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CLIENT MORAL COMPASS IN SOCIAL WORK

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The importance of individual moral sensibility to achieving healthy social life can hardly be overemphasized. Lustig (2017a) proposes, with particular applicability to social work, that four major crises of American society—the healthcare crisis, the Social Security crisis, the opioid crisis, and the depression crisis—have a shared provenance: "The systemic confusion and conflation of *pleasure* with *happiness*," whose characteristics he contrasts:

Pleasure	*Happiness*
Short lived	Long lived
Visceral	Ethereal
Taking	Giving
Experienced alone	Experienced with others
Achievable with substances	Not achievable with substances
Extremes lead to addiction	No potential for addiction
Dopamine [neurotransmitter]	Serotonin [neurotransmitter]

Lustig (2017b) cautions that, ". . . the more pleasure you seek, the more unhappy you get and the more likelihood you will slide into addiction or depression." The simple explanation is that *pleasure*-producing activities, powered in their effects by morally unrestrained sensuality and materialism, routinely lead to addictions that are self-destructive and harmful to others in one's marriage, family, community, commerce, and nation (the last two, given the economic and national security consequences of metabolic syndrome diseases).

The detrimental effects of the widespread decline of moral sensibility (Norman 2017) and behavior are multiplied by ubiquitous commercially driven rationalizations that promote unchecked pleasure-seeking (Gustafson 2001; Waide 1987). Some of the more blatant corporate messaging includes: "Do what feels good!" (Coke), "If it feels good, do it!" (Burger King), "Freedom of expression—it's what it's all about" (Botox Cosmetic), "You can never have too much fun" (Apple), and "When you have passion, you have everything" (Don Julio Tequila).

The corporate consolidations of Big Food, Big Pharma, Big Chem, Big Porn, and Big Tech have led to market domination by a handful of massive companies than span multiple sectors of the American economy. Through near-total control of information-media, marketing, and manufacturing, they have addicted a large segment of the public to products that provide immediate pleasure, including: sugar (Avena 2008; Wiss 2018), alcohol and drugs (DeWeerdt 2019; Van Zee 2009), pornography (de Alarćon 2019; Love 2015), and electronic devices (Shoukat 2019; Hou 2019). Simultaneously, they have created persistent compelling distractions (Dekimpe 1995) from the long-term consequences of abandoning moral boundaries.

The societal consequences may remain out of mind because, in the age of sophisticated information technology, the Internet, and mobile personal computing, which now dominate our social life, the cultural acceptance of amoral autonomy as an unassailable good implicitly rationalizes doing what is pleasurable for oneself regardless of the costs to oneself and others.

Susceptibility to this kind of narcissistic behavior may originate in infancy, the result of failed attachment, which takes hold neurologically from ongoing developmental trauma. In other words, "Affect regulation, which is the single most important accomplishment during the first 3 years of life, does not organize in those with developmental trauma" (Fisher 2014, loc. 638). One commonplace outcome is dissociation that appears as self-entitlement to the diversionary *pleasures* of physique, position, privileges, possessions, and power, which replace the unobtainable missing source of *happiness*, i.e., emotionally bonded relationships—in family life, in community activity, in productive work, and in active citizenship—safeguarded customarily by moral-spiritual boundaries.

Assessment of Spirituality

By the time we finish our professional education for social work and receive a degree, we should know to familiarize ourselves with the spiritual and religious forces in the lives of our clients, as well as the dangers of "religion-blind" and "spirituality-blind" practice, which ". . . frequently risk imposing culturally incompetent 'secular' or 'rationalist' interventions on service users, who may have very different needs and actual wishes" (Gilligan 2006, 634).

The social work approach to "spirituality" emphasizes the practitioner's "cultural competence," which is necessary but not sufficient. It is not enough to understand clients' spiritual and religious beliefs and practices if we ignore their moral character, regarding it as beyond the legitimate scope of social work, despite its harmful consequences. This self-defeating posture has been a part of training social workers, wherein the trainers note that ". . . the client's [spiritual] position must be accepted and not judged" (Darrell 2017), even though family therapists have recognized for decades that the potential of therapy is limited if the drivers of moral decisions are not plumbed but merely accepted "non-judgmentally" (Stander 1994).

Social workers, nonetheless, often limit their appraisal of a client's spirituality and religiosity to whether they can function as potential sources of therapeutic strength. This approach may unwittingly overlook that faith-life without moral sensibility makes possible a lifetime of self-serving excuses for damaging behavior.

It reminds me of my first unambiguous view of the disconnection between claimed spirituality and moral action in a professional setting, which was demonstrated many years ago by the director of a youth outreach program, where I was working as a volunteer. The director would arrive at staff meetings and announce that he had "prayed very hard" about what he was going to do. Then he would reveal an immoral or unethical decision, such as his intention to fire a staff member without having identified any shortcomings in that person's evaluations. Without apparent self-consciousness, he often spoke of himself as a very spiritual person.

The most egregious publicized examples in this vein, particularly disturbing to me as a rabbi, are the minority of clergy of all faiths who have been implicated in child sexual abuse, following decades of posturing as spiritual guides and teachers of religion.

Social workers may not recognize that declarations of spirituality and religiosity, of themselves, tell us nothing about a client's covert moral insensibility and more subtle, harmful immoral behavior. The disconnection between claimed faith-life and behavioral morality may exist because problematic behavior often occurs in the absence of any consciousness of consequences for oneself and others. The behavior in question may also be regarded as "personal" to oneself, as with pornography addiction, but which nevertheless is highly damaging to the addict and others (Dines 2010; Kuhn 2014; Steffens 2006; Stewart 2012; Tarrant 2016). The behavior may be rooted in the client's insecure attachment and developmental trauma history, strengthened by the previously noted ubiquitous commercial messaging to do whatever feels good.

Clients may go through counseling or therapy, appear to resolve thoughts, feelings, and behavior, but never bring into consciousness or unravel the particulars of their long-lived, often unconscious moral insensibility. Unlike others who have had a secure attachment in infancy and thus have a mostly unhindered capacity for empathy and socio-emotional bonding, incognito immoral clients often lack empathy, ". . . a hallmark issue for children and adults with histories of developmental trauma" (Fisher 2014, loc. 616), so they treat others as objects, to be used more or less.

A client may thus act without meaningful comprehension of emotional and practical consequences, even though the behavior in question may vaguely be understood intellectually and admitted as "wrong" if confronted. An example of these circumstances is marital infidelity, which social workers, with some confidence, treat as relationship or family-systems problems or as the disorder of one or both members of the couple; but in any case, the unfaithful partner repeats the same infidelity in an ongoing absence or perversion of morality.

Cross-Cultural Moral Values

The justification usually given for the exclusion of client morality as a focus of social work has been that morality is culturally relative. Although we repeatedly witness the devastating effects of immorality, the widely accepted guidelines for social work practice still caution us to avoid prioritizing a client's lack of morality when considering mental and emotional disorders and problematic behavior, and when developing a treatment plan. In my experience of social work counselors and therapists over more than a half-century (as their client, student-trainee and teacher), the morality of their clients was never specified as an essential component of their theories or methods.

But substantial evidence exists to conclude that moral values are not always culturally idiosyncratic. Certainly, morality may be defined as one's sui generis beliefs about right and wrong, and there is a diversity of moral beliefs, some of which seemingly are not related to any standard of reason or even relevance to human welfare. Yet my professional experience in several different settings has repeatedly led me to conclude that moral ideations and actions of diverse individuals in the U.S. more often than not cross cultural boundaries, although that may be much less true of our current performative morality in politics.

Working openly as a rabbi with Christian clients at a Samaritan counseling center, the agency director and I agreed that the religious and cultural differences between the clients and myself had virtually no effect on our therapeutic relationships.

My work as a prison chaplain included, ironically, occasional attendance by Muslim and Christian inmates at the Jewish worship services I conducted, which many confided to me were helpful to them.

My faith-based community organizing also revealed extensive cultural crossover on issues with moral implications, but in a different context (ben Asher 1992; 2001). During initial community organizing membership drives, parish and congregation members were often surprised to learn that, disparate ethnic and racial groups within their churches, which historically had been isolated from one another, when relating one-

to-one and in small groups had much more in common than they ever imagined. In one Catholic church, Anglos, Latinos, and Vietnamese were compartmentalized in their church's internal organizations. But in workshops they discovered that, when reflecting together on their beliefs about the action prompted by their experiences, they had the same hopes and dreams for themselves and their children, the same concerns about schools, drugs, and gangs in the larger community, the same beliefs about parental responsibility and the obligations of public officials, and the same desire to work responsibly for needed reforms.

When the members of that church came together in an area-wide campaign with members of non-Christian religious communities, they found that they also had much more in common with them than they had previously imagined, despite their different cultures and faith traditions. They were soon working together in a *faith-based* campaign that required large amounts of time, energy, and spirit. In the first meeting of the campaign's 50-plus-member steering committee, there was an aura of wonder and celebration, because previously distanced people of diverse faiths and cultures were working together for improvements in the larger community. This should not be surprising, since the world's major religions, and many of the minor ones, teach their followers to welcome and, presumably, get to know the stranger (AFSC n.d.).

The same quality of cross-cultural interaction occurred in my locality-based organizing, when members of different racial and ethnic groups from low-income, working-class, and middle-class neighborhoods came together to tackle problems they had in common. In addition to their cultural diversity, their religious affiliations were with a myriad of faith traditions.

In my macro social work, virtually everyone discovered, to their surprise and delight, that their beliefs about right and wrong were widely shared. My conclusion was that cultural boundaries are far less rigid than media sensationalism suggests and far less embattled than divisive politicians might want the public to believe. Au contraire, at the extreme, murder, torture, enslavement, and other forms of physical, social, political, and economic oppression are believed to be morally evil everywhere, including where they are de rigueur. But even unexceptional immoral behavior, such as stealing, violating promises, betraying trust, lying, abusing verbally, tale-bearing, and gossiping are also widely condemned across cultural boundaries. So we ought not to mistake personal or institutional pressure to accept or engage in such behavior as popular endorsement of its moral legitimacy within a culture.

Consider that the prevalent de facto and de jure discrimination and violence against women, especially but not exclusively in second and third-world nations (Johnson 2008), may be openly endorsed and imposed by ruling classes of men, and embedded in male-dominated culture (Adegbeye 2020; Parker 2017). Of course, any suggestion that such discrimination against women can make a claim of morality to be honored by social work, given the devastating consequences for women, is disabused by the profession's Code of Ethics (NASW 2017), which calls for ". . . respect [for] the inherent dignity and worth of the person"; and by the United Nations Universal Declaration of Human Rights (United Nations 1948), which declares in the first Article: "All human beings are born free and equal in dignity and rights." Women robbed of their dignity and rights, suffering discrimination of one kind or another, undoubtedly agree overwhelmingly, if only privately for safety, that their own oppression is not moral.

Universal moral values notwithstanding, it's obvious that cultural differences in the particular ways values are expressed can be volatile, creating distrust and distance, even open hostility, aggression, and violence. These differences often arise from different moral beliefs about sexual status and activity, such as whether homosexuality and premarital sex are considered immoral or within an one's freedom of choice (Graham 2016); and from the ways in which animals are regarded—whether permitted or not for consumption, considered only as domestic pets or as working breeds, or treated as sacred (Szücs 2012). Notably, the effects of these differences are mostly confined to private life, with much less impact in public settings.

My social work has been with many people of different cultures. The backgrounds of their members were African, Irish, Italian, Jewish, Korean, Mexican, Puerto Rican, and Vietnamese. What they have in common is hope and faith in the possibility of righteousness, truth, justice, freedom, peace, and compassion—which for many represent the values that brought them or their parents or grandparents to the United States.

Even with the cultural value-conflicts, we have sufficient evidence to conclude that it is still practicable and productive, within the canons of social work, to include in our professional practice the primary treatment objective of fostering client moral sensibility.

Fostering Moral Sensibility

The caveat for social workers who choose to help clients develop moral sensibility, literally their ability to sense and make conscious decisions about their behavioral moral choices and their consequences, is that accomplishing this objective depends on several enabling conditions:

- Social workers who are culturally competent to deal with a diversity of cultural backgrounds and faith traditions. There is nothing new in this requirement. It has been recognized for decades and extensive social work education and training resources have been developed to meet this need.
- Social workers who consistently screen prospective clients for possible histories of insecure attachment and developmental trauma (Flaherty 2009) and, when confirmed, refer them to recognized neurofeedback practitioners for treatment simultaneous with their psychotherapy (Fisher 2016).

- Social workers who employ a morally indeterminate treatment model that does not seek to impose any system of morality but is purposively designed to focus the client's attention on self-assessment of his or her specific choices and their consequences and desirability.
- Treatment (employing Socratic questioning) that is framed within the context of *universal* moral values and standards, which serve as a *foundation of faith*, making it possible for clients to see that their happiness can be achieved by internalizing a well-developed moral compass to successfully negotiate one's day-to-day challenges.

Cultural competence is essential if social work practice is to foster the moral sensibility of clients. It's fortunate that barriers to effective cross-cultural counseling have been reasonably well-understood for nearly a half-century (Sue 1977). But the culturally based inhibitions to revealing intimate aspects of one's life to a stranger can still be problematic.

Instances include the value of self-control among Americans of Asian background, which highlights the importance of sensitivity to clients' ". . . potential discomfort or inexperience with sharing personal problems with a professional counselor. . ." (Wang 2010). Although a social worker's cultural sensitivity is essential to eliciting self-disclosure, differences in the ethnicity of the client and counselor may in fact have little influence on self-disclosure by clients of Asian background. On the other hand, the potential for loss of face is likely to be crucial in that regard, so ". . . one [successful practice] pathway . . . may involve counselors learning face-saving strategies and skill sets to help manage and/or restore face, which, in turn, may facilitate self-disclosure in treatment" (Zane 2014, 71-72). For example, counseling may communicate that in almost all moral systems, "Self-development is itself considered a mandatory obligation" (Eckensberger 2008, 28).

In Eastern cultures, prevention of anti-social behavior relies much more on the initiative of groups rather than individuals. Western and Eastern cultures are distinctively different in that moral identity in the former stresses "individuality oriented morality" while the latter "considers a highly moral person to be societally oriented" (Jia 2017). The difference can potentially work as an insurmountable bar to exploring moral sensibility with some clients. But with many others the effect may be mitigated, because clients of Chinese background, for example, respond well to counseling (1) that is guided by an "active and directive" therapist, (2) that emphasizes their own responsibilities in their treatment, (3) that is non-judgmental, (4) that helps them to understand the perspectives of others, and (5) that helps them to consider how they feel about others who are involved in their lives (Ng 2013).

Neurofeedback will be indispensable to the development of moral-compass by a client who has a neurologically untreated history of insecure attachment and developmental trauma, because DTD (developmental trauma disorder, which has yet to be included in the DSM) ". . . dysregulates both the structures and foundational rhythms of the brain" (Fisher 2014, loc. 918); thus ". . . the effects of neglect on the developing brain are devastating. These effects may, in fact, be even more catastrophic than the effects of abuse" (Fisher 2014, loc. 605).

We know that developmental trauma begins with insecure attachment. The gift to the child by the mother or other primary caregiver in the attached relationship is a self-regulating brain, which neurofeedback can restore when it's missing.

> "Being held in the mind and the arms of the mother is the way affect regulation begins in the human species. . . . As talk therapists we can, unfortunately, promote an illusion that understanding this need will suffice. . . . But for many who have suffered developmental trauma and are left profoundly disorganized and dysregulated, the transference that would allow an intersubjective experience doesn't develop. They do not have the preexisting template—me and mother—that would allow them to experience intersubjectivity. When they do have the semblance of a template, the intersubjectivity can feel perilous, riddled with hypervigilant fear of abandonment and often ruptured by intense affect that can be difficult for either patient or therapist to contain. (Fisher 2014, locs. 802-813) The hope against hope for a mother, for self-organization and self-regulation, is why these patients endure therapy at all. No matter how this motherlessness is felt and expressed, I think it is best understood at the level of the CNS, as the primary infant need for affect regulation. We know our mothers across time through the regulation of our nervous systems. Our mothers are encoded not solely in our minds but in our brains and our bodies. Training the brain to regulate itself may well give the CNS its first experience of being "mothered." When the CNS begins to regulate, the person begins to feel mothered. Neurofeedback that teaches CNS regulation in the context of an attuned relationship with the therapist is the next best thing to having a mother who did this for you in the first place." (Fisher 2014, locs. 834-847)

Without neurofeedback, clients with developmental trauma, handicapped by a neurological brain dysrhythmia (Fisher 2014, loc. 704), remain unreachable at the level of the amygdala by psychotherapy alone. Two of the most telling talk-therapy failures are unrelieved inability to experience empathic feelings and inability to undo lifelong destructive patterns of dissociation (Fisher 2014, loc. 627). Both of these disabilities must be overcome to develop moral compass.

Morally indeterminate treatment accommodates a long-lived social work caution in regard to focusing on

client morality, based on predictable pitfalls when a social worker's moral bias is introduced into practice, a residual of the era in the profession's history when a primary concern was client morality (Reamer 2014, 167). The practice then was based on the belief that the immorality of clients was the cause of their poverty, a class-based and self-righteous profession-wide affectation that was jettisoned early-on with the growth of the settlement house and Progressive movements. And, of course, not even in religiously based human services is it productive or ethically appropriate to offer help conditioned on the practitioner's personal morality.

But the current accepted social work principle that the morality of clients should remain exclusively within the jurisdiction of clergy, appears ill-advised when carefully examined, operating as a needless treatment handicap when applied in an increasingly depersonalized, amoral society. We would regard it as absurd if lawyers were bound by a convention that required they not use knowledge of psychology and sociology in their defense of a client. We would regard it as absurd if clergy rejected the use of social work knowledge in their pastoral counseling. As social workers we would be at a huge disadvantage if we disallowed knowledge of the political, economic, and social forces on the lives of our clients. It's unthinkable that we would try to help a client suffering from alcoholism while ignoring the client's lack of education and chronic unemployment. Similarly, ignoring a client's lack of moral sensibility and internalized system of morality or moral compass has substantial effects on the outcomes of social work.

We are far less helpful than possible when we ignore that the morality of clients can play a pivotal role in their problematic attitudes and actions. Treatment that disregards a client's lack of positive internalized morality potentially leaves untreated a source of significant dysfunction, which can emerge repeatedly over a lifetime with harmful effects, long after a "successful" course of social work has ended.

The treatment approach proposed here eschews conventional religiosity and spirituality. The social worker's role is not to propose or encourage what the client should believe or do in the future, but rather to create a framework through which the client, based on self-reflection and recall of past experience, becomes increasingly morally conscious, self-identifying possible choices and future consequences of actions. This approach, gauged to inculcate moral compass does not seek to impose a particular definition of moral responsibility in matters of sex, diet, relationships, work, etc. It is, instead, morally indeterminate, designed to help clients connect their behavior to outcomes that *they* come to feel and believe are harmful to themselves and others, and thus to be avoided.

Why wouldn't this approach simply lead clients to reinforce their lifelong self-serving, morally insensible behavior? The overwhelming majority of our clients are not sociopaths, they are not without conscience; but many have not developed the empathy needed for socio-emotional bonding and internalized moral compass. Most of them are bereft of a mind map to redirect their lives based on empathy and moral sensibility.

An Essential Foundation of Faith

Assuming that an individual has the capacity for empathic feelings, another necessary prior condition to the development of internalized moral compass is the presence of an internal *foundation of faith*. If individuals are going to find it worthwhile to contemplate the consequences of their actions, ipso facto they must have "faith" in the possibility of greater goodness emerging in their lives. Faith is a necessity because we have no certainty of the possibility of greater goodness or that each of us has the potential to bring it about.

The development of that faith is bolstered by the universal values of humankind, because faith is conditioned on hopefulness, which in turn is strengthened by knowing that we are not alone in our longing for greater goodness. Hope and faith are part of the antidote to the self-paralyzing beliefs that one is "unlovable and unloved" and "it's a cold cruel world," residuals of insecure attachment and developmental trauma. The universal values provide a conscious successor to those disabling thoughts and feelings.

A systematic survey of the world's seven great religions and of the documents of several secular organizations, including the American Atheists, American Humanist Association, and the United Nations, confirms a substantial number of universal moral values (Kinnier 2000, 9-10):

Commitment to something greater than oneself

- To recognize the existence of and be committed to a Supreme Being, higher principle, transcendent purpose or meaning to one's existence
- To seek the Truth (or truths)
- To seek Justice

Self-respect, but with humility, self-discipline, and acceptance of personal responsibility

- To respect and care for oneself
- To not exalt oneself or overindulge, to show humility and avoid gluttony, greed, or other forms of selfishness or self-centeredness
- To act in accordance with one's conscience and to accept responsibility for one's behavior

Respect and caring for others (i.e., the Golden Rule)

- To recognize the connectedness between all people
- To serve humankind and to be helpful to individuals
- To be caring, respectful, compassionate, tolerant, and forgiving of others
- To not hurt others (e.g., do not murder, abuse, steal from, cheat, or lie to others)

Caring for other living creatures and the environment

Universal moral values may be introduced therapeutically through open-ended questions during a client's self-reflections. Raised when appropriate to the client's focus, the question-formula might be: Why do

you imagine that people all over the world place such a high value on seeking the truth? Have you ever been lied to in a way that caused you to suffer? Why do you imagine that in virtually every culture in the world, the great majority of people condemn greed? Has anyone's greediness ever affected you? Why do you imagine that almost all people everywhere believe it's wrong to hurt others? Have you ever been hurt by someone you thought cared about you? Why do you imagine that in every society, most people believe it's wrong to destroy the environment? Have you ever gone somewhere hoping to have a beautiful day, only to find that others had trashed the place? The follow-ups to these questions include, "How did you feel after that?" and "Have you ever done that?"

Moral Character and Empathy

While a foundation of faith is necessary to a client's purposive formation of moral compass, undoubtedly it is not sufficient. Without empathy, moral compass may serve as nothing more than an intellectual construct, a set of ideals rarely if ever actualized in one's day-to-day life.

Secure attachment to caregivers in infancy and childhood, the socio-emotional bonding ordinarily initiated between mother and infant, provides the neurological foundation of feelings, thoughts, and actions for the greater good, beyond oneself—our empathic *moral* character (Ringel 2008). Extensive peer-reviewed research confirms that the potential for development of moral sensibility and empathy is based on attachment (Fonagy 1997; Fumagalli 2006; Govrin 2014; Koleva 2013; Marazziti 2013; Mendez 2009; Njus 2016; Mikulincer 2005; Pascual 2013; Schore 2014; Shaver n.d.; van IJzendoorn 2010).

When the potential for moral sensibility and empathic sociability is brought to full effect by the acquisition of a developed system of morality, especially at an early age, the individual's emerging moral character is refined and serves in later life to overcome narrowly self-serving behavioral motivations. Thus it becomes possible to prevail over the allure of immediate sensual and material gratification which, when unrestrained by moral boundaries, often produces tragic outcomes. Fully realized, the internalization of moral compass may permanently displace the inclination toward harmful behavior (Hasanović 2010, 203).

Clients who are saddled from infancy or childhood with dysfunctional brain neurology, primarily because of the early failure of parenting or other caregiving, and subsequent developmental trauma, live with an embedded source of lifelong moral self-harm and harm to others (Tuck 2021; Kidwell 2021).

Compounding their disability, parents and other caregivers who fail the children in their care by modeling immoral behavior, such as infidelity in their marriages, typically also fail to inculcate in those children a system of moral behavior standards, leaving them without a foundation for moral character. It's not incidental that when the failure of parents or other caregivers reflects their own immorality, they also serve as dysfunctional models for the children's observational learning, priming them for the same or similar immorality. The familiar legacy of such failures is the lying and deceit, breaking of vows, and shattering of trust by unfaithful partners, which often produce emotional trauma, family breakup, divorce, disease, crime, and violence.

However we view the precursors of unfaithfulness, unfaithful partners often have less harmful options to deal with the challenges in their relationships. But lacking brain health, empathy, and moral sensibility, many choose betrayal instead, which is universally considered immoral. With their deficits of moral character, these individuals bounce from pillar to post, thoughtlessly making choices to get what they want, mostly on the basis of what serves as a feel-good diversion, one that is convenient, familiar, or useful in the moment. They become adept at creating pseudo-moral rationalizations for anything they want to do in any situation, and they often feel good doing it over and over again, oblivious to the depth of their harmful effects on others and themselves.

Social workers should not ignore the absence of clients' moral sensibility, which may originate in brain dysrhythmia and predispose them to choose betrayal over loyalty, lies over truth, dishonesty over fair play, disrespect over regard, degradation over honor, oppression over liberation, aggression over peacefulness, harm over care, and cruelty over compassion. Possibly more than ever before in the U.S., such choices no longer reflect moral compass within individuals. Social workers, especially, should not remain aloof from the impact of waning moral sensibility, given its devastating personal and political consequences.

Self-Acquisition of Moral Compass

For the last half-century or more, the main social work concerns relative to morality have been the ethical norms and standards of the profession (Reamer 1998; Gray 2010) and the conflicting demands of personal and professional morality (Hodge 2004; Janssen 2016). Concentrating on the moral sensibility of clients would be a significant addition to practice, but one that is not inherently retrogressive.

Within the boundaries of moral character, clients may act in their relationships to uphold or overturn the widely admired ideals of righteousness, truth, justice, freedom, peace, and compassion. When these ideals have practical implications in our day-to-day lives, we typically have expectations and demands for reciprocal moral behavior, which constitutes the moral-spiritual infrastructure of social life (ben Asher 2020). When these ideals have not been upheld by our clients, their self-reflections to develop their moral character can be useful therapeutically (Griffith 2011). As already noted, barring an untreated legacy of insecure attachment and developmental trauma, therapy designed to encourage a ". . . process of making deliberate, conscious moral

decisions" can be effective, especially when a client's problematic behavior has been unusually destructive, such as committing violent felonies (Ferguson 2012, 2).

There is evidence (Whiting 2005, 33) that, "By refusing to accept immoral behavior [as beyond the scope of therapy], the therapist is modeling morality to clients: caring for them by holding them accountable"—that is, as proposed here, prompting them to be accountable to themselves. Gray (1996, 7) proposes that for *social workers*, ". . . moral sensibility is something which can be learnt, refined and improved through moral reflection and the development of moral understanding. People can develop their awareness of moral issues." And it is not far-fetched to imagine that culturally competent social workers serving as models can enact this potential practice and its benefits for their clients' observational learning.

The objective of helping a client to self-acquire moral compass is attained by the *client's self-directed choices* to internalize moral guidelines and boundaries, defining right and wrong, buttressed by the society's moral-spiritual infrastructure, to bias behavior towards non-destructive forms. This model is entirely unlike the early practice of judging the immorality of clients and attempting to impose a narrow, class-based morality on them.

The most powerful impetus for a client to begin moral self-inventory in earnest is the advent of crisis. The word crisis is based on the Greek word "κρίση," which describes a pivotal moment in the course of an "illness," when the opportunity for intervention to produce adaptive new behavior is especially promising. (Stevens 1995). This occurs predictably at times of psychic and emotional turmoil, when the catastrophic loss of highly valued relationships, material security, and self-concept is likely and immanent.

In times of crisis, clients who pray regularly, formally or informally, may benefit, especially if they have a secure attached relationship with God. For Jews who adhere to traditional Jewish belief and practice, it's possible to realize many of the blessings of secure attachment by following the *masorah* (traditional) guidance to achieve *devekut* (דְּבֵקוּת—cleaving) to God. The essence of *devekut* is that we bond with God in both the "upper" and "lower" worlds—that is, in both our spiritual and material experience; that our thoughts and words and deeds take place in God's reality; and that we come to know, "By the power of what you do below with true love and awe, will you be able to bond with the Creator . . . " (Ben Eliezer 1993, locs. 25, 75, 150 & 275). Experience of *devekut* with the Divine is that, like all secure attached relationships, we wear our heart on our sleeve; our thoughts, feelings, and spirit become shared and bonded with those of the God of the Torah, Who we experience personally.

Faith-based practices generally are associated with ". . . higher levels of life satisfaction, and with lower levels of depressed affect, psychological distress, and feelings of loneliness . . . (Ellison 2014, 213)—all of which predispose clients to self-inventorying. Prayer has been shown to improve one's ability to focus attention, increasing information relevant to a problem or challenge (Adams 2017, 2). Possibly most significant, ". . . prayer can counteract the deleterious effects of self-control depletion" (Friese 2014, 90) in a crisis.

The treatment method proposed here is a variant of cognitive behavioral therapy (CBT) which, as understood in the context of moral compass, does not deny or ignore the importance of other psychological or emotional disorders or macro social forces that affect clients. CBT is based on the assumption that by changing cognition—perceptions, beliefs, attitudes, emotions, and memories—it is possible to significantly change the worst self-destructive and anti-social behavior (Clark 2010). The transformative potential of CBT has been enhanced by the past few decades of neurobiological science (Porto 2009).

CBT successful outcomes are enabled by conditioning of the mind using various methods that effect neural energy and information flow, which can modify mental, emotional, and physical initiatives and responses. Treatment methods with the potential to alter the neural architecture of the mind include Eye Movement Desensitization and Reprocessing (EMDR), Emotionally Focused Therapy (EFT), Psychobiological Approach to Sex Addiction Treatment (PASAT), mindfulness, meditation, yoga, and movement techniques (Pierce 2013), all of which have been successfully used in various therapeutic modalities.

But recognizing that ". . . the brain is the infrastructure of the mind. . . . ," and that it ". . . regulates itself via the electrical domain of frequency and timing" (Fisher 2014, locs. 897, 918), we can understand how neurofeedback gains its unequaled therapeutic power, because it directly effects the rhythm of the brain's waves. During the past few years, researchers and clinical practitioners have demonstrated the exceptional power of neurofeedback to reach the deepest level of brain dysrhythmia (Gapen 2021; Rogel 2020; Fisher 2010; Askovic 2009), which has been shown to be the primary cause of a wide range of highly destructive dysregulated behavior (Felitti 2009; Flaherty 2009; Fisher 2014, locs. 527, 942).

When clients have the brain-based ability to engage constructively in therapy, it's possible for them to deconstruct their past immoral behavior, especially when they encounter, face-to-face, the hurt and anger experienced by those victimized by their behavior. As we would expect, their empathy is linked to activation in particular areas of the brain in response to the client-observer and the person the client has harmed who is observed in pain (Meyer 2013, 449-450). Many, on their own initiative, although ideally with professional guidance, begin in earnest a psychological, emotional, and spiritual self-inventory that awakens their empathic sensibility.

We should recognize clients' potential for greater empathy early in the course of their treatment, since

empathy towards those they formerly regarded as "outgroup" individuals, different from themselves, can be learned (Hein 2016, 84). This may be especially true in treatment settings where stress levels have been intentionally reduced (Martin 2015).

The Professional Take-Away

Social workers can appropriately take the initiative to help clients plumb their own deficits of moral character. In doing so, as always, the ". . . role of the professional is to help the user[s] make their own choices and decisions in a way informed by proper knowledge and understanding" (Clark 2006, 81). We can help clients uncover the origins, dynamics, and consequences of their harmful behavior, and then encourage them to adopt and internalize their own system of behavioral morality.

These social work objectives and methods do not infringe on a client's right of self-determination, according to the standards of the profession (NASW 2017). Once well underway with any individual client, however, clergy and other religious and spiritual advisors may be best able to help refine the particulars of a client's moral compass.

The practice principle that there is no right or wrong client morality is only sensible therapeutically if that morality has no significant connection to long-term problematic thinking, emotions, or behavior—which is never true. As long as we are unable or unwilling to help clients recover the moral dimensions and outcomes of their behavioral choices, our professional helpfulness will be stunted needlessly.

If that's our posture, we might ask ourselves: When our social work with clients ends, what morality do we expect them to rely upon to deal with the challenges they will face in the future; and with what consequences, for them, their families, and others in their lives?

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