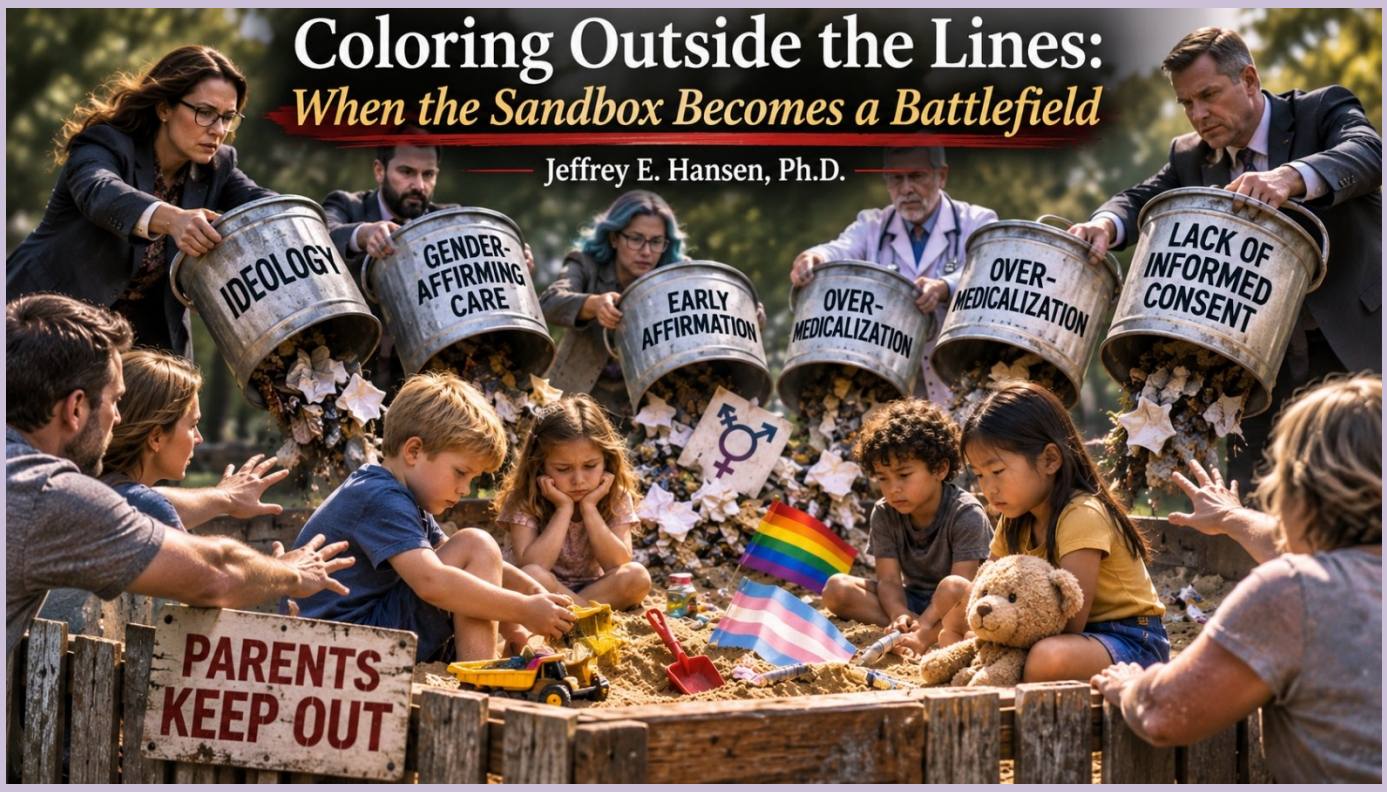


On moral injury, courage, and standing together for children

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Before Jumping in - Prologue

For those of you who know me, I love to write. One of my favorite ways to do that is through essays and blogs, my musings, my pontifications, and occasionally the thoughts that probably should have remained between me and my morning coffee. Four books have grown out of those sandboxes: *Old Psychologist in the Sandbox*, *Storms in the Sandbox*, *Special People in the Sandbox*, and most recently, *Science in the Sandbox*. (Hansen, 2026a, 2026b, 2026c, 2026d)

I have recently been invited, as a member of the American College of Pediatricians (ACPeds), to contribute essays on adolescence, mental health, and the building of resilience in young people. ACPeds is a conservative alternative to the American Academy of Pediatrics (AAP). I joined because I believe pediatric medicine needs the courage to question prevailing orthodoxies. In my judgment, the AAP has become so ideologically captured on certain contentious questions that it has compromised the moral independence I expect of a medical institution. That is my assessment, and I am prepared to defend it. After more than four decades as a psychologist, I have some things to say. Some are encouraging. Some are provocative. And some may irritate people who prefer that everyone stay politely inside the lines. (American College of Pediatricians, n.d.; American Academy of Pediatrics, n.d.)

Six in the Morning, and a Word from Russell

Shortly before six this morning, I read an email from Dr. Russell Gombosi. Russell, triple-boarded in internal medicine, pediatrics, and sleep medicine, is a physician I greatly respect. I came to know him through Shed Some Light in Williamsport, Pennsylvania, where I was honored to speak. But it was not his credentials that gripped me this morning. It was his willingness to say aloud what many colleagues were thinking.

Writing to a handful of colleagues I affectionately call the **ACPeds Inner Circle**, Russell put the elephant squarely in the room: the November 3 elections. Democrats won control of both houses of Congress and made significant gains elsewhere. Russell fears that the political shift will embolden efforts to expand abortion access, impose contested approaches to adolescent gender care, and narrow freedom of conscience. I share his concern. When the political winds change, laws, regulations, and professional expectations can change with them. The sandbox can become a very different place to play. (Associated Press, 2026).

Thank you, Russell. You were the first colleague in our circle to name this moment so plainly. I needed to hear it. So did others. His message was not a call to despair. It was a call to stand firm, to speak honestly, and to remember we are not supposed to face the storm alone.

Our sense is that newly elected progressive leaders will seek to reverse some of the gains that Russell and I believe have been made for parental involvement, professional conscience, and open clinical inquiry. I expect those gains to be challenged. If you think changes in political power cannot reach into an examination room, a licensing board, or a therapist's office, I think you are kidding yourself.

Which reminds me of a story.

When I was in kindergarten, my teacher called my mother in for a conference. “Mrs. Hansen,” she explained, “we know Jeffrey has the motor skills to color inside the lines. We simply cannot understand why he insists on coloring outside them.”

My poor mother. Little did that teacher know she was witnessing something prophetic.

Seventy years later, I am still coloring outside the lines. And I have no intention of stopping.

I respect legitimate authority. I respect thoughtful rules, ethical boundaries, and the responsibilities that come with professional licensure. But I have little patience for rules that become more important than the people they were designed to serve. And almost no patience for stupid rules.

During nearly ten years in the Department of Defense, I saw how quickly bureaucracy could get between a patient and the care they needed. If a patient I had treated wanted to return after

more than six months away, they had to use up a primary care appointment, get a referral to me by name, then wait in line for a new intake. It could take months to get them back into the same chair in my office. Some of those patients needed follow-up right away. So I put them on my schedule whenever I could. I got in trouble for it, and I kept doing it. For God's sake, a patient in crisis can get hurt or die while the paperwork makes its rounds.

The stakes were higher when a soldier faced court-martial over personal choices that, in my professional judgment, had no bearing on her conduct as a soldier. I believed the case was unjust. Leadership wanted me to stay out of it. I quietly volunteered to testify anyway. My testimony was taken, and she was exonerated. Any psychologist who knows something that could matter to the outcome owes it to the person facing judgment to speak up. I knew something that mattered, so I spoke up.

Those are only a few examples. Senior psychology leadership wanted me to color inside its lines. Had I done so when those lines conflicted with patient care and conscience, I would have forfeited my own integrity. Near the end of my Defense Department service, a provider accused me of governmental fraud; the allegations were cleared, and threats concerning my josaphen followed. My strong impression was that the provider's ideological disagreement with my public positions on gender-related care for children helped drive the attack. I cannot establish another person's private motive. What I can tell you is how it felt to have professional disagreement turned into allegations capable of damaging a career.

I need to say something about my colleagues at Madigan, and I want to say it carefully. I loved those people. I still do. Nearly without exception, I worked alongside extraordinary psychologists and mental health professionals; gifted clinicians with genuinely compassionate hearts for children and families. I admired their skills, their dedication, and their humanity. I am not taking any of that away from them.

Here is the painful part. As I recollect, when institutional authority needed to be confronted openly, I cannot remember a single colleague standing alongside me. Not one. I love them as people. I respect their skill and their heart for children. But I do not respect the lack of moral courage I witnessed when standing up carried a price. I say that with sadness, not pleasure.

I know the stakes. Careers, reputations, salaries, licenses, families: these are no small things. But moral courage means very little when there is nothing to lose. If we are only willing to defend our patients when leadership approves, what exactly are we defending?

How Institutions Teach Good People to Be Quiet

Most people do not wake up one morning and decide to abandon their integrity. They begin by protecting something entirely understandable: their livelihood, their license, their reputation,

their family, their place on the team. They fear getting in trouble. They fear being singled out. They fear that one complaint, one supervisor, or one accusation could unravel years of faithful work. I understand that fear. I felt it myself.

But fear is also how an institution can teach decent people to be silent. The lesson rarely arrives as an explicit order to betray a patient. It comes in smaller doses: Don't make waves. Follow the pathway. Don't put that in an email. Let leadership handle it. Think about your career. Before long, the line between prudence and surrender becomes harder to recognize. No one has to order every clinician to stop asking hard questions. The culture has already taught them what questions are costly.

That is how institutions become captured. A system that should serve patients begins serving its own reputation, rules, and preferred ideology. The people inside it learn to keep their heads down. In children's mental health, that kind of silence is dangerous. It can leave the most vulnerable people in the system without a defender.

And that is how children pay the price. A clinician avoids a difficult question. A frightened family is offered only the approved explanation. A teenager discovers that certain fears or uncertainties cannot safely be spoken aloud. The sandbox gets smaller. The child is the one boxed in. We do not need to be fearless. We need to know what we are obligated to do while we are afraid. What does this child need? What does the evidence show? What does professional conscience require? The cost of speaking up may be real. The cost of keeping quiet may land on a child.

Writing

I recently wrote an essay about moral injury, a wound that can occur when the very institutions, leaders, or moral principles we trusted betray us. My reflections began with the soldiers who served in Vietnam, many of whom returned carrying wounds far deeper than those inflicted on the battlefield. They had served their country, endured the horrors of war, and returned to a nation that too often failed to offer them the understanding, compassion, and embrace they desperately needed. But moral injury is not confined to the battlefield. It can also reach into hospitals, medical practices, and mental health institutions, where physicians, psychologists, nurses, and other professionals may find themselves pressured to compromise their ethical convictions by the very systems they entered to serve.

And what happens to us as medical and mental health professionals when the institutions that entrusted us with caring for children turn against us for exercising our professional judgment? When a psychologist is pressured to remain silent, a physician fears professional retaliation for raising legitimate concerns, or a clinician is forced to choose between institutional compliance

and professional conscience? There is a profound potential for moral injury in that conflict. We entered these professions to heal, to protect, and to serve. Yet the very institutions that entrusted us with those responsibilities may become the forces preventing us from fulfilling them. The resulting wound is not simply professional frustration or disagreement with leadership. It is the deeper anguish of being asked to betray the very principles that brought us into the healing professions in the first place.

But now consider the child. What happens when the very institutions entrusted with protecting children become sources of injury themselves? When a teenager enters treatment seeking understanding, safety, and guidance, only to encounter a predetermined script rather than a thoughtful, listening clinician? When parents seeking to protect their children find themselves marginalized or excluded from important conversations? We speak often of moral injury among soldiers and health care professionals, but what about the moral wounds children may carry when institutions lose sight of their fundamental responsibility to protect them?

And here is the terrible intersection: When institutions silence the conscience of the clinician, they may also silence the very person entrusted with protecting the child. The clinician suffers the betrayal of professional integrity. The child risks suffering the consequences of that betrayal. And the institution, rather than confronting its failures, may reward compliance and punish dissent.

That is how institutional dysfunction becomes something far more consequential than bureaucratic inconvenience. It becomes a matter of moral responsibility.

And it brings us back to the question Russell's email stirred in me: When the institution demands our silence, and the children entrusted to our care need our voices, where are we going to stand?

The threat is not simply that clinicians will suffer. It is that fearful clinicians may be taught to cooperate with harm—and children will have to live with the consequences.

When Speaking About Children Draws Fire

Years ago, before the current administration, I was invited to deliver a keynote at a conference on pornography's harms to children in Cottonwood, AZ, sponsored by Turning Point. I had treated young people whose pornography consumption had become compulsive and disruptive, and I had seen firsthand why the issue deserved serious clinical attention.

Before the conference, a writer who used the name Josephine interviewed me. I made one request: be fair. That did not seem unreasonable.

The resulting article, in my view, distorted what I had said. It criticized me for treating pornography addiction in adolescents because 'pornography addiction' is not listed as a stand-alone DSM-5 diagnosis. My response is simple: the DSM is a diagnostic manual, not a list of every problem worthy of clinical care. We treat many significant conditions and harmful patterns without pretending that every clinical concern needs its own DSM heading. Dismissing patients on that basis is not sound clinical reasoning (McAuliffe, 2024).

I also said that pornography consumption can be one of several influences contributing to some young people's confusion about sexuality and gender. That remains my clinical concern. I did not say it explains every adolescent's experience, and I refuse to be told that a therapist may not even explore the possibility. Pornography exposure, trauma, family dynamics, peer influences, online communities, and developmental questions are all legitimate subjects for careful assessment when relevant to the person seeking help. Therapy must be free to ask questions rather than arrive with answers already dictated.

The article generated such controversy that when I arrived to deliver my keynote presentation, sponsored by **Turning Point**, law enforcement officers were present for security and safety reasons. Imagine that. I was there as a clinical psychologist to speak about the harms of pornography to children and adolescents, a subject I believe deserves serious attention, thoughtful discussion, and professional scrutiny. Yet the controversy had escalated to the point that police protection was considered necessary.

Really? Have we reached a place where speaking publicly about protecting children requires law enforcement to ensure the speaker's safety? I wasn't there to threaten anyone, incite violence, or attack anyone's humanity. I was there to raise concerns about the psychological and developmental consequences of pornography exposure among young people. And somehow, that had become controversial enough to warrant a police presence.

How did we get here? How low have we sunk?

But perhaps the more troubling question is what this says to other clinicians who might otherwise have the courage to speak openly about controversial issues affecting children. What happens when physicians, psychologists, and other mental health professionals begin calculating the personal and professional costs of expressing their clinical judgments? When speaking out might mean public attacks, threats to one's license, or retaliation from the very institutions that employ them?

Intimidation does not have to silence everyone to be effective. It only has to convince enough good people that speaking up is no longer worth the risk. And that, my friends, is how fear takes hold, professional courage erodes, and silence becomes the safest choice.

When good people become afraid to speak, who is left to protect the children?

This is the tactic that troubles me: abandon the argument, mischaracterize the clinician, invoke the licensing board, and make an example of anyone who refuses to repeat the approved language. People may challenge my conclusions as vigorously as they like. They do not get to turn disagreement into proof of professional misconduct.

If you disagree with me, bring your data. Challenge my logic. Show me better evidence. I will listen. But do not threaten a psychologist's livelihood because he is willing to raise uncomfortable questions about children.

Why the Sandbox Matters

I've always loved the sandbox as a metaphor for psychological development. Watch a child build a small world out of sand. There are roads and mountains, castles and rivers. A structure collapses and is rebuilt. Alone, a child can rehearse mastery, frustration, imagination, and control. In the company of other children, something even more interesting happens: one child's road crosses another child's castle.

Now we have conflict. Whose shovel? Whose mountain? Who knocked down the wall? Welcome to human civilization.

When the sandbox is sufficiently safe, children have room to negotiate, disagree, repair, and try again. Adults sometimes need to intervene, of course. But adults do not strengthen children by forbidding every disagreement or preselecting every conclusion. Resilience grows when children can explore difficulty with protection, guidance, and the freedom to learn.

That applies to the therapy room as well. When an adolescent brings me confusion about identity, relationships, anxiety, trauma, or sexuality, my first obligation is not to provide an ideological script. It is to listen, assess carefully, ask thoughtful questions, and understand the particular child in front of me. Exploration should not have a predetermined destination

That is why ***Chiles v. Salazar*** matters so much. On March 31, 2026, the Supreme Court held that Colorado's restriction on certain therapeutic conversations discriminated on the basis of viewpoint and was subject to strict First Amendment scrutiny. The Court rejected the notion that labeling psychotherapy as "professional conduct" gives the government unrestricted authority to dictate what clinicians may say to their patients. This was a landmark victory for freedom of speech in the therapy room (*Chiles v. Salazar*, 2026).

I had the privilege of joining other distinguished physicians and mental health professionals, including several colleagues from the American College of Pediatricians (ACPeds), in preparing amicus briefs supporting First Amendment protections for therapeutic speech. We understood

precisely what was at stake: the freedom of clinicians to practice according to their professional judgment, to ask difficult questions, and to help patients explore deeply personal struggles without the government prescribing acceptable conclusions. Genuine psychotherapy cannot flourish when the clinician must constantly look over one shoulder to determine whether a therapeutic question might violate a politically prescribed boundary.

Chiles affirmed a constitutional principle worth defending: **the state does not own the words spoken in the therapy room.** Yet I fear that this victory will face renewed challenges through legislation, regulation, licensing boards, and institutional pressures. The political winds have shifted, and protections secured today may be contested tomorrow. That is precisely why professional courage, solidarity, and a willingness to stand together matter more than ever.

Where Are We Going to Stand?

So let us name the elephant in the room. The November 3 election shifted national political power toward Democrats and progressive policy priorities. These leaders were duly elected. They have the authority to propose their agendas, and those of us who disagree have every right, and every professional obligation, to scrutinize the consequences. Russell suspects that progressives will move to undo advances we value. So do I. I expect renewed battles over parental rights, adolescent gender-related care, professional licensing, conscience, and the right to explore unwanted feelings and conflicting identities in psychotherapy. (Associated Press, 2026).

The powers that be can write new laws and revise old regulations. New lines will be drawn. Some may get narrower and narrower, until people who once exercised independent clinical judgment are expected to ask permission to think. The question is not whether we know how to color inside those lines. The question is whether the lines are right.

Where are we going to stand? What are we made of?

And please, do not imagine this is only about our bruised professional pride. Think of the children. A child can experience profound betrayal when the very institution that promises care will not listen, will not question its assumptions, or will not allow the child to speak honestly. A teenager should not have to conform to an adult ideology, progressive, conservative, or any other, to receive attentive, competent care.

Compassion can become a cloak for power. An institution can say it is protecting children while making dissent impossible, elevating ideology above inquiry, and punishing clinicians who ask necessary questions. I have seen institutions protect themselves first. That is why I insist we examine what policies actually do, not merely the reassuring language used to sell them.

A child is not a political trophy. A teenager is not an instrument for winning a cultural argument. And the therapy room is not a place for adults to impose a prefabricated worldview, mine, yours, or the government's.

So where are we going to stand? When a colleague is accused for speaking candidly? When a licensing threat is waved like a club? When a parent's questions are dismissed? When a teenager needs a therapist who will listen rather than recite a script? Are we going to avert our eyes because taking a risk might put our own comfort in danger?

Or are we going to stand together—colleague beside colleague, clinician beside family—defending the freedom to ask, to examine, to disagree, and to care for each child as an individual?

Where are we going to stand? Think about that.

Two Are Better Than One

I keep thinking about the words of Ecclesiastes: "Two are better than one ... For if they fall, one will lift up his companion" (Ecclesiastes 4:9–10, NKJV).

That is not simply a lovely sentiment for a greeting card. It is a practical instruction for stormy weather.

When a colleague is targeted for legitimate professional speech, we can stand beside that colleague. When a law attempts to prescribe a therapist's viewpoint, we can challenge it through the courts, scholarship, and public advocacy. When a child needs more than a script, we can insist on individualized care. When one of us is exhausted, another can pick up the shovel.

Stormy skies are ahead. There will be institutional pressure, professional fear, and trash in the sandbox. I do not want us to discover, one by one, that silence was the easier choice until the day a child needed our voices and no one spoke.

There will be trash in the sandbox. There always has been. Our calling is not to pretend otherwise or to turn the sandbox into another battlefield of slogans. Our calling is to keep it safe enough for children to play, question, struggle, learn, and grow. And sometimes that means standing shoulder to shoulder with the adults who are trying to protect them.

Lean into the wind. Lean into the storm. Not as isolated heroes, and not with cruelty toward those who disagree, but shoulder to shoulder, with professional competence and moral courage. We are called to keep the sandbox safe for children, not make it convenient for the powerful.

Thank you, Russell. Thank you, good doctor, for speaking first, for encouraging your colleagues, and for reminding us that two are better than one. We do not know every turn the storm will take. We do know where we must stand: beside the children entrusted to our care—and beside one another.

And somewhere, I suspect, my kindergarten teacher is still shaking her head.

Jeffrey is coloring outside the lines again.

This time, I hope there are a few more of us holding the crayons. And I thank God for that!

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