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Understanding the Effect of Moral Transgressions in the Helping Professions: In Search of Conceptual Clarity

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Abstract

There is a vast academic literature on the moral dimensions and ethical dilemmas of what are commonly referred to as the helping professions, (e.g. nursing, medicine, social work, counseling, teaching, etc.). Over the past several decades, increasing attention has been paid to the issue of moral transgressions perpetrated, witnessed, or experienced by these professionals and their accompanying psychological and social outcomes. Scholars seeking to understand moral transgressions and their effects have proposed and examined a variety of constructs, including *moral distress*, *demoralization*, and *moral injury*. This article examines to what extent constructs related to moral transgressions and their associated psychological, emotional, and social effects overlap and diverge to describe similar and/or distinct phenomena and proposes a unified conceptual model of *moral suffering*. Understanding the moral dimensions of the helping professions is critical for effective research and just, ethical practice.

[Key words: demoralization; helping professionals; moral distress; moral injury]

Introduction

Professions that are geared toward caring for and aiding the physical, mental, emotional, or spiritual well-being of others, including teaching, social work, counseling, nursing, medicine, and ministry, are commonly referred to as the helping professions (Esterson 1982; Hawkins et al. 2012). The term “helping” suggests a core value of altruism that is shared across these different

specialized professions. Skorupski (1998) defines morality as "that set of convictions whose function is to promote human flourishing, to enable us to live together on terms of mutually beneficial cooperation" (sec. 2, para. 1). Therefore, the helping professions are, to some degree, shaped in moral terms. In addition to having an identity rooted in morality, many of the helping professions, including social work (National Association of Social Work 2017), psychology (American Psychological Association 2017), nursing (American Nurses Association 2015), and medicine (AMA Council of Ethical and Judicial Affairs 2016), are guided by formal codes of ethics, which provide standards for professional behavior and outline the core beliefs, values, and moral principles to which all professionals are expected to adhere. Even for helping professions that lack a formal, nationally adopted code of ethics, like teaching, ethical codes have been established by national unions (National Education Association 1975) and state-level licensing boards (e.g., Code of Ethics for Minnesota Teachers, Minnesota Administrative Rules 8710.2100).

The academic literature on the moral dimensions and ethical dilemmas of the helping professions is vast (e.g., Jameton 1984; Goodlad, Soder, and Sirotnik 1991; Carr 2000; Campbell 2003; Strike and Soltis 2009; Reamer 2013). One area of the literature on morality in the helping professions that has garnered increasing attention in the 21st century concerns moral transgressions that are perpetrated, witnessed, or experienced by professionals, along with the accompanying psychological and social outcomes. Scholars seeking to understand moral transgressions and their effects have proposed and examined a variety of constructs, including *moral injury* (Shay 1994, 2014; Litz et al. 2009), *moral distress* (Jameton 1984, 1993), and *demoralization* (Gabel 2011, 2012, 2013; Santoro 2011). Because these constructs (which will be described in depth in the next section) appear to address the influence of potentially morally

transgressive events on a helping professional's psychological, emotional, and social well-being, questions arise as to what distinguishes them from each other. Are these constructs describing the same phenomena but employing different terms, depending on the academic and professional discipline? Are they describing related but distinct phenomena with clear conceptual boundaries? If the constructs relate to each other, how are they related?

Understanding the moral dimensions of the helping professions and their practice contexts, particularly in terms of the sources and outcomes of moral violations, is critical for promoting just and ethical care and positive outcomes for recipients. To increase this understanding, it is necessary to have conceptual clarity in order to develop applicable theoretical models that can be used to guide research and practice. This article answers the following question: To what extent do constructs related to moral transgressions and their associated psychological, emotional, and social effects overlap and diverge to describe similar and/or distinct phenomena? A broader conceptual understanding of these constructs and how they relate to one another will allow for more effective research into the moral actions, transgressions, and outcomes across the helping professions. In the next section, I summarize the existing literature on each of the following constructs: moral injury, moral distress, and demoralization. Following these summaries, I present an analysis of the areas of similarity and divergence among the constructs and then present a proposed integrated model of *moral suffering*. The article ends with a discussion of the significance of moral suffering to social work practice and research.

The Constructs

Moral Injury

Moral injury refers to the lasting emotional, psychological, and existential harm that occurs when an individual "perpetrates, fails to prevent, bears witness to, or learns about acts that transgress

deeply held moral beliefs and expectations" (Litz et al. 2009, 700). Moral injury occurs when an individual experiences deeply troubling cognitive dissonance between their internal moral code and the actions that they engage in or witness (Litz et al. 2009). Symptoms of moral injury include guilt, shame, anxiety, depression, and anger (Litz et al. 2009; Dombo, Gray, and Early 2013; Jinkerson 2016) and can lead to a loss of trust in oneself or others, existential dread, and deep demoralization (Jinkerson 2016). The symptoms of moral injury can be long-lasting, do not resolve easily on their own, and are often resistant to typical psychological treatments for trauma (Litz et al. 2009). The damage to one's internal moral schema or moral belief system is a particularly significant outcome of moral injury that can lead to irreparable change in an individual's self-identity (Dombo et al. 2013). Moral injury causes a "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" (Drescher et al. 2011, 9), and a "breakdown in global meaning" (Currier et al. 2015, 26).

Jonathan Shay, a military psychiatrist (1994, 2009, 2011, 2014), first used the term *moral injury,* and the vast majority of research on moral injury has occurred within the military context. Although the military is not traditionally considered to be a helping profession, it operates from a strong moral code and has a focus on self-sacrifice and helping others gain freedom, liberty, and safety. This can be viewed as a type of caring and altruism, and thus, for the purposes of this article, the military will be considered a helping profession. Many participants who have reported experiencing moral injury also have a diagnosis of Post-Traumatic Stress Disorder (PTSD; Haight et al. 2016); however, scholars insist that moral injury, though it may occur concurrently with PTSD, is a distinct condition (Litz et al. 2009; Dombo et al. 2013; Shay 2014). In PTSD, traumatic events threaten one's safety and mortality; in moral injury, the troubling act

threatens the validity of one's internal moral framework (Dombo et al. 2013). Although research on moral injury has occurred predominantly in military contexts, an increasing number of researchers have empirically explored the applicability of moral injury to other populations, such as refugees (Nickerson et al. 2015), teachers in El Salvador (Currier et al. 2015), women with substance abuse histories (Hartman 2015), women who have experienced intimate partner violence (Otte 2015), police officers (Papazoglou and Chopko 2017), parents and professionals involved in the child protection system (Haight, Sugrue, and Calhoun 2017; Haight, Sugrue, Calhoun, and Black 2017*a*, 2017*b*), and professionals in the US K12 education system (Sugrue, under review).

MORAL DISTRESS

The term *moral distress* was first coined by nursing ethicist Andrew Jameton (1984), and it refers to the "painful feelings and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action" (Corley 2002, 636-637) due either to internal constraints (e.g., fear) or external constraints (e.g., lack of time, lack of resources, legal limits, hierarchical decision-making; Corley 2002; McCarthy and Deady 2008). Individuals experience moral distress when "they know the right thing to do, but they are unable to do it; or they do what they believe is the wrong thing to do" (McCarthy and Deady 2008, 254). In 1993, Jameton refined his theory to distinguish between *initial moral distress* and *reactive moral distress*. Initial moral distress refers to the emotional reaction (e.g., frustration, anger, and anxiety) experienced when one is confronted with a conflict between one's moral values and available actions, while reactive moral distress refers to the lasting distress individuals experience after not acting in a way that is consistent with their moral values (Jameton 1993). Symptoms of moral distress include anger,

frustration, guilt, shame, anxiety, loss of self worth, depression, and powerlessness (Corley 2002). Research finds that nurses cope with moral distress by avoiding patient interaction (Raines 2000; Corley 2002; McCarthy and Deady 2008), abandoning their moral principles all together (Webster and Baylis 2000; Hamric 2012), or leaving the profession (Corley 2002; McCarthy and Deady 2008; Hamric 2012).

Jameton (1984) distinguishes between moral uncertainty, in which individuals are unsure about the right action to take, and moral distress, in which individuals know what to do but are unable to do it. McCarthy and Deady (2008) clarify that moral distress goes beyond emotional or psychological distress. For example, a nurse could be emotionally distressed when performing a work task, such as restraining a patient, but not morally distressed if the nurse believed the restraint was the right thing to do (McCarthy and Deady 2008). Additionally, Weinberg (2009) argues that moral distress is distinct from an ethical dilemma. While ethical dilemmas are conceptualized as problems at the individual level, the conceptualization of moral distress acknowledges the role of larger systems including "political dimensions of practices, thereby enabling structural issues to be recast as ethical problems" (Lynch and Forde 2016, 96)

Moral distress has received significant attention in the academic literature, both conceptually and empirically, but the research has been primarily confined to the field of nursing. A Scopus search conducted on January 14, 2018 found 784 articles on moral distress published between 1987 and 2018. All but four of the articles were published in nursing or other medical journals. Despite the substantial body of literature on moral distress, there has been some uncertainty over the specifics of its definition (McCarthy and Deady 2008; Dudzinski 2016). Dudzinski (2016) states that the exact definition and meaning of moral distress "is famously nebulous" (321). Some scholars choose to focus on the role of external social and

institutional constraints in eliciting moral distress (e.g. Jameton 1984, 1993; Corley 2002), while others include the role of internal constraints (Webster and Baylis 2000). Hanna (2004) argues that some scholars (e.g., Jameton 1984, 1993; Wilkinson 1988) focus too much on the psychological aspects of moral distress, to the point that they are conflating psychological distress with moral distress and ignoring the more salient ethical components of the phenomena. In response to this conceptual muddiness, McCarthy and Deady (2008) propose that moral distress should be considered "a cluster concept or umbrella concept" (259) capturing a range of symptoms and experiences of individuals who are morally constrained.

Not only has the majority of research on moral distress occurred in nursing contexts, but it has occurred specifically in North American nursing contexts (Pauly, Varcoe, and Storch 2012). Interestingly, in Scandinavia, there is a body of work within nursing literature that uses different terms, such as "moral stress" (Lützén et al. 2003) and "troubled conscience" (Glasberg et al. 2006), for what appears to be moral distress. In this literature, "moral stress" refers to the emotional experience that occurs "when nurses are aware of what ethical principles are at stake in a specific situation and external factors prevent them from making a decision that would reduce the conflict between the contradicting principles" (Lutzen et al. 2003, 314). "Troubled conscience," as explained by Ann-Louise Glasberg and colleagues (2006), stems from the discrepancy that arises among one's internal conscience or "voice," internal desires or inclinations, and external demands when an individual "does not follow the voice of conscience" (635). Some of the differences between moral distress and its counterparts in the Scandinavian literature could be due to translation alone, but an integration of the North American and European constructs could help to clarify moral distress's conceptual ambiguity (Pauly et al. 2012).

Recently, some scholars have pushed back against Jameton's (1984, 1993) assertion that moral distress must involve a situation of moral constraint (Johnstone and Hutchinson 2015; Campbell, Ulrich, and Grady 2016; Fourie 2017). Johnstone and Hutchinson (2015) argue that the dominant conceptualization of moral distress is based on the flawed assumption that nurses always know the right thing to do and the only reason they are not doing the right thing is because they are unable to, due to internal or external constraints. The authors assert that to assume "the unequivocal correctness and justification of nurses' moral judgments" (8) is a fallacy and this conceptualization of moral distress "understates the moral responsibility of nurses to take remedial action, even in difficult environments, and thus risks being apologist for their incapacities" (8). Similarly, Campbell and colleagues (2016) point out that "life as a moral agent is complex" (3), and that frequently it is difficult if not impossible for nurses to know the correct moral action to take. In contrast to Jameton (1984), who distinguishes between moral dilemmas (which are a source of moral distress) and moral uncertainty (which is not), Campbell and colleagues assert (2016) that both moral dilemmas and moral uncertainty can lead to moral distress. Fourie (2017) proposes that moral distress is comprised of multiple categories, including the constraint-based moral distress as defined by Jameton (1984, 1993) and the uncertainty-based moral distress as identified by Campbell and colleagues (2016).

DEMORALIZATION

Demoralization is a construct that is used to describe "feelings of impotence, isolation, and despair" (Clarke and Kissane 2002, 734) in response to a perceived inability to deal effectively with a stressful experience (Clarke and Kissane 2002). Demoralization is related to both an individual's *moral* beliefs and actions and with a loss of *morale* when important beliefs and values are lost (Gabel 2013). When individuals are demoralized, they feel trapped, helpless, and

unable to respond to a stressful situation in a way that feels appropriate to them, all of which results in feelings of anxiety, depression, and “a sense of meaninglessness of life” (Clarke and Kissane 2002, 734).

Stewart Gabel (2011, 2012, 2013) has examined demoralization in the context of healthcare professionals and defines demoralization as “a condition of diminished morale or hopelessness that occurs when one's principles, values, or standards are threatened" (Gabel 2011, 892). Gabel (2013) argues that medicine and healthcare are rooted in moral beliefs and practices. Over the centuries, newly graduating physicians have recited oaths and declarations focused on the common theme of “the obligation of physicians to strive to aid those seeking help” (Gabel 2013, 119). Demoralization can occur when the moral foundation of healthcare practice is threatened by a lack of resources, increasing commercialization of healthcare, or policy changes that limit the ability of professionals to provide the type of care that they feel morally obligated to provide.

Demoralization has also been applied in the field of education by Santoro (2011), who defines teacher demoralization as the phenomenon that occurs when a teacher is unable to access the moral rewards of teaching. Santoro (2011) argues that “morals, values, and principles comprise the essence of teaching” (4) and “the moral rewards of teaching are activated when educators feel that they are doing what is right in terms of one's students, the teaching profession, and themselves” (2). Teacher demoralization happens when teachers lose the ability to act pedagogically in a way that feels right to them due to being overburdened by policies that are not consistent with their beliefs and values about their profession (Santoro 2011). Santoro describes demoralized teachers as feeling “depressed, discouraged, shameful, and hopeless” (Santoro 2011, 18).

Santoro (2011) cites the hyper-focus on standardized testing after the passage of No Child Left Behind as a significant source of demoralization for teachers, as they are unable to exercise their moral agency while operating under policy requirements that dismiss their pedagogical knowledge, constrain their pedagogical judgment, and restrict their pedagogical authority (16). When teachers attempt to challenge the policy requirements regarding standardized testing and measurement, they are characterized as self-serving, lazy, and incompetent (Santoro 2016). Santoro (2016) introduces the term "moral madness" to refer to the deep feelings of confusion and disorientation experienced "when a person's moral claims are not recognized as moral and the individual is disregarded as a moral agent" (2).

Gabel's (2011, 2012, 2013) and Santoro's (2011) work on demoralization in the context of healthcare professionals and educators, respectively, acknowledges that demoralization is a contributing factor to the more frequently discussed construct of burnout, but clarifies that the two are distinct constructs. Maslach, Schaufeli, and Leiter (2001) describe burnout as "a psychological syndrome in response to chronic interpersonal stressors on the job" (399) that consists of three dimensions: exhaustion, cynicism/depersonalization, and ineffectiveness (Maslach and Leiter 1997; Maslach et al. 2001). Gabel (2013) argues that, although demoralization and burnout share similar symptoms such as anxiety, depression, and feelings of inefficacy, burnout can be considered primarily "a prolonged reaction to chronic stressors in the work environment" while demoralization "results from a threat to or loss of personal or professional values that are perceived to be crucial to an individual's sense of well-being" (122).

Santoro (2011) argues that demoralization, defined as "the inability to access the moral rewards of teaching" (3), is often "misdiagnosed as burnout" (3). Many researchers of teacher burnout conceptualize it as a problem related to the characteristics and actions of the individual

teacher and not to the context in which the teacher operates (Santoro 2011). For example, teachers who are at most risk of burnout are often described as being overly idealistic and having difficulty establishing a healthy work-life balance (Farber 2000; Chang 2009). From these perspectives, burnout is viewed primarily as a condition resulting from the depletion of a teacher's internal resources for coping with the job and one that can be avoided with better self-care (Santoro 2011). In contrast, according to Santoro (2011), demoralization is rooted in the structure and context of education as a practice. Unlike burnout, demoralization "is not the result of a lack of personal fortitude or moral sensibility but a fundamental change in the rewards available through the work" (Santoro 2011, 17).

Discussion

Table 1 provides a summary of the key characteristics of moral injury, moral distress, and demoralization. The following section presents an integrated analysis of the three constructs.

Conceptual Similarities

Whereas research on moral injury has been primarily confined to military contexts, moral distress to healthcare settings, and demoralization to healthcare and education, there is clear overlap among the three constructs. All three constructs describe emotional, psychological, and existential distress related to a violation of moral expectations and deeply held values (Jameton 1984; Webster and Baylis 2000; Litz et al. 2009; Gabel 2011; Shay 2014). Clarke and Kissane's (2002) assertion that individuals experience demoralization when "they have lost, or feel they are losing, something critical to their sense of self" (737) echoes Dombo and colleagues' (2013) argument that the core of moral injury is "the threat to self-identity" (207) and Webster and Baylis's (2000) description of the permanent change in self-identity that results from experiences of moral distress.

Like authors who describe moral injury's lasting wounds (e.g., Litz et al. 2009), some scholars of moral distress describe deep wounds and threats to one's moral integrity that can occur after violating one's moral beliefs (Webster and Baylis 2000; McCarthy and Deady 2008). Webster and Baylis (2000) refer to these lingering feelings of distress as "moral residue." Additionally, authors describe how moral distress permanently changes individuals' sense of identity and the manner in which they connect with others (Webster and Baylis 2000; Hanna 2004). Webster and Baylis (2000) quote a medical student who experienced moral distress as saying that, "In the deepest part of yourself, you feel you will never be the same and you carry this with you for the rest of your life" (224). These types of long-lasting injuries to the self and resulting existential crises arising from moral distress echo the descriptions of moral injury and its effects (Shay 1994, 2014; Litz et al. 2009; Drescher et al. 2011; Dombo et al. 2013). Similarly, the "sense of meaningless of life" that Clarke and Kissane (2002, 734) identify as an outcome of demoralization appears to be equivalent to the "breakdown in global meaning" (p. 3) that Joseph Currier and colleagues (2015) attribute to moral injury. In fact, Jinkerson (2016) points out that, "the final state of moral injury has been described as deep demoralization" (124).

Conceptual Differences

Despite their having some similarities, there are several clear distinctions among moral injury, moral distress, and demoralization. Conceptualizations of demoralization and moral distress focus on the inability of the primary actors to change their circumstances (Jameton 1984, 1993; Clarke and Kissane 2002; Santoro 2011). In the demoralization literature, this inability is frequently referred to as "impotence" (Clarke and Kissane 2002), while the moral distress literature discusses "internal and external constraints" (Jameton 1984, 1993). In both cases, the results are feelings of helpless and hopelessness as one is unable to respond in a manner that

feels morally right (Corley 2002; Gabel 2011; Santoro 2011). In contrast, internal or external constraints, although they may be present, are not required for a person to experience moral injury. An individual could experience moral injury after having mistakenly or freely transgressed their moral expectations. The action and one's interpretation of the action as being morally transgressive leads to moral injury, regardless of whether or not the action occurred due to any constraints placed on the individual actor. For example, a military veteran could experience moral injury after accidentally killing a civilian. In this situation, the veteran may not have been personally forced to kill the civilian but made a mistake that resulted in the violation of a deeply held belief about the protection of civilians.

The role of the individual experiencing distress also varies among conceptualizations of moral injury, moral distress, and demoralization. A person can experience moral injury by perpetrating a moral transgression and/or witnessing or being the victim of someone else's action, if that action was evaluated by the individual as being a violation of deeply held moral beliefs and expectations (Litz et al. 2009; Shay 2014). In contrast, in demoralization and moral distress, the source of distress is the individual's own immoral actions (or inactions) or their own inability to act in a way that is congruent with their moral beliefs (Clarke and Kissane 2002; Gabel 2011; Santoro 2011).

Emerging Conceptual Convergence

As I previously stated, in recent years a number of scholars have advocated for broadening the conceptualization of moral distress (Campbell et al. 2016; Fourie 2017). These broader conceptualizations have functioned to decrease the distinctions between moral injury and moral distress. Campbell and colleagues (2016) propose the following definition of moral distress: "one or more negative self-directed emotions or attitudes that arise in response to one's

perceived involvement in a situation that one perceives to be morally undesirable" (6). By including the phrase "one's perceived involvement," Campbell and colleagues (2016) explain that they are being intentionally vague to allow for a wide range of roles that the individual could play in relation to the morally troubling event. In this definition, the individual experiencing moral distress may be the perpetrator of the moral transgression, but also may be "simply connected, professionally or personally, to others who are more centrally involved in a morally undesirable situation" (Campbell et al. 2016, 6). This broader conceptualization of the role of the individual in the moral transgression is similar to that of moral injury, in which the morally injured person may be the perpetrator, a witness, or a victim of the immoral act.

In addition to broadening the role of the morally distressed individual in the transgression, Campbell and colleagues (2016) also advocate for broadening the potential sources of moral distress beyond situations involving moral constraint (Jameton 1984) and moral uncertainty (Fourie 2017) to include those involving what they term "moral luck." Campbell and colleagues (2016) use this term to refer to experiences in which "agents perform what they deem to be the morally best action based on the best information and evidence available to them at the time, without any internal or external constraints. Yet, their actions, in conjunction with factors beyond their control, turn out to have morally undesirable consequences" (5). In response to and in support of Campbell and colleagues (2016), Andrew McAnich (2016) points out that their conceptualization of moral distress is "similar to, and perhaps encompasses, another self-directed negative emotion that is characteristic of a particular domain: namely, moral injury among combat veterans" (30). A commonly cited event associated with moral injury is the killing of civilians due to the ambiguity of combatants who are often embedded within civilian communities (Drescher and Foy 2008; Litz et al. 2009). Consistent with Campbell and

colleagues' (2016) description of "moral luck," this type of morally injurious event can be characterized as a morally best action that resulted in morally undesirable consequences.

Conceptualizations of moral injury have also moved from the narrow to the broad. McAnich (2016) notes that Shay's original definition of moral injury was narrower, with a focus on the response to a betrayal by a person in authority in high-stakes context (Shay 1994, 2014). However, Litz and colleagues (2009) broadened this conceptualization to include actions by peers or the service member himself. Most recently, McDonald (2017) challenged researchers and clinicians to expand their understanding of the true sources of moral injury. McDonald (2017) argues that when veterans experience moral injury, they are not solely troubled by what they or their colleagues did or failed to do, but by "the specter of a world without morals" that arises when one is confronted with deeply morally troubling events. Experiences of war shatter long held beliefs in rightness and wrongness and leave individuals facing "a world that has become morally irreconcilable" (McDonald 2017, 6). According to McDonald (2017), this destruction of one's belief in the world as a moral place should be considered the core of moral injury. Interestingly, McDonald's (2017) insistence on the significance of moral context as it relates to an individual's experience of moral injury is echoed in Santoro's (2011) writing on teacher demoralization. Santoro (2011) argues that teachers experience demoralization when they can no longer access the moral rewards of teaching because the moral context of teaching is endangered. In Santoro's (2011) view, it is not the individual characteristics or even the individual actions of teachers that are the source of demoralization, but it is teaching itself that has become, in McDonald's (2017) words, "morally irreconcilable" (6).

PROPOSED INTEGRATED MODEL OF MORAL SUFFERING

As the conceptualizations of moral injury, moral distress, and demoralization are broadening, the overlaps that have always existed among these constructs are increasing. These increasing similarities suggest that an integrated model is both more possible and more necessary. In figure 1, I present a proposed integrated conceptual model that I term *moral suffering*. This model captures the key components and overlapping conceptualizations of moral distress, demoralization, and moral injury. Similar to Litz and colleagues' (2009) model of moral injury, the model of moral suffering begins with an experience of dissonance between an individual's moral beliefs, values, and expectations and an experience of moral transgression. In this model, a morally transgressive experience can involve individual immoral actions, similar to those described by Litz and colleagues (2009) or a more general experience of trying to operate within an immoral context, echoing McDonald's (2017) idea that moral injury arises in the face of "the specter of a world without morals" (6) as well as Santoro's conceptualization of demoralization as resulting not from individual immoral actions but from an educational context that is "morally irreconcilable" (6).

In the proposed model of moral suffering, the relationship between individual immoral actions and an immoral context is circular and reciprocal; individual immoral actions collectively produce an immoral context or environment, while an immoral context also produces individuals' immoral actions. This model also includes the perspective of more recent researchers of moral distress (e.g. Johnstone and Hutchinson 2015; Campbell et al. 2016; Fourie 2017) who argue that Jameton's (1984) assertion that moral distress must involve a situation of moral constraint, in which an individual knows the right action to take but is unable to take it, is flawed. In this model of moral suffering, individuals may commit a moral transgression for a variety of reasons, including because of an internal or external constraint as Jameton (1984)

proposes, because they are experiencing moral uncertainty and are unsure of what to do as Campbell and colleagues (2016) propose, because they committed an action and only later understood its moral implications, or because they accidentally committed a moral transgression. In this model of moral suffering, I am proposing that how or why a person experiences a moral transgression is much less important than the resulting moral cognitive dissonance and accompanying existential and psychological outcomes of this dissonance.

As is illustrated in figure 1, the dissonance resulting from the mismatch between one's moral beliefs and morally transgressive experiences leads to the loss of faith in oneself and others to act morally and the rejection of the belief in the world as moral place. This sense of moral confusion and betrayal leads to feelings of guilt, shame, anxiety, anger, and depression. Moral suffering represents the experience of losing one's moral beliefs and expectations and the accompanying psychological and emotional symptoms. The experience of moral loss that is at the core of moral suffering is stressed in the writings of other prominent scholars of moral injury (e.g. Dombo et al. 2013; Drescher et al. 2011; Currier et al. 2015), moral distress (Webster and Baylis 2000), and demoralization (Clarke and Kissane 2002; Santoro 2011); although, it is absent from Litz and colleagues' (2009) model of moral injury.

This proposed model of moral suffering can be applied across a continuum of severity of symptoms and across contexts. For example, a military veteran who participated in an operation in Afghanistan that resulted in the deaths of young children may have more severe psychological symptoms than a social worker who placed children in a foster home where they experienced extreme psychological distress and trauma. Yet, both experiences could be described and explained by this model of moral suffering. Depending on an individual's moral beliefs and expectations, their reactions to moral transgressions may vary in severity both within and across

contexts. However, the underlying mechanisms and resulting symptoms can all be understood within this model of moral suffering.

An integrated model of moral suffering may be helpful in addressing the siloed nature of the current literature on the effect of moral transgressions on helping professionals. As is demonstrated in table 1, most of the constructs have been researched nearly exclusively within one academic discipline or professional field. In addition, there appears to be very little communication among the researchers of each individual construct. In Haight and colleagues' (2016) review of 27 empirical studies on moral injury published between 2011 and 2015, only four mentioned moral distress and none of the studies examined moral distress and its relationship to moral injury empirically. The similarities between moral distress and demoralization, as defined by Gabel (2011, 2012, 2013) and Santoro (2011) are particularly strong, yet neither researcher mentions moral distress in their work, even though Gabel conducts research with healthcare providers. The adoption of a unified construct, like that of moral suffering, could enhance cross-discipline research on the sources of and effects of moral transgressions in the context of helping professions that could help illuminate not just the suffering of individual professionals and clients but also the larger political, social, and structural forces that create situations in which moral transgressions occur. These forces and systems need attention and action from academics and practitioners in the helping professions, but to address them effectively we must be able to speak the same language.

Implications for Social Work Practice

I conclude with a discussion of the implications of the constructs discussed in this article, and specifically my proposed model of moral suffering, to social work practice. Despite the literature on moral injury, moral distress, and demoralization having originated in the fields of

nursing, military psychology, and medicine and education, respectively, over the past 5–10 years, it has gradually gained attention among social work scholars. Dombo and colleagues (2013) were the first social work scholars to propose the applicability of moral injury beyond the military battlefield to understand the suffering experienced by multiple different types of clients of clinical social work practitioners. Haight and colleagues (2017) find that moral injury could be a useful construct in understanding and improving the experiences of professionals working in the child protection system. Illustrating my argument for the significant conceptual overlap between moral injury and moral distress, Mänttäri-van der Kuip (2016) conducted a similar study on child welfare social workers in Finland, but applied the construct of moral distress instead of moral injury, and finds significant evidence of moral distress among this population. Other studies of moral distress in social work literature have been primarily conducted on hospital-based social workers (e.g., Lev and Ayalon 2016; Fantus et al. 2017; Fronek et al. 2017), perhaps due to moral distress's origins in the field of hospital-based nursing. More broadly, Oliver (2013), Weinberg (2009), and Lynch and Forde (2016) write convincingly of the need for moral distress to be a guiding concept in teaching ethics to social work students and in engaging social work practitioners in ethical practice, as it can reorient our field to the inherently moral nature of our work and help examine ways to address moral transgressions and injustice.

In making the case for the usefulness of moral suffering as a critical construct for social work practice, I draw primarily upon Weinberg's (2009) argument for the usefulness of moral distress to social work. First, moral suffering highlights the fact that social work practitioners experience real psychological and existential pain and suffering when they are involved in actions and environments that violate their moral beliefs and expectations. As a profession, especially one that is "committed to the psychological health of people" (Weinberg 2009, 146), it

is ironic that we have not focused more on the negative psychological and social outcomes of moral suffering for social work practitioners. Attention to moral suffering could aid in supporting the well-being, effectiveness, and professional retention of social workers with strong moral codes and a sensitivity toward injustice.

Second, and I would argue more important for social work practice, is the role that moral suffering can play in drawing attention to the sources of injustice and immorality inherent in the contexts in which social workers practice. Weinberg (2009) argues that social work ethics have become too narrowly construed, focused mostly on "the dyadic relationship between worker and service user" (143), and suggests that moral distress can highlight the connection between individual social workers and the larger social, political, and economic structures in which they work. According to the proposed model of moral suffering, if an individual social worker experiences moral suffering this signifies that moral transgressions are occurring. Most likely, the victims of these immoral actions and contexts are the individuals and communities who social workers are charged with helping. Thus, the construct of moral suffering can be used to identify the structural and systemic sources of injustice and oppression that all social workers, by nature of our professional code of ethics (National Association of Social Work 2017) and historical mandate, have a responsibility to address.

Finally, in addition to helping to highlight sources of moral injustice, the application of a model of moral suffering to social work practice and scholarship can contribute to the development of effective strategies for responding to these sources of injustice in social work practice. As many organizations that employ social workers have become increasingly dominated by neo-liberal and market-driven approaches to social welfare, social workers are increasingly finding themselves in situations in which their actions are being shaped by immoral

systems and structures. Some researchers call for a renewed focus on social work practitioners exercising moral courage (Fenton 2016), engaging in moral action (Keinemans and Kanne 2013), and using both covert and overt strategies in responding to moral injustices (Fine and Teram 2013). In addition to being a sensitizing construct for injustice, awareness of and understanding of moral suffering can spark a call to action for individual social workers and social work as a field to engage in the necessary systemic, structural, and political work required to promote social justice.

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Table 1: Comparison of the Research Contexts, Characteristics, and Effects of Moral Injury, Moral Distress, and Demoralization

				Impact		
Construct	**Primary Context of Research**	**Role of the Individual in the Moral Transgression**	**Characteristics of the Morally Transgressive Activity**	**Psychological/ Emotional**	**Existential**	**Social**
Moral injury	Military	Perpetrator; witness; victim	Individual commits a moral transgression either intentionally, accidentally, or because they feel they have no other choice; individual may or may not be fully aware of the immorality of the action prior to it being carried out	Anxiety, depression, anger, shame, guilt	Loss of trust in self and others; breakdown in global meaning	Social withdrawal
Moral distress	Nursing	Perpetrator	Individual knows what the moral choice is, but chooses the immoral choice due to internal or external constraints on their actions; individual experiences moral uncertainty about the right action to take	Anxiety, depression, frustration, anger, shame, guilt, powerlessness	Threat to sense of self	Distancing from patients; leaving the profession
Demoralization	Healthcare professionals; teachers	Perpetrator; witness	Individual is impotent; unable to act in a way that is morally congruent with his/her beliefs and expectations, usually due to structural/systemic constraints	Helplessness, hopelessness, anxiety, depression, shame	Threat to sense of self; lack of meaning to the world	Leaving the profession

Figure 1: A Conceptual Model of Moral Suffering