Moving From Moral Distress to Moral Resilience Using Acceptance and Commitment Therapy

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Abstract

Moral distress (MD) is a problematic experience for healthcare workers, with career engagement implications including burnout, job turnover, and career turnover. Instances of MD have been increasing since the start of the COVID-19 pandemic, threatening greater problems for the healthcare system. Although a range of interventions have been explored, no evidence-based treatment has been identified. Because of how embedded ethical decision-making is in the healthcare field, it is unlikely that MD will be eradicated; however, it is suggested that MD can be learned from and transformed into moral resilience. Some evidence indicates that healthcare workers could benefit from mindfulness-based and emotion regulation skills, alongside values-based and action strategies, to support the development of moral resilience. This article proposes the applicability of Acceptance and Commitment Therapy (ACT) and its six core skills—acceptance, cognitive defusion, mindfulness, self-as-context, values, and commitment—to the work of career practitioners as a means of developing moral resilience skills among healthcare workers.

Keywords: Moral distress, moral resilience, healthcare, Acceptance and Commitment Therapy (ACT), career engagement

Moral distress (MD) is becoming an increasingly familiar term and common concern in the healthcare field (Ulrich & Grady, 2018). Given the multiple impacts of the COVID-19 pandemic and the strain it has placed on healthcare systems and the careers of healthcare providers within them, issues of MD are receiving more attention for the toll they take on workers. Early findings are already suggesting that levels of MD since the start of the COVID-19 pandemic have been elevated (Spilg et al., 2022). Smith-MacDonald and colleagues (2022) emphasized that "a large mental health crisis will be forthcoming for [healthcare professionals] once the pandemic is over" (p. 2). They went on to list the numerous contributing factors to MD throughout the pandemic: uncertainty, lack of information, fear of viral exposure, tensions and miscommunications between professionals, policies that hinder care, practicing within crisis standards of care, new roles, unfamiliar tasks and routines, and scarcity of medical resources. This highlights the difficult circumstances that healthcare professionals are navigating on a daily basis and poses significant concern around levels of burnout and career disengagement among this population (Helmers et al., 2020; Rushton et al., 2022; Spilg et al., 2022). Further, studies suggest that workplace stressors including MD are contributing to decreased job satisfaction and healthcare professionals' intent to leave their jobs (job turnover) and leave their field (career turnover) (Austin et al., 2016; Sheppard et al., 2022; Shoorideh et al., 2015). Given this rise in MD and associated concerns, it is important for career practitioners to be aware of MD and its potential impacts, as well as healthcare providers who might be dealing with it. This paper starts by defining MD and its career impacts, next it reviews the concept of moral resilience for addressing MD, and finally goes on to propose Acceptance and Commitment Therapy (ACT) as a fitting approach that career practitioners can consider for supporting people dealing with MD alongside specific application examples of the core ACT skills.

Moral Distress

MD was originally described as "[w]hen one knows the right thing to do, but institutional constraints make it nearly impos-

sible to pursue the right course of action" (Jameton, 1984, p. 6). This concept of MD emerged from nursing ethics literature but has since been applied to the experiences of healthcare professionals more broadly. Since Jameton first defined MD, both nursing researchers as well as researchers in other healthcare fields have debated and built on the concept.

The expansion of MD into a transdisciplinary understanding has resulted in it taking on new elements as it has been applied to diverse healthcare practices over time (Musto & Rodney, 2018). Some theorists have suggested that MD could follow from an unsatisfactory decision, as well as from uncertainty or inaction (Morley et al., 2019; Musto & Rodney, 2018). Other definitions have focused on MD as a threat to healthcare workers' moral integrity (Spilg et al., 2022). It has also been highlighted that constraints on moral judgments can be both internal or external to the healthcare provider (Musto & Rodney, 2018). Building on his original definition, Jameton (1993) later added that inaction in the face of obstacles can elicit psychological distress, thus MD can be composed of the initial distress as well as subsequent "reactive distress" (p. 542). This updated definition underscored that ambivalence and immobility in the face of a moral conflict might be a trigger for psychological distress. It also suggests that taking action may help diminish the distress (Jameton, 1993; Morley 2019). Importantly, Ulrich and Grady (2018) emphasized that compromised integrity is not an inevitability when experiencing MD and considered moral challenges as potential opportunities for growth and learning.

Although some are satisfied with the definition of moral judgment and constraint on action, others contend that it is too narrow and must be broadened to expand its utility (Morley et al., 2020). There is substantial empirical evidence that constraint on action is the central cause and characteristic of MD; however, some also argued for the inclusion of uncertainty in the definition (Morley et al., 2017; Morley et al., 2020). The counter to this is that there is a significant and necessary distinction between scenarios that are morally distressing and those that are simply morally challenging or uncertain. Despite definitional debate, MD continues to be a construct that resonates for many healthcare providers, particularly given the centrality of moral and ethical decision-making in healthcare (Musto & Rodney, 2018; Rushton et al., 2017).

An essential element of MD is inherent in the name *moral* distress. Some critiques of the concept highlighted the potential conflation of MD with psychological distress, emphasizing the importance of MD as a uniquely ethical challenge that differentiates it from other forms of distress (Musto & Rodney, 2018). In discussing what constitutes a necessary and sufficient definition, Morley and colleagues (2017) used the analogy of a pressure ulcer, suggesting that although many factors can make a pressure ulcer more likely to occur, the one necessary and sufficient causal condition is continual pressure on the skin. From this perspective, psychological distress is seen as a necessary though not sufficient condition for MD; it is necessary that the psychological distress be directly and causally linked to a moral event. There is not a universally accepted definition of MD, however, it commonly contains a relationship between: (1) a moral conflict, (2) some form of constraint, be it internal or external (e.g., institutional), (3) the "initial distress" and subsequent "reactive distress" or "moral residue," and (4) a compromising or violation of one's moral integrity (Campbell et al., 2018; Morley et al., 2017). This broad definition will be the foundation for the discussion of MD in the remainder of this paper.

Impacts and Consequences of Moral Distress

Given the constancy of moral and ethical decision-making in healthcare practice, the experience of feeling morally compromised is likely impactful to both the personal and professional aspects of a healthcare worker's life. The potential impacts of MD have significant consequences, not just on the individual, but on healthcare teams, healthcare systems, and on the provision and quality of healthcare services.

Beyond the immediate context of COVID-19, MD has been associated with a range of psychological and professional symp-

toms. It includes both emotional symptoms such as frustration, anger, emotional distress, numbness, exhaustion, and depersonalization, as well as internal experiences including feeling belittled, unimportant, unintelligent, or feeling isolated and having one's integrity threatened (Epstein & Degaldo, 2010; Rushton et al., 2017). MD has also been linked to the traumatic response of moral injury, as well as burnout, and job turnover and attrition (Helmers et al., 2020; McAndrew et al., 2018; Rushton, 2017; Sheppard et al., 2022; Shoorideh et al., 2015; Smith-MacDonald et al., 2022; Spilg et al., 2022). Finally, it is important to note that these impacts go beyond the personal distress on healthcare workers; MD in healthcare can lead to "diminished moral sensitivity" (p. S11) resulting in poor patient care.

This magnitude of recent stressors and cumulative toll of MD foreshadows a substantial threat to both healthcare providers and healthcare provision, that career practitioners may have a role in buffering against (Helmers et al., 2020; Rushton et al., 2022). Career practitioners could be well suited to support healthcare workers in learning coping skills and ways of working through the impacts of these morally distressing circumstances to prevent outcomes like disengagement and burnout (Helmers et al., 2020; Rushton et al., 2022; Spilg et al., 2022).

As Lutz and colleagues (2023) pointed out, it can be helpful to have a framework for understanding career engagement in order to support healthcare workers grappling with disengagement stemming from work-related stressors. They described how the Career Engagement model by Neault and Pickerell (2013) depicts how feeling overwhelmed or underutilized at work can lead to career disengagement. This model acknowledges that engagement can wax and wane, which would be considered normal engagement; however, early experiences of feeling overwhelmed or underutilized could be considered "amber lights" (such as in traffic lights) for possible concern. This parallels aspects of the MD framework outlined by Pavlish et al. (2018), which looks at instances of MD as being a "downstream" or cumulative effect of exposures, but which can also lead to moral disengagement or moral success depending on interventions and responses. Similarly, the MD model by Morley et al. (2021) demonstrates how successive experiences of moral distress can compound and lead to professionals feeling as if they have no choice but to exit the position or even the field. These frameworks suggest that professionals who are exposed to morally and ethically challenging experiences, without having the right skills and supports to problem solve and make sense of those events, will be more likely to experience MD, subsequent disengagement, and eventual burnout, job turnover, or career turnover.

Morley and colleagues (2020) discussed how MD has become a construct with substantial power when used, highlighting how labeling the experience as "morally distressing" helps build awareness and frame the problem. Until recently, MD was experienced but not openly discussed in healthcare settings. Offering a definition to healthcare providers allows greater understanding of their lived experiences and ability to seek support. Education about the nature of MD have been a core component of MD interventions thus far and should remain an integrated component of working with this concern, alongside new strategies to combat the resulting psychological and vocational impacts of such distress.

Addressing Moral Distress

Although the growing attention on MD is sure to develop into helpful strategies, at this point little is known about how to support individuals and organizations in dealing with this increasingly urgent career problem. It is apparent that solutions for MD will need to be multifactorial and address all levels of the healthcare system (Amos & Epstein, 2022; Rushton, 2017; Ulrich & Grady, 2018). Given that systemic change is slow, organizational factors are relatively unmodifiable at least in the short-term. Meanwhile, healthcare workers are continuing to experience distress which impacts their ability to work and is causing people to consider leaving their roles. Research has provided rich descriptions of MD experiences; still, the intervention research on MD has yielded little in terms of evidence-based interventions (McAndrew et al., 2018; Rush-

ton, 2017). Several reviews have been conducted on interventions for MD which mostly suggest that continued investigation is needed into interventions and solutions for this problem (Amos & Epstein, 2022; Deschenes et al., 2021; Morley et al., 2021).

Although links have been made between MD and adverse mental health and career outcomes, few studies have empirically addressed factors that may help prevent and manage MD among healthcare workers (Spilg et al., 2022). No evidence-based treatment for MD has been identified, although some findings do point to promising areas of exploration. Findings have identified some success in using mindfulness-based stress reduction techniques for reducing MD (Vaclavik et al.,2018); others have suggested the benefits of teaching emotional regulation skills (Morley et al., 2021). Along similar lines, Rushton (2017) proposed the cultivation of *moral resilience*. She suggested that MD could be viewed as a "warning sign," and that cultivating certain skills and practices could support healthcare workers in effectively navigating these ethically challenging circumstances.

In describing her perspective on transforming *moral distress* into *moral resilience*, Rushton (2017) turned to literature on post-traumatic growth, suggesting that in order to shift from distress to resilience, one must first address the relationship to the suffering experienced. She emphasized the importance of mindful awareness and curiosity, and turning toward a view of solutions and possibilities.

Moral Resilience

Although the focus on moral resilience is an admirable and desirable route for supporting the career sustainability of healthcare workers, a pathway toward developing the necessary skills to achieve this transition is less clear. There have been several decades of research dedicated to documenting experiences of MD but the possibility of developing morally distressing events into opportunities for growth and resilience is a newer area of exploration (Holtz et al., 2018; Rushton, 2017). Resilience has been broadly defined as the ability to adjust, recover, or "bounce back" easily after a difficult or negative event (Earvolino-Ramirez, 2007; Lachman, 2016). Growing research has demonstrated that resilience is not simply an inborn trait, but something that can be cultivated, and thus interventions can be designed to support and encourage its development (Earvolino-Ramirez, 2007). In her concept analysis, Earvolino-Ramirez (2007) identified resilience as being composed of six characteristics: (1) *rebounding/reintegration*, the ability to bounce back in the face of adversity and re-engage with life in a positive way after a challenge; (2) *high expectancy/self-determination*, sense of purpose and achievement in life; (3) *positive relationships/social support*, meaningful relationships that provide opportunities for communication; (4) *flexibility*, adaptability and the ability to roll with changes; (5) *sense of humour*, the ability to make light of adversity and moderate the intensity of emotional reactions, and (6) *self-esteem/self-efficacy*, referring to how a person feels about themselves and their belief in their own abilities.

Despite the term moral resilience having been used in several papers, a clear definition of the concept has not been concretely established. Lachman (2016) described it as the "ability and willingness to speak and take right and good action in the face of adversity that is moral/ethical in nature" (p. 122). However, this definition seems incomplete, based on the way the term is used in other contexts. Rushton (2017) discussed moral resilience in a way that implies many of the facets of resilience outlined by Earvolino-Ramirez (2007). The characteristics Rushton (2017) associated with moral resilience include: cultivation of mindfulness, learning self-regulation, developing self-awareness and insight, deepening moral sensitivity, discerning ethical challenges and principled actions, taking courageous action, finding meaning in adversity, and preserving one's integrity and the integrity of one's team. Similarly, Holtz et al. (2017) identified personal integrity, relational integrity, buoyancy, self-regulation (including mindfulness), self-stewardship, and moral efficacy as the characteristics of moral resilience. In another study, healthcare workers used a combination of taking action, reflection and perspective-making, and es-

tablishing supports to help them stay resilient to MD (Helmers et al., 2020). Although these studies used different terms, they all underscored the multitude of skills that make up resilience, including self-reflection, maintaining one's values and beliefs, connection with one's team, tolerance of uncertainty and challenge, mindfulness and self-regulation, self-care and honouring one's boundaries, and acting from a place of courage for what is morally right. As such, moral resilience seems the fitting target outcome of interventions for MD–and bolstering the career sustainability of healthcare workers.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is an empirical therapeutic approach that incorporates cognitive, behavioral, acceptance, and mindfulness-based principles, and shows a promising evidence base (Hayes et al., 2006; Hayes et al., 2013). Central to ACT is the construct of *psychological flexibility*, which is seen as the "ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes et al., 2006, p. 6). Psychological inflexibility, on the other hand, is seen as the cause of psychological and emotional difficulty. Thus, from the ACT perspective, psychological difficulties are rooted in *psychological inflexibility*, "a pattern in which behavior is excessively controlled by one's thoughts, feelings and other internal experiences, or to avoid these experiences, at the expense of more effective and meaningful actions" (Levin et al., 2014, p. 156). The goal of ACT is to increase psychological flexibility through the development of six core processes: (1) acceptance, (2) defusion, (3) mindfulness, (4) self as context, (5) values, and (6) committed action (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019; Tyndall et al., 2020).

Although ACT has not be directly applied to MD, it has been successfully used in diverse contexts, including to support career difficulties (Hoare et al., 2012; Luken & de Folter, 2019), as well as a range of health and mental health conditions such as traumatic stress, burnout, anxiety, and chronic pain (Dindo et al., 2017; Prudenzi et al., 2022; Smith-MacDonald et al., 2021). It has been suggested that ACT could be a good fit for supporting healthcare workers in the workplace to ameliorate the impacts of burnout (Prudenzi et al., 2022). Another program has proposed applying ACT to the treatment of moral injuries among healthcare workers (Borges et al., 2020; Smith-MacDonald et al., 2022). Given the suggested uses of ACT for circumstances closely associated with MD (such as burnout and moral injury) and promising preliminary findings, its exploration for this context seems a natural application.

Further, Rushton (2017) suggested that although MD cannot be eradicated, it can potentially be transformed into moral resilience. Her descriptions of interventions that change the relationship to the morally distressing situation and support movement from distress to resilience seem to closely parallel the foundational skills of ACT. Thus, ACT appears amply prepared and even ideally situated to facilitate this process.

Cultivating Moral Resilience Through Acceptance and Commitment Therapy

The benefits of ACT for addressing psychological distress and career concerns such as burnout and turnover intent among healthcare workers have in part been attributed to its cultivation of mindfulness skills and commitment to values (Prudenzi et al., 2022). Smith-MacDonald et al. (2021) discussed how ACT has been conceptualized as "supporting the cultivation of acceptance of moral pain in the service of one's values instead of challenging the content of that pain" (p. 3). Their approach suggested that ACT interventions are applicable to the needs of healthcare workers. Through the lens of ACT, MD might be conceptualized as a state of "stuckness" or cognitive inflexibility, wherein the real or perceived constraints on action lead to psychological experiences of distress (Prudenzi et al., 2022). Prudenzi et al. (2022) highlighted how in a healthcare setting, psychological flexibility could involve improved ability to experience unpleasant thoughts and emotions that arise at work; greater ability

to be present (mindful) at work, including tasks, internal experiences, and interactions; and consistent engagement in behaviors that align with one's goals and values while at work. These abilities and behaviors are well aligned with the tasks of achieving moral resilience and the foundational skills of ACT. The central goal of ACT, as stated above, is to reduce psychological inflexibility and increase psychological flexibility, which it does through the cultivation of six core psychological skills (acceptance, cognitive defusion, mindfulness, self-as-context, values, and commitment), which are further described in the following sections (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). This article proposes that ACT skills could benefit healthcare workers in moving from a state of MD toward moral resilience.

Acceptance

ACT conceptualizes acceptance as an allowance or embracing of one's internal experience, without trying to alter or change it, even when it includes unpleasant stimuli such as distressing thoughts, feelings, or sensations (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). Acceptance is seen as the opposite experience of avoidance, in which one might try to distance or control undesired thoughts, feelings, or sensations. Although avoidance might temporarily decrease distress, it is understood as contributing to distress and psychological difficulty when overused or used long-term. Through avoiding an internal stimulus, such as anxiety, we strengthen or reinforce the perception of that stimulus as intolerable; meanwhile the actions we take to comfort or soothe also become associated with the negative stimulus, such that the unpleasant experience grows in magnitude. Through learning and practicing acceptance, we become flexible in how we respond to internal experiences. Development of acceptance as a skill is seen as a way of increasing values-based action—and is also seen as a means to transform the emotional experience itself.

Because experiences of MD can build toward worsening symptoms over time leading to what some call *moral residue* or even *moral injury*, acceptance could be a valuable contribution to the resiliency building among healthcare workers. Learning to accept one's internal responses to difficult moral experiences could potentially curtail the development of both initial and reactive distress. Acceptance can also be seen as strengthening moral resilience through developing the ability to acknowledge a situation as it is, without judgement, as well holding realistic expectations about one's own role and responsibilities (Holtz et al., 2017).

Cognitive Defusion

ACT describes defusion as a way of changing how a person interacts with, or relates to, their thoughts, rather than trying to change the thoughts themselves (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). Cognitive defusion is seen as the opposite of cognitive fusion, which occurs when a person treats their thoughts as literal, rather than recognizing thinking as simply mental activity. In Cognitive Behavioral Therapy, this might be dealt with through reality testing or thought challenging; in ACT, this is addressed through cognitive defusion practices, such as mindfully observing the act of thinking as it happens, and simply noticing one's thoughts.

Given that MD frequently entails experiences of negative thoughts and beliefs about one's actions and responsibilities, developing the skill of defusion could be a valuable asset to healthcare workers. Rather than getting fused to the content of one's thoughts and over-identifying with them, it can be helpful to observe thoughts for the mental activity that they are, and practice allowing them to come and go. Holtz et al. (2017) similarly described the moral resilience skills of being able to "step back" and "recheck one's thoughts" as well as the importance of being able to stay grounded and self-reflective.

Mindfulness

ACT emphasizes the importance of flexible contact with the present moment, also known as mindfulness (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). Mindfulness is contrasted with loss of contact with the present, a desire to

distance from or detach from the reality where difficult events are occurring. In mindfulness, a person learns to actively observe and attend to what is present—both within and outside of themselves. This allows a person to be more accurately in touch with what is happening in their environment and internal experience, and thus more connected to their values through their "inner compass." Mindfulness thus enables a person to behave in ways that are more consistent with their values, have more control over their behavior, and allow for better stress management by preventing cognitions like ruminating, worrying, and judgment.

Mindfulness-based practices have been shown to help decrease MD and improve coping among nurses, thus contributing to increased resilience (Vaclavik et al., 2018). It is anticipated that this skill could help healthcare providers across the spectrum, particularly given that mindfulness strategies can be combined with acceptance-based skills, as well as relaxation and stress reduction tools, such as in mindfulness-based stress reduction. Mindfulness is also described by Holtz et al. (2017) as a key component of moral resilience for its role in self-regulation. They described self-regulation as the ability to stay "grounded" and self-aware, allowing one to stay engaged and not become distressed, such as when there is a conflict between one's own values and someone else's.

Self-as-Context

ACT centers the self as the context or perspective through which experience is observed (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). This is important in ACT because it allows one to observe their inner experiences from a new vantage point in which they are less threatening, developing defusion and acceptance. Self-as-context is contrasted with attachment to a conceptualized self (self-as-content), wherein a person might become overly fused with rigid expectations or evaluations of who they are or ought to be.

Self-as-context could theoretically decrease MD (and move toward moral resilience) through allowing healthcare workers to observe the flow of their own experience without forming strong attachment or meaning about it and build self-regulation. Self-as-context skills can also potentially contribute toward building moral resilience through building of self-awareness and insight, as Rushton (2017) called for. These skills are also linked to the ability to take the perspectives of others, empathize, and communicate, which are all necessary for team-based MD interventions.

Values

ACT underscores the importance of values to guide life direction in a subjectively meaningful way (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). Values are seen as expressions of the kind of person one wants to be; they are differentiated from goals in that a value cannot ever be "completed" but can guide action moment to moment. Problems with values tend to stem from lack of clarity, compliance (rather than personal choice), and avoidance.

Values work is an especially important skill that ACT has to offer to MD because of the centrality of morals and values in this condition. MD frequently involves circumstances of competing values and can be aided by self-reflection on one's values and the outcomes of given values-based behavior, as indicated by self-reflection and debriefing interventions for MD (Amos & Epstein, 2022). Holtz et al. (2017) described moral resilience as including an ability to stay true to one's values in the face of adversity. Values work appears helpful in addressing MD by aiding healthcare workers through actively assessing and clarifying their goals and discerning necessary and appropriate actions that correspond with their values. In this way, values work could contribute to maintaining one's personal integrity.

Commitment

ACT highlights the importance of committed values-based action, even in the face of fears and obstacles (Hayes et al., 2006; Hayes et al., 2013; Luken & de Folter, 2019). Committed action is contrasted with inaction, impulsivity, or avoidance. Commitment is largely the behaviour change

component of ACT, in which goal setting and action come in to play.

Committed action appears key to the development of moral resilience, which relies on taking courageous action and preserving one's integrity (Holtz et al., 2017; Rushton, 2017). Where MD can lead to disengagement, commitment reinforces the importance of values-driven action. Having developed other skills that support self-reflection, self-regulation, and acceptance, committed action could then put healthcare workers back in touch with the necessity of action within their roles and enable them to move forward even in times of challenge and uncertainty.

ACT in Practice for Moral Distress

ACT has been applied to various workplace contexts since its inception, with the first ACT randomized-controlled trial conducted in a workplace (Flaxman et al., 2013). An existing standardized and validated ACT workplace intervention was recently modified for healthcare workers by Prudenzi and colleagues (2022), focusing on increasing the participants' capacity for mindfulness and values-based action. This intervention included four two-hour sessions over the course of four weeks and followed a group format. This intervention was found to reduce the participants' levels of psychological distress. Another ACT intervention was developed to address moral injury for healthcare workers and was also a group-based intervention (Smith-MacDonald et al., 2021). Based on the existing literature on ACT interventions in the workplace and recent application to healthcare workers, we advocate for a group-based workplace intervention using an ACT framework to target MD.

Workplace interventions for MD may focus on increasing healthcare workers' awareness of their experience of MD and teach ACT skills to manage the associated psychosocial impacts of MD. Such interventions could utilize existing protocols, including mindful breathing exercises, values card sorts, guided imagery exercises, and awareness and acceptance of body sensations (Prudenzi et al., 2022). Interventions can also include educational components that inform healthcare workers of existing organizational supports and procedures, to aid healthcare workers in assessing action steps they may wish to take.

For counsellors providing individual therapy or career interventions to healthcare workers, incorporating ACT components into treatment seems appropriate to help address the experience of MD. The six core processes of ACT (acceptance, cognitive defusion, mindfulness, self-as-context, values, and commitment) can inform the goals that counselor and client set to reduce MD and lead to moral resilience.

Conclusion

MD is a complex career concern, one that may need a range of approaches in order to be adequately addressed. Removing morally and ethically complex circumstances from healthcare work is an impossibility because moral and ethical decision-making is an integral and necessary part of the role of all healthcare workers. Thus, interventions need to be suited to helping healthcare professionals navigate and cope with the difficult moral and ethical circumstances they will encounter in their work. Healthcare worker moral resilience can be supported by developing skills that enable them to continue to stay engaged with their roles, even during times of great challenge.

Unfortunately, a rising tide of complex moral circumstances flowing from the COVID-19 pandemic, as well as other burdens on the healthcare system, risks leaving many healthcare workers feeling as though they are drowning. It is often commented that people tend to go into healthcare work with a sense of "a calling," which might also play a role in why these moral events are especially impactful (Helmers et al., 2020). Some healthcare workers also describe the love of their work as a sustaining factor during times of great difficulty, if resilience skills can be called upon (Helmers et al., 2020). ACT appears theoretically well suited to the needs of supporting healthcare workers in developing skills that bolster their resilience.

ACT provides a useful framework and tools for understanding the challenges of MD and strengthening the inner resources and resilience of healthcare workers, to support career

sustainability. The core skills of ACT—acceptance, cognitive defusion, mindfulness, self-as-context, values, and commitment—seem to be a good fit for the development of moral resilience. These skills could assist healthcare workers in accepting challenging circumstances, being mindful in their roles, staying grounded and emotionally regulated, building and maintaining positive working relationships, and self-reflecting; this also could allow them to stay connected to their values and identify appropriate actions for moving forward in their fields with integrity. ACT is also a flexible approach that can be tailored to the needs of the individual.

Of course, neither strengthening resilience skills, nor any other educational approach, is intended to be a complete solution. Systemic change is needed in order to address these difficulties at all levels, and advocacy for those changes to be addressed comprehensively will be an important step. Nonetheless, this is a time of great challenge for society overall, and it is important to be creative and innovative with the tools that are available in order to mitigate the impacts and support the sustainability of healthcare workers as much as possible. ACT is a robust, evidence-based approach which has been found useful in many associated circumstances, and appears well positioned to support healthcare workers in moving from moral *distress* to moral *resilience*.

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