acculturation that exhibits what Berry (2003) describes as retained "valued features of one's heritage culture" (p. 31). I will now consider three sets of discernment criteria that can assist a therapist in developing practical wis-dom: (1) the three sources of morality, (2) the criteria of moral double effect, and (3) the criteria of moral cooperation.

The Three Sources of Morality

One foundational set of discernment criteria involves exploration of what is called *the three sources of morality* (Catholic Church 2000, no. 1750; John Paul II 1993b, no. 74). For a voluntary act to be entirely good, morally speaking, all three sources (or moral aspects) of a voluntary action must be good: (1) the act itself, (2) the person's intended goal, and (3) the circumstances surrounding the act performed (Catho-lic Church 2000, no. 1755; see also Aquinas 1981, I-II, q. 18, a. 4).

The first source to consider in moral discernment involves reflection upon the character of the volun-tary act itself, "what" that act is (morally speaking; Catholic Church 2000, no. 1751; John Paul II 1993b, no. 74-79; see also Cessario 2013, 160-63; McNerny 1997, 81-83). This consideration does not focus on a physical act as such (e.g., an act of killing or an act of sexual intercourse) but rather upon that act understood in light of further moral conditions (such that morally speaking that act is either an act of murder or combat, either an act of adultery or mar-ital intercourse; Aquinas 1981, I-II, q. 18, a. 5, ad 3; see also q. 18, a. 7, ad 1). Among such kinds of moral acts, there are some that are entirely proscribed in the Catholic tradition as involving "intrinsic moral evil" (Catholic Church 2000, no. 1761; John Paul II 1993b, no. 80-83, no. 115). This is because, John Paul II (1993b) observes, such an act is in and of itself incapable of being oriented to God or manifest-ing the image of God in the person who performs that act (this kind of voluntary act is inherently devoid of charity and justice; no. 81).

The second source to consider in moral discern-ment involves reflection upon a person's intention for performing the voluntary action, "why" he or she chooses to perform the act (Catholic Church 2000, no. 1752-53; Cessario 2013, 167-71). A person's intention will concern the goal that he or she wishes to attain by means of the act performed (Catholic Church 2000, no. 1752). It is important to note that, according to Catholic teaching, intending a good goal does not justify a person in performing an act that involves intrinsic moral evil (Catholic Church 2000, no. 1759; John Paul II 1993b, no. 77). As will be clear below, this source is particularly important for a Catholic therapist to explore with respect to dis-cerning his or her therapeutic intention.

The third source to consider in moral discernment involves reflection upon other circumstances sur-rounding the performance of the action (Catholic Church 2000, no. 1754; Cessario 2013, 171-75). Such circumstances pertain not only to the action itself (such as where or when the act is performed) but also to the person who performs the action. It is possible for a good kind of act (such as marital intercourse) to become morally problematic in cer-tain circumstances (such as engaging in marital intercourse at an inappropriate time). With respect to the circumstances of the person performing the act, the *Catechism of the Catholic Church* (2000) recognizes that numerous psychological and sociolo-gical factors impact whether or not a person has full or partial moral responsibility when performing an

action (no. 1754; for specific factors, see nos. 1735, 1746, 1754, 1756, 1860, 2352, and 2355).

Therapist Intention and Moral Double Effect

In connection with discerning a person's intention (moral source two discussed just above), practical wisdom also enables one to evaluate one's responsibility for foreseen yet unintended bad consequences that result from a course of action (Catholic Church 2000, no. 1737). This topic pertains to the therapist's foresight that a client might apply treatment outcomes in a way that violates the therapist's private value system. A therapist would not be held morally responsible for such unintended consequences (even though they are foreseen) as long as the three sources of morality are all morally good (on the part of the therapist) and also as long as (a) the bad consequences do not serve as means to bring about an intended treatment goal and (b) the quantity of bad consequences seem to be less than or at least equal to the quantity of good consequences that are therapeutically intended (Ashley, Deblois, and O'Rourke 2006, 54–55; Haas 2017, 249–50). If such criteria are met, then an unintended bad consequence resulting from a client's treatment can be construed as a *moral double effect* or side effect that a Catholic therapist tolerates or permits (Cavanaugh 2006; Woodward 2001; see also Catholic Church 2000, no. 2263). In addition to these customary criteria, one should emphasize that (a) the bad consequences must not arise due to the therapist's negligence (a kind of culpable ignorance; Catholic Church 2000, no. 1736) and (b) the therapist would altogether avoid the bad consequences if such were possible (Catholic Church 2000, no. 1737).

Therapist Moral Cooperation in Client Applications

When a therapist has foresight that the outcomes of a treatment plan will be utilized by a client for attaining further goals that contradict the therapist's private value system, the therapist may want to continue to explore his or her moral connection to the client's subsequent actions. In this case, it is helpful also to reference traditional criteria that contribute to the development of practical wisdom. There are several questions that a therapist might ask concerning *moral cooperation* in this regard (see also Catholic Church 2000, no. 1868).

A first question is: do I affirm, approve of, or endorse the act under consideration? A typical

bioethics example here is of a nurse who willingly chooses to assist a surgeon who is carrying out an abortion procedure and where the nurse also desires that the abortion occur (Austriaco 2011, 264). By analogy, should a therapist affirm (in thought, word, or deed), approve of, or endorse the foreseen immoral act of a client, then the therapist's cooperation would be consensual and therefore *formal* (Ashley, Deblois, and O'Rourke 2006, 55; Austriaco 2011, 264; Fisher 2005, 30; Pontifical Academy for Life 2006, 545; see also Catholic Church 2000, no. 2272). Other forms of moral cooperation are categorized as *material* (Ashley, Deblois, and O'Rourke 2006, 55; Austriaco 2011, 264–65). Formal cooperation in intrinsically evil actions is to be altogether avoided (Catholic Church 2000, no. 1761; see also the discussion of formal cooperation in an intentional abortion procedure at no. 2272).

Second, one should ask: does my involvement immediately participate in the immoral act under consideration? This question aims to explore whether a person's involvement is copresent to the act and likewise necessary in order that the act be performed (Ashley, Deblois, and O'Rourke 2006, 56; Fisher 2005, 31). Broadly speaking, any *immediate moral cooperation* with an immoral act (whether formal or material) is to be avoided (Austriaco 2011, 265; Pontifical Academy for Life 2006, 545). Even if such involvement does not entail affirmation in interior thought (e.g., a nurse who grudgingly participates in an abortion procedure), there is still affirmation by way of the voluntary exterior performance (see Capps 2015, 682). As such, some moral theologians refer to immediate involvement as "implicitly formal" rather than as "material" (Fisher 2005, 30–31). This kind of cooperation will not typically be the concern of a Catholic therapist since foreseen client applications of treatment outcomes will occur outside of therapy.

Third, one should next ask: if my involvement is not immediate, does my involvement still enable the act to occur in some way? This question aims to explore the issue of enablement. And this is where a Catholic therapist should focus his or her discernment. This kind of cooperation on the part of the therapist can be justified depending upon further considerations (Ashley, Deblois, and O'Rourke 2006, 56; Austriaco 2011, 265). To gain clarity here, a therapist must explore how connected his or her involvement is with the client's subsequent action. This clarity requires considering the causal connection between the therapist's contribution and the subsequent act that the client performs. Such a causal connection can be very close and entail *proximate*

moral cooperation; alternatively, the connection may be more distant resulting in *remote moral cooperation* (Austriaco 2011, 265–66; Fisher 2005, 31–32; Pontifical Academy for Life 2006, 545). With respect to a proximate connection, a bioethics example is of an anesthesiologist who prepares a patient to undergo a voluntary sterilization procedure but who leaves prior to the procedure itself (Austriaco 2011, 265–66). As long as the therapist's intention (in accordance with the treatment plan) is focused on morally sound mental health goals (such as client growth in self-confidence), then any further action a client performs later as enabled by the treatment (such as pursuing an adulterous affair) need not be intended by the therapist. However, in addition to satisfying all of the double-effect criteria outlined above, the moral cooperation criteria would require that a therapist have a grave and serious reason for proximate involvement or a good reason for remote involvement (Ashley, Deblois, and O'Rourke 2006, 56).

As a final consideration, one should ask: am I doing all that I reasonably can in order to avoid scandal (Austriaco 2011, 266)? This question aims to explore the issue of tacit approval with respect to the immoral actions performed by others. Concern with scandal is one reason the Apostle Paul suggests that the Corinthians refrain from eating food sacrificed to idols because eating such food might confuse others who are not as strong in their Christian faith (1 Cor. 8:9). A typical means one might employ to avoid scandal and also avoid appearing to approve of an immoral action is to vocalize protest or express disagreement with respect to the other person's performance of that act (Austriaco 2011, 266; Pontifical Academy for Life 2006, 546). In order to avoid culpable *passive cooperation* in the immoral acts of others, the vocalization of such disclosures on the part of Catholic persons (described above in terms of values exposure) is morally necessary in situations "when we have an obligation to do so" (*cum ad id tenemur*; Catholic Church 2000, no. 1868; for the Latin, see Catholic Church 1997, no. 1868). Further consideration must be given in a separate study regarding which clinical situations might impart such a Christian moral responsibility to a Catholic therapist. Generally speaking, growth in the virtue of practical wisdom will assist a therapist in discerning how to integrate this Christian moral responsibility with professional and legal responsibilities (and also with respect to the particular professional setting in which that therapist works).

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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