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The Nature of Moral Injury, Moral Distress, and Demoralization

I know the moment when I discovered the concepts of moral distress and moral injury. I could not label what I was experiencing; at the time, the terms did not exist, and there was no vocabulary to describe these phenomena. That language and terminology would emerge many years later, as professionals and scholars began to label what has been part and parcel of human services since their inception.

Early in my career, I was a social worker on a locked forensic unit of a state psychiatric hospital. The client population included people who had been charged with serious crimes, such as murder, rape, child molestation, armed robbery, and arson, and who were not competent to stand trial or had been found not guilty because of their severe psychiatric illness. The unit also included clients who had been convicted of serious crimes and sentenced to prison and who, while serving their sentences, were unable to function in the prison setting because of their serious mental illness. Most of the clients on the forensic unit were being treated for a psychotic disorder. Many had attempted to commit suicide at some point in their lives.

One of the forensic unit clients with whom I worked had been convicted of attempted murder and illegal possession of a gun. The police and court records indicated that the client had become enraged when he learned that his sister planned to marry a man the client did not approve of. The records indicated that the client had pulled out a gun and threatened to kill his sister and her fiancé if she did not agree to call off the wedding. The client, who had been diagnosed with schizophrenia five years earlier, yelled obscenities at his sister and her fiancé while he backed them up against a wall. Fortunately, the client's older brother arrived on the scene and was able to restrain the client. A neighbor who heard the commotion called the police, which led to the client's arrest.

At trial, the client's defense attorney did her best to convince the judge that the client should be found not guilty because of his mental illness, which was an

option under state law. However, the judge ruled that the client's mental illness did not prevent him from appreciating the criminal nature of his conduct. The client was convicted and sentenced to serve four years in a maximum security state prison.

During his incarceration, the client began manifesting serious symptoms of mental illness. Records indicated that he was hearing voices and displaying significant symptoms of paranoia. The client often defied correctional officers' orders and was repeatedly placed in segregation. While in segregation, where the client was confined 23 hours per day, his psychiatric symptoms worsened. He began banging his head against the cell wall and smeared his feces on his mattress. During his 42 days in segregation, the client attempted to commit suicide and was hospitalized.

After hearing reports of her client's deteriorating condition, the client's lawyer petitioned the court to approve his transfer to the forensic unit of the state hospital for treatment. According to the protocol, clinical staff at the forensic unit would treat the client in an effort to stabilize his mental health. The client's status would be reviewed every 90 days. I knew that if the review team concluded that the client's mental health had stabilized, he would be returned to prison to continue serving his sentence.

On the basis of my extensive contact with this client, I came to believe that returning him to prison would likely exacerbate his psychiatric symptoms and greatly increase the risk that he would again engage in behaviors that would lead to segregation and another suicide attempt. In my professional judgment, the client belonged in a psychiatric hospital, not prison. Yet I worked in a system that, as a matter of law and policy, required the forensic unit treatment staff to do their best to stabilize this client so that he could return to prison. I felt guilty about my efforts to help this man, knowing that my success would mean that he would once again be exposed to prison conditions that would likely traumatize him and worsen his condition.

Only years later did I understand that my experience with this client on the state hospital's forensic unit was a classic example of what is now regarded as moral distress and moral harm. When I worked with this client, I felt caught between the proverbial rock and a hard place; I wanted to help this man, yet I was obligated to follow official protocol that might cause him harm. What is more, I was not in a position to directly change the governing law and institutional policy that, in my view, would cause further injury. As I explore in this book, I think about these issues, and possible courses of action, differently today.

Moral Distress and Harm

Human services professionals—including social workers, mental health counselors, clinical and counseling psychologists, marriage and family therapists, substance use disorder counselors, psychiatrists, and psychiatric nurses, among others in the helping professions—often encounter challenging ethical dilemmas. These dilemmas might involve deciding whether to disclose confidential information, without clients' consent, to protect third parties from harm; managing complex boundary and dual relationship issues; preventing conflicts of interest; allocating limited resources; and responding when colleagues engage in unethical conduct.

Among the most challenging ethical dilemmas in human services is what has become known as moral injury. *Moral injury* is ordinarily defined as the sort of harm that results when someone has perpetrated, failed to prevent, or witnessed acts that transgress deeply held moral beliefs (Campbell, Ulrich, & Grady, 2016; Fourie, 2017; Griffin et al., 2019; Hamric, 2012; Jinkerson, 2016; Kidder, 2005; Shay, 2014). What these phenomena have in common are instances when practitioners must decide how to handle work-related circumstances that are deeply troubling because they have caused, or have the potential to cause, harm (Jaskela, Guichon, Page, & Mitchell, 2018; McAninch, 2016; McDonald, 2017; Osswald, Greitemeyer, Fischer, & Frey, 2010; Sunderland, Catalano, Kendall, McAuliffe, & Chenoweth, 2010; Varcoe, Pauly, Webster, & Storch, 2012).

A compelling example involves counselor Leyaniro Trevino, who was employed by a private youth shelter that provided services to children and adolescents who come to the United States alone or are separated from their families at the border and are referred by the U.S. Office of Refugee Resettlement (ORR), a division of the U.S. Department of Health and Human Services' Administration for Children and Families. Trevino provided counseling services to a Honduran teenager, Kevin Euceda, who had been in detention for more than two years when his request for asylum was heard by a U.S. immigration judge (Dreier, 2020). During the hearing, a lawyer for Immigration and Customs Enforcement (ICE) introduced as evidence against Euceda clinical notes signed by Trevino. The notes included the following statement: "Youth reports history of physical abuse, neglect, and gang affiliation in country of origin. Unaccompanied child self-disclosed selling drugs. Unaccompanied child reports being part of witnessing torturing and killing, including dismemberment of body parts" (Dreier, 2020, para. 3).

These incriminating clinical notes were disclosed by the ICE attorney even though Trevino had assured Euceda that their conversations were confidential (unless disclosure was necessary to protect Euceda or others from harm). According to a *Washington Post* investigative report,

This kind of information sharing was part of a Trump administration strategy that is technically legal but which professional therapy associations say is a profound violation of patient confidentiality. To bolster its policy of stepped up enforcement, the administration is requiring that notes taken during mandatory therapy sessions with immigrant children be passed onto ICE, which can then use those reports against minors in court. Intimate confessions, early traumas, half-remembered nightmares—all have been turned into prosecutorial weapons, often without the consent of the therapists involved, and always without the consent of the minors themselves, in hearings where the stakes can be life and death. (Dreier, 2020, para. 5)

According to reports, Euceda told his counselor about being abandoned by his parents and raised by his grandmother, who struggled with alcoholism. He described how his grandmother had sliced into his back with a machete and had once thrown a rock at his head. Euceda explained that after his grandmother died,

the gang MS-13 took over their shack. With nowhere else to go, he stayed even as gang members tortured rivals on the patio, slept in his bed and made him run their errands. The gang eventually put him to work selling drugs. (Dreier, 2020, para. 6)

Trevino's notes stated, "Youth denied committing murder; however, when asked if he had ever physically hurt another individual, minor stated I did things I regret" (Dreier, 2020, para. 6).

In 2018, ORR entered into a Memorandum of Agreement with ICE that required therapists to "develop additional information about children during weekly counseling sessions where they may self-disclose previous gang or criminal activity to their assigned clinician" (Dreier, 2020, para. 23). According to the new policy, therapists were to file a report within four hours to be passed to ICE within one day.

Because of what Euceda disclosed in the privacy of a therapy session, ORR sent him in hand and leg shackles to its highest security facility in Virginia.

Trevino was so distraught that she resigned her position as a result of the harm caused by the release of her clinical notes without her consent (King, 2020).

Many scenarios can cause moral harm and injury, including these examples:

- A psychiatrist received a telephone call from a colleague, a clinical psychologist, who was deeply distressed. The psychologist explained that he had made a terrible error in judgment and wanted consultation about how to manage his serious mistake. He disclosed that he had become sexually involved with one of his clients. The psychologist said he wanted help identifying the best way to end the inappropriate relationship. He asked the psychiatrist to promise him that she would keep their consultation confidential.
- A mental health counselor employed by a large, multisite, for-profit counseling organization was asked by an administrator to sign a collection of documents certifying that she had provided clinical supervision to unlicensed agency clinicians. The signed documents were required for the organization to be paid by the state's Medicaid program for mental health services provided to clients. The counselor was troubled by the administrator's request, given that he had not, in fact, provided face-to-face, regularly scheduled supervision to the unlicensed clinicians whose names appeared on the forms. The counselor knew that strict state and federal regulations required that licensed supervisors provide this supervision for the organization to be paid for services with government funds. The counselor believed he would be committing fraud if he signed the documents.
- A clinical psychologist worked in a state psychiatric hospital's forensic unit. The locked unit provided mental health services to residents who had been charged with crimes and were unable to stand trial because of their psychiatric symptoms. The psychologist was assigned to work with a patient who had been charged with murdering his estranged spouse and their two young children. The patient faced the death penalty if convicted in criminal court. The psychologist, who was personally opposed to capital punishment, was instructed by her supervisor to work with the patient in an effort to stabilize him so that he could stand trial. The psychologist was eager to help the patient become competent but was deeply troubled that clinical success would likely mean that the patient would be executed after conviction in criminal court.

- A social worker employed in a residential treatment program counseled clients who struggled with posttraumatic stress disorder (PTSD). The social worker's principal goal was to help clients understand the connections between trauma they experienced in their lives (for example, being the victim of child abuse and neglect) and their struggles in life. During her tenure at the program, the social worker witnessed multiple incidents in which staffers physically and emotionally abused clients. Over time, the social worker became increasingly distressed and considered whether to disclose what she observed to program administrators.

Moral injury in human services occurs when practitioners experience some form of moral suffering associated with their professional work. Litz et al. (2009) defined *moral injury* as the “the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations” (p. 697). Drescher et al. (2011) defined moral injury as “disruption in an individual’s confidence and expectations about one’s own or others’ motivation or capacity to behave in a just and ethical manner” (p. 9).

The term “moral injury” was first coined by psychiatrist Johnathan Shay (2014) when describing the “undoing of character” he observed among Vietnam veterans. Initially, discussions of moral injury concerned active-duty military personnel’s moral distress when they witnessed or perpetrated an act in combat that was morally repugnant. Such acts might involve, for example, witnessing soldiers murder innocent villagers, being ordered to torture enemy combatants, or being privy to details about sexual assaults among military personnel. Prominent discussions address soldiers’ moral struggles associated with the use of deadly force in combat and causing harm to or killing civilians (whether intentionally or accidentally); giving orders in combat that result in the injury or death of other service members (Blinka & Harris, 2016); following orders that are illegal, immoral, or against the Rules of Engagement or Geneva Convention (Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014); failing to provide medical assistance to an injured civilian or service member (Gibbons, Shafer, Hickling, & Ramsey, 2013); failing to report knowledge of a sexual assault or rape committed against oneself, another service member, or civilians (“What Is Moral Injury?” n.d.); knowing about the execution of cooperating local citizens (Dombo, Gray, & Early, 2013; Farnsworth, Drescher, Evans, & Walser, 2017); and wrestling with questions about the necessity or justification for war, during

or after one's service (Brock & Lettini, 2012; Litz, Lebowitz, Gray, & Nash, 2016; Maguen & Litz, 2012).

There is also evidence of significant moral injury among military veterans (Drescher & Foy, 2008; Drescher et al., 2011; Johnson, 2014). Research on what have become known as morally injurious experiences has documented veterans' reported experiences with guilt, shame, anger, self-handicapping behaviors, relational and spiritual or existential problems, and social alienation that emerges after witnessing or participating in war zone events that challenge one's basic sense of humanity (Currier, Holland, & Malott, 2015). The U.S. Department of Veterans Affairs has mounted an ambitious array of behavioral health services for veterans who struggle with moral injury arising out of their active-duty service in the armed forces (Currier, McCormick, & Drescher, 2015; Frankfurt & Frazier, 2016; Norman & Maguen, n.d.).

Over time, discussions of moral injury have expanded to include other professions, primarily in health care (Austin, Bergum, & Goldberg, 2003; Austin, Rankel, Kagan, Bergum, & Lerner, 2005; Huffman & Rittenmeyer, 2012; Jameton, 1993; Oh & Gastmans, 2015; Wilkinson, 1987–1988). Research has suggested that health care practitioners encounter morally troubling dilemmas in three principal domains: clinical, administrative, and interpersonal (Ganz, Wagner, & Toren, 2015; Hanna, 2004; McCarthy & Deady, 2008; Pauly, Varcoe, & Storch, 2012; Pauly, Varcoe, Storch, & Newton, 2009).

Clinical challenges arise when nurses are troubled by clinical orders they are given by supervising physicians and nurses (Brazil, Kassalainen, Ploeg, & Marshall, 2010; Corley, 1995, 2002; Corley, Minick, Elswick, & Jacobs, 2005; Keinemans & Kanne, 2013; Numminen, Repo, & Leino-Kilpi, 2017), such as when a doctor orders a nurse to administer the wrong dose of chemotherapy or to withhold information from a patient to which, according to hospital policy, the patient is entitled.

Administrative challenges occur when nurses are expected to comply with organizational policies and practices that they consider to be immoral, for example, compromised staff-to-patient ratios, inadequate informed consent protocols, pressure to discharge at-risk patients, inadequate medical equipment, and refusal of services to uninsured or undocumented patients (Epstein & Hamric, 2009; Griffin et al., 2019; Källemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Shay, 2014).

Finally, interpersonal challenges occur when nurses believe that a colleague is impaired or has behaved unethically, for example, when a nurse is the victim of sexual harassment (Dudzinski, 2016; Fiester, 2014; Kopacz et al., 2016; Lützn, 2016).

Blom, Ewalds-Kvist, & Winch, 2010; Lützén, Cronqvist, Magnusson, & Andersson, 2003; Lützén & Kvist, 2012; Manttari-van der Kuip, 2016). According to Ganz et al. (2015),

There is a dual loyalty inherent to the role of the nurse manager, where there is a tension between the needs and values of the organization and those of the nurses, patients, and families. Nurse managers are socialized as nurses, yet they are expected to act as representatives of their organization. Conflicts arise between clinical nursing values (where quality of patient care is primary) and organizational values (where competition, cost, and productivity are stressed). Increasing technologies, complexity of the healthcare environment, and increased emphasis on the efficiency, efficacy, and productivity of healthcare organizations have led to increased value conflicts where moral and ethical challenges have become a normal part of the hospital environment. Nurses are especially affected by these challenges as our nursing values are humanistic in nature. (p. 44)

The moral challenges faced by human services professionals are reminiscent of those encountered by health care professionals. However, there is significantly less scholarly discussion and research on moral injury and distress in human services than in the military and health care professions (Briggs & Fronek, 2019; Fantus, Greenberg, Muskat, & Katz, 2017; Fine & Teram, 2013; Fronek et al., 2017; Haight, Sugrue, & Calhoun, 2017; Haight, Sugrue, Calhoun, & Black, 2016, 2017; Janssen, 2016; Kopacz, Simons, & Chitaphong, 2015; Lev & Ayalon, 2018; Lynch & Forde, 2016; Manttari-van der Kuip, 2016; Oliver, 2013; Weinberg, 2009).

Moral injury can lead to what Corley et al. (2005) referred to as “moral residue.” *Moral residue* is the product of the cumulative effect of unresolved moral distress. Moral distress can occur when professionals engage in immoral conduct that takes several forms: verbal and emotional misconduct, sexual misconduct, physical misconduct, and financial misconduct.

Verbal and emotional misconduct occur when a colleague engages in workplace behavior that involves degrading personnel or clients, telling hurtful and disrespectful jokes, name calling, yelling, making insulting comments, humiliating, criticizing, blaming, and accusing. Sexual misconduct refers to inappropriate sexual contact with colleagues or clients that involves unwanted touching,

demanding or forcing sex, name calling with sexual epithets, or videotaping or photographing sexual acts (Celenza, 2007; Reamer, 2020).

Physical misconduct in the workplace or associated with one's employment involves pushing, biting, pinching, slapping, beating, kicking, choking, throwing objects, using or threatening the use of a weapon, and stalking clients or colleagues, among other threatening behavior. Financial misconduct in the workplace can include fraud (for example, involving expense reimbursement, payroll fraud, or falsified annual reports), embezzlement of agency funds, theft of agency property, misappropriation of funds (for example, use of agency funds for personal use or skimming of cash receipts), and bribery and kickbacks (for example, bribing public officials in exchange for a government contract).

Moral injury and distress in human services can result from four unique, albeit related, phenomena (Litz et al., 2009): (1) perpetrating acts that transgress deeply held moral beliefs, (2) witnessing acts that transgress deeply held moral beliefs, (3) failing to prevent acts that transgress deeply held moral beliefs, and (4) learning about acts that transgress deeply held moral beliefs.

Perpetrating Acts That Transgress Moral Beliefs

Human services professions typically attract practitioners who care deeply about addressing human suffering and clients' trials and tribulations. The vast majority of professionals have altruistic instincts and would not knowingly harm the people they serve.

Sadly, some practitioners do harm others. Their actions have a negative impact not only on their victims but also on their colleagues, who may experience secondary trauma or moral distress as a result. Here are several examples of human services professionals who exploited clients and others:

- Cynthia Guy was a mental health counselor at Central Wyoming Counseling Center. In May 2014, she asked one of her clients, whom she believed to have gang affiliations, to arrange for her ex-husband's murder. Evidence in the case showed that Guy wanted to make the crime look like a robbery or a suicide (Meyer, 2016; Schrock, 2015). Guy's client contacted police. Casper, Wyoming, law enforcement officials arranged for the client to record a conversation with Guy, during which the informant gave her a phone number for an undercover agent posing as a hit man. The informant said the presumed hit man was her cousin and would kill Guy's ex-husband as a favor to her. Guy agreed to pay \$4,000 for the

murder. She set up a time to meet with the supposed hit man and told the undercover agent how to enter her ex-husband's home. The agent later sent a coded text message to Guy informing her that the murder had been committed. Police then went to Guy's house and informed her that her ex-husband had been found dead under suspicious circumstances. She faked an emotional grief response but was arrested. Guy was eventually convicted and sentenced to serve 20 to 25 years in prison.

- A Seattle child psychologist was sentenced to serve six-and-a-half years in federal prison for attempted travel to engage in illicit sexual conduct and attempted receipt of child pornography. Jonathan Wulf posted an ad on Craigslist and began a conversation with a person who turned out to be an undercover agent working for ICE's Homeland Security Investigation. Through various communications by phone and Internet, Wulf said he wanted to have sex with the agent's fictional 12-year-old stepdaughter. Because Wulf used the word "daddy" in both the ad's title and the body of text, the agent believed he could have a potential interest in having sex with minors, court documents said. Wulf talked to the undercover agent by phone and through e-mail, texts, and social media to arrange a meeting and discuss how to coax the girl to pose nude for photographs, according to evidence introduced in court. He was also said to have advised the undercover agent to start having some fairly explicit conversations with her about sex. Wulf was arrested when he arrived at the hotel selected as the meeting place for the sexual encounter (Clarridge, 2016).
- A former Pennsylvania psychiatrist accused of overprescribing antiaddiction and antianxiety drugs and trading them for sex with female patients was sentenced to serve 11 to 22 years in prison (Lord, 2016). Thomas Radecki and a network of affiliated physicians at one point served nearly 1,000 patients who were prescribed buprenorphine, an opioid. Evidence introduced at trial focused on his prescribing to 13 women, some of whom moved into one of his properties and had a personal relationship with him. Radecki impregnated one patient. According to a grand jury document, Radecki sold the buprenorphine product Subutex for between \$3 and \$5 per pill, making an annual profit of around \$280,000 on that drug alone. One of his former patients testified that she could then sell the drug for \$20 to \$25 per pill on the street. Radecki voluntarily surrendered his Pennsylvania medical license before the grand jury report

charging him was publicized by state prosecutors in 2013, a year after his offices were raided and closed by state agents.

- A Utah social worker was sentenced to serve five years to life in prison for having a sexual relationship with a teenage client. Donovan Faucette worked at a mental health center (Romero, 2016). At his sentencing hearing, Faucette told the court he had lived in “absolute hell” thinking about the pain he had caused so many people and that he had made a series of horrible choices. Faucette was ordered to enroll in a sex offender treatment program at the Utah prison to which he had been sentenced. Faucette had been employed as a social worker who served a school district that enrolled more than 15,000 children in more than 30 schools (Felix, 2008).
- Guy Thompson, the former head of the United Way of Santa Rosa County (Florida), pleaded guilty in federal court to 20 counts of wire fraud and three counts of tax evasion. Between 2011 and 2018, Thompson embezzled more than \$650,000 from a human services organization using a complex check fraud scheme. Thompson took checks that were written as charitable donations and misled the United Way bookkeeper into thinking that he had deposited them. Thompson made it look like all of the organization’s books were balanced when in fact he was pocketing between \$80,000 and \$90,000 a year in money that was supposed to go to charity. Evidence showed that Thompson used that money to buy a BMW, a beach condo, and other luxury items for himself and his family. Thompson addressed the court toward the end of the hearing: “I stand here before you. I am ashamed of what I have done,” Thompson said. “I am sorry and I ask for forgiveness” (Blanks, 2020, “Thompson speaks his piece to the courtroom,” para. 7). The judge sentenced Thompson to serve 51 months in federal prison (Blanks, 2020).

In some instances, practitioners admit their guilt and take responsibility for the harm they have caused. In other instances, practitioners deny their guilt and are held accountable when they have been found guilty in criminal court, liable in malpractice lawsuits filed against them, and sanctioned by state licensing boards.

Witnessing Acts That Transgress Moral Beliefs

Some harmful acts, such as those described earlier, are witnessed by other human services professionals. These professionals may be tormented by what they have witnessed and struggle with secondary trauma. Practitioners often grapple with

ethical decisions about whether to disclose or blow the whistle on colleagues' alleged wrongdoing, which I describe in detail in chapter 4. Here are several examples of practitioners who witnessed wrongdoing in conjunction with their professional position and who were forced to take on the role of whistleblower:

- A California prison psychiatrist alleged in a lawsuit that state corrections officials provided misleading information about the mental health services provided to inmates. Karuna Anand claimed that she refused orders to have psychiatrists sign off on work being done with inmates by psychologists who had yet to complete their training and receive their state licenses, something she said was illegal and contributed to patient deaths (Stanton, 2018). Anand said she was fired by corrections officials who wanted to silence her when she complained that they were providing inadequate care and inaccurate medical records. Anand also alleged that after she blew the whistle, her computer access and password were disabled, and her state-issued cell phone was disconnected. The psychiatrist claimed she was assigned to work in a mail room, where she was told to search incoming inmate mail for pornographic photos.
- A counselor at a U.S. Department of Veterans Affairs (VA) counseling center alleged on national television that the VA did not provide adequate behavioral health care to veterans (Kube & Gardella, 2019). Social worker Ted Blickwedel, a former Marine, said he resigned his position after management increased counselors' workloads by requiring more counseling visits at a level that interfered with the quality of care they could provide to their clients. Blickwedel worked at a site that is one of 300 that the VA operates across the United States through its Vet Centers program. The program includes 80 mobile Vet Centers, 20 Vet Center "outstations," and almost 1,000 community access points.
- Christine Martino-Fleming, a counselor and coordinator of staff development and training at a Massachusetts mental health center, was concerned that the agency was using unqualified, unsupervised mental health workers and unqualified supervisors to treat its clients ("Health Center Pays \$4 Million Settlement," 2019). Martino-Fleming also believed that the agency fraudulently billed a state program that funds services for Medicaid-eligible residents. When Fleming realized the extent of the wrongdoing, she shared her concerns with her superiors. Martino-Fleming alleged that key agency administrators and officers knew of the ongoing fraud and that

these practices compromised the quality of care provided to the agency's clients. Martino-Fleming filed a formal whistleblower claim under the Massachusetts False Claims Act (2006). The agency and the Commonwealth of Massachusetts settled the case for \$4 million.

- A prison psychologist filed and then settled a complaint under the California Whistleblower Protection Act (2007) alleging blatant abuse by state prison guards against lesbian, gay, bisexual, transgender, and queer (LGBTQ) prisoners (Chappell, 2019). Lori Jespersen, who had worked for the California Department of Corrections and Rehabilitation (CDCR) until her resignation, filed a complaint against various prison officials and guards that alleged ongoing abuse of LGBTQ prisoners at the California Medical Facility in Vacaville. In her complaint, Jespersen identified numerous incidents in which prison staff harassed LGBTQ prisoners. Jespersen's complaint also revealed a Facebook post by CDCR employees that outed a transgender prisoner, with derogatory comments posted on the site.

Failing to Prevent Acts That Transgress Moral Beliefs

Sometimes practitioners learn about immoral and unethical conduct in their workplace and experience moral distress because they did not take steps to address it. According to Wilkinson (1987–1988), *moral distress* is “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the behavior indicated by that decision” (p. 16). Here are several examples:

- A mental health counselor worked for three years in a therapeutic boarding school that served adolescents with serious psychiatric symptoms. The program was owned by a for-profit corporation, listed on a prominent stock exchange, that operated multiple sites around the country. The counselor provided individual and group counseling to the teenagers, most of whom had been diagnosed with clinical depression, anxiety, bipolar disorder, or substance use disorder. Over time, the counselor became concerned that the program was admitting clients whose clinical needs could not be met by the program's staffers because of the severity of their symptoms and limited resources. The counselor believed that the admissions staff and other program personnel pressured parents into

enrolling their children in the program to meet enrollment quotas and generate revenue. Eventually the counselor resigned her position but did not disclose her concerns.¹

- A social worker at a prominent program that serves people experiencing homelessness directed the agency's crisis intervention unit, providing behavioral health services to clients who struggle with mental health and substance use issues. Many of the clients served by the unit have engaged in suicidal ideation or threatened to harm others. The social worker learned from the executive director's administrative assistant, who had become the social worker's close friend and confidante, that the executive director had been siphoning off significant sums of the agency's funds, including federal grant money, for his personal use. The executive director had allegedly developed a gambling addiction and had been diverting agency funds to cover gambling debts that he had incurred at a nearby casino. The social worker decided that it was not her place to disclose this information.
- A substance use disorder counselor worked in a medication-assisted treatment program for clients with opioid addiction. The counselor, who was in recovery, regularly attended 12-step meetings. At one particular meeting, the counselor encountered one of the program's clients, who was also in attendance. The client used this opportunity to disclose to the counselor that she was involved in a sexual relationship with one of the counselor's workplace colleagues, who also provided counseling services to the client. According to the client, the two had become sexually involved about two months after the start of their counseling relationship. The client told the counselor at the 12-step meeting that she was feeling guilty about the sexual relationship and wanted advice about how to deal with the situation. The client asked the counselor who attended the 12-step meeting to promise not to disclose their conversation. The counselor agreed but later regretted doing so.
- A graduate student enrolled at a university's counseling program was an intern at a public middle school. The intern provided services to students who were experiencing anxiety, interpersonal conflict with other students, depression, and other issues that affected their schoolwork. As part of her

¹Unless otherwise noted, case descriptions are based on confidential communications between the author and other parties. To protect privacy and confidentiality, identifying information has been disguised.

training, the intern sat in classrooms to observe students' behavior. On a number of occasions, the intern observed that a particular teacher spoke to some students in a very abusive manner. According to the intern, this teacher occasionally screamed at students and called them derogatory and racially insensitive names. At the end of the academic year, the intern shared her concerns with her academic advisor at the university. The intern told the adviser that she had been afraid to speak up earlier about what she observed because of her intern status.

Learning about Acts that Transgress Moral Beliefs

In some instances, human services professionals learn about allegedly unethical conduct that they do not witness directly. Typically, these practitioners hear about transgressions indirectly from workplace colleagues or outside parties. Here are several examples:

- A social worker at a county agency that serves vulnerable older adults directed the agency's protective services unit, responding to reports of suspected abuse or neglect of older adults. One afternoon, the social worker received a telephone call from a close friend who was a dispatcher at the local police department. According to the dispatcher, one of the police department's officers had investigated the alleged abuse of a 92-year-old woman by her adult son. According to the dispatcher—who disclosed the information to the social worker confidentially—the alleged perpetrator was the social worker's boss, the executive director of the agency. The social worker, who had not been notified of the alleged abuse of the woman, suspected that there was a deliberate effort to cover up the alleged abuse and police investigation to protect the privacy and reputation of the agency director.
- A psychiatrist who worked with military veterans had a patient who had been stationed with the Army in Afghanistan. The patient had been diagnosed with PTSD and generalized anxiety disorder. During one counseling session, the patient told the psychiatrist that he was being tortured by disturbing memories and nightmares. After some time, the patient told the psychiatrist that he was feeling horribly guilty about having raped an Afghan teenager one night. The patient explained that while on patrol one night, he had gotten drunk with contraband alcohol and accosted a

teenager who was out alone. The patient described in graphic detail the horrific abuse he inflicted on his victim.

- The director of behavioral health services at an inpatient psychiatric hospital was contacted by one of her staff counselors, who asked for an appointment. During their meeting two days later, the counselor informed the director that she had observed one of her colleagues, also a mental health counselor, make several explicitly sexual comments to two patients. The counselor who reported the information told the director that she was deeply troubled by the inappropriate comments and was concerned about their impact on the patients who heard them, both of whom had a history of trauma. At the conclusion of their meeting, the director told the counselor that she wanted her to write and sign a detailed statement describing what she witnessed. The counselor told the director that she was afraid to get involved and refused to prepare the statement.
- A psychologist in private (independent) practice provided counseling services to a client who was in the middle of a contentious divorce and child custody dispute with his estranged wife. During counseling, the client told the psychologist that he was afraid that the lawyer representing his wife would learn about, and disclose, a serious mistake the client had made several years earlier. The client told the psychologist that, during a period of time when the client was dealing opioids, he had gotten into a dispute with one of his customers. According to the client, the dispute spun out of control, and the client shot and killed the customer. The client told the psychologist that the murder was never successfully investigated by the police and that his estranged wife was the only person who knew what happened. The psychologist was tormented by what he had learned—that his client had committed a murder—but believed he could not disclose this information because of strict confidentiality rules.

Patterns of Moral Harm

Many instances of moral injury are associated with the mistreatment of clients and third parties by human services professionals or others. In some cases, practitioners knowingly perpetrate the mistreatment. In other cases, the mistreatment is inadvertent.

Extensive research has explored and documented the diverse reasons why people behave in ways that lead to moral harm and injury (Hagan, 2017; Reamer,

2003, 2005, 2017; Siegel, 2018). The pattern of reasons includes acts of compliance; desperation; fear; greed, exploitation, and opportunism; rage; revenge and retribution; misguided frolic; and impairment. Some of these acts are committed by human services professionals; others are witnessed or not prevented by them. In other instances, human services professionals simply learn about acts of mistreatment from third parties, such as their colleagues or clients.

Acts of Compliance

Some acts that cause moral harm and injury arise when human services professionals feel obligated to comply with government or agency policies that govern their professional activities. For example, in 2020, soon after the coronavirus 2019 (COVID-19) pandemic shut down mental health counselors' ability to provide face-to-face counseling services to clients, I received ethics queries from many practitioners around the United States who were distressed to learn that some states' laws prohibited them from providing distance (telehealth) counseling services to their current clients. This was particularly challenging for clinicians who counseled college students who were forced to return to their homes in other states once their dormitories were closed down. Some of these students moved back home to states that required the practitioners to be licensed in those states to provide distance counseling. The clinicians who contacted me shared their moral distress about being unable to continue counseling their clients.

Also, practitioners in public child welfare agencies who are obligated to place high-risk teenagers in group homes may have serious misgivings about the quality of the residences that are available. These practitioners suffer intense pangs of guilt when, in accordance with agency policy, they drop clients off and drive away. Professionals in county or state social services agencies who must determine whether vulnerable people are eligible for assistance may feel anguish when strict eligibility criteria, which seem draconian, require these staffers to deny services to people who desperately need them. In each of these instances, human services professionals experience spasms of conscience as they follow policy and carry out their duties.

One of the most dramatic examples of this moral struggle has involved human services professionals who are employed by agencies that expect staffers to report to federal immigration authorities any violation of federal immigration law by any applicant for services and benefits. For example, according to Arizona law ("Verifying Applicants for Public Benefits," 2012), employees of state and local government agencies who are responsible for the administration of public benefits that are not federally mandated must verify the identity of each applicant

for those benefits and verify that the applicant is eligible for benefits. The law requires all employees to make a written report to federal immigration authorities for any violation of federal immigration law by any applicant for benefits that is discovered by the employee. Moreover, failure to report discovered violations of federal immigration law is a crime.

For some human services professionals, this legal mandate causes moral distress and harm, particularly when compliance with this law would deprive vulnerable individuals of much-needed public benefits related to housing, health, and employment. For some, compliance with the law, known in Arizona as Proposition 200, clashes with practitioners' moral duty. This dilemma is reflected in the sentiments shared by an attorney with the National Association of Social Workers (NASW) (Morgan, 2013, p. 8):

The requirements of Proposition 200 have alarmed many social workers who are responsible for assisting applicants for public benefits and those who may refer clients to public agencies in order to apply for benefits. Should an applicant for public benefits remain silent when asked for verification of immigration status or make a statement that no documents are available? A subtle distinction between silence versus answering "no" has become a focal point of Arizona law. What may have previously been an insignificant consideration for applicants who are likely to be stressed, ill-informed, and non-native speakers of English, may now form the basis of a life-altering decision for themselves and their families. Arizona social workers who provide services to immigrant clients face serious and complex legal and ethical dilemmas related to the implementation of Proposition 200 and HB 2008.

I have encountered practitioners in other settings who have similarly daunting ethical choices involving potential moral distress and harm. For example, some human services professionals consider applying for jobs offered by national corporations that have federal contracts to provide services on behalf of ICE. These companies advertise positions for counselors and case managers who assist immigrant detainees. In 2019, the GEO Group, a corporation listed on the New York Stock Exchange, signed contracts with ICE to provide 4,490 processing center beds. In a press release, the GEO Group reported that the contracts are worth more than \$200 million in annual revenues for the company. According to the for-profit company website (Business Wire, 2019, para. 6):

The GEO Group (NYSE: GEO) is the first fully integrated equity real estate investment trust specializing in the design, financing, development, and operation of secure facilities, processing centers, and community reentry centers in the United States, Australia, South Africa, and the United Kingdom. GEO is a leading provider of enhanced in-custody rehabilitation, post-release support, electronic monitoring, and community-based programs. GEO's worldwide operations include the ownership and/or management of 130 facilities totaling approximately 96,000 beds, including projects under development, with a growing workforce of approximately 23,000 professionals.

Some human services professionals are attracted to positions whose mission is to assist immigrants who have been detained in the United States. These practitioners recognize the need to address mental health, trauma, and other issues faced by these detainees. However, some of these professionals also have profound moral qualms about accepting employment at a for-profit corporation whose revenues rely on detaining immigrants. They are concerned that their employment by a corporation that is greatly financially enriched by immigrant detention would create what moral philosophers call the problem of “dirty hands,” that is, that human services professionals who accept employment in such corporations would contribute to moral harm and would be ethically compromised as a result. This moral challenge is acknowledged explicitly by Byers and Shapiro (2019):

Cases of active complicity with state violence . . . should be distinguished from the far more common situation of social workers striving to practice ethically within underresourced agencies in which they may witness or play a role, either directly or indirectly, in pervasive neglect and abuse. Still, treatment today with undocumented children and families shows that this line between complicity and working within the system can grow blurry. For undocumented youths, separation from their parents or guardians can constitute a traumatic experience . . . , especially following an uncertain journey from their country of origin, that may have long-lasting and negative impacts on their health and mental health. Holding these youths in detention without adequate care adds to this trauma and may constitute the type of toxic stress shown to negatively affect the developing brain and stress response

system. . . . On the one hand, if social workers meet with some of these children, they may help to mitigate some harm. On the other hand, the presence of licensed social workers can serve as a fig leaf, obscuring larger institutional neglect and abuse. (p. 176)

For many years, I have had the opportunity to provide ethics training to human services professionals in the U.S. Armed Forces in various European and Asian countries. I have had many discussions with dedicated and principled social workers, psychologists, mental health counselors, substance use disorder professionals, and others who care deeply about the well-being of active-duty military personnel. Some of these practitioners have spoken openly about their moral struggles when they encounter a soldier, sailor, marine, or airman who is coping with challenging mental health issues and, as a result, is placed on limited or restricted duty. These practitioners may be required to provide counseling services that, if effective, would return these military personnel to their units that are likely to be deployed and placed in harm's way. For some practitioners, having a hand in facilitating military personnel's return to combat settings, with all of the potential harm that may result, is morally unsettling.

Acts of Desperation

Many acts that cause moral harm and injury are committed by human services professionals who are desperate or who believe that they are living in the midst of desperate circumstances. These are people who conclude that they have run out of options and end up committing a harmful act in their attempt to resolve their seemingly untenable predicament.

The word *desperate* means "having lost hope," "moved by despair or utter loss of hope," and "involving or employing extreme measures in an attempt to escape defeat or frustration" ("Desperate," n.d.). Some acts of desperation are committed in the context of acute crises, in which human services professionals thrash around for a quick way out of what are, or at least appear to be, desperate circumstances. In one case, the director of program operations at a prominent program that served high-risk young adults was responsible for overseeing a federally funded evaluation of the program. The federal agency required a comprehensive assessment of outcomes for the clients, who received a range of counseling and case management services. Conducting this evaluation felt burdensome to this administrator, who preferred to spend his time on program planning, budgeting, and personnel issues.

About one month before the agency's program evaluation report was due to the federal agency, the administrator prepared a draft that primarily included falsified data on outcomes such as program completion rates and clients' academic and job achievements, clinical progress, and opinions about the quality of services. After submission of the report, the agency's director was contacted by the federal grant administrator, who informed the agency director that she suspected that the program director had submitted falsified data. The grant administrator reported that one of her staffers, a statistician, had examined the data set that accompanied the report and noted significant coding discrepancies and inconsistencies that suggested fraud. The agency director confronted the program director, who admitted that he had falsified the data. "I am so ashamed and humiliated," the program director said.

I've never done anything like this in my life. The truth is, I ran out of time to complete the evaluation and I knew that continued federal funding depended on submission of this report. I used poor judgment, and I feel awful about it.

The program director promptly resigned his position.

Many acts of desperation have a financial stimulus. These offenses are committed in an effort to fix a money-related problem. In one case, the executive director of a for-profit substance use disorder treatment program, a licensed chemical dependency professional, was distraught about declining revenues. For more than a year, the program had been having difficulty meeting payroll and other expenses because of reduced admissions, insurance reimbursements, and residents' lengths of stay. In addition, several of the program's contracts with state government agencies had not been renewed.

In a fit of desperation, the executive director created fraudulent bills for nonexistent clients and submitted them to a state agency that paid for services provided to low-income clients. A routine audit of the program by the state uncovered the massive fraud. The executive director was indicted on fraud charges and convicted. At his sentencing hearing, the executive director read a prepared statement expressing his deep sense of remorse. The executive director's therapist submitted a letter to the court describing in detail the executive director's profound guilt.

Other acts of desperation have little or nothing to do with money and much more to do with interpersonal conflict, for example, interpersonal disputes that spin out of control. In one case, a counselor in a substance use disorder program, who was in recovery, relapsed. The counselor had struggled for years with cocaine

addiction. He relapsed after his wife announced that she was seeking a divorce. One evening, the counselor agreed to meet a drug dealer at a nearby park to buy cocaine. When the counselor arrived at the park, he was shocked to discover that one of his clients was there as well; coincidentally, the client was dating the drug dealer. In a moment of panic, the counselor handed the client \$100 and asked her whether that was enough money for her to keep quiet about what she had witnessed.

One week later, the counselor decided to disclose to the program director that he had relapsed and would need some time off to address his struggles. With great remorse, the counselor told the program director about his inadvertent encounter with a client when he had arranged to purchase cocaine.

Acts of Greed, Exploitation, and Opportunism

Some human services practitioners commit acts leading to moral injury that are motivated by self-centered greed, exploitation, and opportunism. The definition of *greed* is “a selfish and excessive desire for more of something (such as money) than is needed” (“Greed,” n.d.). *Exploitation* (“Exploitation,” n.d.) means “to make use of meanly or unfairly for one’s own advantage,” and *opportunism* is “the art, policy, or practice of taking advantage of opportunities or circumstances often with little regard for principles or consequences” (Opportunism, n.d.).

In one case, a psychologist was sentenced to federal prison and ordered to pay \$1.46 million in restitution for submitting false insurance claims to Medicare and four private companies (Kim, 2019). According to federal prosecutors, the psychologist submitted insurance claims for mental health services that were not provided. Evidence showed that the psychologist was out of state on the dates she was supposed to have provided services, and some of the claims submitted were for a person who was not one of her clients. The psychologist told one of her former clients to lie to investigators about co-payments and the number of treatment sessions. According to prosecutors in this case, the psychologist

was not desperate for money to put food on the table or a roof over her family’s head. On the contrary, she was highly educated, had a profitable practice and enjoyed a high standard of living before she began her fraud scheme. (Meadows, 2019, para. 5).

The psychologist admitted to her crime.

In another case, a psychiatrist was sentenced to more than 12 years in prison for his role in a \$155 million health care fraud scheme (Ackerman, 2018). He was also ordered to pay \$20.6 million in restitution to Medicare and \$2.2 million to

Medicaid. According to prosecutors, the psychiatrist indiscriminately admitted and readmitted patients into an intensive psychiatric program, often for years on end; many of the patients had severe Alzheimer's disease or dementia and were unable to participate in the treatment. Evidence showed that the psychiatrist falsified medical records and signed false documents to make it appear as though patients needed and received intensive psychiatric services. He also billed Medicare for psychiatric treatment he never actually provided.

Acts of Rage

Occasionally, human services professionals engage in acts of rage that lead to moral injury. In these cases, practitioners typically react impulsively to situations that are profoundly upsetting to them. Their actions are not the result of careful planning or calculation. In one case, David Barrett, a psychiatrist at an outpatient mental health clinic, was charged with murder after a confrontation with a man at a gas station. According to court records, Barrett shot his victim during an intense argument. Barrett was convicted of second-degree murder and of carrying firearms without a license. At trial, Barrett argued that he shot the victim in an act of desperation and in self-defense when the victim intervened in an argument between Barrett and the clerk at the gas station's convenience store. Barrett was sentenced to serve 30 years in prison. At his parole board hearing, Barrett expressed his profound remorse for his decision to shoot his victim in the midst of an intense dispute (*State v. David Barrett*, 2001).

In another case, a former hospital employee assaulted his former supervisor. Leon Morris concealed a baseball bat and knife beneath his coat when he returned to the hospital several days after his employment was terminated (Donnelly, 2019). The assistant district attorney said Morris intended to exact revenge on his former supervisor, Giovanna Palumbo, who he mistakenly believed had caused him to be fired. Evidence presented in court showed that Morris hit the victim multiple times with the bat and threatened her and other workers with the knife. He was charged with felony counts of attempted first-degree assault and second-degree assault. Morris was convicted in criminal court and sentenced to serve 3.5 years in prison.

Acts of Revenge and Retribution

Some acts that lead to moral injury arise out of human services professionals' deliberate, calculated attempts to avenge some sort of perceived wrongdoing. In one case, a mental health counselor in a large community mental health center

was engaged in an ongoing conflict with another counselor at the agency who had been promoted to an assistant director position, for which both of them had applied. The counselor who did not get the promotion felt he was more qualified and believed that his colleague was awarded the position only because she was good friends with the agency's director.

This counselor felt so resentful that he created a false e-mail address and sent a scurrilous message to a large number of agency staffers that included unfounded rumors about the assistant director's alleged substance use and sexual conduct. The assistant director learned about the e-mail messages and hired a digital forensics expert in an effort to identify their source. The forensic investigation exposed the counselor who concocted the scheme.

The victim filed a licensing board complaint against the perpetrator. At the licensing board hearing, the perpetrator confessed that he had authored and circulated the e-mail messages. He accepted responsibility for his unethical conduct and shared his insights about the ways in which his poor self-esteem and need for revenge led to his poor judgment. The licensing board suspended the counselor's license and mandated that he complete an ambitious set of tasks, including ethics consultation and therapy, before applying for reinstatement.

In another case, a caseworker in the behavioral health unit of a state prison had a complaint filed against him by an inmate. The complaint alleged that the caseworker missed several appointments and did not arrange mental health services requested by the inmate. The caseworker was incensed that the inmate had filed the complaint. The caseworker responded by filing false disciplinary reports against the inmate alleging that, on several occasions, the inmate had yelled at the caseworker, used profanity, and threatened the caseworker. An internal affairs investigation found that the caseworker's disciplinary reports, which led to the inmate being placed in punitive segregation for 30 days, were bogus. In an effort to keep his job, the caseworker wrote a formal letter of apology to the inmate and supervisors.

Acts of Misguided Frolic

Some acts that lead to moral injury do not entail any sinister intent. Rather, they result from lapses in judgment on the part of human services professionals that involve a wish to have fun, albeit at clients' expense. In one case, a counselor in a residential psychiatric facility for adults decided it would be amusing to taunt several patients diagnosed with schizophrenia. Unbeknownst to the counselor, his taunts were recorded on security cameras. A hospital investigator happened to view the footage when she was reviewing random segments of video storage

as part of the hospital's risk management protocol. The counselor apologized for his conduct and was placed on administrative leave.

In another case, a mental health counselor in private practice provided psychotherapy services to a woman who was distressed about marital conflict. Occasionally, the counselor and client exchanged text messages to schedule and reschedule appointments. Over time, the text messages became more casual, personal, and flirtatious. Several messages included content related to their respective weekend and vacation plans.

At one point, the client sent the counselor a photo of herself in a skimpy bathing suit, accompanied by the message, "I thought you might like to see what I look like when I'm not dressed for therapy! :-)" The counselor, who was attracted to his client, sent a reply message with a photo of himself bare chested while lifting weights: "Well, two can play this game! Here's what I look like when I'm not dressed for therapy sessions!" The two continued to exchange chatty, flirtatious text messages.

After about two weeks of these exchanges, the counselor and client exchanged "sext" messages that included graphic photos of their genitals. The client's husband saw these photos when he scrolled through his wife's text messages, unbeknownst to her, because he suspected that she was having an extramarital affair. The husband filed a licensing board complaint against the counselor. The counselor surrendered his professional license and had to terminate his counseling relationship with the woman.

Acts of Impairment

Some acts that lead to moral injury are the result of impaired judgment and behavior on the part of human services professionals. Research has indicated that a relatively small, albeit nontrivial, percentage of practitioners are impaired as a result of mental illness, substance use disorder, personal distress (for example, related to relationship conflict, financial difficulties, or legal challenges), and other causes (Reamer, 2015). On occasion, practitioners' compromised condition leads them to engage in actions that harm others, including their clients.

In one case, a counselor at an Arkansas state psychiatric hospital escorted a patient out of the institution and fled with him out of state. The counselor and former hospital patient were arrested in Las Vegas. The counselor, whose position at the hospital included providing individual and group counseling, was convicted in criminal court, sentenced to probation, and required to undergo regular drug screens (Lynch, 2019).

In another case, a state medical licensing board suspended a physician's license for two years and placed his license on probation for four years after accepting a hearing panel's finding that his paranoid behavior affected his ability to safely practice medicine (Farrish, 2019). The licensing board concluded that allowing the physician to continue to practice posed a danger to the public. Conditions of probation required the physician to be treated by a psychiatrist. According to state records, the state Department of Public Health had ordered the physician to undergo a psychiatric evaluation after he had sent e-mails to the department alleging corruption and organized crime in the U.S. medical system, law enforcement, and the state public health department. A psychiatrist who examined the physician testified at a hearing that the physician was loud, threatening, overbearing, paranoid, and not responding to logic.

Role of Demoralization

Many professionals who experience moral injury, whether directly or indirectly, feel demoralized. *Demoralization* is defined as a change in morale that may include disheartenment, dejection, hopelessness, loss of values, and despondency (Briggs, 2013; Gabel, 2012). The vast majority of the literature on demoralization has focused on the ways in which practitioners' clients may feel demoralized as a result of emotional, physical, social, financial, and legal circumstances in their lives (Briggs & Fronek, 2019; Clarke & Kissane, 2002; Connor & Walton, 2011; Gabel, 2012, 2013). Relatively little research has focused on the ways in which human services practitioners themselves may experience demoralization, particularly as it is correlated with practitioners' experiences of moral harm and injury (Gabel, 2012, 2013).

Clearly, human services professionals can experience demoralization. Writing about demoralization among psychiatrists, Gabel (2012) observed,

Psychiatrists working in many mental health care organizational settings, be they in the public or private sectors, may be at particular risk for demoralization. This is due partly to stressors that threaten their own professional values because of factors such as programmatic cutbacks, budgetary reductions and changing social emphases on the value of mental health treatments. They also may be at risk for demoralization because of the effects on them of the governance styles of the agencies in which they are employed. (p. 489)

Demoralization can be both a cause of practitioners' actions that lead to moral injury and a result of engaging in actions that harm others. That is, human services professionals who feel despondent or hopeless about their work, or who have strayed from core values that are central to the helping professions, may be more likely to engage in conduct that harms the very people they serve (Aisner, 2008). In one case, a former therapist with the University of Michigan Health System was sentenced to prison for sexually assaulting patients he treated as part of a traumatic brain injury recovery team. Evidence introduced in court showed that Thomas Higgins had inappropriate sexual contact with three patients on multiple occasions. The incidents occurred in his office, in the patients' homes, and in a hospital van. According to news reports, Higgins appeared emotional as he read prepared statements about his actions to the court (Aisner, 2008). He admitted to fondling the breasts and buttocks of each of the victims for his own sexual gratification and escalating the sexual contact with one of the women under his care. Higgins confessed to using his position and trust established with the victims to manipulate them to engage in sexual activity.

In another case, a California physician was sentenced to 30 years to life in prison for the murders of three of her patients who fatally overdosed. During the trial, the prosecutor told jurors that in one instance Hsiu-Ying Tseng wrote a man's name on prescriptions so his wife could get twice as many pills, openly referred to her patients as "druggies," and sometimes made up medical records (Gerber, 2016).

The prosecution maintained that the doctor's motivation was financial in nature. Between 2007, when Tseng joined a medical clinic where her husband worked, and 2010, tax returns show that their office made \$5 million, according to the prosecutor.

In court, Tseng issued an apology. In a letter submitted to the court, Tseng said that she realized that personal problems—undiagnosed depression, hoarding, and difficulty juggling work and her children—interfered with her abilities to be a good physician. "I was not the doctor I should have been for the patients who came to me," she wrote. "I know that being remorseful for my failures as a doctor and as a person does not reverse time or does not help the families heal their grief. . . . No words can properly describe the sadness" (Gerber, 2016, para. 38). In another letter Tseng wrote to the judge, she said she wanted him to "understand how shameful and remorseful I feel as a result of having broken all the professional rules and standards while practicing medicine and having my treatment and prescriptions be part of my patients' addictions" (Keith, 2016, para. 8).

Practitioners' struggles with feelings of guilt because of the harm they may have caused others may also lead to demoralization. In one case, a former high school guidance counselor in Ohio was sentenced to serve two years in prison after pleading guilty to having sex with a student. According to court records, Rebecca Sparrow, a mother of two, told the teenager on more than one occasion that she would lose her job and likely go to jail if their actions were exposed to school officials, to whom she lied about the relationship several times. According to the prosecutor, the student was in a very fragile emotional state at the time of the sexual encounters; he had experienced suicidal thoughts during his parents' divorce. During her court hearing, Sparrow acknowledged her acts of "betrayal and broken trust." "I know no words can heal the pain I've caused," Sparrow said (Miller, 2019, para. 5).

Addressing the court nine months after she began serving her prison sentence, Sparrow said,

I would just like to say that I have taken the time since I have been incarcerated over the last nine months to reflect on my actions and the awful, horrible decisions that I have made. I take full responsibility for all of those things that I did and I don't know if I will ever be able to forgive myself for the hurt that I have caused my family, the destruction that I have caused in my marriage, to my children; I just hope that I can continue focusing on being the best mom that my kids deserve. They deserve to have a good mom and for me to be able to be there for them. (Nethers, 2019, para. 7).

In another case, the founder of a prominent conversion therapy program, who came out as gay, apologized for harm he believed he had caused as a result of his efforts to convince people who are gay to become heterosexual. For two decades, McKrae Game led a faith-based conversion therapy program designed to suppress or eradicate a person's LGBTQ identity (Majchrowicz, 2019). Conversion therapy has been widely discredited by several prominent national organizations, including the American Medical Association, NASW, the American Psychological Association, the American Counseling Association, the American Psychiatric Association, and the American Association for Marriage and Family Therapy. In an interview, Game expressed his remorse and deep distress about his multiyear efforts to convert people who identify as LGBTQ: "I was a religious zealot that hurt people. People said they attempted suicide over me and the things I said to them. People, I know, are in therapy because of me. Why would I want that to continue?" (Gajanan, 2019, para. 11).

Conclusion

Recognition of moral distress, moral harm, moral injury, and demoralization has come of age in human services. Today's practitioners recognize that, throughout history, human services professionals have struggled with feelings of guilt and remorse associated with their efforts to help people. Only recently, however, have human services professionals formally recognized these phenomena and developed the vocabulary and conceptual scaffolding necessary for practitioners to address them constructively. Across the helping professions, we now know more than ever about the diverse ways in which moral distress, moral harm, moral injury, and demoralization manifest themselves. We understand that these challenges arise because of the way some practitioners perpetrate, witness, and fail to prevent acts that transgress their deeply held moral beliefs.