**Exploring Moral Injury in Mental Healthcare Professionals: A Multimethod Approach**

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**Thesis Abstract**

Moral injury has been defined as the psychological distress as a result of witnessing or perpetrating acts which violate professionals' own values and beliefs. Psychiatric professionals are facing an increase in demand whilst facing increasing pressures on resources such as time and staffing. Psychiatric professionals have expressed several sources of moral injury including inadequate resources and understaffing. This thesis aimed to deepen the understanding of moral injury among psychiatric professionals. The systematic review used thematic synthesis to explore the lived experiences of moral injury among psychiatric professionals. The empirical project explored moral injury among mental health nurses who work in the National Health Service. The systematic review synthesised 23 studies with 1013 participants, one overarching theme emerged: *psychiatric professionals feeling powerless in a morally distressing system*. The empirical project findings suggested that the average Moral Injury Symptom Scale for Healthcare Professionals was 44.58 (SD=12.88), with PHQ-9 and support from colleagues being significant factors in the regression model. Overall, both the systematic review and empirical project highlighted several organisational and individual factors which contribute to the experiences of moral injury.

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**Table of Contents**

*List of tables* ..... *6*

*List of figures* ..... *6*

*Acknowledgements* ..... *7*

*Chapter 1: Introduction* ..... *8*

*Chapter Two: Systematic review* ..... *15*

Abstract ..... 16

Aims ..... 19

Methods ..... 19

Results ..... 31

Discussion ..... 39

Conclusion ..... 45

References ..... 47

*Chapter Three: Bridging chapter* ..... *54*

*Chapter Four: Empirical project* ..... *56*

Abstract ..... 57

Method ..... 60

Results ..... 64

Discussion ..... 69

Conclusion ..... 74

References ..... 76

*Chapter Five: Extended methodology for empirical project and extended results for systematic review* ..... *82*

Extended Methodology for Empirical project ..... 83

Additional Results for the systematic review ..... 86

*Chapter Six: Discussion and critical evaluation* ..... *90*

Summary of findings ..... 91

Combined discussion ..... 91

Strengths and limitations of the systematic review and empirical project ..... 93

Implications for theory ..... 94

Clinical implications ..... 96

Future research ..... 98

Overall conclusion ..... 99

*Thesis Portfolio References* ..... *100*

*Appendices* ..... *115*

**Appendix: A Author guidelines for Clinical psychology & psychotherapy** ..... **115**

**Appendix B: Quality appraisal ratings for the systematic review** ..... **122**

**Appendix *C:* Distribution of articles across themes** ..... **127**

**Appendix D: Author guidelines for Journal of Clinical psychology** ..... **129**

**Appendix E: G* Power calculations for Spearman Rho correlation, ANOVA for the Kruskall Wallis test, Mann Whitney U test and linear multiple regression** ..... **140**

**Appendix F: Non-normal distribution data** ..... **144**

**Appendix G: Participation Information Sheet** ..... **145**

**Appendix H: Debrief sheet** ..... **148**

**Appendix I: Ethical Approval** ..... **150**

**Appendix J: HRA decision tool confirmation** ..... **154**

**Appendix K: Moral Injury Symptom Scale -healthcare professionals version** ..... **155**

**Appendix L: Generalised Anxiety Disorder-7 (GAD-7)** ..... **157**

**Appendix M: Patient Health Questionnaire – Depression (PHQ-9)** ..... **158**

**Appendix N: Bespoke single item questions** ..... **159**

**Appendix O: Advertising poster** ..... **164**

**Appendix P: Process of code development and refinement for systematic review** ..... **165**

**Appendix Q: Verbatim extracts from studies with applied codes** ..... **179**

## List of tables

**Chapter two: Systematic review**

**Table 1.** Study Characteristics.....25
**Table 2:** Descriptive Statistics.....64

**Chapter four: Empirical project**

**Table 3:** Proportion of mental health nurses who experience functional impairment and the mean MISS-HP total score for that group.....66
**Table 4:** Spearman Rho correlations exploring variables association with MISS-HP scores..67
**Table 5:** Mann-Whitney U test exploring the difference in MISS-HP scores for religion, gender, completion of additional training and contract type.....68
**Table 6**: A multiple linear regression examining whether PHQ-9 total score, GAD-7 total score, feeling supported by colleagues, having adequate resources, feeling their power matches their level of responsibility and length of time qualified as MHN predict moral injury in MHNs.....69

## List of figures

**Chapter two: Systematic review**

**Figure 1.** PRISMA Flow Diagram.....22
**Figure 2:** Themes and subthemes which emerged from the thematic synthesis.....31

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# Chapter 1

Introduction

Word count: 2365

Healthcare professionals are under ever growing pressure; including increased workloads, staff shortages and inadequate time to complete tasks (Al Fayez et al., 2024; Bamforth et al., 2023; National Institute for Occupational Safety and Health, 2024). These pressures require professionals to work within limited resources, whilst balancing their own physical and mental health (Greenberg et al., 2020). Subsequently, a high workload has been reported to increase exhaustion and impact on both job satisfaction and quality of care (Marković et al., 2024).

Consequently, healthcare professionals are experiencing heightened stress which is having a significant impact on their wellbeing (Marković et al., 2024; Smith et al., 2022). This often results in professionals experiencing burnout. Burnout has been defined as mental and physical exhaustion which causes an individual to become cynical and/or emotionally distant, impacting on their sense of achievement at work (Maslach et al., 2001). Healthcare professionals who experience burnout are more likely to consider leaving their job and/or profession (National Academy of Medicine, 2019). Inadequate resources and understaffing, combined with high demands and limited control are suggested as key contributing factors to healthcare professionals leaving their roles due to burnout. In turn, this creates additional pressures on the healthcare systems (De Vries et al., 2023).

In comparison to other domains of work, the National Health Service (NHS) in the UK has a high level of stress-related sickness (Ravalier et al., 2020). The sickness rate across professionals in the NHS increased in 2025 to 5.7% from 5.3% in 2024, citing the most reported reason for sickness was anxiety, depression or other mental health conditions (NHS Digital, 2026). The annual State of Care report highlighted healthcare staff are feeling overworked and burnt out due to being short staffed, poor skill mix, lack of capacity and difficulties with retention (Care Quality Commission, 2025b). Additionally, the NHS staff survey highlighted 28.83% of NHS staff who completed the survey were thinking about leaving the organisation, and only 27.01% of staff felt they never have unrealistic time pressures (NHS England, 2024b).

The psychiatric workforce consists of multi-disciplinary professionals such as psychiatric nurses, psychiatrists, clinical psychologists, support workers, peer support workers and occupational therapists (Robiner, 2006). When considering the pressures on the psychiatric workforce specifically, the Care Quality Commission (2026) highlighted that the demand for mental health services has increased by 15% in 2024-2025, with a particular rise in urgent referrals to crisis teams. Additionally, a limited capacity in acute inpatient wards has required community teams to manage higher levels of risk. A report by Health Services Safety Investigations Body (2025) highlighted that several system constraints impacted on psychiatric professionals' ability to deliver satisfactory care within an acute inpatient setting. This included understaffing, recruitment difficulties, and lack of appropriate

therapeutic environment. Subsequently, research has suggested that psychiatric professionals are experiencing moral injury (Eder et al., 2025; Hadson et al., 2024; Tomura, 2023).

**Moral injury and Moral distress**

Moral injury (MI) was first understood in the context of military services, where the military population were deployed to highly threatening locations which required engaging in activities or decisions which violated their moral codes and/or personal values leading to high levels of post-traumatic stress disorder (PTSD), depression and interpersonal difficulties in military professionals (Williamson, Greenberg, et al., 2020; Williamson, Murphy, et al., 2020). More recently, MI has been explored in health care professionals (Koenig & Al Zaben, 2021; Richardson et al., 2020; Riedel et al., 2022). There is no standardised definition of MI, however MI has been understood as the prolonged psychological distress as a result of witnessing, perpetrating, or failing to prevent an event which violates a person's moral beliefs (Litz et al., 2009; VanderWeele et al., 2025). However, Drescher et al. (2011) defined MI as the confidence and expectations about others and one's own ability to behave in an ethical manner. In contrast, Shay (2014) defined MI as the betrayal of what is right in a high stakes situation by an authority figure. It should be noted that these definitions were developed in the context of a military population. Furthermore, research has suggested that exposure to Potentially Morally Injurious Events (PMIEs; an event which may include acts of a person's own or others' acts of omission, commission or betrayal) in a military population has been associated with an increased risk of psychological distress and as a result individuals are more likely to have poorer mental health (Held et al., 2017). It is important to clarify, that moral injury has several overlapping characteristics with PTSD this includes symptoms of re-experiencing, negative cognitions, changes in mood, avoidance and suicide risk (Jinkerson, 2016). However, it has been suggested that moral injury is distinguishable from PTSD (VanderWeele et al., 2025). The key difference in MI is the threat to moral beliefs which result in guilt, shame or betrayal, in contrast to PTSD where there is a perceived threat to life (Koenig & Al Zaben, 2021; VanderWeele et al., 2025).

When considering the healthcare professional population the term moral distress (MD) and MI has been used interchangeably (Wilson et al., 2024). However, MD has been defined as the acute psychological distress following an event which violates an individual's moral beliefs (Jameton, 1993). Whereas, it has been suggested that MI develops as a result of the accumulation and persistent experience of MD (VanderWeele et al., 2025). Nonetheless, due to the terms being used interchangeably in research literature, and there being no agreed standardised definition of MI, this thesis used the term moral injury to encompass both experiences of MI and MD. MI in this thesis will be defined and operationalised using the most commonly reported definition of MI by Litz et al.

(2009): the prolonged psychological distress as a result of witnessing, perpetrating, or failing to prevent an event which violates a person's moral beliefs.

**Socio-Cognitive theory of moral identity**

The socio-cognitive theory of moral identity suggested that there are several predisposing factors which lead to moral injury (Bonson et al., 2023). The theory highlighted that childhood experiences shape an individual's moral development (Bandura et al., 1991). A person's values and moral attributes are developed through observing their parents, kin, peers and other adults. Through these observations they are socialised to a variety of standards and behaviours which combined with their self-structure form their moral identity (Bandura et al., 1991; Kvitsiani et al., 2023). These beliefs about the world, self and others inform an individual's cognitive appraisal of PMIEs. Acts of transgressions which violate a person's moral beliefs results in the development of moral injury due to the inability to integrate the event into the beliefs held about the self, world and others (Litz et al., 2009). Additionally, the model suggests that different situational contexts may inhibit or increase moral behaviour, indicating even those with strong moral identity still may act against their moral values depending on the context (Aquino et al., 2009).

**Cognitive Behavioural Model of Moral Injury**

The cognitive behavioural model of MI by Rozek and Bryan (2021) understands MI as a mode which can be activated through PMIEs. Similarly to the socio-cognitive theory of moral identity, cognitive behavioural model suggests there are several factors which may predispose an individual to MI, including job (e.g., military or first responders), cognitive inflexibility and deficits in emotional regulation. In this model, PMIEs activate the acute moral injury mode which are suggested to disrupt the individual's moral beliefs and/or schemas developed throughout childhood and early adulthood. The MI mode comprises of three components: cognitive, behaviour and physical domains. A core component within the model is the cognitions associated with the MI event, where people may have thoughts such as 'I'm a monster or bad person'. These thoughts can trigger emotions such as guilt and shame and occasionally grief. This can result in an individual isolating themselves or increase avoidance. It is important to note that the MI mode is sensitive to reactivation after the first episode and is often worsened by common life stressors.

**Dynamic Model of Moral Injury**

The Dynamic Model of Moral Injury (DMMI) by (Kvitsiani et al., 2023) suggested a process by which MI develops. It suggested that the emotional reaction is determined by how the event is evaluated and justified in line with the individuals' moral values. An individual may experience a negative reaction if they deem that their own behaviour transgresses their moral beliefs resulting in a breakdown of their schemas of the world, self and others. This results in the experience of guilt,

shame and generally a negative self-perception. However, if the perceived transgression is related to other people's behaviours this leads to experiences of helplessness and a sense of injustice. The model suggested that these negative emotions are only reduced through the restructuring of schemas, creating adapted moral values.

**Moral Injury Formation Model**

The Moral Injury Formation Model (MIFM) proposed by Vaknin and Ne'eman-Haviv (2025) suggested that moral conflicts begin with a moral dilemma, where an individual is required to decide an action based on competing values. The model holds the assumption that an individual has prescriptive cognitions (should or ought thoughts about the world) using these cognitions to inform which value will lead to the moral ideal. This action is termed a 'moral experience' and a 'personal judgement'. The personal judgement is neither good nor bad; however, some moral ideals may be unattainable resulting in the individual choosing what is necessary rather than ideal. This may result in the individual experiencing guilt. There are three ways this can occur, first when a moral value is chosen over another. Second, when an internal conflict arises due to personal values not aligning with the societal values. Lastly, when external factors force a person to make a moral decision which conflicts with their values. Moral stress is the result of individuals who are forced to choose an action that does not align with their moral ideals, this can lead on to the individual experiencing feelings of moral failure. Following a situation where a person has acted in conflict with their values, MIFM suggested that individuals go through a reflective cognitive process where they re-evaluate their actions; this process was termed post hoc. The post hoc stage is comprised of two components: pathological, or the healthy and adaptive path. Within this stage cognitive flexibility is key, as individuals can effectively address the moral tension and adapt their values. Whereas cognitive rigidity results in continuous conflict with moral ideals and the individuals' values, consequently, these repeated conflicts can lead to MI. MIFM defined moral injury as the loss of moral direction resulting in the individual questioning what is right and wrong. This internal uncertainty may lead to moral frameworks being abandoned which can reduce distress. Thus, moral injury is the incompatibility between an individual's beliefs and their experiences leading to a loss of both personal and social moral frameworks.

**Moral injury in the context of healthcare**

Healthcare professionals are frequently exposed to daily ethical dilemmas in high pressured circumstances, which can result in the development of MI due to the healthcare professionals moral beliefs being violated (Williamson et al., 2023). PMIEs for healthcare professionals include: working beyond their clinical competence, feeling betrayed by senior management, the breakdown of managerial relationships, lack of resources, and understaffing which resulted in feeling unable to

provide satisfactory care (Rabin et al., 2023; Williamson et al., 2023). These experiences often result in healthcare professionals feeling shame and guilt. These feelings of guilt and shame in the context of MI have been associated with a negative sense of self (Jinkerson, 2016). It has been reported that MI in healthcare professionals can be triggered by a single or an accumulation of PMIEs (Reis & Lesandrini, 2025). Furthermore, MI in healthcare professionals has been strongly associated with mental health difficulties and burnout. It has also been suggested that individuals who have pre-existing mental health difficulties are predisposed to developing MI (Williamson et al., 2023).

In comparison to other healthcare professionals, psychiatric professionals are often exposed to similar ethical decision making relating to service user care, including implementing restrictive interventions which go against a service users wishes (Tomura, 2023). In addition, psychiatric professionals experience systemic pressures including inadequate resources, understaffing and inappropriate placement of service users. These pressures often resulted in psychiatric professionals experiencing MI and expressing feelings of powerlessness, blame and resentment (Thompson et al., 2024; Webb et al., 2024a). When considering mental health nurses, they reported experiencing guilt and shame when they have been unable to meet the professional code expectations (Thompson et al., 2024).

It is important to acknowledge that MI is an emerging construct within healthcare and research continues to expand the understanding of moral injury from a healthcare perspective (Čartolovni et al., 2021). Consequently, there is considerable overlap in the terms used such as MI, Moral distress and burnout used to describe the psychological and emotional impact of ethical dilemmas faced in healthcare. Furthermore, the sources and impact of moral injury across contexts and different healthcare professionals are not yet fully understood (Mewborn et al., 2023; Thibodeau et al., 2023; Wilson et al., 2024). This highlights the gaps in the current understanding of MI and the impact on healthcare professionals. Despite, the research of MI expanding to healthcare professionals there is limited awareness of this concept among healthcare professionals. British Medical Association (2021) highlighted that 48.40% of doctors had not heard of the term moral injury and after learning about MI, 78.40% felt it resonated with their experiences.

**Overview of the thesis portfolio**

This thesis portfolio aims to expand the research on moral injury in psychiatric professionals, considering the current pressures that psychiatric professionals are facing, the impact on their wellbeing and exposures to PMIEs. There is currently no overarching review of the lived experiences of MI among psychiatric professionals and therefore, Chapter two presents a thematic synthesis of the lived experiences of MI among psychiatric professionals. Chapter three bridges the key findings from the systematic review and how these findings informed the empirical project. Chapter four

presents the empirical project, which sought to further understand the factors associated with MI among mental health nurses working in the NHS. To the best of the authors' knowledge this is the first study to explore MI quantitatively among mental health nurses working in the NHS.

# Chapter Two: Systematic Review

## What are the Lived Experiences of Moral Injury in Psychiatric Professionals? A Thematic Synthesis

**Word count: 8883 (excluding abstract, tables and references)**

*Prepared for submission to clinical psychology & psychotherapy. This includes key practitioner messages and key words. (see Appendix A for author guidelines).*

**Abstract**

Moral injury (MI) is the psychological distress professionals experience after witnessing or perpetrating behaviours, which transgress their moral beliefs. Psychiatric professionals are often exposed to situations which require complex ethical decisions relating to service user care, leading to MI, which is exacerbated by factors, such as understaffing, yet no review has been conducted to explore lived experiences of moral injury in the psychiatric professionals. This systematic review aimed to develop a qualitative understanding of psychiatric professionals' lived experience of MI. APA PsycInfo, MEDLINE Ultimate, CINAHL Ultimate, and Academic Search Ultimate databases were searched, identifying 23 studies (N = 1013 psychiatric professionals). Results, analysed using thematic synthesis, revealed an overarching theme: *psychiatric professionals feeling powerless in a morally distressing system*. Four supporting themes emerged: (1) system and organisational constraints resulting in MI; (2) individual sources of MI; (3) consequences of MI; (4) helpful and unhelpful ways of dealing with MI. This suggested MI develops cumulatively from a system/organisational level to an individual level. Psychiatric professionals experienced both emotional and physical distress, including exhaustion, guilt, shame, and hopelessness, due to being unable to provide or witnessing inadequate care. Subsequently, they developed different ways of coping and reducing the distress.

**Key practitioner message:**

- Through a systematic review it highlighted that there appears to be a need for greater recognition for the systemic sources of moral injury among psychiatric professionals in order to reduce moral injury at an individual level.
- To support the reduction in MI among psychiatric professionals it may be beneficial to encourage avenues for peer support and the provision of reflective practice spaces.
- Clear consistent communication between organisations, senior professionals and the team, this may, in turn, reduce the sense of powerlessness experienced by psychiatric professionals and subsequently MI.

**Keywords**

Moral injury, psychiatric professionals, mental health services, organisational constraints and thematic synthesis

Moral injury (MI) relates to the psychological distress experienced by professionals when their moral beliefs are threatened. Research and recognition of MI have increased considerably across different populations including both military and non-military. However, the definition of MI has been widely debated. One of the most commonly cited definitions is Litz et al. (2009), who suggested that moral injury is the experience of psychological distress as a result of either perpetrating, witnessing or failing to prevent events which violate the individual's moral beliefs.

**Impact of Moral Injury**

Research has suggested that exposure to potentially morally injurious events (PMIEs) in a military population has been associated with an increased risk of psychological distress and, as a result, individuals are more likely to have poorer mental health (Held et al., 2017). MI has been linked to feelings of guilt, shame and the loss of spiritual and/or religious beliefs. Consequently, these feelings of guilt and shame can impact their sense of self, whereby individuals perceive themselves as bad and/or evil (Jinkerson, 2016). Additionally, the negative cognitions about themselves and/or others can lead to the development of mental health conditions such as depression and post-traumatic stress disorder (Greenberg et al., 2020). It is important to distinguish that when the individual feels responsible for the event that has resulted in MI, they are more likely to engage in self-punishment behaviours such as isolating themselves and substance misuse (Jinkerson, 2016). However, when responsibility is attributed to someone else, this can result in difficulties trusting and forgiving others which can manifest as feelings of anger (Barnes et al., 2019). Although MI has a significant impact on psychological wellbeing, Molendijk et al. (2022) suggested that MI was not deemed a mental health disorder; but rather a reasonable response to the feelings of guilt and shame as a result of violating ones moral beliefs. More recently, however, MI has been recognised within the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*,* termed as 'moral problem' (American Psychiatric Association, 2025).

**Moral Injury and Distress in the Context of Health Care**

The COVID-19 pandemic highlighted that healthcare professionals regularly faced ethical dilemmas, whereby the decisions they made may determine whether a person lives (Čartolovni et al., 2021; Koenig & Al Zaben, 2021). Complex circumstances with ethical dilemmas can result in the development of MI due to the healthcare professional's moral beliefs being violated (Williamson et al., 2023). Moreover, it has been noted that MI in healthcare professionals can be triggered by either an isolated event or an accumulation of PMIEs (Reis & Lesandrini, 2025). A study conducted by Hegarty et al. (2022) explored the experiences of MI in healthcare professionals during the COVID-19 pandemic; participants reported feeling betrayed by the government, feeling unable to fulfil their duties, as well as, experiencing a deterioration in their mental health. Furthermore, Williamson et al.

(2023) highlighted that both systemic and organisational factors contribute to the development of MI in healthcare professionals during the COVID-19 pandemic, such as inadequate staffing and a lack of funding. Additionally, healthcare professionals reported feeling unsupported and were required to work beyond their clinical competence (Hegarty et al., 2022). Furthermore, nurses who experience MI are more likely to have adverse health concerns, including sleep difficulties and mental health problems. It was suggested that the sleep difficulties were a consequence of working shifts which impacted on their circadian rhythm (Fard et al., 2020).

It is important to recognise that research exploring MI among healthcare professionals has largely focused on the impact of the COVID-19 pandemic, such as the increase of patients requiring care and witnessing unnecessary suffering (Čartolovni et al., 2021; Hegarty et al., 2022; Reis & Lesandrini, 2025; Williamson et al., 2023).

The psychiatric workforce consists of multi-disciplinary professionals such as psychiatric nurses, psychiatrists, clinical psychologists, support workers, peer support workers and occupational therapists (Robiner, 2006). Compared to other healthcare professionals, psychiatric and psychological professionals are often exposed to unique ethical decision-making relating to patient care in difficult circumstances which can result in MI. This includes working with individuals who may have reduced capacity on psychiatric inpatient wards, where psychiatric nurses may have to administer treatments which go against the individuals wishes (Tomura, 2023).

It has been suggested that system constraints prevented the psychiatric professionals from fulfilling their professional duties, and in turn, this impacted on their sense of power and control over the resources (Austin et al., 2003; Tomura, 2023). However, Eder et al. (2025) reported in comparison to psychiatric nurses and support workers, psychiatrists working on a child and adolescent inpatient ward had higher levels of moral distress. This difference was attributed to the increased responsibility and exposure to ethically challenging situations combined with limited coping mechanisms. There were several other factors which contributed to the moral distress on a child and adolescent inpatient ward, such as providing treatment which the professional believes will not be effective, having limited resources, and ethical dilemmas around coercive treatment.

Abo Shereda et al. (2025) highlighted that psychiatric nurses experience moderate levels of moral injury which was associated with high levels of compassion fatigue. It was noted that more senior psychiatric nurses with a master's degree often took on higher levels of responsibility and ethical decision making, increasing the degree of moral injury experienced. Conversely, it was highlighted that psychiatric nurses with more than 10 years' experience had lower moral distress. It was suggested that psychiatric nurses with more experience may have developed effective coping strategies supporting them to cope with complex ethical decisions. Furthermore, psychiatric

professionals exposure to PMIEs was associated with burnout and secondary trauma (Morris et al., 2022).

More recently, the COVID-19 pandemic is believed to impact MI in psychiatric professionals, with forced changes in the nature of contact with service users, changes to the place of work, and dilemmas around balancing the risk of illness to their families whilst wanting to provide a good service, impacting on the experiences and levels of MI (Wall et al., 2024).

There are several primary research studies which have explored MI qualitatively through interviews or surveys, which have increased since the COVID-19 pandemic. However, to date, there has been no overarching review of qualitative experiences and perceptions of MI in psychiatric professionals.

## Aims

A qualitative systematic review using a thematic synthesis (Thomas & Harden, 2008) aimed to develop a deeper understanding of psychiatric professionals' lived experiences of moral injury. By enhancing this understanding, this review provides contextual insights into the potential ethical dilemmas, consequences, and systemic factors experienced by psychiatric professionals in the context of moral injury.

## Research Question

What are the qualitative experiences of moral injury among psychiatric professionals working in psychiatric settings?

## Methods

A protocol was registered on Prospero on 22nd September 2025 (CRD420251141561). The systematic review was reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and Enhancing Transparency in Reporting the Synthesis of Qualitative Research (Tong et al., 2012).

### Study Design

#### *Search Strategy*

An electronic search was conducted on 25th October 2025 on EBSCO including the following databases: APA PsycInfo, MEDLINE Ultimate, CINAHL Ultimate, and Academic Search Ultimate. These databases were selected as they contain a wide source of relevant medical and social science research articles across different professional lenses, which reflects the multi-disciplinary aspect of the research question.

Search terms were categorised under psychiatric professionals, psychiatric services, moral injury and experiences. The search terms used are as follows (experiences or perceptions or attitudes or views or feelings) NOT (military or veterans or soldiers or armed forces) AND (mental

health profession* or mental health nurs* or mental health worker* or psychiatric nurs* or psychiatrist* or psychiatric support work* or Clinical Psychologist* or Psychological therapist*) AND (moral injury or moral distress or spiritual injury or ethical distress) AND (community mental health services or mental health care or psychiatric services).

***Exclusion and Inclusion Criteria***

Eligibility criteria was determined through using the Population, Exposure, Outcome (PEO) framework (Bettany-Saltikov & McSherry, 2024). There were no restrictions on the year or country of publication.

***Population***

**Inclusion Criteria**

- Mental health professional
- Mental health nurses
- Mental health support worker or peer support worker
- Psychiatrist
- Clinical Psychologist
- Psychological therapist
- Working in a psychiatric setting including community, inpatient or forensic.

**Exclusion Criteria**

- Working in a physical health setting
- Physical health professional
- Military, veterans, soldiers or armed forces

***Exposure***

**Inclusion Criteria**

- Studies exploring moral injury, moral distress or symptoms which align with the definition of moral injury or distress

**Exclusion Criteria**

- Studies which did not explore moral injury or distress or symptoms which align with the definition of moral injury or distress

***Outcome***

**Inclusion Criteria**

- Experiences of moral injury or moral distress

**Exclusion Criteria**

- Studies which did not explore experiences of moral injury or distress

***Other Inclusion and Exclusion Criteria Based on Study Design***

**Inclusion Criteria**

- Qualitative or mixed methods
- Questionnaires
- Surveys
- Interviews
- Focus groups
- Case Studies
- Observational studies

**Exclusion Criteria**

- Quantitative methods
- Systematic reviews
- Articles which are not classified as research

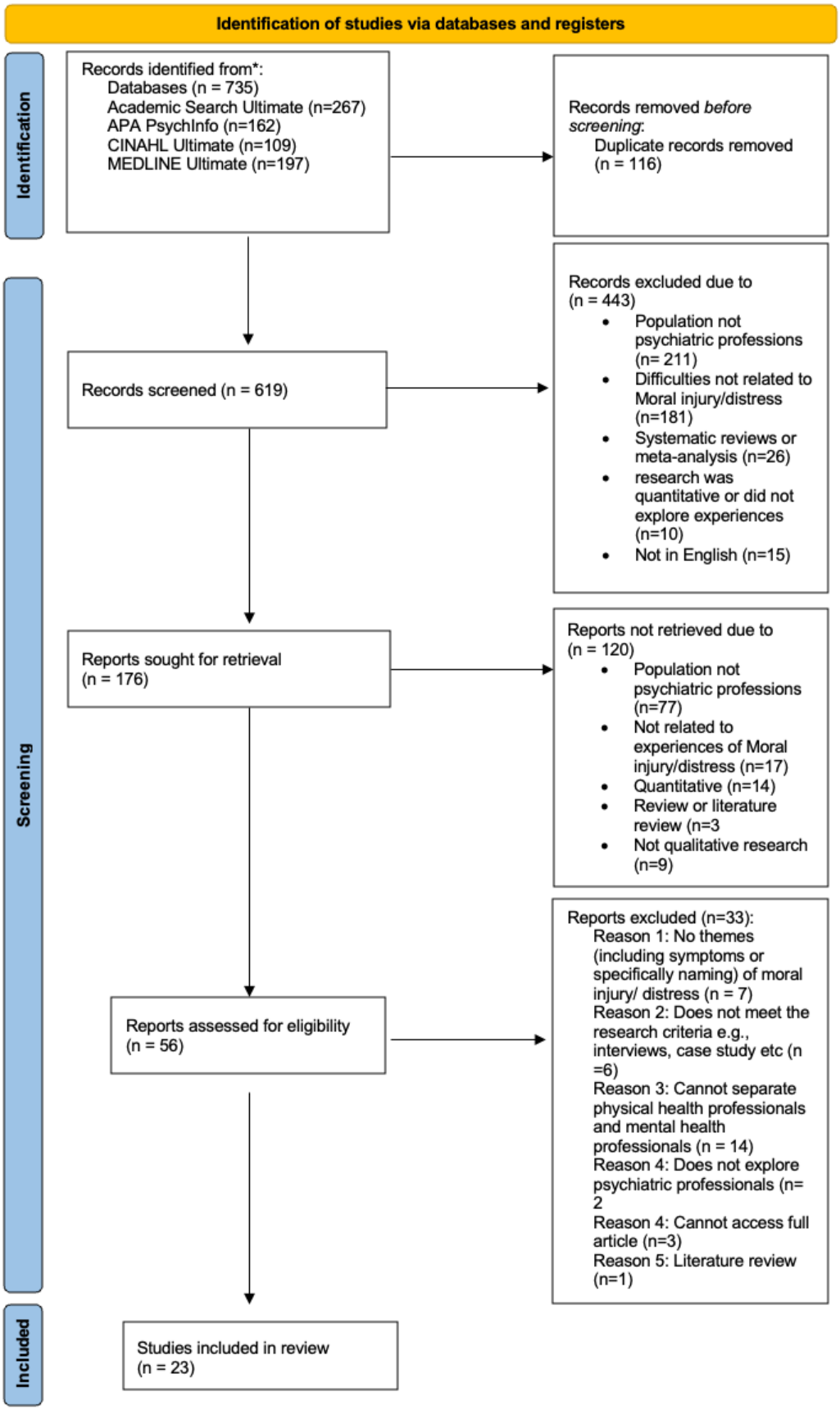
**Study Selection**

All search results were collated in the reference manager software Endnote, as well as on Excel, and any duplicates were removed. The primary author screened the titles and then abstracts for eligibility. A second rater reviewed 20% of the titles and then 20% of the abstracts to ensure they met inclusion criteria. When the primary author was unsure whether the article met criteria in abstract screening, the full-text article was reviewed by the primary author and the second rater until a consensus was reached. The inter-rater reliability was calculated based on the percentage of agreement between raters. The inter-rater reliability for titles was 91.13% and abstracts was 85.71%. Full-text of all articles that appeared eligible for inclusion were retrieved. The primary author assessed the full text of all the eligible articles against the inclusion criteria alongside using a quality assessment tool (The Critical Appraisal of Qualitative Studies, Centre of Evidence Based Medicine amended from Greenhalgh & Taylor, 1997). A second rater independently rated 20% of the full text articles and any disagreements were resolved by consensus. The inter-rater reliability for full text screening was 68.75%.

Any study excluded was documented and a reason recorded in the PRISMA (See Figure 1).

**Figure 1.**

*PRISMA Flow Diagram*



**Quality Appraisal**

The Critical Appraisal of Qualitative Studies amended from Greenhalgh and Taylor (1997) evaluates qualitative research based on eight categories: appropriate qualitative approach, appropriate sampling strategy, data collection methods, data analysis and quality control, researcher position, results, whether the conclusions are justifiable, and whether the results are transferable (see Appendix B). A second rater independently quality rated 20% of the studies included, the inter-rater reliability for quality rating was 91.13%.

***Appropriate Qualitative Approach***

All studies met the criterion as each sought to explore participants views, opinions or experiences.

***Appropriate Sampling Strategy***

Ten studies(Ando & Kawano, 2016; Austin et al., 2003; Austin et al., 2005; Hadson et al., 2024; Jansen & Hanssen, 2017; Lloyd et al., 2024; Musto & Schreiber, 2012; Oliveira et al., 2020; Tavakol et al., 2023; Wall et al., 2024) did not meet the criterion for an appropriate sampling strategy. This was due to the use of convenience sampling, a lack of information provided regarding the sampling method, or limited detail provided regarding attempts to diversify the sample. As highlighted by Etikan et al. (2016), convenience sampling can impact the researcher's ability to achieve a diverse sample.

***Data Collection***

Two studies (Austin et al., 2003; Austin et al., 2005) did not meet the criterion for data collection as there was insufficient information to support the replication of the data collection process.

***Data Analysis***

Three studies (Austin et al., 2005; Klingemann et al., 2025; Oliveira et al., 2020) did not meet the criterion for data analysis, due to lack of information regarding the analytical process and/or a lack of reported steps taken to ensure quality control such as team discussions.

***Researcher's Position***

Eleven studies (Hadson et al., 2024; Matthews & Williamson, 2016; Musto & Schreiber, 2012; Upasen & Saengpanya, 2021; Ando & Kawano, 2016; Austin et al., 2003; Austin et al., 2005; Klingemann et al., 2025; Lloyd et al., 2024; Oliveira et al., 2020; Pérez-Toribio et al., 2022) did not report their research positionality or reflexivity.

***Results***

Five studies (Ando & Kawano, 2016; Hadson et al., 2024; Jansen, Hem, et al., 2022; Jansen & Hanssen, 2017; Thompson et al., 2024) did not meet the criterion for the results section. This was

due to participants quotes not being indexed, insufficient contextual information for participants, and limited or absent reporting of outliers.

***Conclusions***

All studies met the criterion for their conclusions being justified, and all provided recommendations and/or clinical implication.

***Transferable Findings***

Fourteen studies (Ando & Kawano, 2016; Austin et al., 2003; Austin et al., 2005; Hadson et al., 2024; Jansen & Hanssen, 2017; Lloyd et al., 2024; Matthews & Williamson, 2016; O'Donnell et al., 2023; Oliveira et al., 2020; Pérez-Toribio et al., 2022; Tavakol et al., 2023; Thompson et al., 2024; Upasen & Saengpanya, 2021; Wall et al., 2024) did not meet the criterion for transferability due to small samples size, and limited sample diversity including the context and/or participants.

**Data Extraction and Synthesis**

The primary author extracted and managed the data for each of the included studies using a structured data recording form on Excel. This included any relevant information about the study characteristics (e.g., sample size, population, research design). All participant and author interpretations were then transferred into the NVivo 14 software (Lumivero, 2023) to support data analysis.

The data from the studies were analysed using thematic synthesis methodology (Thomas & Harden, 2008) to explore the experiences of moral injury among psychiatric professionals. This methodology has also been referenced in the Enhancing Transparency in Reporting the Synthesis of Qualitative Research, whereby reporting standards have been collated to support transparency in the synthesis of qualitative research (Tong et al., 2012). According to this procedure, all text labelled as findings or results in the articles related to moral injury and/or moral distress were included in the analysis. Thematic synthesis was broken down into three stages: Stage one is defined as inductive line by line coding and stage two is developing descriptive themes through finding similarities and differences. The last stage is generating analytical themes which go beyond the primary findings (Thomas & Harden, 2008). Additionally, Tong et al. (2012) highlighted that to ensure transparency in qualitative synthesis, a systematic review may include direct quotations to support the themes developed. This review adopted a critical realist stance, recognising psychiatric professionals' lived experiences, feelings and views as real whilst understanding them as shaped by the wider social and political context such as the healthcare system in which they occur (Busch, 2026; Thomas & Harden, 2008; Tong et al., 2012).

**Table 1.**

*Study characteristics*

| Study ID (Author, Year) | Location and area of work | Study Aim | Sample size | Methodology / Design (e.g., Phenomenology, Grounded Theory) | Findings |
|---|---|---|---|---|---|
| Ando and Kawano (2016) | Japan, Acute mental health wards | Exploring psychiatric nurses responses to ethical challenges and how the outcome of those issues. | N= 130 | Survey Qualitative analysis by Funashima (2001) | Psychiatric nurses were exposed to ethical problems. Moral distress impacts on psychiatric nurses' health and resulting in low quality of care.<br>Themes include:<br>Lack of action and no change<br>Experiencing problems and feeling gloomy<br>Pointing out misconduct<br>consulting among staff and resolution or lack of resolution<br>Consulting with physician and getting positive or negative responses<br>Searching for and providing evidence-based care<br>Thinking for themselves |
| Austin et al. (2005) | Canada, Setting unknown | Exploring psychologists' experiences of moral distress | n= unknown | Interviews interpretive inquiry method of hermeneutic phenomenology. | Through acknowledging moral distress, it can support a shift in the way moral choices are perceived in the context of practice.<br>Themes include:<br>Moral distress<br>Code of ethics<br>Cut adrift<br>Acting in secret<br>To speak or stay silent<br>To stay or go<br>Being able to look in the mirror |
| Austin et al. (2003) | Canada, setting unknown | Exploring what situation mental health nurses find morally distressing, the experience of raising ethical concerns and what supports or impairs ethical practice | n=unknown | Interviews, hermeneutic phenomenological approach | Moral distress for mental health nurses was linked with the expectations and responsibilities imposed by society without the necessary power or control<br>Themes include:<br>Lack of resources (time and staff)<br>Lack of respect<br>Absence of recognition |

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| Eder et al. (2025) | Sweden, Acute adolescent inpatient mental health wards | Exploring experiences of moral distress in child and adolescent mental health ward. | Qualitative total n=54 | Mixed methods, using and online survey qualitative data was analysed using thematic analysis | Moral distress is present amongst psychiatric professionals on adolescent inpatient mental health.<br>Themes include:<br>Providing care one does not believe in<br>Ethical dilemmas about coercive measures |
| Gabrielsson et al. (2016) | Sweden, Acute psychiatric ward | Exploring nurses and assistant nurses' experiences of good nursing practice. | N = 12 | Interviews using an interview guide, Content analysis | Good nursing practice relies on moral direction, defending humanistic values, and taking personal responsibility. Lower care standards may be the result of prioritising practical tasks instead of being with patients.<br>Themes include<br>Taking personal responsibility |
| Hadson et al. (2024) | United Kingdom, Acute psychiatric ward | A mixed methods exploration of work environmental factors which contribute to moral distress and/or moral injury in psychiatric health care assistants to develop recommendations for intervention and practice policies. | Psychiatric health care assistants n= 7 | Mixed methods using a survey and interviews | Moral distress in psychiatric health care assistants as a result of threats of violence, structural racisms, and limited communication.<br>Three themes emerged:<br>Inhibitive hierarchies prevent contributions to care<br>Trust as a factor in de-escalating patient violence<br>Navigating psychosocial challenges |
| Jansen et al. (2020) | Norway , Acute psychiatric hospital | What are the sources and features of moral distress experiences by psychiatric nurses in acute mental health wards. | n= 16 | Interviews and Thematic analysis | Moral distress is present in acute mental health settings.<br>Themes include:<br>Experienced dilemmas between nurses' perceptions of capacity and patients' needs, risk of violence<br>dilemmas concerning coercion,<br>experienced physical and mental reactions to moral distress. |
| Jansen, Danbolt, et al. (2022) | Norway, Acute psychiatric ward | Exploration of political, therapeutic ideas and new legislations impact nurses within acute psychiatric care that may cause moral distress due to challenges and conflicting interests. | Total psychiatric nurses n = 30 | Interviews across time points 2017 and 2018 then a focus group Thematic analysis | Political and therapeutic ideal of reducing coercive treatments may reduce moral distress in those who perceive coercive measures as ethically challenging. Whilst the idealistic care is hard to meet and may increase moral distress.<br>Themes include:<br>1) Challenging behaviour and risk of violence<br>2) Minimising the use of restraints and coercion created uncertainty<br>3) Legal changes may frustrate treatment<br>4) Consequences for the nursing staff. |

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|---|---|---|---|---|---|
| Jansen and Hanssen (2017) | Norway, setting unknown | Psychiatric nurses' experiences and perspectives of patient participation. | Total psychiatric nurses n = 9 | Semi structured discussions – three focus groups hermeneutic analytic approach | There are several factors which result on moral distress such as conflict between treatment philosophies and nurses being both physically and emotionally close to patients leaving them feeling morally conflicted.<br>Themes include :<br>Ambiguity and different perceptions<br>Patient support<br>Diffuse concept and conflicting values<br>Being mediators and patients spokespersons<br>Individuation<br>moral burden |
| Jansen, Hem, et al. (2022) | Norway, Acute psychiatric ward | How do psychiatric nurses cope with moral distress working on an acute psychiatric ward? | Total interviews n= 16<br>Total focus group n= 14 | In depth interviews and focus groups Thematic analysis | Coping with moral distress led to the development of moral resilience for some psychiatric nurses, whereas psychiatric nurses struggled to leave their work at work and feeling loyalty towards the system was a source of moral distress.<br>Themes include:<br>Sorting thoughts and feelings<br>Not taking their work home with them<br>Loyalty versus speaking up |
| Klingemann et al. (2025) | Poland, Outpatient Clinics, Day ward, Community Treatment Team, Inpatient ward | Peer support workers experience of emotional burden in mental health care in Poland. | Total peer support workers n = 14 | Interviews using interview guidelines computer-assisted qualitative data analysis (CAQDAS) was chosen. | Individual values and barriers the peer support workers face when taking what they perceived to be the correct action<br>Themes included:<br>Emotional burden and resilience<br>Moral distress<br>Organisation strategies to reduce the risk of mental health crises |
| Liberati et al. (2021) | England, including secondary mental health services (inpatient and community) | Exploring the challenges in the NHS mental health settings for psychiatric staff during the first wave of the Covid-19 pandemic in 2020. | N =35 | Interviews using a topic guide and a Constant comparative method | Participants dealt with a range of moral dilemmas which challenged their wellbeing and ability to provide adequate mental health care.<br>Main themes include:<br>Changes in the services and nature of the work<br>Impacts of Covid-19-related service changes on staff<br>Dilemmas and challenges<br>Wellbeing and the use of support |

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| Lloyd et al. (2024) | West Midlands, England, Acute psychiatric ward | Exploring ethical challenges of managing weight in psychiatric acute ward and whether this leads to moral distress. | Total n = 6 | Interviews interpretative phenomenological analysis (IPA) | Least restrictive procedures for managing obesity has potential to cause moral distress leading to feelings of frustration, powerlessness and anxiety, in particular in relation to environmental constraints.<br>Themes include:<br>The uphill battle of health promotion<br>Practicing in the least restrictive way: a juggling act on a tightrope |
| Matthews and Williamson (2016) | United Kingdom, Acute adolescent inpatient mental health wards | Exploring the impact demanding situations in secure mental health settings have on health care assistants' health and wellbeing with the aim to provide recommendations for enhanced support. | N=10 | diaries and follow-up semi-structured interviews and the study used the principles and processes of Interpretive Phenomenological Analysis | Psychiatric health care assistants feel tensions between personal moral codes driving compassionate support and organisational expectations of being detached and controlled.<br>Themes include<br>'normalizing an abnormal environment';<br>'Between compassion and control'<br>'Imbalance of occupational demands and support'. |
| Musto and Schreiber (2012) | Canada, Acute adolescent inpatient mental health wards | Develop an understanding of mental health nurses' experiences of moral distress and how the processes they use to cope with it | n=12 | Semi-structured interviews using Grounded Theory approach to analyses | Participants expressed questioning whether the care they provide was the best they could do. Engaging in several processes to reach a conclusion around this question which links with the below themes:<br>Experiencing moral distress<br>Engaging in dialog<br>Experiencing the dialog<br>Shifting the perspective |
| Navarro et al. (2021) | Madrid, Spain. Working in public hospitals | Exploring Psychiatric professionals' experiences of mechanical restraints and what influences decision to implement mechanical restraint. | N=19 | Grounded theory approach using focus groups | Psychiatric professionals experience mechanical restraints as an ethical dilemma which conflicts with how they view their professional role.<br>Three themes emerged<br>Experiences preceding mechanical restraint<br>Experiences during the indication of mechanical restraint<br>Experiences after the use of mechanical restraint. |
| O'Donnell et al. (2023) | Republic of Ireland, urban and rural localities,<br>Work setting unknown | Exploring the work-related experiences of consultant psychiatrists in the Republic of Ireland during the COVID-19 pandemic. | n = 18 | Interviews based on a topic guide<br>Inductive thematic analysis | Several challenges arose which increased complexity in providing care to vulnerable patients during the pandemic which led consultant psychiatrist to feel uncertain loss of control and moral distress.<br>Themes include:<br>Uncertainty |

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| | | | | | System broken from the top down<br>Cultural expectation to eschew personal needs |
| Oliverira (2020) | Brazil<br>Psychosocial Care Centre | Experiences of moral distress in psychiatric nursing professionals | n= 7 | Semi-structured interviews<br>Bardins thematic Content analysis | Moral distress was the result of insufficient structure and funds which resulted in nurses feeling demotivated. Speaking and bonding with colleagues was seen to be essential to cope.<br>Themes were as follows:<br>Environment as a source of moral distress;<br>Lack of funding and improvisation<br>Feelings that emerged from the experiences of Moral Distress<br>Coping Mechanisms of professionals |
| Perez-Toribio et al. (2022) | Spain,<br>Acute mental health ward | Exploring Spanish mental health nurses' experiences of mechanical restraint | N=10 | Semi-structured interviews<br>Thematic analysis | Mental health nurses experience moral injury as a result of restrictive practices, leading them to reduce empathy towards service users to be able to implement restraints.<br>Themes include:<br>symmetrical trauma<br>moral injury and<br>broken trust. |
| Tavakol et al. (2023) | Iran,<br>Master Centre for Psychiatry in Southern Iran in Shiraz | How do psychiatric nurses cope with moral distress | n= 12 | Semi-structured interviews<br>data analysis process agreeing to Granheim and Landman's method, | Psychiatric nurses suffer from moral distress and use personal and unique strategies to help them cope.<br>Themes include<br>"Coping strategies,"<br>"Establish therapeutic and professional communication,"<br>"Managerial support for nurses,"<br>"Commitment to religious beliefs." |
| Thompson, et al. (2024) | United Kingdom,<br>Acute psychiatric ward | Exploring the reasons for compromised care and the impact of this on mental health nurses. | N=530 | Mixed methods using an online survey with open ended questions. The qualitative part used - Thematic analysis in a deductive approach moving towards an inductive approach in second stage<br>Constructivist-interpretive approach | The impact of understaffing, not meeting professionals standards resulting in a loss of pride and feelings of pressure, shame and fear.<br>Three main themes;<br>'Understaffing',<br>'Professional code expectations<br>'Moral Distress'<br>'Management' |

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|---|---|---|---|---|---|
| Upasen and Saengpanya (2021) | Thailand, Acute psychiatric ward | Understanding the moral distress experienced by mental health nurses in acute mental health hospitals | N=41 | Interviews and a narrative approach | Mental health nurses face emotional distress and physical difficulties due to difficulties managing moral dilemmas. Themes include the following:<br>The frustration in doing the best,<br>Concerning the patient safe,<br>Being stressed at work,<br>Experiencing self-condemnation,<br>Difficulty sleeping while giving care for patients. |
| Wall et al. (2024) | United kingdom, Community mental health teams (CMHT) | Exploring the impact of Covid-19 in CMHT's in northwest of England highlighting moral distress, powerlessness and helplessness. | Total n = 21 | Semi-structured interviews using a topic guide<br>Constant comparison thematic approach | The changes in service provision creates hidden challenges and costs such as moral distress, powerlessness and helplessness. Themes include<br>Changes in the nature of contact with service users<br>changes to the place of work<br>difficulties of balancing risks to the families of CMHT staff and service users |

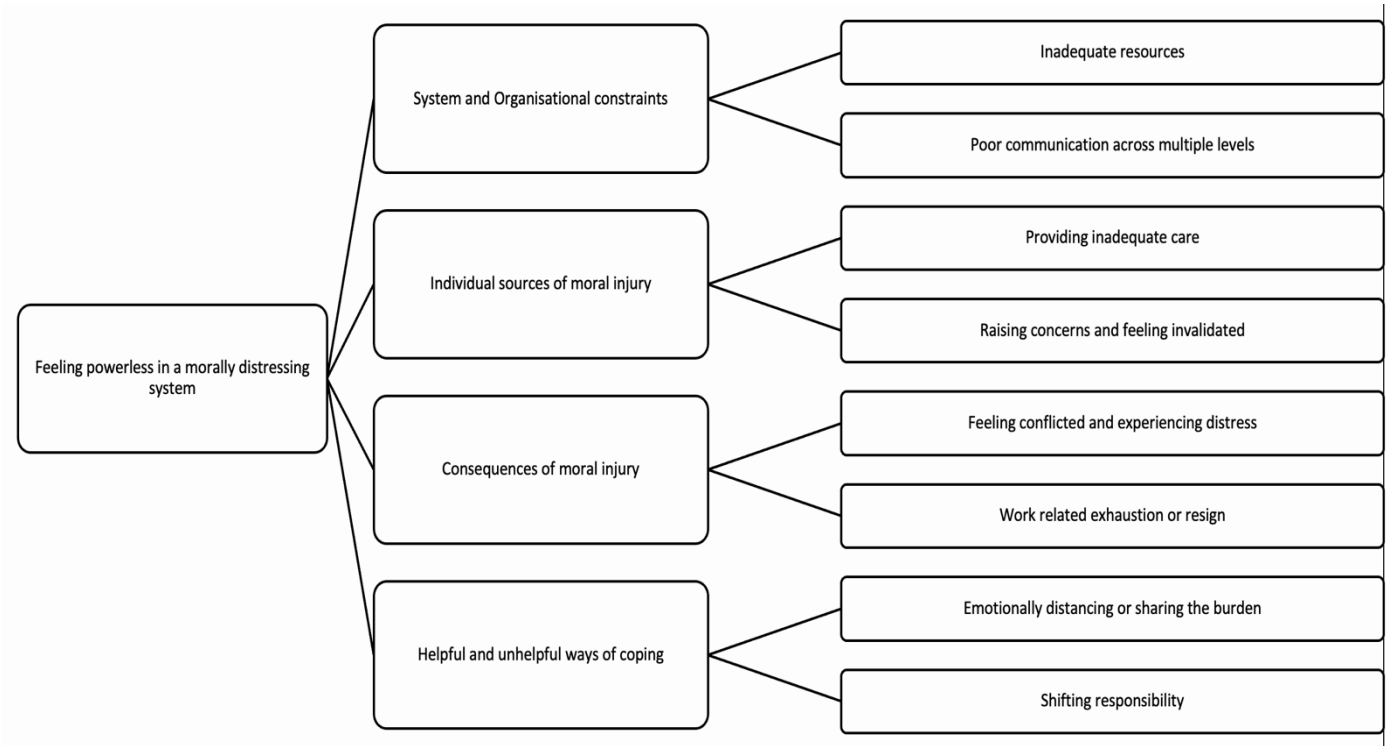
## Results

The final sample consisted of 23 studies, with a total of 1013 psychiatric professionals: psychiatric nurses (n=849), psychiatrists (n=43), clinical psychologists (n=9), psychiatric health care assistants (n=18), psychotherapists (Cognitive Behavioural Therapy therapists, family therapists; n=5), peer support workers (n=14), a associate specialist (n=1), a nursing associate (n=1), a occupational therapy instructor (n=1) and other (n=8). Eight studies did not break down their sample into different professionals and/or report the sample size. The sample consisted of males (n= 103), females (n=277) and prefer not to say (n=5), however six studies did not report gender data. The age ranged from 20-71 years old; it is important to note that only six studies reported age. The psychiatric professionals' length of experience ranged from six months to 46 years, this was reported in six studies.

Through a thematic synthesis (Thomas & Harden, 2008), psychiatric professionals experiences of moral injury were explored and one overarching theme emerged, *psychiatric professionals feeling powerless in a morally distressing system*, from which 4 themes and 11 subthemes were generated (Figure 2). The themes highlight a cumulative process of which moral injury develops starting at a system and organisational level progressing onto the individual impact.

**Figure 2.**

*Themes and subthemes which emerged from the thematic synthesis*



## Psychiatric Professionals Feeling Powerless in a Morally Distressing System

### *System and Organisational Constraints Resulting in Moral Injury*

There were several systemic and organisational constraints which appeared to result in psychiatric professionals experiencing moral injury. These include two sub-themes inadequate resources and poor communication across multiple levels.

#### Poor Communication Across Multiple Levels

Poor communication was identified as a key contributing factor for moral injury across five studies (Eder et al., 2025; Musto & Schreiber, 2012; O'Donnell et al., 2023; Oliveira et al., 2020; Tavakol et al., 2023). Poor communication was described as inconsistent, conflicting and incongruent, or absent, often resulting in confusion at both individual and team levels.

Collectively, moral injury was most attributed to poor communication from senior management and colleagues around decision making regarding patient care. Participants reported that this was a source of moral injury, a participant described feeling “set up” by their team members when key information was not communicated consistently to service users as a team, suggesting a breakdown in trust (Musto & Schreiber, 2012). However, the impact of poor communication was not isolated to internal systems (managers, teams and colleagues). External systems such as “Health Service Executive and World Health Organisation” were perceived as untrustworthy due to providing conflicting or changing information, which in turn further undermined communication at management and team levels (O'Donnell et al., 2023). The difficulties in communication have resulted in moral conflict and leaving participants with a reduced sense of confidence in what is ‘right’. When information was not passed down in a timely or transparent manner, there appeared to be a sense of individual powerlessness. A psychiatric nurse expressed, "A manager has to share a few things, especially when it will directly interfere with teamwork. [...]we come to know some things too late, and there’s nothing we can do about them” (Oliveira et al., 2020, p. 193). Communication from senior management around allocation of resources was a source of moral injury for consultant psychiatrists, placing strain on the professional relationships (O'Donnell et al., 2023). This appeared to be a common thread through these studies whereby the impact of poor communication results in additional pressures and/or breakdown of trust with those who are in leadership positions, subsequently leading to the individual experiencing moral injury.

#### Inadequate Resources

Across six studies, inadequate resources emerged as a source of moral injury for psychiatric professionals (Eder et al., 2025; Gabrielsson et al., 2016; Jansen et al., 2020; Oliveira et al., 2020; Thompson et al., 2024; Wall et al., 2024). Inadequate resources were commonly described as a lack of staff, untrained staff, insufficient time, and inadequate facilities. Collectively, these constraints

were associated with compromised quality of care and safety, leaving participants unable to fulfil their role contributing to experiences of moral injury. One study further highlighted that lack of resources, particularly staff shortages, resulted in the legal entitlement of Section 17 leave not being fulfilled (Thompson et al., 2024). Additionally, working in facilities that were unable to meet the needs of the population, alongside overcrowding and high service user turnover due to early discharges, were identified as sources of moral injury (Oliveira et al., 2020).

Compromised care was reported affecting staff safety as well as service user safety. Participants working in acute ward settings described how limited time for one-to-one interactions with service users increased the risk of violence and aggression.

One participant expressed:

> Staff and patients have been injured on my ward, due to inappropriate staffing levels. Staff are unable to do personal care and spend the 1:1 time needed to support and de-escalate patients. As a result, agitated patients escalate, and can have aggressive outbursts.
>
> (Thompson et al., 2024, p. 55)

This highlighted that the decisions around staffing levels resulted in inadequate resources leading to a sense of poor personal safety and increased risk. Furthermore, the impact of inadequate resources appeared to place participants in a moral dilemma where they had to choose between whether to prioritise being present with service users or complete the other administrative demands of the role.

One participant described this tension:

> It was a Sunday evening at five minutes to eight….I was thinking that I should write something, but then I saw through the window a girl just getting back from leave. Well, now I have a choice. I either make three notes for tomorrow's rounds or I go and talk to her. I chose her, and then I complimented myself for choosing her over the computer. You have those choices all the time that you have to make.
>
> (Gabrielsson et al., 2016, p. 438)

Overall, these resource constraints had a secondary impact on the psychiatric professionals' ability to take their annual leave and/or lunch breaks, which often resulted in extended working hours and contributed to burnout and exhaustion. In turn, contributing to psychiatric professionals' experiences of moral injury.

### *Individual Sources of Moral Injury*

#### Providing Inadequate Care

When considering individual sources of moral injury, providing inadequate care was a common theme across 14 studies, (Ando & Kawano, 2016; Austin et al., 2003; Eder et al., 2025;

Gabrielsson et al., 2016; Jansen, Danbolt, et al., 2022; Jansen, Hem, et al., 2022; Klingemann et al., 2025; Liberati et al., 2021; Lloyd et al., 2024; Musto & Schreiber, 2012; O'Donnell et al., 2023; Tavakol et al., 2023; Upasen & Saengpanya, 2021; Wall et al., 2024). The delivery of substandard care was viewed to be the consequence of systemic and organisational constraints. Providing inadequate care often resulted in participants feeling that they were letting service users down. This was particularly evident in studies exploring the impact of COVID-19 restrictions. These restrictions meant that the service was offering a reduced provision, and psychiatric professionals expressed being unable to notice the early warning signs of deterioration in service users due to isolation practices. One participant described this tension:

> Another personal pressure is I'm in this job because I want to help people and I've felt really like held back from that… the message at the beginning was don't see clients, and I, kind of, really understood that. I've been taking the Covid really seriously in terms of like not going to supermarkets… but I felt really conflicted that we were leaving some very, very vulnerable clients without care.
>
> (CBT therapist, Early Intervention Service; Liberati et al., 2021)

However, the feeling of providing inadequate care was not unique to the COVID-19 pandemic, other participants expressed not being able to deliver care to the standard required by their registration or witnessing colleagues engaging in behaviour they viewed as unjustifiable. This was highlighted by an author: "one of the nurses had furthermore witnessed 'unjustifiable' conduct that could escalate into dangerous situations both from unskilled extras and professional staff" (Jansen, Hem, et al., 2022, p. 29). However, there were no explicit examples given about what 'unjustifiable' behaviour represents. Additionally, some participants highlighted feeling constrained by the medical model and/or witnessing medication being withheld in ways that resulted in service users becoming increasingly unwell. Sub-optimal care also was reported because participants felt unable to implement restrictions such as, restricting unhealthy foods, or social media usage to prevent service users from 'socially disgracing themselves' (Jansen, Danbolt, et al., 2022; Lloyd et al., 2024). This was not consistent across the studies as some participants found that restrictive practices such as restraints, were impacting on their ability to provide adequate care leaving them feeling morally conflicted and "unhappy with the work" (Upasen & Saengpanya, 2021). It is evident that complex ethical decisions around service user care such as implementing restrictions, often led to beliefs that psychiatric professionals were providing inadequate care which left participants feeling they were unable to fulfil their caring duties and ultimately experiencing moral injury.

**Raising Concerns and Feeling Invalidated**

When considering individual sources of moral injury, raising concerns and feeling invalidated was a common theme across seven studies (Ando & Kawano, 2016; Austin et al., 2003; Austin et al., 2005; Hadson et al., 2024; Musto & Schreiber, 2012; Thompson et al., 2024). There were several factors which impaired psychiatric professionals want and/or ability to raise concerns. Across the studies the types of concerns included: structural racism, safety concerns, and misconduct. One participant demonstrated moral conflict of witnessing racism and feeling unsure how to communicate this concern: "How do you say this person is purposefully treating this patient worse or more aggressively because of their race, but they're not racist? They don't mean to be doing it. They don't realize"(Hadson et al., 2024). A consistent factor was participants feeling invalidated and unheard when raising concerns; this appeared to be the result of perceived inaction or dismissal leaving participants feeling hopeless. An author illustrated this: "Several interviewees were seriously contemplating changing jobs. They had tried to speak up about problems like understaffing that could lead to inadequate patient care, but their complaints had neither been validated nor led to any change" (Jansen, Hem, et al., 2022, p. 176). This may link in with the other experiences where participants have felt unable to raise concerns due to hierarchical and power dynamics. As suggested, there appears to be a cultural element where raising concerns may result in difficult relationships with senior management, this resulted in participants experiencing moral injury from witnessing malpractice and not feeling able to report it. This ethical conflict was demonstrated by a participant: "If I see something wrong with like care from like a nurse am I going to report that if I have to like work with the person the next 10 days, and there's a power dynamic on top of it?"(Hadson et al., 2024). Other participants expressed that there was no space to talk about their moral injury. A participant described this experience:

> She doesn't really allow for moral distress. . . I mean, there just isn't the place or a time for her to allow that. . . it's like suck it up and move on. . .so what do you do? You just don't talk to her then.
>
> (Musto & Schreiber, 2012, p. 142)

The inaction followed by raising concerns appeared to leave psychiatric professionals feeling dismissed, resulting in a sense of hopelessness and powerlessness to change the source of moral injury. Consequently, this became a source of moral injury.

***Consequences of Moral Injury***

When considering the impact of moral injury there were several consequences for the psychiatric professionals. This resulted in them feeling morally conflicted and experiencing emotional distress such as, guilt, shame, frustration and feeling powerless. Overall, participants expressed symptoms in line with work related exhaustion.

**Work Related Exhaustion or Resign**

As a consequence of experiencing moral injury, there were several emotional, physical, and life impacts that appeared to link with work related exhaustion, this appeared in 17 studies (Ando & Kawano, 2016; Austin et al., 2003; Gabrielsson et al., 2016; Jansen et al., 2020; Jansen, Hem, et al., 2022; Klingemann et al., 2025; Liberati et al., 2021; Lloyd et al., 2024; Matthews & Williamson, 2016; Musto & Schreiber, 2012; Navarro et al., 2021; Oliveira et al., 2020; Pérez-Toribio et al., 2022; Rushton et al., 2022; Thompson et al., 2024; Upasen & Saengpanya, 2021; Wall et al., 2024).

Across several studies participants experienced an increase in self-doubt and questioning the quality of their clinical practice. Collectively, self-doubt alongside high standards and/or a blame culture appeared to increase participants need for certainty as demonstrated by this participant:

> Human nature is to react but on a professional level can we? (.)and what's appropriate and reasonable?. . . so I get really anxious unless I'm 100% certain that's the right stage or if I haven't dealt with it before you can panic that perhaps you aren't doing the right thing and then if you leave them are you not caring for them so I can get quite nervous about it (.) obviously you've got the risk to them and then you've got to live with it (.) I think it can be really daunting (Lucy, Interview)."
>
> (Matthews & Williamson, 2016, p. 1047)

Others reported moral injury impacting on their physical wellbeing, whereby they were unable to sleep, experiencing tension headaches, high blood pressure and at times struggling to breathe. Some described that moral injury was only impacting on them at an emotional level, leading to emotional numbness, feeling "cold" and demotivated. In turn, psychiatric professionals described feeling unmotivated to engage in their personal life such as, not wanting to socialise or exercise, not being able to be present with their families, or feeling unable to turn their thoughts off. Some participants questioned whether they wanted to continue the role and others resigned due to being unable to resolve the ethical dilemma causing moral injury. One participant demonstrated this ethical dilemma:

> I worked in a place where the funding was being misused, and that meant that people needing help were being denied service, and so I drew that to the attention of some people in charge and then when nothing happened, I quit. I had to leave because I just felt I could not be there with such a misuse of funds and such exploitation and such denial.
>
> (Austin et al., 2005, p. 210)

**Feeling Conflicted and Experiencing Distress**

Feeling conflicted and experiencing distress appeared in 18 studies (Austin et al., 2003; Austin et al., 2005; Eder et al., 2025; Jansen, Danbolt, et al., 2022; Jansen et al., 2020; Jansen, Hem, et al.,

2022; Jansen & Hanssen, 2017; Klingemann et al., 2025; Liberati et al., 2021; Lloyd et al., 2024; Matthews & Williamson, 2016; Musto & Schreiber, 2012; Navarro et al., 2021; Oliveira et al., 2020; Pérez-Toribio et al., 2022; Thompson et al., 2024; Upasen & Saengpanya, 2021; Wall et al., 2024). Participants expressed feeling morally conflicted as their values were not aligning with the care that they were able to provide. A common experience across studies was feeling unable to meet the "caring" value of a psychiatric professional, some participants described having a conflicting role, whereby, they felt they are being caring at the same time as asserting control. This was demonstrated by a participant when discussing their experience of using restraints:

> We are trained to care... and suddenly, we realize that we are carrying out a social role. [...] I feel like a jailer... You say, really I'm doing the job of a prison guard, without having studied to be one.
>
> (Navarro et al., 2021, p. 11)

Psychiatric professionals who experienced conflict with their values often experienced guilt, shame and helplessness. The guilt and shame appeared to impact on the participants for varying amount of time, some described feeling guilty for months. There was a sense that participants felt powerless and therefore had no choice but to act against their values, this was described as "loyalty to the system" (Jansen & Hanssen, 2017). For some participants there appeared to be a fear that there would be repercussions from the organisation and/or their team; participants also worried about "alienating their colleagues" or being labelled as a "problem" (Austin et al., 2005; Musto & Schreiber, 2012; Navarro et al., 2021).

Other consequences of moral injury related to the distress experienced such as feeling frustrated, angry, dishonest, and alone. One participant described feeling isolated:

> So isolated … I just feel like I am on my own … Everybody is just kind of on their own. The aides are even worse off, they don't even have a patient assignment. They have tasks. It's very disconnected.
>
> (Austin et al., 2003, p. 181)

These emotional responses appeared to be a consequence of a perceived loss of professional integrity and a sense of feeling morally conflicted.

### *Helpful and Unhelpful Ways of Dealing with Moral Injury*

#### Emotionally Distancing or Sharing the Burden

When considering the ways psychiatric professionals deal with moral injury, it appeared they either emotionally distanced themselves or attempted to share the burden with others; this was a common theme across 11 studies (Ando & Kawano, 2016; Austin et al., 2005; Gabrielsson et al., 2016; Jansen et al., 2020; Jansen, Hem, et al., 2022; Musto & Schreiber, 2012; Navarro et al., 2021;

Oliveira et al., 2020; Pérez-Toribio et al., 2022; Tavakol et al., 2023; Upasen & Saengpanya, 2021). Majority of the participants expressed wanting to distance themselves from the distress experienced at work, this involved either sick leave, taking a day off, hiding their involvement in the process of reporting concerns, or attempting to keep work and home life separate.

A psychologist highlighted hiding their involvement in whistleblowing:

> I never revealed to anyone there that it was me. And I didn't feel that I needed to reveal it to anyone because I felt that my intervention had solved the problem. But clearly this was an exceptional situation that required intervention, and we seemed to be unable to provide that intervention within the regular mechanisms available to us. I have my own obligations as a psychologist. I felt I have my own professional obligations to myself first and second to my organization that I belong to. So if I had not done anything, and if this had created a situation where this person continued to suffer, I feel I would have been in violation of my professional ethics.
>
> (Austin et al., 2005, p. 206)

Others attempted to cope through compensating for what they perceived as inadequate care from their colleagues. Whereas some participants used normalisation to cope with morally conflicting elements of their role such as physical restraints; this normalisation appeared to develop into desensitisation over a period of time. There was a sense of participants feeling unable to refuse to engage in aspects of their role, and therefore needed to emotionally distance themselves to be able to continue working in the role. However, this raised concerns for some participants in their ability to be emotionally available. Some participants consciously used distraction methods to create some distance from the distress they experienced.

Another way participants expressed coping with moral injury was through communication, this appeared to help the psychiatric professionals share the burden through seeking advice from experienced colleagues or their professional bodies. Additionally, through reflecting on their practice or, holding their colleagues accountable, appeared to help participants share the burden of moral injury. Participants expressed that positive interactions with colleagues helped them to process moral injury and view the moral conflict through a broader lens. When they were unable to do this, their moral injury remained (Musto & Schreiber, 2012).

**Shifting the Responsibility**

Psychiatric professionals appeared to shift their responsibility onto those in more senior positions or the wider system in an attempt to absolve their moral injury; this was a common theme across seven studies (Eder et al., 2025; Gabrielsson et al., 2016; Jansen et al., 2020; Jansen, Hem, et

al., 2022; Lloyd et al., 2024; Musto & Schreiber, 2012; Navarro et al., 2021). This included deferring responsibility to the responsible psychiatrist and/or physician, senior management, or 'the state'. One participant demonstrated this process:

> Theory helps me a lot. Thinking philosophically helps me to process it and put myself in a role of saying there's a part that isn't my responsibility, there's a part that isn't me 100% the exercising agent, I'm exercising the invisible hand of the State, I'm the exercising hand of the social, the social has made use of me in the same way as it has made use of the police. (Navarro et al., 2021, p. 11)

Across studies, participants described that they just "followed orders"; there appeared to be a sense of powerlessness among the psychiatric professionals to challenge or disengage from the morally injurious events and/or behaviour. One study highlighted that capacity assessments had become a "tick box exercise" used to absolve individual responsibility in complex ethical decisions (Lloyd et al., 2024).

Collectively, the absolution of individual practitioners' responsibility for ethically challenging situations appeared to function as a way of reducing their moral injury.

## Discussion

This systematic review sought to understand psychiatric professionals' experiences of moral injury. To the best of the author's knowledge this is the first qualitative systematic review exploring the lived experiences of moral injury in psychiatric professionals collectively across a variety of different contexts.

### Summary and Interpretation of Findings

This thematic synthesis (Thomas & Harden, 2008) of 23 studies highlighted an overarching analytical theme: *psychiatric professionals feeling powerless in a morally distressing system*. Four additional themes were also identified: (1) system and organisational constraints resulting in moral injury; (2) individual sources of moral injury; (3) consequences of moral injury; (4) helpful and unhelpful ways of dealing with moral injury. These findings appear to have a cumulative effect where moral injury at an individual level appears to originate from multiple and sustained systemic and organisational factors.

### System and Organisational Constraints Resulting in Moral Injury

A key source of moral injury across psychiatric professionals in this review appeared to be associated with system and organisational constraints such as lack of resources and poor system-wide communication. This aligns with a study which explored moral injury in healthcare workers highlighting that increased burden was often placed on the healthcare workers to compensate for systemic resource failures (Rabin et al., 2023). This combined with poor communication, particularly

from senior management, increased their sense of powerlessness, as well as mistrust towards those in senior positions. Furthermore, O'Donnell et al. (2023) highlighted that during the COVID-19 pandemic a breakdown in the trust between senior management and the psychiatrists was the result of external professional bodies not providing consistent recommendations. In contrast, this perceived conflict of information may reflect new research that emerged during the COVID-19 pandemic, which led to amended recommendations as new evidence emerged (Mohamed Nour et al., 2025). Subsequently, this impacted the communication at a team level and ultimately left the individuals feeling mistrustful of the information they received. French et al. (2022) had previously suggested that healthcare professionals felt betrayed by leadership due to their lack of accountability, however, betrayal was not a theme which emerged in this review from the psychiatric professionals' experiences of moral injury.

It is important to consider the wider impacts on the organisations, such as funding for mental health services. As highlighted by the psychiatric professionals in this review a key experience of moral injury at both an organisational and individual level was linked to the lack of resources. It has been reported that the proportion of funding allocated to mental health services in the United Kingdom has decreased from 8.78% in 2023-2024 to 8.71% in 2025-2026 (Department of Health Social and Care, 2025). However, the mental health care accounts for more than 20% of the need in the National Health Service, and the demand for mental health support is predicted to increase from £14.90 billion to £15.60 billion (Department of Health Social and Care, 2025; Royal College of Psychiatrists, 2025). These funding difficulties are not isolated to the United Kingdom. A report by World Health Organization (2025), highlighted that globally more than one billion individuals were living with a mental health disorder. Furthermore, mental health systems worldwide face gaps in resources, services, governance, and research, with other health conditions often prioritised over mental health care. Therefore, psychiatric professionals' experiences of inadequate resources in this review appear to reflect the broader reality of underfunded services.

**Individual Sources of Moral Injury**

Providing inadequate care is a common source for moral injury among healthcare workers and psychiatric professionals *(Eder et al., 2025; Hegarty et al., 2022; Rabin et al., 2023).* For psychiatric professionals in this review, this was linked to insufficient resources to provide adequate care, including staffing shortages or inappropriate facilities. This lack of resources placed undue pressure on psychiatric professionals working across different settings, particularly those working on an acute ward. Insufficient staffing resulted in legal requirements (Section 17 leave) being unfulfilled. The Care Quality Commission (2025a) highlighted that preventing service users from taking leave under Section 17 of the Mental Health Act (1983) has a negative impact, delaying

recovery and increasing distress for service users. As well as contributing to moral injury among psychiatric professionals (Thompson et al., 2024). Previous studies (Hegarty et al., 2022; Liberati et al., 2021; O'Donnell et al., 2023; Williamson et al., 2023) have highlighted the impact that the COVID-19 pandemic had on delivering an adequate standard of care for both healthcare professionals and psychiatric professionals; however, a minority of studies informing this theme related to the COVID-19 pandemic. This suggests that experiences of providing inadequate care in this synthesis are not isolated to the pandemic context, but that ongoing constraints continue to impact psychiatric professionals' ability to deliver a standard of care that they perceive to be adequate.

Additionally, this review highlighted a key theme of raising concerns and feeling invalidated leading to moral injury. This theme can be linked to the organisational constraints, particularly poor communication across multiple levels. As noted in the previous theme, psychiatric professionals expressed feelings of mistrust due to ineffective communication, which may contribute to the experiences of invalidation when they raise concerns. Raising concerns appeared to leave professionals with a sense of hopelessness. It could be hypothesised that the combined impact of poor communication and invalidation may result in psychiatric professionals developing learned helplessness. Learned helplessness is a mental state that can emerge following repeated experiences of uncontrollable negative events, leading individuals to develop the belief that they have limited influence on the outcomes. This sense of powerlessness can reduce confidence and motivation, consequently, reducing the likelihood that individuals will attempt to change their circumstances (Seligman, 1978; Wang et al., 2025).

Tomura (2023) suggested that a lack of perceived formal power was significantly correlated with moral distress in psychiatric nurses. Formal power refers to the characteristics of a role which enables the nurses to take action to achieve the organisational goals, such as providing care to service users (Spence Laschinger et al., 2010; Tomura, 2023). This suggests that psychiatric nurses may experience moral distress when there is disparity between their level of responsibility and their sense of power in their job role (Austin et al., 2003; Musto & Schreiber, 2012; Tomura, 2023).

**Consequences of Moral Injury**

These experiences of morally injurious situations appear to have consequences for psychiatric professionals which take the form of exhaustion or choosing to resign, as well as having an emotional impact.

Work related exhaustion was a key theme in the studies and has been defined as both mental and physical fatigue as a result of their work (Arnetz et al., 2025; Arnetz & Hasson, 2007). Both physical and mental exhaustion has been linked to burnout which in turn can impact negatively

on healthcare professionals' physical and mental wellbeing, as well as their ability to perform in their role (Batanda, 2024). However, moral injury has been distinguished from burnout based on the presence of distress experienced by the professionals, whereas burnout has been characterised by an absence of distress (Rosen et al., 2022). Although some participants expressed feeling 'cold' and emotionally detached, this also appeared to cause them distress (Jansen et al., 2020). Thompson et al. (2024) suggested that work-related exhaustion affects psychiatric nurses' physical health and their personal lives, noting that it can lead to mistakes at work, and that a blaming culture further exacerbated these difficulties. This in turn, may link with the difficulties in communication with senior management as noted in the themes: poor communication, and raising concerns and feeling invalidated. Additionally, psychiatric professionals described several physical health difficulties as a result of moral injury such as, headaches, high blood pressure and poor sleep (Jansen et al., 2020; Jansen, Hem, et al., 2022; Upasen & Saengpanya, 2021). This is consistent with previous research, a systematic review explored both military and non-military populations (teachers, students, refugees, and law enforcement) and reported that sleep disturbances and physical health difficulties were associated with moral injury (Hall et al., 2022). The physical health impact of moral distress has been reported as strongly correlated with leaving or considering leaving their role (Stanojević & Čartolovni, 2022). This may be evident in this synthesis, as some participants chose to leave the profession, or their role, or were on sick leave due to experiencing moral injury (Austin et al., 2005; Jansen et al., 2020). However, it is important to consider there may be other factors linked to moral injury causing psychiatric professionals to leave their role.

In the results of this synthesis psychiatric professionals appear to experience conflicts between the values they hold and their own actions, as well as the actions of others. These value conflicts often resulted in increased feelings of shame, guilt, and helplessness. This aligns with the descriptions of moral injury, which occurs when an individual's moral beliefs are transgressed (Litz et al., 2009). However, these value conflicts often did not result in changing their behaviour, this was attributed to feeling powerless and/or being fearful of the repercussions. This may be influenced by team culture; Besharaty et al. (2025) highlighted that a bullying or blaming culture in emergency departments impaired nurses ability to make ethical decisions, thereby increasing moral distress. Moreover, Jansen and Hanssen (2017) suggested that the psychiatric nurses had a sense of loyalty to the system, therefore this alongside a difficult culture may contribute to experiences of moral injury in psychiatric professionals.

This synthesis highlighted that the experience of self-doubt is present across several psychiatric professions and contexts such as countries and place of work. There may be several factors which contribute to the development of self-doubt, such as work-related exhaustion or

experiencing conflicts with their values. Moreover, it has been suggested that, in the context of the COVID-19 pandemic, self-doubt may arise as a consequence of inadequate communication from the healthcare system or organisation, thereby weakening healthcare professionals sense of identity (Liu, 2025). Jinkerson (2016) further suggested that moral injury impacts on the individual's sense of self, which may, in turn, be closely linked to their professional identity. Self-doubt has been suggested to impact on healthcare professionals wellbeing, increasing feelings of despair, guilt and anxiety (Altaf, 2022; Gold & Gold, 2024). Psychiatric professionals in this synthesis expressed experiencing distress which included feelings of guilt, shame, frustration, and powerlessness. These emotions have been reported as symptoms of moral injury, in particular shame and guilt are distinctive features of moral injury (Molendijk et al., 2022).

As a result of these experiences psychiatric professionals appear to have developed different ways of coping.

**Helpful and Unhelpful Ways of Dealing with Moral Injury**

Psychiatric professionals in this review appeared to use emotionally distancing themselves as a way to cope with moral injury, and this took several forms (normalisation, taking days off work, or hiding their involvement with reporting concerns). Others attempted to share the burden through compensating for their colleague's inadequate care or speaking with their colleagues. It was highlighted by Musto and Schreiber (2012), that psychiatric nurses seek guidance and knowledge from their colleagues, reassurance about their behaviour from their professional bodies and emotional support from their friends and family. Similarly, a study exploring moral injury in veterans suggested that support from an empathetic peer resolved moral conflict reducing the overall emotional distress (Williamson, Murphy, et al., 2020). Therefore, it may be beneficial to strengthen the opportunities for peer support in teams. Several of the studies highlighted that psychiatric professionals try to separate their work life from their personal life, at times this was successful, but others found this particularly difficult expressing that they are unable to leave their work at work (Jansen, Hem, et al., 2022; Oliveira et al., 2020). Therefore, psychiatric professionals may benefit from additional support in managing their moral injury. Some participants used reflection to support them to process moral injury, it was highlighted that reflective practice is an effective way to reduce moral injury as it supports practitioners to reflect back on the morally injurious event (Meziane et al., 2018). A scoping review by Jack and Kotronoulas (2023), highlighted that healthcare professionals may avoid reflection in an attempt to cope, this aligns with some of the results of the synthesis where some psychiatric professionals tried to cope through emotionally distancing themselves through normalising and/or desensitising to the morally injurious behaviour.

Others coped by shifting the responsibility onto those in senior position or the government and/or state. Gabrielsson et al. (2016) suggested that not taking personal responsibility was linked to team culture and lack of resources, which ultimately resulted in inadequate care. Psychiatric professionals used language such as “followed orders” or being a “part of the system”, which appeared to be a way of absolving their moral injury (Jansen et al., 2020; Navarro et al., 2021). This may link to the previous themes in this thematic synthesis, whereby the accumulation of morally injurious events from both organisational and individual sources may result in psychiatric professionals feeling powerless, reinforcing the notion of learned helplessness.

**Strengths and Limitations**

A key strength of this systematic review is that to the best of the authors’ knowledge, it is the first qualitative systematic review to explore experiences of moral injury among psychiatric professionals. This contributes valuable insight into how psychiatric professionals across different contexts experience moral injury. Thomas and Harden (2008) reported the use of thematic synthesis aligns closely with the original meaning of the content, which increases transparency and reliability in the results generated.

Moreover, the large number of studies (n=23) included in this review, increased the diversity of the sample and supported experiences from multiple countries to be represented, including the United Kingdon (26.09%), Iran (4.35%), Canada (13.04%), Norway (17.39%) , Sweden (8.70%), Spain (8.70%), Thailand (4.35%), Brazil (4.35%), Poland (4.35%), Republic of Ireland (4.35%), and Japan (4.35%). This enhances the breadth of experiences covered. However, it should be noted that United Kingdom had the largest proportion of participants which may limit the generalisability to other healthcare contexts. Additionally, while the study aimed to explore the experiences of moral injury across psychiatric professionals, the sample was largely composed of psychiatric nurses (83.81%). Consequently, this may impact the transferability of the findings to other psychiatric professions such as psychologists or psychiatric healthcare assistants, who were under-represented in the study samples. Furthermore, it is difficult to draw conclusions in relation to diversity such as age and ethnicity due to lack of reporting.

All studies were of various quality, only six studies (Eder et al., 2025; Gabrielsson et al., 2016; Jansen et al., 2020; Jansen, Hem, et al., 2022; Liberati et al., 2021; Navarro et al., 2021) met all of the criteria for the Critical Appraisal of Qualitative Studies adapted from (Greenhalgh & Taylor, 1997). Two studies (Jansen, Danbolt, et al., 2022; O'Donnell et al., 2023) met all criteria but one. The rest of the studies did not meet varying amount of criteria, in particular Austin et al. (2005), which had the largest unmet criteria (n=5). There were no studies excluded based on quality appraisal as per the guidelines of Cochrane Guidance as it was suggested that poor quality qualitative studies did not

impact on the overall results of a qualitative synthesis (Noyes et al., 2018). However, Austin et al. (2005) features throughout three out of four of the themes (see Appendix C) and therefore, the results of the systematic review should be interpreted with caution.

**Clinical Implications and Future Research**

This systematic review highlighted that psychiatric professionals across different contexts appeared to experience moral injury as a result of multiple factors, including system constraints. To cope with the experiences of moral injury psychiatric professionals have developed various strategies such as communicating with their colleagues or reflecting on their practice. Therefore, it may be beneficial to encourage avenues for peer support and the provision of reflective practice spaces to reduce the impact of moral injury relating to systemic pressures.

Another factor which should be considered in clinical practice is clear consistent communication between organisations, senior professionals and the team. This may, in turn, reduce the sense of powerlessness experienced by psychiatric professionals as this may support them to feel informed and involved in the decision-making processes, particularly when these concern reallocation and/or reduction in resources.

Psychiatric professionals identified several experiences which may be beneficial to explore quantitatively to understand whether there are any factors which predict moral injury such as, impact of system constraints, or physical health symptoms.

Additionally, it may be beneficial to explore the individual psychiatric professionals' experiences of MI, particularly those who were under-represented in this systematic review such as clinical psychologists.

Overall, there appears to be a need for greater recognition of the systemic sources of moral injury among psychiatric professionals, in order to reduce their experiences of moral injury at the individual level.

## Conclusion

To the best of the authors' knowledge, this was the first qualitative systematic review to explore psychiatric professionals' experiences of moral injury. The findings suggest that psychiatric professionals' experiences of moral injury appear to be a cumulative process, stemming from system and organisational constraints. These constraints lead to individual sources of moral injury, impacting on their ability to provide adequate care to service users. Consequently, psychiatric professionals internalise these experiences resulting in both physical and emotional distress such as, exhaustion, guilt, shame and hopelessness. As a result of the distress experienced, psychiatric professionals developed two ways of coping by either emotionally distancing themselves or sharing the burden. However, several limitations may affect the transferability of the findings, including

limited information regarding sample diversity and a large proportion of psychiatric nurses within the sample.

Overall, there was a sense that psychiatric professionals in this review are feeling powerless in a morally distressing system. Further research should aim to explore the different factors which predict moral injury as well as, different avenues of support for psychiatric professionals.

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**Chapter Three**

**Bridging chapter**

**Word count: 384**

## Bridging Chapter

The systematic review aimed to explore the lived experiences of moral injury (MI) among psychiatric professionals. These findings highlighted that systemic and organisational pressures are key factors when considering sources of MI in psychiatric professionals. These pressures included having inadequate resources such as time, staff and facilities. As well as poor communication across multiple levels (organisational, senior leadership, and team levels). Poor communication was described as inconsistent, incongruent, conflicting or absent. These factors impacted on psychiatric professionals' ability to provide adequate care which appeared to contribute to the experiences of MI. Furthermore, Psychiatric professionals reported raising concerns and feeling invalidated which appeared to leave them feeling powerless. Consequently, Psychiatric professionals appeared to internalise these experiences, resulting in both physical and emotional distress such as work-related exhaustion, guilt, shame, frustration and feeling hopeless.

There was an overarching sense that psychiatric professionals were feeling powerless in a morally distressing system. Where they coped through either emotionally distancing themselves or sharing the burden with others. Psychiatric professionals cited colleagues being a key source of support.

Within the systematic review a large proportion of the participants were mental health nurses (MHN). When considering the National Health Service (NHS), MHNs constitute a third of the NHS workforce (Palmer et al., 2023). Moreover, the NHS is under ever growing pressure, particularly the mental health services where demand has increased (Care Quality Commission, 2025b, 2026; NHS England, 2024b). This includes several system constraints such as understaffing, recruitment difficulties and inappropriate facilities (Health Services Safety Investigations Body, 2025). Research has suggested that these systemic pressures often resulted in psychiatric professionals, particularly, MHNs experiencing MI (Thompson et al., 2024). Alongside this, the systematic review highlighted the widespread impact of MI among psychiatric professionals and identified several factors reported to contribute to the development of MI. Despite these challenges identified in the review, there has been no quantitative research exploring the factors associated with or predictive of MI among MHNs working in the NHS. Therefore, the systematic review identified several factors which informed the selection of predictive variables used to explore MI in MHNs. Therefore, the empirical study presented in Chapter four aimed to fill this gap through exploring the association with MI and several individual and organisational factors; including inadequate resources, working overtime, perception of power matching responsibility and feeling supported.

# Chapter Four: Empirical Project

## Exploring Predictive and Associated Factors of Moral Injury in Registered Mental Health Nurses Employed in the National Health Service

**Word count: 6475 (excluding tables)**

*Prepared for submission to Journal of Clinical Psychology (see Appendix D for author guidelines)*

**Abstract**

**Background:** Moral injury (MI) is the psychological distress which arises when professionals' own values and beliefs are violated in their practice. More recently, healthcare professionals' experiences including Mental Health Nurses' (MHN) have been explored, which highlighted sources of MI such as systemic pressures (understaffing and inadequate resources).

**Objective:** This study aimed to explore the individual, organisational and mental health outcomes associated with, or predictive of, moral injury among MHNs working in the National Health Service (NHS).

**Method:** This study used an exploratory cross-sectional design to explore the individual, organisational, and mental health outcomes associated with, or predictive of, MI among NHS MHNs (N=103). An online survey was utilised, including the Moral Injury Symptom Scale for Healthcare Professionals (MISS-HP), PHQ-9, GAD-7, and bespoke questions (individual and workplace factors). Non-parametric statistical analyses explored associations with MISS-HP total score, whilst a multiple regression examined MI predictive variables.

**Results:** The mean MISS-HP total score was 44.58 (SD=12.88), with 56.30% of NHS MHNs scoring above the functional impact threshold. MI was significantly associated with GAD-7, feeling that their level of responsibility matches their power and adequate resources. PHQ-9 was significant in the regression model, while perceived support from colleagues emerged as a significant inverse predictive variable of MI.

**Conclusion:** The findings suggest MI is highly prevalent and has a moderate to severe impact on the respondents. The associations with Depression and perceived support from colleagues' are important considerations when supporting MHNs.

**Key words**: Moral injury, mental health nurses, and National Health Service

**Moral Injury**

Moral Injury (MI) relates to the psychological distress experienced by professionals when their own values and beliefs are violated in their practice, which impacts on their mental wellbeing. Research into moral injury has increased substantially; once only considered within military populations, it has now expanded to include paramedics, police, and healthcare professionals (Rimon & Shelef, 2025). The definition of MI has been widely debated, however, one of the most widely accepted definitions is Litz et al. (2009) who defined moral injury as psychological distress as a result of perpetrating, witnessing, or failing to prevent an event which violates a person's moral beliefs.

In previous literature, MI has been reported as having an adverse impact on individuals' health, including military and non-military populations (teachers, journalists, veterinarians, and police officers), this includes mental health difficulties such as depression and sleep difficulties (Greenberg et al., 2020; Williamson et al., 2018). VanderWeele et al. (2025) suggested MI can be considered as a spectrum whereby the greater severity and persistence of moral distress, the greater the impact on an individual's ability to function; as a result, an individual is likely to experience shame, guilt, anger and betrayal. The emotional impact of MI can differ depending on whether the person has perpetrated or witnessed the transgression; if others have transgressed the person's moral beliefs this often results in a sense of hopelessness, protest and injustice. Whereas, when the MI is directly linked to one's own behaviours, this impacts on a person's sense of self, resulting in shame, loss of confidence and generally a negative self-appraisal (Kvitsiani et al., 2023).

**Moral Injury in Health Care Workers**

More recently MI research has expanded into healthcare professionals, as it has been suggested that within their work they are frequently exposed to Potentially Morally Injurious Events (PMIEs), which can lead to an accumulative harm (Riedel et al., 2022). It is evident that the standard of care being delivered to patients has been impacted by the ever-growing pressure on the National Health Service (NHS; Cooksley et al., 2023). In comparison to other domains of work, the NHS has a high level of stress-related sickness (Ravalier et al., 2020). A study by Ravalier et al. (2020), highlighted several themes which have impacted on NHS workers wellbeing at work, including high workloads, feeling under supported and frequent organisational changes due to the pressures on the NHS. This was exacerbated during the COVID-19 pandemic, where NHS workers experienced an increase in burnout as a result of changes in their role, ineffective breaks, emotional pressures, and changes to social support (Gemine et al., 2021). However, NHS staff are still expressing dissatisfaction with their working conditions beyond the COVID-19 pandemic. The annual State of Care report (Care Quality Commission, 2025b) highlighted healthcare staff are feeling overworked

and burnt-out due to short staffing, poor skill mix, lack of capacity and difficulties with retention. Additionally, the NHS staff survey highlighted 28.83% of NHS staff who completed the survey think about leaving the organisation, 50.34% of staff maintain a good work life balance, and only 27.01% of staff felt they never have unrealistic time pressures (NHS England, 2024b). Furthermore, high workloads and persistent staff turnover contributing to workforce shortages and burnout have been suggested as sources of moral distress among healthcare professionals (Eder et al., 2025; Loyal et al., 2025)

Several studies have explored MI in healthcare professionals, including doctors, nurses, occupational therapists, health care assistants and speech and language therapists, with a large proportion of participants identifying as nurses (Hegarty et al., 2022; Rabin et al., 2023; Williamson et al., 2023). Healthcare professionals are often faced with ethical decisions which may determine whether a person lives (Koenig & Al Zaben, 2021); ethical decisions within complex circumstances can lead to the development of moral injury due to the person's moral beliefs being violated (Williamson et al., 2023). Examples of PMIEs for healthcare professionals can include working beyond their clinical competence, feeling betrayed, experiencing a breakdown in managerial relationships and facing a lack of resources and understaffing, which results in feeling unable to treat patients effectively (Rabin et al., 2023; Williamson et al., 2023). Of the healthcare professionals, nurses have been reported having an increased vulnerability to developing MI due to having greater exposure to patients and a lack of decision-making power (Riedel et al., 2022; Williamson et al., 2023). However, these studies largely explored MI in the context of physical health settings during the COVID-19 pandemic. Research has suggested that symptoms of MI in healthcare professionals are strongly associated with higher rates of psychological distress and burnout, as well as suggesting that pre-existing mental health difficulties can predispose individuals to developing MI (Williamson et al., 2023).

**Moral Injury in Mental Health Nurses**

Mental health nurses (MHN) constitute 12.90% of the nursing workforce in the United Kingdom (Farrah, 2025). In the context of psychiatric inpatient wards, MHNs often work with individuals who have reduced capacity and administer treatments which go against the service users' wishes (Tomura, 2023). MHNs working on inpatient wards are also exposed to aggression and violence which may result in them engaging in physical restraints or implementing seclusions (Tomura, 2023; Webb et al., 2024a). This means that MHNs are often exposed to constant ethical dilemmas and decision making in high stress situations (Lamoureux et al., 2024).

Previous literature (Thompson et al., 2024; Webb et al., 2024a) has highlighted several factors which contribute to moral distress in psychiatric settings. MHNs reported experiencing

shame and guilt when they are unable to meet professional code expectation; particularly in situations where service user care or dignity may be compromised (Thompson et al., 2024). Organisational models of care which are task led, rather than service user led, were reported as a key driver for moral distress (Webb et al., 2024a). In addition, systemic pressures such as inappropriate placement and/or discharge of service users, alongside management practices and team culture which foster feelings of powerlessness, blame, resentment and mistrust among psychiatric professionals, can result in moral distress (Thompson et al., 2024). Other factors which have been identified include being understaffed, power not matching their level of responsibility and feeling disrespected (Austin et al., 2003; Thompson et al., 2024).

As a result, healthcare workers are frequently exposed to PMIEs, which can lead to MI. However, there is limited research exploring moral injury in mental health nurses, even though MHNs are experiencing ethical dilemmas and exposures to PMIEs similarly to other healthcare professionals, such as short staffing, service user aggression, lack of resources, and feeling unable to provide adequate care.

To the best of the authors' knowledge, to this date, there has been no quantitative study exploring MI in MHNs working in the NHS. Therefore, this study aims to broaden the research on moral injury in mental health professionals and understand what factors may contribute to MI among MHNs working in the NHS.

## Research Questions

1. What are the mean and median scores of the MISS-HP total score in mental health nurses working in the NHS, what proportion score over the threshold of functional impact and what percentage report experiencing functional impairment?
2. To what extent is moral injury associated with adverse psychological outcomes, demographic characteristics and workplace factors?
3. What factors predict moral injury in mental health nurses working in the NHS?

## Method

### Design

An exploratory cross-sectional design was used to explore what factors predict MI in MHNs working in the NHS using an online survey.

### Participants

The sample was recruited using a purposive sampling method as the study requires specific characteristics to participate in the study (Andrade, 2020). The sample consisted of registered mental health nurses who currently work in the NHS, and all participants completed the survey on a

voluntary basis. Snowball sampling was also utilised as all participants were encouraged to share the survey across their professional networks (Ahmed, 2024).

### *Inclusion Criteria*

Registered mental health nurses who worked in the NHS were eligible to participate in this study. Participants were required to have the ability to read and write in English due to the format of the survey. Mental health nurses were required to be working either full time or part time and those who had additional qualifications beyond their core mental health nursing qualification were also eligible to participate.

### *Exclusion Criteria*

Mental health nurses who no longer had a registration, no longer practicing and were not working in the NHS were not eligible for this study.

## Measures

### *Demographic Information*

The basic demographic information collected included: age, caring responsibilities, gender identity, relationship status, ethnicity, and NHS banding. Additionally participants were asked whether they worked in an inpatient or community team, the population they work with [children & adolescents (0-18 years), youth (18-25), adults (18-65) and older adults (65+)], the duration they have worked in their current role (years and months), whether they were part time or full time, and the total duration they have been a registered mental health nurse (years and months). There were additional open-ended questions for participants to clarify whether they worked within a specialist population or whether they had gained extra training qualifications such as Cognitive Behavioural Therapy.

### *Moral Injury Measure*

Moral injury was measured using the Moral Injury Symptom Scale for Health Care Professionals (MISS-HP; Mantri et al., 2020). This measure was adapted from the military version of the Moral Injury Symptom Scale and was deemed to have strong reliability and validity (Mantri et al., 2020). The MISS-HP measure was implemented as it measures the accumulation of moral injury rather than a single event. This was hypothesised to better capture the variables that may predict moral injury in mental health nurses, such as social support and lack of resources, rather than focusing on single events of moral injury which are more relevant in military contexts. According to Mantri et al. (2020) a MISS-HP score exceeding 36 is indicative of moderate to severe impact on functioning with 84% sensitivity and 93% specificity. Permission was granted by the survey authors for the use of the survey within this study. The internal reliability for this study was measured using Cronbach alpha and was .70, which was similar to past studies where it was .73 (Mantri et al., 2020).

A Cronbach alpha score of .70 is deemed acceptable to determine strong internal validity (Taber, 2018).

***Mental Health Measures***

Anxiety was measured using the Generalised Anxiety Disorder-7 scale (GAD-7; Spitzer et al., 2006) and depression was measured using Patient Health Questionnaire-9 scale (PHQ-9; Kroenke et al., 2001). GAD-7 and PHQ-9 have good psychometric properties (Johnson et al., 2019; Kroenke et al., 2001).

***Single Item Questions***

To examine independent variables, the survey also included a bespoke question set based on a 5-point Likert-style scale. The question set was developed from previous themes identified in qualitative research (Rabin et al., 2023; Ravalier et al., 2020; Tomura, 2023; Webb et al., 2024a), as well as contributions through a Patient and Public Involvement (PPI) advisor, a registered MHN, who shared what they felt contributes to MI in MHNs. Through combining both PPI involvement and previous themes of research, the following single item questions were developed.

These questions include:

1. In the last two weeks did you take your allocated breaks?
2. How do you perceive your staffing levels in the team you are working in?
3. Do you feel adequately supported by supervisors, line managers, colleagues, friends, and family?
4. How much over the last two weeks did you work over your contracted hours?
5. Do you feel you have had adequate resources to deliver what you believe to be satisfactory care?
6. Have you ever experienced aggression from a service user?
7. Have you felt that you have received inappropriate referrals or admissions to your team in the last two weeks?
8. In the last two weeks how often have you disagreed with discharging a service user from your team?
9. Do you feel that your current responsibilities match the level of power you feel you have in the team?
10. Are you considering leaving the profession of mental health nursing?

**Procedure**

The survey was distributed through social media platforms such as Facebook, X and Instagram via an account created specifically for the research. This included public Facebook groups which did not require posts to be screened prior to the advert being posted. The survey was also

distributed on LinkedIn and through three professional distribution lists (Mental Health Nurse Academics UK, National Mental Health and Learning Disability Nurse Directors Forum and The Queen's Institute of Community Nursing).

The advert for the research was accompanied by a poster of information about the study. When participants accessed the anonymous survey link on Jisc, they were presented with a participation information sheet. This informed them about the content of the study and their right to withdraw. They were then presented with the demographic questions, followed by MISS-HP, PHQ-9, GAD-7 and the individual Likert item questions. Upon completing all the questions, participants were then shown a debrief sheet with signposting for further support if needed. The data collection was live from 24th March 2025 to 25th October 2025.

**Analysis**

The statistical analyses were two tailed with an alpha level set at .05. An a priori power analysis was conducted using G*Power to estimate the sample size for a multiple regression, correlation, ANOVA and Mann-Whitney U test (see Appendix E). The power was set to b= .80, this is the recommended level for statistical analysis to reduce the chance of a false negative (Serdar et al., 2021).

Due to non-normal sample distribution (see Appendix F), non-parametric statistical analyses were applied to explore associations between the MISS-HP total score and the independent variables. These included Spearman's rho correlation, Kruskal-Wallis test and Mann-Whitney U test. However, due to a small sample size and the need to maintain adequate statistical power, only seven variables were entered into the multiple regression model. Each predictive variable was selected based on the strength of its association with the MISS-HP total score, as assessed using Spearman's rho correlation, the Kruskal-Wallis test and Mann-Whitney U test, as well as previous research (Heinze et al., 2024). A multiple regression was used to analyse whether PHQ-9 total score, GAD-7 total score, feeling supported by colleagues, having adequate resources, feeling their power matches their level of responsibility, age, and length of time qualified as MHN predict moral injury in MHNs. However, due to age and length of time qualified as a MHN being highly correlated (r = .915), age was removed from the analysis to avoid multi-collinearity.

Due to the nature of self-reported measures all Likert-scale data were treated as interval. It is widely debated whether Likert-scale data should be treated as interval due to the possible impact of outliers and the assumptions around equal spacing between data points (Alkharusi, 2022; Koo & Yang, 2025). However, it has been argued that Likert scale data can be treated as continuous (interval & ratio) in parametric testing as the equal spacing has limited impact on the results with the exception of extreme outliers (Pasta, 2009; Williams, 2020).

## Ethical Considerations

This study was granted ethical approval through the Faculty of Medicine and Health Sciences at the University of East Anglia. Participants were provided with a Participation Information Sheet (PIS) and were informed of their right to withdraw. There was no identifiable information collected in this study and all data was stored in compliance with Data Protection Act (2018) and University of East Anglia Research Data Management Policy (2019). To ensure all participants felt supported appropriate signposting was included in the PIS and debrief page.

## Results

### Descriptive Statistics

There was a total of 103 participants who completed the survey. Demographic characteristics can be found in Table 2 below.

54.40% of MHNs reported disagreeing or strongly disagreeing that they had adequate resources to be able to deliver satisfactory care. 32.00% of MHNs reported that they had a fully staffed team most days and in a two-week period, 35.90% of MHNs reported that they often received inappropriate referrals or admissions. However, 36.00% of MHNs rarely disagreed with discharging a service user. 49.50% of MHNs reported sometimes experiencing aggression from service users. 5.80% of MHNs reported feeling that their responsibility never matches their perceived power in their team.

**Table 2:**

*Descriptive Statistics*

| Characteristics | N | Percentage | Mean | SD | MISS-HP score | | |
|---|---|---|---|---|---|---|---|
| | | | | | Mean | SD | Median |
| Total | 103 | 100.00 | - | - | 44.58 | 12.88 | 44.00 |
| Gender | | | | | | | |
| Non-binary | 1 | 0.97 | - | - | 32.00 | - | 32.00 |
| Female | 81 | 78.64 | - | - | 44.42 | 12.49 | 44.00 |
| Male | 21 | 20.39 | - | - | 45.81 | 14.59 | 44.00 |
| Age total | 103 | 100.00 | 43.07 | 12.00 | - | - | - |
| 24-28 | 18 | 17.50 | - | - | 49.39 | 17.21 | 49.00 |
| 29-33 | 11 | 10.70 | - | - | 46.00 | 11.79 | 43.00 |
| 34-38 | 12 | 11.70 | - | - | 46.00 | 11.82 | 46.00 |
| 39-43 | 12 | 11.70 | - | - | 41.00 | 7.65 | 43.00 |
| 44-48 | 12 | 11.70 | - | - | 50.58 | 13.13 | 48.50 |
| 49-53 | 6 | 5.80 | - | - | 43.00 | 6.90 | 42.00 |
| 54-58 | 23 | 22.30 | - | - | 40.00 | 12.52 | 38.00 |
| 69-64 | 9 | 8.70 | - | - | 40.89 | 11.51 | 41.00 |
| Relationship status | | | | | | | |
| Single | 25 | 24.27 | - | - | 44.72 | 13.55 | 43.00 |
| In a relationship | 32 | 31.07 | - | - | 43.50 | 10.47 | 44.00 |
| Married | 41 | 39.81 | - | - | 44.88 | 13.49 | 43.00 |
| Prefer not to say | 5 | 4.85 | - | - | 48.40 | 20.76 | 52.00 |
| Caring responsibilities | | | | | | | |
| Yes | 31 | 30.10 | | | 45.84 | 13.39 | 45.00 |
| No | 70 | 67.96 | | | 43.41 | 12.15 | 43.00 |
| Prefer not to say | 2 | 1.94 | | | 66.00 | 16.97 | 66.00 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ethnicity | | | | | | | |
| White | 89 | 86.40 | - | - | 45.63 | 13.06 | 44.00 |
| Asian/Asian British | 2 | 1.90 | | | 43.00 | 8.49 | 43.00 |
| Black/ African/Caribbean/Black British | 8 | 7.80 | | | 33.38 | 8.78 | 33.50 |
| Mixed/Multiple ethnic groups | 1 | 1.00 | | | 47.00 | - | 47.00 |
| Prefer not to say | 3 | 2.90 | - | - | 43.67 | 9.61 | 42.00 |
| Religion or spirituality | | | | | | | |
| Yes | 35 | | | | 40.71 | 12.59 | 45.20 |
| No | 68 | | | | 46.57 | 12.72 | 38.50 |
| GAD-7 | 103 | 100 | 6.27 | 4.77 | - | - | - |
| PHQ-9 | 103 | 100 | 7.17 | 4.82 | - | - | - |
| Location of work | | | | | | | |
| Community | 69 | 66.99 | - | - | 43.59 | 12 | 43.00 |
| Inpatient | 20 | 19.42 | - | - | 42.35 | 14.3 | 37.50 |
| Other | 14 | 13.59 | - | - | 52.64 | 12.92 | 46.00 |
| Client populations | 101 | 98.06 | - | - | | | |
| Older Adults and/or Adults | 46 | 45.55 | - | - | 44.30 | 14.21 | 43.50 |
| Child & Adolescents and/or Youth | 19 | 18.81 | - | - | 44.95 | 11.73 | 45.00 |
| Youth and Adults | 16 | 15.84 | - | - | 44.53 | 14.77 | 39.00 |
| Youth, Adults and Older adults | 11 | 10.89 | - | - | 40.18 | 6.34 | 42.00 |
| All populations (Older adults, Adults, youth and children/adolescents) | 9 | 8.91 | - | - | 48.56 | 12.33 | 45.00 |
| NHS Pay banding | | | | | | | |
| Band 5 | 13 | 12.62 | - | - | 45.85 | 12.36 | 47.00 |
| Band 6 | 53 | 51.46 | - | - | 44.21 | 12.32 | 44.00 |
| Band 7 | 18 | 17.48 | - | - | 46.89 | 13.46 | 44.00 |
| Band 8 (A,B and C) | 19 | 18.45 | - | - | 42.58 | 14.74 | 42.00 |
| Contract type | | | | | | | |
| Substantive | 100 | 97.09 | - | - | 44.75 | 12.1 | 44.00 |
| Agency | 3 | 2.91 | - | - | 39 | 34.07 | 24.00 |
| Working hours | | | | | | | |
| Full time | 81 | 78.60 | - | - | 45.84 | 12.21 | 45.00 |
| Part time | 22 | 21.40 | - | - | 39.95 | 14.48 | 36.50 |
| Average years qualified as a MHN | 103 | 100.00 | 16.71 | 12.43 | - | - | - |
| Average time in current post | 103 | 100.00 | 4.01 | 3.93 | - | - | - |
| Time worked over contracted hours in a two-week period | 103 | 100.00 | 5.57 (Median= 2.00) | 9.24 | - | - | - |
| Location of training | | | | | | | |
| United Kingdom | 99 | 96.12 | - | - | 44.80 | 13.04 | 44.00 |
| Abroad | 4 | 3.88 | - | - | 39.25 | 6.85 | 37.00 |
| Additional training completed | | | - | - | | | |
| Yes | 44 | 43.14 | - | - | 43.48 | 12.17 | |
| No | 58 | 56.86 | - | - | 45.53 | 13.51 | |
| Considering leaving the profession | | | - | - | | | |
| Yes | 31 | 30.10 | - | - | 51.42 | 14.65 | 48.00 |
| No | 37 | 35.90 | - | - | 40.81 | 10.21 | 41.00 |
| Maybe | 34 | 33.00 | - | - | 42.24 | 11.70 | 42.50 |
| Prefer not to say | 1 | 1.00 | - | - | 52.00 | - | 52.00 |

**Research Question One: What are the mean and median scores of the MISS-HP total score in mental health nurses working in the NHS, what proportion score over the threshold of functional impact and what percentage report experiencing functional impairment?**

The mean score of the MISS-HP was 44.58 (SD= 12.88) and the median was 44.00. 56.30% of MHNs scored above 36. When considering their perceived impact on their ability to function, 3.88% of nurses reported that MI had an extreme impact on their functioning with an average MISS-HP score of 63.00. 10.68% reported that MI very much impacted their ability to function with an average MISS-HP score of 57.09, and 27.18% of MHNs reported that MI had a moderate impact on their ability to function with an average MISS-HP score of 46.00. A further 32.00% of MHNs reported that MI had a mild impact on their ability to function with an average MISS-HP score of 42.82, while 26.21% reported that MI did not impact their ability to function with an average MISS-HP score of 37.44 (see Table 3).

**Table 3.**

*Proportion of mental health nurses who experience functional impairment and the mean MISS-HP total score for that group*

| Functional impact | Not at all | Mild | Moderate | Very much | Severe |
|---|---|---|---|---|---|
| Percentage of MHN's (%) | 26.21 | 32.00 | 27.18 | 10.68 | 3.88 |
| MISS-HP mean score | 37.44 | 42.82 | 46.00 | 57.09 | 63.00 |

**Research Question Two: To what extent is moral injury associated with adverse psychological outcomes, demographic characteristics and workplace factors?**

A Spearman rho correlation was conducted to examine the association between MISS-HP total score and several ordinal and continuous variables (see Table 4). Preliminary analysis highlighted that the dependant variable had a non-normal distribution and therefore non-parametric tests were conducted. After correcting for multiple comparisons using the Holm Bonferroni method (Holm, 1979), the following variables had significant association with the total MISS-HP score: the PHQ-9 (r = .467, P=<.001, adjusted P = .028), GAD-7 (r= .421, p= <.001, adjusted P = .028), feeling that their level of responsibility matches their power (r= -.367 = <.001, adjusted P = .028), feeling supported by colleagues (r= -.348, p = <.001, adjusted P = .028), feeling that there were adequate resources (r= -302, p = .002, adjusted P = .048). No other variables measured had a significant relationship with the total MISS-HP score.

**Table 4:**

*Spearman Rho correlations exploring variables association with MISS-HP scores*

| Variable | N | Spearman Rho correlation |
|---|---|---|
| PHQ-9 | 103 | .467* |
| GAD-7 | 103 | .421* |
| Perception of responsibility matching the level of power in the team | 103 | -.367* |
| Feeling supported by colleagues | 103 | -.348* |
| Perceived adequate resources to deliver satisfactory care | 103 | -.302* |
| Feeling supported by line manager | 103 | -.270 |
| Taking breaks allocated breaks | 103 | -.269 |
| Feeling supported by family | 102 | -.233 |
| Length of time registered a mental health nurse | 103 | -.186 |
| Perceived staffing levels | 103 | -.182 |
| Feeling supported by supervisor | 103 | -.186 |
| Age | 103 | -.174 |
| Feeling supported by friends | 103 | -.154 |
| Feeling that they have received inappropriate referrals | 103 | .144 |
| Experiencing aggression from a service user | 103 | .135 |
| Length of time in current role | 103 | -.098 |
| Pay banding | 103 | -.048 |
| Amount of time worked over contracted hours | 101 | -.008 |
| Disagreeing with the discharge of a service user | 103 | -.005 |

*adjusted p=<.005

A Mann-Whitney U test was run to explore the association between the binary nominal data and MISS-HP total score (see Table 5). All assumptions for Mann-Whitney U were met. There were no significant differences after correcting for multiple comparisons. However, the small sample size may have limited the statistical power of the analysis.

**Table 5:**

*Mann-Whitney U test exploring the difference in MISS-HP scores for religion, gender, completion of additional training and contract type*

| Group 1 | Group 2 | Group 1 Mean rank | Group 2 Mean rank | N1 | N2 | U | Z | P-Value | Adjusted p-value | Effect size |
|---|---|---|---|---|---|---|---|---|---|---|
| Identifies as having a religion or spirituality | Does not identify with having a religion or spirituality | 38.00 | 45.00 | 35.00 | 68.00 | 853.00 | -2.348 | .019 | 0.342 | -.230 |
| Male | Female* | 51.33 | 52.14 | 21.00 | 81.00 | 864.00 | .112 | .911 | 0.342 | .002 |
| Full time hours | Part time hours | 55.79 | 38.05 | 81.00 | 22.00 | 584.00 | -2.472 | .013 | 0.273 | -.240 |
| Completed additional training | No additional training completed | 49.83 | 52.77 | 44.00 | 58.00 | 1202.50 | -.497 | .619 | 0.342 | .005 |
| Identified as a carer | Identified as having no caring responsibilities | 54.00 | 49.67 | 31.00 | 70.00 | 1178.00 | .685 | .493 | 0.342 | 0.07 |

A Kruskal Wallis Test was run to explore the association between categorical data and the MISS-HP total score. All assumptions for the Kruskal Wallis were met. However, the small sample size may have limited the statistical power of the analysis. There were no significant differences between all variables and the MISS-HP total score: relationship status [H(3) =.232, p=.972, client populations [H(4) =2.50, p=.645], location of work [H(2) =5.79, p=.055, adjusted p value = 0.342]. There was a significant association between considering leaving the profession and MISS-HP total score H (2) =8.53, p = .014. However, after accounting for multiple comparisons, there were no significant differences found (adjusted p value = 0.28).

**Research Question Three: What factors predict moral injury in mental health nurses working in the NHS?**

Due to the limited sample size, the following variables were selected to run in the multiple regression based on level of association and previous research.

A multiple linear regression was implemented to explore whether PHQ-9 total score, GAD-7 total score, feeling supported by colleagues, having adequate resources, feeling their power matches their level of responsibility and length of time qualified as MHN predict moral injury in MHNs. Following this, all assumptions were met, according to critical values [see Table 6; Tolerance levels > .1, and Variance Inflation Factor [VIF] values < 10; Mahalanobis distance was calculated no outliers appear to affect the data ($D^2$ (6) =17.69, p =.001), critical value = 22.46; maximum Cooks Distance =0.095 which is less >1; Pallant, 2016)]. A significant regression equation was found (F (6,103) =

13.38, $p < .001$), with an $R^2$ of .421. The model explained 42.10% of the variance in MISS-HP total scores. The Holm Bonferroni correction method was applied and the following predictive variables were significant (Holm, 1979):

Feeling supported by colleagues was found to be a significant inverse predictive variable of MI (b= -3.55, $SE_b$= 1.09, t = -3.27 p =.002, adjusted p value =.01). Therefore, implying that when MHN respondents feel more supported by their colleagues they experience less MI. PHQ-9 was a significant factor within the regression model of MI (b=1.05, $SE_b$=.30, t = 3.52, $p < .001$, adjusted p value =.006), indicating that MHN respondents who experience higher levels of depression have higher levels of MI. However, length of time as a registered MHN was not a significant factor in the regression model of MI (b= -.01, p = .061) along with GAD-7 (b= .09, p = .772). Perception of having adequate resources to deliver satisfactory care was not a significant factor in the regression model of MI, after correcting for multiple comparisons (b=-2.06, $SE_b$= .91, t = -2.28, p= .025, adjusted = .10).

**Table 6**:

*A multiple linear regression examining whether PHQ-9 total score, GAD-7 total score, feeling supported by colleagues, having adequate resources, feeling their power matches their level of responsibility and length of time qualified as MHN predict moral injury in MHNs*

| | Unstandardized Coefficients | | Standardized Coefficients | | | | Collinearity Statistics | |
|---|---|---|---|---|---|---|---|---|
| | B | Std. Error | Beta | t | Sig. | Adjusted P value | Tolerance | VIF |
| (Constant) | 60.87 | 5.818 | | 10.461 | <.001 | | | |
| GAD-7 | .088 | .303 | .033 | .291 | .772 | 0.982 | .451 | 2.218 |
| Colleagues supportive | -3.548 | 1.086 | -.278 | -3.266 | .002 | 0.01 | .784 | 1.275 |
| Adequate resources | -2.063 | .906 | -.188 | -2.277 | .025 | 0.10 | .832 | 1.202 |
| Responsibility matches perceived power | -.776 | 1.123 | -.061 | -.691 | .491 | 0.982 | .721 | 1.388 |
| PHQ-9 | 1.048 | .298 | .392 | 3.516 | <.001 | 0.006 | .456 | 2.191 |
| Length as RMN | -.013 | .007 | -.151 | -1.893 | .061 | 0.183 | .895 | 1.118 |

## Discussion

To the best of the authors' knowledge, this is the first study to explore moral injury quantitatively in mental health nurses working in the NHS. This study explored the association of MI with professional and demographic factors and whether these factors predict MI. The average MISS-HP total score was 44.58 (SD=12.88). In prior work (Mantri et al., 2020), the reported cut off score for impact on functioning for the MISS-HP is 36.00 and 56.30% of MHNs scored above 36.00. Over half (59.18%) of the MHNs reported that their perceived impact of MI was having a mild or

moderate impact on their overall functioning. However, of those who reported that their perceived impact on functioning was mild or moderate, 33.91% had a score of 36.00 or higher. This suggests that MHNs perception of the impact of MI on their functioning is lower than the impact reflected by their MISS-HP total scores. These findings may indicate that the scale's cut off score may over-estimate the functional impacts of MI among MHNs, or alternatively, reflect under-reporting and/or a lack of recognition of their own functional impairment. Nevertheless, the scale highlighted a gradual increase in the mean MISS-HP total score across increasing levels of reported functional impact, thus supporting the scale's ability to measure differences in severity. However, adjustment of the criteria may be required to support sensitivity within this population.

This study indicates that MI is highly prevalent and having a significant impact on the MHN respondents working in the NHS in this study, with the average score indicating that many of the respondents have functional difficulties in their work relating to moral injury. As a comparison, Mantri et al. (2020) also reported that the average MISS-HP score for health care professionals in physical health settings (outpatient, inpatient, intensive care unit, critical care unit and emergency room) working in North Carolina was 36.80 (SD = 13.30) for 181 participants. Similarly, a large-scale study conducted by Wang et al. (2022) in China found that the average MISS-HP score among 3006 physicians and nurses working in a hospital setting (inpatient, outpatient, intensive care unit and emergency) was 46.90 (SD= 12.70). This suggests that the MHN respondents are experiencing levels of MI that are higher or equivalent to those of healthcare professionals working in a physical health setting. Additionally, most research appears to be in the context of hospital or acute settings, however, the majority of MHNs work within a community setting (Palmer et al., 2023). Subsequently, when comparing these studies caution should be exercised due to them being conducted in different countries, and the differences in the healthcare systems and other contributing factors to MI.

**Individual Factors**

When considering age, previous research has suggested that younger healthcare professionals (<40 years) are more likely to have higher levels of MI (Fattori et al., 2024; Rabin et al., 2023). This study highlighted that individuals aged 24-28 (M =49.39, SD= 17.21 Mdn= 49.00) and 44-48 (M =50.58, SD= 13.13 Mdn= 48.50) had the highest average levels of MI among the respondents. It is important to consider different factors which may be impacting the average MI across these age groups. NHS England (2025) highlighted two key areas impacting the retention of NHS staff: early and late careers. Individuals in their early careers tend to leave the job within 2 years and for those in late careers, particularly women, it has been suggested that menopause can have a negative impact, with one in five women aged between 45 to 54 reporting being unable to go to work as a

result. Therefore, when interpreting the higher levels of MI in the 24-28 and 44-48 age group, it is apparent that there may be other distinct factors contributing to their level of MI which were not measured in this study but would be useful to explore in future research. In this study, 30.00% of MHN respondents said they were considering leaving the profession, nonetheless, this was not significantly associated with MI after correcting for multiple comparisons. Additionally, neither length of time as a MHN since qualification, nor length of time in their current role, was identified as having a significant relationship with MI. This aligns with the systematic review conducted by Webb et al. (2024a) which highlighted that both student nurses and experienced mental health professionals experience similar levels of PMIEs. Whereas, qualitative research has suggested that healthcare professionals who have less experience are more likely to experience MI (Rabin et al., 2023). Conversely, it is thought that healthcare professionals with higher length of time in the role accumulate more PMIEs, therefore also experience higher levels of MI (Hegarty et al., 2022). This may be linked to the crescendo effect, whereby the more PMIEs someone experiences the more likely they are to develop MI (Epstein & Hamric, 2009). Whereas this study highlights that both factors may be occurring for the MHN respondents working in the NHS.

In previous research, not having a religion was deemed a significant predictive variable of MI (Rushton et al., 2022), however, after correcting for multiple comparisons there were no significant differences between MISS-HP total scores of those who identified as having a religion to those who did not. On average those who identified as not religious or spiritual had higher levels of MI. Furthermore, Mantri et al. (2021), highlighted that those who do not have a religion and/or spirituality were more likely to score lower on the MISS-HP. This is important to hold in mind when interpreting the results due to the possible impact of the two religious questions on the total MISS-HP score.

In this study, it was highlighted that feeling supported by colleagues had an inverse association with MI; in comparison to line manager, supervisor, friends and family support which all had a weak negative association. This partially aligns with the qualitative findings of Rabin et al. (2023) who highlighted that health care professionals who feel less supported by colleagues and line managers are more likely to experience MI. Likewise, a qualitative study by Thompson et al. (2024) highlighted that MHNs working in an inpatient setting reported that a key factor which contributes to their MI was feeling unsupported by management as a result of a blame culture.

**Mental Health Outcomes**

Similar to previous studies (Amsalem et al., 2021; Levi-Belz & Zerach, 2022; Wang et al., 2021) there was a positive correlation between depression (PHQ-9) and/or anxiety (GAD-7) and MI. Depression was seen to be a significant factor in the regression model which aligns with previous

research for healthcare professionals (Amsalem et al., 2021; Coimbra et al., 2024; Fradley et al., 2025). This may be understood through the role of shame in depression (World Health Organization, 2025). As highlighted by VanderWeele et al. (2025), individuals who experience MI are more likely to experience shame and guilt, particularly when the perceived transgressions are directly linked to the individuals behaviour (Kvitsiani et al., 2023). It's important to hold in mind that although depression is a significant factor in the regression model, the study did not explore whether depression pre-existed any morally injurious experience and therefore no causal links can be made between depression and MI. In contrast to pre-existing research (Kvitsiani et al., 2023; Rodríguez et al., 2021), anxiety was not a significant factor in the regression model of MI in MHNs. Nonetheless, this study did find that anxiety was correlated with MI, indicating a moderate association between anxiety and MI, but this association did not remain significant in the regression model.

**Organisational and Clinical Factors**

The study highlighted that there are several workplace factors which are associated with MI among the MHN respondents. MHNs who were at a post-entry pay grade level (Health Careers NHS, 2024) had a higher average MI. It is of note that the NHS survey highlighted that only 32.05% of NHS staff are satisfied with their pay. However, there was a negative weak association with MI, suggesting that MI is not strongly associated with pay banding. Furthermore, perceptions of MHN respondents' responsibility matching their perceived power in the team was significantly correlated with MI but did not go on to have a significant result in the regression model. This contrasted previous qualitative research whereby Webb et al. (2024a) highlighted that feeling powerless contributed to the development of MI in psychiatric professionals in acute settings in particular. However, this study highlighted that this may not be a difficulty for the MHN respondents, as only 5.80% of MHNs felt that their power never matched their level of responsibility within their team. It is important to recognise the differences in the studies, as this study explored MHNs across a variety of settings and therefore considers both community and inpatient MHNs experiences. However, there were no significant differences in MI when comparing work setting.

This research highlighted that MHN respondents who perceived that they have inadequate resources to deliver satisfactory care are associated with higher levels of MI. This aligns with previous qualitative research with healthcare professionals whereby having limited resources to effectively care for patients increased the risk of MI (Rabin et al., 2023; Williamson et al., 2023). Previous research (Austin et al., 2005; Gabrielsson et al., 2016; Oliveira et al., 2020) highlighted inadequate resources for psychiatric professionals included having insufficient time and inadequate facilities resulting in compromised care and safety. This included mental health facilities that were deemed unsuitable and overcrowded, as well as therapy rooms that were not soundproofed, raising

concerns about confidentiality. This appeared to be a difficulty for the MHN respondents as it was reported that over half (54.40%) of MHNs felt they did not have adequate resources to deliver satisfactory care. However, after controlling for multiple corrections, perception of inadequate resources did not predict MI. It is also worth emphasising that the MHN respondents, on average over a two week period, are working 5.57 hours overtime, and 42.70% of MHN respondents never or almost never took their allocated break, these factors were not significantly associated to MI. Hegarty et al. (2022), highlighted that healthcare workers often overwork to compensate for systemic and/or organisational failures which in turn contributes to MI. Thompson et al. (2024) highlighted MHNs expressed a need to work unpaid overtime in order to provide satisfactory care in the context of limited resources.

**Clinical Implications**

This study highlighted that the MHN respondents working in the NHS are experiencing MI, which has a moderate to severe impact on their functioning. However, feeling supported by their colleagues appears to reduce MI, suggesting that encouraging peer support amongst MHNs may be a key factor in mitigating MI. This may, in turn, increase retention of MHNs in the NHS as MI appeared to be highest in those considering leaving. When considering individual factors, those within the 24-28 and 44-48 age brackets may require further support, as well as further exploration of the individual factors contributing to their MI.

Another important factor in reducing MI is ensuring MHNs feel adequately supported when seeking mental health support, particularly in relation to symptoms of depression, which emerged as a significant factor within the regression model.

Overall, there appears to be a need for increased recognition of MI in the mental health nursing workforce, and organisations need to develop avenues of peer support and psychological support for MHNs experiencing high levels of moral injury.

**Limitations and Future Research**

While this study offered novel insights into MI among MHNs working in the NHS, there are several limitations to consider. Firstly, it is important to acknowledge the small sample size (n=103) which impacted on the number of variables explored in the regression, as well as the lack of power in the Mann-Whitney U test and Kruskal-Wallis test. This may impact the results of the study whereby increasing the chances of making a type 2 error and due to correcting for multiple corrections, there is a risk that there may be some effects which may not have been identified. Therefore, it will be important for this research to be replicated with a larger sample size. The factors which may have resulted in difficulty with recruitment may have been due to the context which MHNs are currently working, as the research suggested MHN respondents are working over

their contracted hours and feeling that they do not have adequate resources to deliver satisfactory care. Therefore, this may have impacted on MHNs capacity to consider taking part in this research.

Another sample limitation was the lack of diversity as the sample largely consisted of white (n=86.41%), female (n=78.64%) participants as well as certain groups being underrepresented in the sample such as agency staff (2.91%) and those who trained abroad (3.88%). This resulted in these variables being excluded from the inferential statistics and therefore, these variables should be considered for future research. It will be important for future research to seek PPI from different ethnicities and genders to understand the best ways to engage them in future research of MI in MHNs. However, it is important to recognise that mental health nursing is a female dominated profession, and the percentage of representation in this study may reflect the gender proportions in the workforce. According to the Nursing Midwifery Council (2024), male nurses tend to make up 11% of the NHS workforce. In the Children and Young People Mental Health Services Census, women made up 86% of the workforce (NHS England, 2024a).

It is important to consider the bias which may occur when completing an online survey. Firstly participants may have a tendency to report socially desirable answers (Choi & Pak, 2004). Secondly, those who do not have regular access to the internet, such as those working in inpatient wards may be unable to complete the survey, which may result in a non-representative sample (Ball, 2019). Additionally, online surveys tend to rely on Likert scales, as mentioned earlier the impact of treating Likert scales as interval data can affect the results due to the impact of outliers and the assumption of equal spacing. However, due to this study being the first to explore MI quantitatively in MHNs working in the NHS, it was beneficial to treat the data as interval in order to explore more variables due to the exploratory nature of this study. Moreover, the study comprised of single Likert items to measure several independent variables, these questions have not previously been used and therefore lack the evaluation of their psychometric properties. However, it has been highlighted that, as in this study, single Likert scale items should have at least five points on the scale for the item to be able to be reliably used in inferential statistical analysis (Alkharusi, 2022; Harpe, 2015).

Additionally, several factors identified in this study warrant further exploration such as anxiety, perception of power matching perceived responsibility, and having adequate resources to provide satisfactory care. As these variables became non-significant when entered into the regression model, further research is needed to clarify their role in MI among MHNs.

## Conclusion

To the best of the authors' knowledge, this was the first study to explore MI among MHNs working in the NHS, and to identify the factors associated with, or predictive of, MI. The findings suggest that MHN respondents experience levels of MI that, on average, indicate there are impacts

on their functioning at work (Mantri et al., 2020). Depression and perceived support from colleagues were significant factors of MI in the regression model, highlighting important factors to consider when supporting MHNs in practice. The study, however, had several limitations, including a small sample size that impacted on statistical power. There were several associated factors which would benefit from further exploration around whether they predict moral injury, such as perceived support from managers and supervisors, taking allocated breaks and perceived staffing levels. Future research should aim to examine these factors using a larger more representative sample.

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# Chapter Five
## Extended methodology for empirical project and extended results for systematic review

Word count: 2657

## Extended Methodology for Empirical project

This chapter provides further detail in relation to the methodology of the empirical project regarding the design, ethical considerations and statistical analysis.

## Method

### Design

The empirical project implemented an online survey design as there were several benefits to using an online survey, including the ability to collect large amounts of data in a short period of time at minimal cost. This was the preferred approach for this study which aimed to reach a diverse national cohort of participants working across multiple organisations. Online surveys are often preferred by participants due to convenience and can reduce desirability bias due to the absence of an interviewer and the increased sense of anonymity (Ball, 2019). However, online surveys may also introduce selection bias, and there may be a risk of under or over representation of different characteristics in the sample (Haddad et al., 2022).

### Measures

The empirical project used the Moral Injury Symptom Scale for Healthcare Professionals (MISS-HP; Mantri et al., 2020) to measure moral injury. Other questionnaires were considered for this study such as, Moral Injury and Distress Scale (Norman et al., 2024), however, due to the specific nature of these questionnaires (e.g. recalling a specific event), it was felt that they would not measure the potential cumulative impact of moral injury when working day-to-day in health services.

### Analysis

During the early stages of recruitment an error was identified in three Likert-Scale items (experience of aggression from service user, inappropriate referrals, and disagreeing with the discharge of service users) the response options “often and always” were presented in the wrong order. Once discovered, the survey was suspended until the error was corrected. Three responses were subsequently re-coded on the inappropriate referrals item, with “often” treated as “always” and vice versa.

The categorical variables were dummy coded as follows: Gender (Female= 0, male =1 and non-binary =2), religion and spirituality (yes = 1 and no = 0), relationship status (single = 0, in a relationship =1, married = 2, prefer not to say = 3), location of work (community = 0, inpatient = 1, other = 2), full or part time hours (full time = 0 and part time = 1), contract type (substantive = 0 and agency =1), additional training (no =0 and yes = 1) caring responsibilities (no = 0, yes =1 and prefer not to say = 2), location of training (United Kingdom = 0 and abroad = 1), Pay banding (band 5 = 0, band 6 = 2, band 7 = 2 and band 8a, 8b, 8c = 3) considering leaving the profession (no = 0, yes = 1, maybe =2 and prefer not to say =3). Due to the ethnicity data being collected as an open response

item, the raw data were collated in line with Office for National Statistics recommended categories (Office for National, 2021). The data were coded as follows: White (British, white British, Cornish, English, White Irish, Irish) = 0, Black, Caribbean, African, Black British (Black African, Black Caribbean) = 1, Asian (British Indian, Indian and Asian) = 2, mixed and/or multiple ethnic groups (mixed White and Asian) = 3 and prefer not to say =4. Due to the MHN's working across a variety of populations, participants were able to select multiple populations. These were coded to ensure there were enough participants in each category for statistical analysis: adults and older adults = 0, youth, child and adolescent = 1, all populations = 2, youth and adults = 3, youth, adults, older adults = 4. Two participants were removed due to their responses could not be grouped into the main categories listed above (child & adolescent, youth and adult).

To account for the multiple-comparisons conducted across the Spearman's rho correlation, the Kruskal-Wallis test, Mann-Whitney U test and the multiple regression, the Holm Bonferroni correction was implemented. An adjusted critical p-value was used to determine the significance of all inferential statistics for research question two and three separately (Holm, 1979). The Holm Bonferroni correction method was chosen as it has been reported to provide greater power than the traditional Bonferroni correction, while still controlling for familywise error rate (Carvajal-Rodredguez, 2010; Holm, 1979).

## Ethical Considerations

### *Informed Consent and Right to Withdraw*

Participants were provided the participant information sheet (see Appendix G) upon first clicking the link to the survey or scanning the QR code. This enabled the participants to make an informed decision on whether to proceed with the research study. Participants were informed of their right to withdraw by exiting the survey at any point prior to submitting their answers. Participants were presented with the statement 'By ticking this box, I consent to taking part in this study and I understand that I can withdraw consent at any point prior to submission by closing the browser.' In order to proceed, the participants were required to tick the consent box. In accordance with University of East Anglia Ethical guidance and Health Research Authority guidance 'Proportionate approach to seeking consent', section 2.6., explicit consent is not required in postal and/or self-completion surveys when no identifying information is being collected in the study (Health Research Authority, 2018; University of East Anglia, 2021). Participants were informed on the participant information sheet that once they had submitted their answers, they would not be able to withdraw their information due to the data being anonymous.

### *Confidentiality*

There was no identifiable data collected in this survey. The data was stored on Jisc which is GDPR compliant (*Data Protection Act*, 2018). Once data collection was completed the data was extracted onto an excel spreadsheet which was password protected and stored on the lead researcher's UEA OneDrive. University of East Anglia Research Data Management Policy (2019) was adhered to, and all non-identifiable information will be stored by UEA for a minimum of 10 years.

### *Coercion and Deception*

There was no deception used within this study, all participants were provided the participant information sheet prior to completing the study. The study was on a voluntary basis, and participants were provided the lead researcher's email address.

### *Distress and Debriefing*

The participants were asked to think about experiences they have had as MHNs, and this may have been distressing for some participants. To ensure all participants felt supported appropriate signposting was included in the participant information sheet and debrief information sheet (see Appendix H). Participants were provided the lead researchers email at three time-points, the poster, participant information sheet and debrief sheet. If participants contacted the lead researcher for support, they were directed to the signposting services as noted in the debrief sheet.

## Patient and Public Involvement

A mental health nurse who had worked in a variety of different mental health settings and with a variety of different populations was involved in the development of this study. They were recruited through professional connections. They consulted on various aspects of the research including the factors which contribute to experiences of moral injury. Following this, they ranked each variable included in the study according to their perceived importance in relation to MI. Consultations were conducted via Microsoft Teams meetings as well as email correspondence. The PPI was also consulted on the acceptability of the study; they advised that the survey should be no longer than 15 minutes as this would deter participants. In terms of recruitment, the PPI suggested the use of online survey distributed through social media platforms would support with the recruitment of MHNs.

## Additional Results for the Systematic Review

The following results are presented separately from the systematic review paper due to the word count constraints, therefore the themes which had a larger presence across the studies were included in the main systematic review. Nonetheless, the additional themes contribute to the overarching theme *psychiatric professionals feeling powerless in a morally distressing system.*

### Psychiatric Professionals Feeling Powerless in a Morally Distressing System

#### *System and Organisational Constraints Resulting in Moral Injury*

##### Gaps in Services Resulting in Compromised Care

The gaps in services resulting in compromised care theme was common across six studies (Eder et al., 2025; Hadson et al., 2024; Liberati et al., 2021; Matthews & Williamson, 2016; Musto & Schreiber, 2012; Rushton et al., 2022). Across the studies, several service gaps were identified which resulted in experiences of moral injury. These included a lack of services to refer to, the cessation of services, and a shift in focus from person centred care to risk and safety management. Participants described wanting to be able to adapt the care they provided to the needs of their service users, as they felt that the treatment was not effective. However, due to the constraints of the service they were unable to adapt their practice. One participant demonstrated this ethical tension:

> It was dismissed in the overall picture cause he just went home and then back to his drug use and it's all falling apart. And—but that's the system, that wasn't people. That wasn't any one individual.. . .Part of my distress in that case was that I knew exactly what was going to happen.. . . in reality, the system didn't allow for anything else to happen.
>
> (Musto & Schreiber, 2012, p. 143)

Whereas other participants described having to cover the gaps in the service themselves. A consultant psychiatrist working in adult services expressed, "There's a culture where [it] falls on the consultant to cover that gap and to say I'm just going to keep going here" (O'Donnell et al., 2023, p. 4). Some participants described feeling morally injured by the lack of control over the access of external services which resulted in prolonged stays and/or readmission to acute mental health wards (Eder et al., 2025; Hadson et al., 2024; Liberati et al., 2021).

Across the studies, gaps in services appeared to impact on psychiatric professionals' ability to deliver satisfactory care, resulting in them experiencing moral injury. Furthermore, the inflexibility of services, the absence of appropriate provision and increased focus on risk management appeared to hinder service users' recovery, which in turn appeared to contribute to participants experiences of moral injury.

#### *Individual Sources of Moral Injury*

##### Balancing Risk, Boundaries and Safety for Self and Others

The theme balancing risk, boundaries and safety for self and others was common across five studies (Hadson et al., 2024; Klingemann et al., 2025; Liberati et al., 2021; Rushton et al., 2022; Wall et al., 2024). Across the studies participants expressed concerns relating to managing risk, including feeling physically unsafe or delaying discharging service users, and balancing the needs of the service user and the risk of exposure to COVID-19. The author demonstrated the moral dilemma of participants needing to reduce their face-to-face contact with service users due to COVID-19 restrictions: "Reliance on telephone calls created uncertainty about discharging service users from their caseloads. This was compounded by a fear that service users may perceive this as further rejection at a time when there was less social support than usual" (Wall et al., 2024, p. 381). In the context of COVID-19 pandemic, participants felt that the personal protective equipment was impacting on their delivery of safe and effective care. An author demonstrated the ethical dilemma of balancing both the risk of infection and safety of both service users and colleagues: "Staff also raised concerns about being able to react to emergencies rapidly because of the time taken to don PPE, and even once they had they reported some service users were startled or distressed by their appearance"(Liberati et al., 2021, p. 7). Furthermore, some participants raised concerns around the legalities of implementing self-isolation protocols when the service user declined to adhere to the guidelines.

Other participants highlighted that feeling physically unsafe impacted on the care they were able to provide. A participant described their experience of feeling unsafe:

> I would equate it to if you were a therapist and were sitting doing therapy with somebody, but you were in a really big room. [.] And right behind you, a guy just kept walking [.],and shadowboxing behind the back of your skull. Trying to conduct therapy with this person would be impossible because you'd be so worried about your own safety.
>
> (Hadson et al., 2024, p. 431)

Furthermore, a study highlighted that a transgression of personal boundaries resulted in participants experiencing moral injury. This was demonstrated by a peer support worker:

> I went a bit too far. I wanted to use my contact with the estate agent to recommend that person to a patient who was really worried about his house and didn't know what to do with it and was thinking of selling it… then I saw the aggression in the patient's sister's eyes, so I backed off.
>
> (Klingemann et al., 2025, p. 663).

Across the studies it was suggested that the dilemma of balancing the risks both of infection and safety as well as maintaining boundaries appeared to lead to participants experiencing moral

injury. However, it is important to recognise that three of the five studies focused on the implications of COVID-19 restrictions.

**Use of coercive or restrictive interventions leading to moral injury**

The use of coercive or restrictive interventions leading to moral injury theme was common across six studies (Eder et al., 2025; Jansen, Danbolt, et al., 2022; Jansen et al., 2020; Lloyd et al., 2024; Navarro et al., 2021; Pérez-Toribio et al., 2022). Restrictive and coercive interventions reported by participants included: restraining and medicating service users, forced tube feeding, and pressuring service users to remain hospitalised. Across the studies there was a sense that psychiatric professionals were uncertain about the implementation of restrictive and/or coercive interventions, and felt compelled to tolerate an increasing level of violent and/or challenging behaviour. A participant demonstrated this ethical dilemma:

> It is difficult to know when we actually should use coercion. We try and try and try again all the measures at our disposal to avoid tight-holding or belts. When the patient in spite of this goes on and on and on ... You get to a point when this is enough [has to be stopped]. But you don't want to use coercion. Afterwards one may think what is right? What is wrong? (Jansen, Danbolt, et al., 2022, p. 5)

Furthermore, participants described being "one of the bad guys" for implementing restrictive interventions and reported feeling pressure from the wider system to reduce the coercive interventions (Eder et al., 2025). In turn, the use of restrictive and/or coercive interventions negatively impacted psychiatric professionals emotionally and physically. Some participants described coercive practices as their "greatest moral dilemma" (Jansen et al., 2020, p. 1319). Across the studies there was a consistent sense that participants felt unable to refuse the use of restrictive and/or coercive interventions, whilst recognising the negative impact on the service users. A participant described their experience:

> I think that it's iatrogenic... and even so I use containment in those cases without... I mean, I wouldn't want to, but if I ask the supervising specialist, they are going to tell me that I should contain them, and that psychiatry [...] is like that. Today in the Community of Madrid, it's like that.
>
> (Navarro et al., 2021, p. 11)

This highlighted a sense of powerlessness to refuse the use of restrictive practices, alongside a pressure to normalise their use in psychiatry.

Additionally, some participants described experiencing moral injury as a result of witnessing the use of restrictive interventions which they believed could have been avoided, or when the

challenging behaviour appeared to be a consequence of a colleagues communication style (Eder et al., 2025; Jansen et al., 2020).

Across the studies, restrictive and/or coercive interventions emerged as a source of moral injury for psychiatric professionals'. This included both the implementation and witnessing of restrictive and/or coercive interventions. These experiences were described as "traumatic" (Eder et al., 2025; Navarro et al., 2021) and a "necessary evil" (Jansen et al., 2020). The moral injury for psychiatric professionals appeared to stem from the uncertainty regarding the appropriate use of restrictive interventions, combined with perceived systemic pressure, and the belief that some instances were avoidable.

# Chapter Six

## Discussion and critical evaluation

Word count: 3819

## Discussion and Critical Evaluation

This chapter will summarise the findings from both the empirical project and the systematic review, including a critical appraisal, clinical implications and suggestions for future research.

## Summary of Findings

### *Systematic Review*

The systematic review contributed a new perspective on the experiences of moral injury among psychiatric professionals. A thematic synthesis (Thomas & Harden, 2008) of 23 studies, revealed one overarching theme: psychiatric professionals feeling powerless in a morally distressing system; underpinned by four themes: (1) system and organisational constraints resulting in moral injury; (2) individual sources of moral injury; (3) consequences of moral injury; (4) helpful and unhelpful ways of dealing with moral injury. These themes suggested a cumulative process of which moral injury develops from a system and/or organisational level to an individual level. Psychiatric professionals experienced both emotional and physical distress from the impact of MI such as, exhaustion, guilt, shame and hopelessness due to being unable to provide or witnessing inadequate care. Subsequently, they developed different ways of coping and/or reducing the distress experienced, such as, emotionally distancing themselves or sharing the burden with others. For individuals who were unable to cope and/or reduce their distress the moral injury remained.

### Empirical Project

This empirical project offered novel insights into the different factors which are associated with moral injury among mental health nurses (MHN) respondents working in the National Health Service (NHS). The study highlighted that over half of the MHN respondents (56.30%) scored over the cut off score (36.00) for the moderate to severe impact of functioning on the Moral Injury Symptom Scale- Healthcare Professional (MISS-HP; Mantri et al., 2020); with the MHN respondents mean total MISS-HP score of 44.58. There were several factors which had significant associations with the total MISS-HP score. This included the PHQ-9, GAD-7, the perception of responsibility matching MHNs perceived power, feeling supported by colleagues and feeling that they had adequate resources to deliver adequate care. However, only PHQ-9 and 'feeling supported by colleagues' went on to be significant in the regression model, suggesting that those who have higher levels of moral injury are more likely to have higher levels of depression and feel less supported by their colleagues.

## Combined Discussion

This thesis portfolio aimed to deepen the understanding of moral injury (MI) within the psychiatric workforce, contributing novel insights to the literature. Both studies highlighted several important factors that appear to contribute to moral injury in this workforce. However, the empirical

project focused specifically on MHNs, as MHNs make up a third of the psychiatric workforce (Palmer et al., 2023). One key finding in the systematic review was psychiatric professionals feeling powerless in a morally distressing system, whereby as a result of systemic pressures they experienced conflicts with their values due to being unable to provide satisfactory care. This aligns with the definition of moral injury, witnessing or perpetrating acts which transgress an individual's moral beliefs resulting in guilt, shame, and anger (Jinkerson, 2016; Litz et al., 2009; VanderWeele et al., 2025). However, these value conflicts often did not result in individuals feeling able to change their care practices, this was attributed to feeling powerless within the mental health system and/or being fearful of the professional repercussions. The repercussions included psychiatric professionals believing that they are unable to influence change due to hierarchical and power dynamics and/or being fearful that challenging the morally injurious behaviour would result in either themselves or their colleagues being alienated.

One consistent finding across both studies was that feeling supported by their colleagues helped psychiatric professionals to cope with and/or reduced moral injury. This aligns with previous research indicating that the sources of support (colleagues, friends, family and professional bodies) serve different functions such as, seeking reassurance from colleagues or emotional support from family and friends (Musto & Schreiber, 2012). However, the empirical project found no significant association between MI and other sources of support (line managers, supervisors, friends and family). This may suggest in terms of mitigating MI, the greater emphasis should be placed on colleague support to share common experiences and burdens of MI. In addition, the themes highlighted in the systematic review suggested that poor communication such as lack of transparency, inconsistent, incongruent, poorly timed or absent communication from senior colleagues can be a source of moral injury, in turn, this may be negatively impacting on how support is experienced.

Moreover, the systematic review highlighted a sense of systemic powerlessness among psychiatric professionals, particularly when raising concerns or in relation to poor communication. Psychiatric professionals in this review reflected that when information was not passed down in a timely or transparent manner, it left them feeling uninformed and unequipped to fulfil their duties. Additionally, MHNs perception of their power and whether they felt this matched their responsibility in their team was significantly associated with MI, however, this did not go on to have a significant result in the regression model. It was highlighted by Tomura (2023), that the sense of powerlessness was linked to the disparity in MHNs level of responsibility and their power in the role. Whereas, Webb et al. (2024a) suggested that the sense of powerlessness was in relation to feeling unable to challenge sources of MI, due to hierarchical power imbalances and/or feeling outnumbered.

Therefore, the concept of powerlessness, and how this is truly defined and felt in the workforce, may benefit from further exploration to understand how the key aspects of powerlessness in the psychiatric workforce interacts with MI.

Another source of moral injury highlighted in both the systematic review and the empirical project was inadequate resources. The empirical project suggested that MHNs who felt they did not have adequate resources to deliver satisfactory care experienced higher levels of MI, however, after correcting for multiple comparisons this was not a significant factor in the regression model. Additionally, the systematic review aligned with previous research (Jansen et al., 2020; Oliveira et al., 2020; Rabin et al., 2023; Williamson et al., 2023), highlighting that inadequate resources (under staffing, insufficient time, and inadequate facilities) resulted in psychiatric professionals being unable to provide satisfactory care. Consequently, the systematic review highlighted that these resource constraints impacted on psychiatric professionals' ability to take annual leave or their lunch break, often resulting in them extending their working hours. Although psychiatric professionals reported frequently working through their break and working over-time to compensate for resource limitations, this was not associated with MI levels. Therefore, both the systematic review and empirical project align with previous research which suggested that healthcare professionals often feel they need to compensate for the failures of the wider system (Hegarty et al., 2022; Rabin et al., 2023). This may be impacted by wider systemic factors such as funding for mental health care; World Health Organization (2025b) highlighted that mental health systems are facing gaps in their resources, services, governance and research where other health conditions are often prioritised over mental health care. When considering the NHS, mental health care accounts for 20% of the overall healthcare demand and this demand is expected to increase (Department of Health Social and Care, 2025; Royal College of Psychiatrists, 2025).

**Strengths and Limitations of the Systematic Review and Empirical Project**

The individual strengths and limitations of each study have been discussed in their respective sections and therefore the focus will be on strengths and limitations on the thesis as a whole. A strength for the thesis is that it provides novel insights into the field of moral injury across different psychiatric professionals. Through combining a qualitative systematic review and a quantitative empirical project, it offered a more comprehensive perspective on both the experiences and factors associated with moral injury.

A limitation of the thesis was the lack of diversity among the samples. The systematic review largely consisted of MHNs, and psychiatric professionals working in the United Kingdom, while the empirical study also showed limited diversity with the sample largely consisting of white females. Moreover, the systematic review also had a disparity between the number of male and female

participants. However, this may be representative of the workforce, as women make up 70% of the health and social care workforce (Boniol et al., 2019). Nonetheless, this may impact the generalisability of the thesis results across the psychiatric workforce in different contexts. Conversely, the strong representation of MHNs across varied contexts including different countries, workplace setting (acute mental health wards, community and forensic settings) and service user population (child, adolescents, adult and older adults) is a key strength of this thesis, suggesting that the results may be more generalisable to MHNs specifically.

It is also important to hold in mind that the systematic review explored experiences of moral distress and/or injury to ensure that all experiences were included in the review as these terms have been used interchangeably in research (Wilson et al., 2024). However, the definition of moral distress suggested it is the acute reaction to PMIES. Consequently, the accumulation of moral distress experienced can lead to the development of MI (VanderWeele et al., 2025). Therefore, caution should be taken when interpreting the thesis as a whole, as the systematic review may be highlighting acute reactions to PMIES and/or the impact of MI. Nonetheless, this offers valuable insight into the different sources and impacts that may be the result of moral distress and/or moral injury, and this should be further explored.

A key strength of the empirical project focused on MHNs working in the NHS, as this is an area which had not previously been explored quantitively. As a result of its exploratory nature, the empirical project provided valuable insight into the different factors which are associated with MI among MHNs working in the NHS. However, the cross-sectional design limits the ability to infer causality, particularly when considering the predictive factors of MI. Furthermore, due to difficulties in recruitment the sample size was limited. There were several factors which may have impacted on recruitment, firstly the study highlighted that the respondents are experiencing MI as well as, inadequate resources, therefore it could be hypothesised that this may have impacted on MHNs capacity to engage with the survey. Secondly, the recruitment strategy relied on social media and professional distribution lists, this may have impacted on the proportion of MHNs who saw the advert. Therefore, it may have been beneficial to use the NHS employer as a gatekeeper; however, this was not used due to time constraints of the thesis. Additionally, due to the focus of the study being on MHNs working in the NHS, this may limit its generalisability to other healthcare settings, or cultural contexts.

### Implications for Theory

Many of the existing theories suggest that MI impacts on the persons perceptions of self, or the perceptions of others and the world (Kvitsiani et al., 2023; Rozek & Bryan, 2021). The Dynamic Model of Moral Injury suggested that there are different impacts of MI depending whether the

transgression was witnessed or perpetrated (Kvitsiani et al., 2023). When a moral injury is the result of witnessing an event which transgresses an individual's moral beliefs, this results in an individual experiencing negative emotions such as, helplessness, loneliness and a sense of injustice. This appears to link with the findings of the systematic review where participants described a sense of helplessness and loneliness. Moreover, if the individual perpetrated the transgression of their moral beliefs this resulted in feelings of self-blame, shame, and in turn, a loss in confidence. This also appears to link with the empirical project, as MI was highly prevalent among the MHN respondents working in the NHS, suggesting that they are collectively experiencing situations which transgress their moral beliefs resulting in moral injury. This was also consistent with the findings of the systematic review, where psychiatric professionals expressed feelings of shame as well as an increase in self-doubt about their own or others clinical practice.

Additionally, the socio-cognitive theory of moral identity suggests that different situational contexts may inhibit or increase moral behaviour. This may align with both the systematic review and empirical project, as both identified several organisational factors that may result in the psychiatric professionals suppressing their moral identity resulting in the experience of MI. Furthermore, the work conducted in this thesis provides support for the cognitive behavioural model (CBM) for MI, which highlights that there are several components of MI: cognitive, behaviour and physical domains (Rozek & Bryan, 2021). This model suggested that MI also results in feelings of guilt, anger, and anhedonia. The emotions highlighted in both the CBM and Dynamic Model of Moral Injury may link with the findings of the empirical project, as depression was a significant factor in the MI regression model. This aligns with previous research where depression was seen to be a predictive variable of MI (Amsalem et al., 2021; Coimbra et al., 2024; Fradley et al., 2025). This may be understood in the context of shame and loss of pleasure as a symptom of depression (World Health Organization, 2025a). Additionally, depression has also been strongly associated with feelings of powerlessness (Gilbert, 2016; Hammell, 2006). Both the systematic review and empirical project highlighted that psychiatric professionals are experiencing feelings of powerlessness. Therefore, it is important to consider the relationship between the powerlessness and depression experienced by psychiatric professionals and how it links with MI.

Furthermore, the CBM for MI highlighted several physical reactions such as muscle tension, aches, insomnia, and pain (Rozek & Bryan, 2021). This aligns with the systematic review findings where psychiatric professionals described experiencing headaches and problems with their sleep. Additionally, the empirical project highlighted that MHN respondents are experiencing MI to a degree which is impacting on their perceived level of functioning across different domains (work, relationships and home life).

The Moral Injury Formation Model (MIFM; Vaknin & Ne'eman-Haviv, 2025), suggested that moral injury was the consequence of the incompatibility of an individual's beliefs and their experiences, resulting in the loss of moral direction. The findings in both the systematic review and empirical project support this view, in that psychiatric professionals are being placed in situations requiring them to act in ways which conflict their values leading them to feel unsupported and powerless in their roles. This aligns with the MIFM as it suggested that individuals who are forced to choose an action which does not align with their values can result in moral injury (Vaknin & Ne'eman-Haviv, 2025). Furthermore, the model also suggested that individuals with cognitive flexibility are more likely to successfully adapt their moral tension and values reducing the distress experienced. This may align with the results in the systematic review where psychiatric professionals who viewed their moral conflict through a broader lens were able to resolve their distress (Musto & Schreiber, 2012). A key distinction in the MIFM from other models is viewing the moral struggles within the context of the individuals' experiences, suggesting that the action is neither good or bad but a conflict between the individuals ideal morals and reality. However, the moral injury occurs when an individual cannot achieve their moral ideal, this may be represented in both studies whereby, psychiatric professionals expressed not being able to deliver satisfactory care to their service users due to the constraints of the system.

**Clinical Implications**

It is evident from the empirical project that MHN respondents working in the NHS experience moral injury which has a moderate to severe impact on their level of functioning. Furthermore, the systematic review highlighted that experiences of moral injury are also evident across the psychiatric professions more broadly. Collectively, these studies identified several factors that contribute to moral injury, including inadequate resources and poor communication, as well as several other factors which are associated with MI such as, depression, anxiety, responsibility matching perceived power and feeling supported by colleagues. These findings highlight the importance of organisations developing an increased awareness of the PMIEs in psychiatric professionals to provide timely and appropriate support at the organisational, team and individual levels. Furthermore, identifying and supporting individuals who are experiencing symptoms of depression may reduce the level of MI experienced; this may include cognitive behavioural therapy for depression. Moreover, this may also decrease the experiences of powerlessness among psychiatric professionals.

As demonstrated by both studies, feeling supported by colleagues was key in helping the participants cope with moral injury, and organisations should develop avenues of peer support. The Schwartz rounds have been implemented as a means of emotional support for healthcare

professionals. The Schwartz rounds are a space for healthcare professionals to reflect as an MDT, or on a whole organisational level, on the emotional impact of their work (Golding, 2024). These forums were introduced as a method to improve staff wellbeing, and in 2009, these were implemented across USA, Canada and England (Robert et al., 2017). In 2015, 28% of the mental health and learning disability teams in the NHS had adopted the Schwartz round intervention to support staff wellbeing (Maben et al., 2018). Furthermore, an evaluation of the Schwartz rounds highlighted the positive impacts of attending, including increased compassion and empathy with colleagues, decreased isolation and more effective communication in teams (Maben et al., 2021). Implementing Schwartz rounds across organisations may increase the experiences of feeling supported for psychiatric professionals, reduce feelings of isolation, and also improve communication, in turn this may reduce the moral injury experienced. It is also important to recognise the value of NHS Staff Support services, and to build awareness of the levels and experiences of moral injury, as this will be crucial to support the psychological provision within the service.

Additionally, the systematic review highlighted that using reflection was a coping strategy used by psychiatric professionals. Clinical psychologists may therefore have a key role in supporting the reflective spaces for staff who are experiencing morally distressing events, as the systematic review highlighted that some participants used reflection to process their moral injury. Meziane et al. (2018) suggested that reflective practice is an effective way to reduce moral injury as it supports practitioners to reflect on the morally injurious event. Furthermore, this thesis highlighted the sources of MI are in the context of cumulative systemic constraints. Therefore, organisations and healthcare systems should recognise the emotional impact caused by the system constraints, and those in leadership positions should foster a culture which acknowledges these morally injurious sources. This might be achieved through MI informed policies which allow psychiatric professionals to raise morally injurious practice without fear of repercussions (Kirkup, 2019; Molendijk, 2025). As such, moving away from blaming the individual and towards a culture which recognises the harm caused by the system is essential.

Another factor which should be considered in clinical practice is clear communication between organisations, senior professionals, and the team. This includes communication in a timely manner which supports psychiatric professionals to adapt to any new information and/or implement any changes required without undue time constraints. As well as, clearly communicating the decisions made at an organisational and/or management level, particularly around the allocation and/or reduction in resources, where possible including the psychiatric professionals in the decision making to reduce the feelings of powerlessness. Furthermore, communicating information in a

validating manner and acknowledging the impact of wider system constraints may reduce the moral injury among psychiatric professionals. This may, in turn, reduce the sense of powerlessness experienced by psychiatric professionals supporting them to feel informed and involved in the decision-making processes.

It is important to consider the wider impacts on organisations such as funding for mental health services. Therefore, further consideration should be given to the provision of resources in the context of increasing demand in order to reduce moral injury within the psychiatric workforce, including, adequate staffing, time, and facilities.

**Future Research**

There were several areas of the portfolio that warrant further research. As noted in the empirical project, the small sample size limits the generalisability of the findings; therefore, this study should be replicated with a larger and more diverse sample. In particular, it would be beneficial to explore the age groups 24-28 and 44-48 in MHNs to better understand the different factors contributing to the higher levels of MI in these groups. Additionally, several factors identified in the empirical project warrant further exploration to clarify their role in MI among MHNs. This included perception of power matching perceived responsibility and having adequate resources to provide satisfactory care, as these variables became non-significant when entered into the regression model.

Further research should also aim to develop a longitudinal understanding of MI among MHNs and psychiatric professionals more broadly. This would support the understanding of the relationship between mental health outcomes and MI. Additionally, research is needed to better understand how powerlessness is conceptualised and experienced within the psychiatric workforce, and its relationship to MI.

Additionally, further research should seek to explore the experiences of MI in the underrepresented psychiatric professionals within the systematic review. Given a small sample of clinical psychologists reported experiencing MI, it would be valuable to investigate MI in this population in more depth.

Lastly, it may be of benefit to explore the validity of MISS-HP within psychiatric professional populations. The empirical project indicated that the scale cut off score may over-estimate the functional impacts of MI among MHNs. Alternatively, this may reflect underreporting and/or the under recognising of the functional impairment. Nevertheless, the scale highlighted a gradual increase in the mean MISS-HP total score across increasing levels of self-reported functional impact, supporting the scale's ability to measure differences in severity. Further investigation may therefore help refine the cut off criteria for this population.

## Overall Conclusion

The empirical project and systematic review aimed to explore the experiences of moral injury in psychiatric professionals as well as factors which are associated with moral injury among mental health nurses working in the NHS. The majority of MHN respondents working in the NHS reported experiencing levels of MI that on average exceed the functional threshold score of 36, suggesting that they are experiencing moral injury which is having a moderate to severe impact on their level of functioning (Mantri et al., 2020). A multiple regression revealed that depression and feeling supported by colleagues were significant factors; highlighting that these are important factors to consider when supporting MHNs in practice to reduce MI. The thematic synthesis of 23 studies highlighted that psychiatric professionals are feeling powerless in a morally distressing system. The studies suggested they experience moral injury as a result of system constraints (inadequate resources or poor communication) which impact on them at an individual level, as they are unable to provide adequate care and are acting in conflict with their own values. Consequently, psychiatric professionals appear to experience emotional and physical distress which they cope with by either emotionally distancing themselves or sharing the burden.

Taken together the studies gained a deeper insight into the impact of moral injury in the psychiatric workforce, as well as the organisational and individual factors which contribute to the experiences of MI. Overall, there appears to be a need for greater recognition of the organisational constraints contributing to moral injury in psychiatric professionals at both leadership and policy levels.

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# Appendices

## Appendix A

## Author guidelines for Clinical psychology & psychotherapy

*Clinical Psychology & Psychotherapy* aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

**Free Format submission**

CPP now offers Free Format submission for a simplified and streamlined submission process.

**2. MANUSCRIPT CATEGORIES AND REQUIREMENTS**

**Research Article:** Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

**Comprehensive Review:** Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

**Measures Article:** Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

**Clinical Report:** Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

**3. PREPARING THE SUBMISSION**

**Parts of the Manuscript**

The manuscript should be submitted in separate files: main text file; figures.

***File types***

Submissions via the new Research Exchange portal can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) formats.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a Latex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the Latex Main Document should be uploaded as a "LaTeX Supplementary File."

Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the "Acknowledgements" section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;

5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

***Authorship***

On initial submission, the submitting author will be prompted to provide the email address and country for all contributing authors.

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

***Acknowledgments***

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

***Conflict of Interest Statement***

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the Conflict of Interest section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

***Abstract***

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a

concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

***Key Practitioner Message***

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

***Keywords***

Please provide five-six keywords (see Wiley's best practice SEO tips).

***Main Text***

1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.

2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

***References***

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the APA FAQ.

Reference examples follow:

*Journal article*

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: 10.1176/appi.ajp.159.3.483

*Book*

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

*Internet Document*

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

***Endnotes***

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

***Tables***

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

***Figure Legends***

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

***Figures***

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

**Figures submitted in color** may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

**Additional Files**

***Appendices***

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

**General Style Points**

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

2. **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

**Wiley Author Resources**

***Manuscript Preparation Tips:*** Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, authors may benefit from referring to Wiley's best practice tips on Writing for Search Engine Optimization.

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Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

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## Appendix B

## Quality appraisal ratings for the systematic review

**Table B 1.**

*Quality appraisal ratings*

| Article | Appropriate qualitative approach | Appropriate Sampling strategy | Data collection methods | Data analysis and quality control | Researcher position | Results | Are the conclusions justified? | Are the results transferable to other clinical settings? |
|---|---|---|---|---|---|---|---|---|
| Ando and Kawano (2016) | Y | N | Y | Y | N | N | Y | N |
| Austin et al. (2005) | Y | N | N | N | N | Y | Y | N |
| Austin et al. (2003) | Y | N | N | Y | N | Y | Y | N |
| Eder et al. (2025) | Y | Y | Y | Y | Y | Y | Y | Y |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Gabrielsson et al. (2016) | Y | Y | Y | Y | Y | Y | Y | Y |
| Hadson et al. (2024) | Y | U | Y | Y | N | N | Y | N |
| Jansen et al. (2020) | Y | Y | Y | Y | Y | Y | Y | Y |
| Jansen, Danbolt, et al. (2022) | Y | Y | Y | Y | Y | N | Y | Y |
| Jansen and Hanssen (2017) | Y | U | Y | Y | Y | N | Y | N |
| Jansen, Hem, et al. (2022) | Y | Y | Y | Y | Y | Y | Y | Y |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Klingemann et al. (2025) | Y | Y | Y | N | N | Y | Y | Y |
| Liberati et al. (2021) | Y | Y | Y | Y | Y | Y | Y | Y |
| Lloyd et al. (2024) | Y | N | Y | Y | U | Y | Y | N |
| Matthews and Williamson (2016) | Y | Y | Y | Y | N | Y | Y | N |
| Musto and Schreiber (2012) | Y | N | Y | Y | N | Y | Y | Y |
| Navarro et al. (2021) | Y | Y | Y | Y | Y | Y | Y | Y |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| O'Donnell et al. (2023) | Y | Y | Y | Y | Y | Y | Y | N |
| Oliveira (2020) | Y | U | Y | N | N | Y | Y | N |
| Perez-Toribio et al. (2022) | Y | Y | Y | Y | N | Y | Y | N |
| Tavakol et al. (2023) | Y | U | Y | Y | Y | Y | Y | N |
| Thompson, et al. (2024) | Y | Y | Y | Y | Y | N | Y | N |
| Upasen and Saengpanya (2021) | Y | Y | Y | Y | N | Y | Y | N |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Wall et al. (2024) | Y | U | Y | Y | Y | Y | Y | N |

*Key: Y= yes, N= No and U= Unclear*

## Appendix *C*

## Distribution of articles across themes

**Table C2.**

*Distribution of articles included in each theme*

| Article | Themes | | | |
|---|---|---|---|---|
| | System and organisational constraints resulting in moral injury | Individual sources of moral injury | Helpful and unhelpful ways of dealing with moral injury | Consequences of moral injury |
| Ando and Kawano (2016) | | x | x | |
| Austin et al. (2005) | | x | x | x |
| Austin et al. (2003) | | x | | x |
| Eder et al. (2025) | x | x | | x |
| Gabrielsson et al. (2016) | x | x | x | |
| Hadson et al. (2024) | x | x | | |
| Jansen et al. (2020) | x | | x | x |
| Jansen, Danbolt, et al. (2022) | | x | | x |
| Jansen and Hanssen (2017) | | | | x |

| | | | | |
|---|---|---|---|---|
| Jansen, Hem, et al. (2022) | | x | x | x |
| Klingemann et al. (2025) | | x | | x |
| Liberati et al. (2021) | x | x | | x |
| Lloyd et al. (2024) | | x | | x |
| Matthews and Williamson (2016) | x | | | x |
| Musto and Schreiber (2012) | x | x | x | x |
| Navarro et al. (2021) | | x | x | x |
| O'Donnell et al. (2023) | x | x | | |
| Oliverira (2020) | x | | x | x |
| Perez-Toribio et al. (2022) | | x | x | x |
| Tavakol et al. (2023) | x | x | x | |
| Thompson, et al. (2024) | x | x | | x |
| Upasen and Saengpanya (2021) | | x | x | x |
| Wall et al. (2024) | x | x | | x |

**Appendix D**

**Author guidelines for Journal of Clinical psychology**

*Overview*

*Aims and Scope*

**Journal of Clinical Psychology**

Founded in 1945, the *Journal of Clinical Psychology* is a peer-reviewed forum devoted to research, assessment, and practice. Published eight times a year, the Journal includes research studies; articles on contemporary professional issues, single case research; brief reports (including dissertations in brief); notes from the field; and news and notes. In addition to papers on psychopathology, psychodiagnostics, and the psychotherapeutic process, the journal welcomes articles focusing on psychotherapy effectiveness research, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioral medicine. From time to time, the Journal publishes Special Sections, featuring a selection of articles related to a single particularly timely or important theme; individuals interested in Guest Editing a Special Section are encouraged to contact the Editors.

## 1. Submission and Peer Review Process

New submissions should be made via the Research Exchange submission portal. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

For help with article preparation Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, and figure preparation.

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*Journal of Clinical Psychology* now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or

format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including statements relating to our ethics and integrity policies (see information on these policies below in Section 1):
- data availability statement
- funding statement
- conflict of interest disclosure
- ethics approval statement
- patient consent statement
- permission to reproduce material from other sources
- clinical trial registration

**(Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and prepare a separate title page containing author details.)**

- Your co-author details, including affiliation and email address.
- An ORCID ID, freely available at https://orcid.org.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

**Open Access**

This journal is a GREEN Open Access title. See here for details. Submissions will be subject to an Article Processing Charge (APC) if accepted and published in the journal. For more information about APCs, and to see if you're eligible for a waiver (through your institution or because the corresponding author belongs to a waiver country) please go here .

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Please review Wiley's data citation policy here.

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**Authorship**

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Please see here and scroll down for a description of authorship criteria.

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The title page should contain**:**

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- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments.

**Main Text File**

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) format

Please ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on a separate page.

The main text file should be in word or PDF format and include:

- A short informative title containing the major key words. The title should not contain abbreviations
- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments;
- Abstract structured (objective(s)/methods/results/conclusion)
- Up to six keywords;
- Main body:
    1. regular section formatted as introduction, materials & methods, results, discussion, conclusion
    2. In Session (invitation only) formatted as introduction, Case Illustration (including separate sections on Presenting Problem & Client Description, Case Formulation, Course of Treatment, Outcome and Prognosis), Clinical Practices and Summary, and Selected References & Recommended Readings
- References (for In Session, please provide no more than 20 references};
- Tables (each table complete with title and footnotes);

- Figures: Figure legends must be added beneath each individual image during upload AND as a complete list in the text.

**Reference Style**

This journal uses APA reference style. Find more information on reference style guidelines here.

**Figures and Supporting Information**

Figures, supporting information and appendices should be supplied as separate files. Click here for the basic figure requirements for figures submitted with manuscripts for peer review, as well as the more detailed post-acceptance figure requirements. Click here for Wiley's FAQs on supporting information.

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## 2. Article Types

| **Article Type** | Description | Abstract / Structure | Other Requirements |
|---|---|---|---|
| **Original Papers** | reports of new research findings or conceptual analyses that make a significant contribution to knowledge | Yes, Structured | Data Availability Statement |
| **Comprehensive Reviews** | critical reviews of the literature, including systematic reviews and meta-analyses | Yes, unstructured | |

| | | | |
|---|---|---|---|
| **Training and Professional Issues** | Original research and training methods related to the education and training of professional psychologists | Yes, structured | Data Availability Statement |
| **Case Reports (by invitation only)** | original articles illustrated through case reports | Yes, unstructured | Data Availability Statement |

**Peer Review**

This journal operates under a double-blind peer review model. You can read more about peer review model here. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.

Wiley's policy on the confidentiality of the review process is available here.

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Please review Wiley's policies surrounding human studies, animal studies, clinical trial registration, biosecurity, and research reporting guidelines here.

This journal follows the core practices of the Committee on Publication Ethics (COPE) and handles cases of research and publication misconduct accordingly (https://publicationethics.org/core-practices).

This journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors here. Wiley's Publication Ethics Guidelines can be found here.

## 3. After Acceptance

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Authors will receive an e-mail notification with a link and instructions for accessing HTML page proofs online. Authors should also make sure that any renumbered tables, figures, or references match text citations and that figure legends correspond with text citations and actual figures. Proofs must be returned within 48 hours of recipes of the email.

## 4. In Session Author Guidelines

The *Journal of Clinical Psychology: In Session* is dedicated to assisting mental health practitioners in selecting and using the most effective assessments, treatments, and relationships. Each issue is devoted to a distinct patient population or a significant therapeutic problem. The Journal promotes the integration of diverse treatments as well as the synthesis of science and practice. We look forward to working with you.

### MANUSCRIPT PREPARATION

**Format.** Manuscripts should be word-processed double-spaced with a 1" margin on all sides. Number all pages of the manuscript sequentially (top right hand corner).

**Style.** Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, sixth edition,* available from the American Psychological Association.

**Length.** Due to space constraints, we ask that you limit your manuscript to 30 double-spaced typewritten pages, including title page, abstract, references, and tables.

**Avoid Theoretical Jargon.** Although theory-based jargon provides a rich network of meaning when speaking with like-minded colleagues, it can serve to obfuscate meaning for those with differing theoretical backgrounds. When preparing your manuscript, please keep in mind that the *Journal of Clinical Psychology: In Session* addresses a broad professional audience with a variety of theoretical orientations.

In short, we ask authors to refrain, as much as possible, from technical “jargon” (i.e., terms from a particular theoretical perspective that don’t translate easily to other perspectives). Wherever possible, please translate your own orientation's language system into ordinary English. For example, "dynamic focus" may be reworded as referring to the patient's ongoing thematic interpersonal conflict; "genuineness" may be depicted as the therapist's open and honest expression of thoughts and feelings. It may be helpful to show a draft of your manuscript to a colleague from a different orientation, asking her to flag any terms or phrases that need "translation."

**Reader-Friendly Style.** The editorial team tries to make each journal issue as practical and reader-friendly as possible. We try to reduce what James Joyce called “the true scholastic stink” to bearable levels. For example, we do not publish footnotes, which tend to impede the flow of articles. Incorporate important content into the text; list acknowledgements and funding sources on the bottom of the title page. For another example, we highlight the central findings and clinical implications of a study, as opposed to highlighting the researcher’s name. Whenever possible, place an author’s names in parentheses.

In a related vein, we aim to **keep the reporting of statistics to a minimum**; we also discourage the use of statistical tables. Thus, if stats are included in your article, keep them simple. The primary goal of your article—even if based on research—is to translate findings (or cases) into principles that will be helpful to practitioners. Thus, discussion of “further research directions” is almost always the wrong path; discussion of “implications for practitioners” is almost always the right path.

Furthermore, because our primary readership consists of practitioners interested in how research or theory can be translated or best used in the service of clinical practice, we ask that you **restrict the number of references cited**. U

## MANUSCRIPT ELEMENTS

**Title Page**. The title page should include the following information: Title of the article; author's name, highest degree, and affiliation; corresponding author's complete mailing address and e-mail address.

**Abstract.** Abstracts are required for all articles. Abstracts are to be 250 words or less, and should be intelligible without reference to the text.

**Keywords.** Kindly list five or six keywords for indexing purposes on the Abstract page.

**Text**. To promote uniformity of presentation, we ask that each article typically contain the following sections: Introduction (untitled); Case Illustration (including separate sections on Presenting Problem & Client Description, Case Formulation, Course of Treatment, Outcome and Prognosis); Clinical Practices and Summary; and Selected References & Recommended Readings. Each of these elements is described below.

*Introduction* (untitled). The introductory section should provide a concise overview (approximately 1/3 of the length of the manuscript) of the therapeutic approach being illustrated. Please include a brief discussion of the theoretical foundations and treatment principles. Summarize the outcome research in a paragraph or two.

*Case Illustration*. The topic of the thematic issue and your therapeutic experience will, no doubt, influence the case presentation. However, we would ask that each presentation include the following headings (you may include additional subheadings if needed):

*Presenting Problem & Client Description*: Concise summary of the presenting problem, and a description of the client's history, background, and life experiences. All identifying client details must be altered to prevent recognition. Please complete the Case Illustration Checklist indicating the client details that have been altered. The Checklist must be submitted with your final manuscript.

*The Therapist*: A brief introduction about therapist's demographic, preferred orientation(s), years of experience as a psychotherapist both in general and in the problem presented by the specific client.

*Case Formulation*: In light of the presenting problem, describe how you formulated the case and how the formulation impacted on your treatment selection. Please avoid the use of jargon.

*Course of Treatment*: Describe the therapeutic process, focusing on the therapist's observations, the therapy relationship, specific interventions, and client reactions. Please use examples of therapist-client interactions to illustrate your approach. You may either reconstruct prototypical exchanges or use excerpts from actual transcripts.

*Outcome and Prognosis*: Case presentations should conclude with a summary of the treatment outcome and a discussion of the client's prognosis. Pre-post measures of change are particularly encouraged. Authors may also elect to integrate personal reflections on the course of treatment and the therapeutic outcome in this section.

*Clinical Practices and Summary.* In this conclusion section, please discuss the implications of the case for future applications of the therapeutic approach and dealing with this type of patient in the future.

*References*. Due to space limitations, we ask that you **provide no more than 25 references**. Please adhere to stylistic guidelines set forth in the APA *Publication Manual* (sixth edition) when preparing your reference list. Journal or monograph series titles should not be abbreviated.

## ILLUSTRATIVE MATERIAL

**Tables.** All tables should have descriptive titles or captions and clearly worded column headings. Tabular material should be organized as simply as possible, eliminating vertical rules and (where possible) special typography (e.g., Greek). Indicate in the text where tables should be inserted.

**Figures.** Any necessary figures should be submitted in a form suitable for direct reproduction. Identify each figure by number, either on an overlay or written with a soft pencil on the back (e.g., "Fig. 3"). All illustrations should be numbered consecutively within the article. Figures should be separated from the text.

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## Appendix E

## G* Power calculations for Spearman Rho correlation, ANOVA for the Kruskall Wallis test, Mann Whitney U test and linear multiple regression

**Figure E1.**

*Spearman Rho correlation G* power*

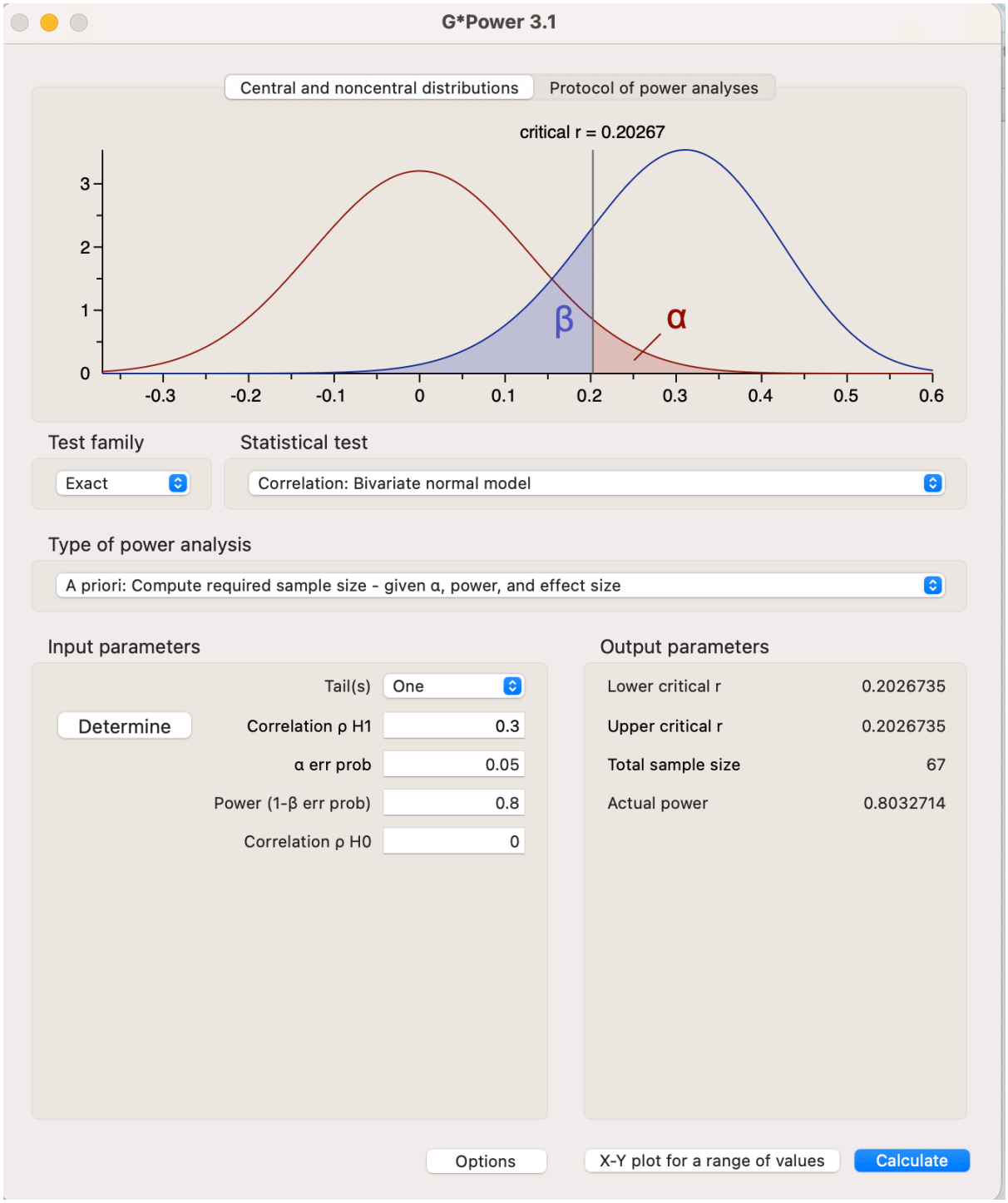


**Figure E2.**

ANOVA Power calculation for Kruskall Wallis test

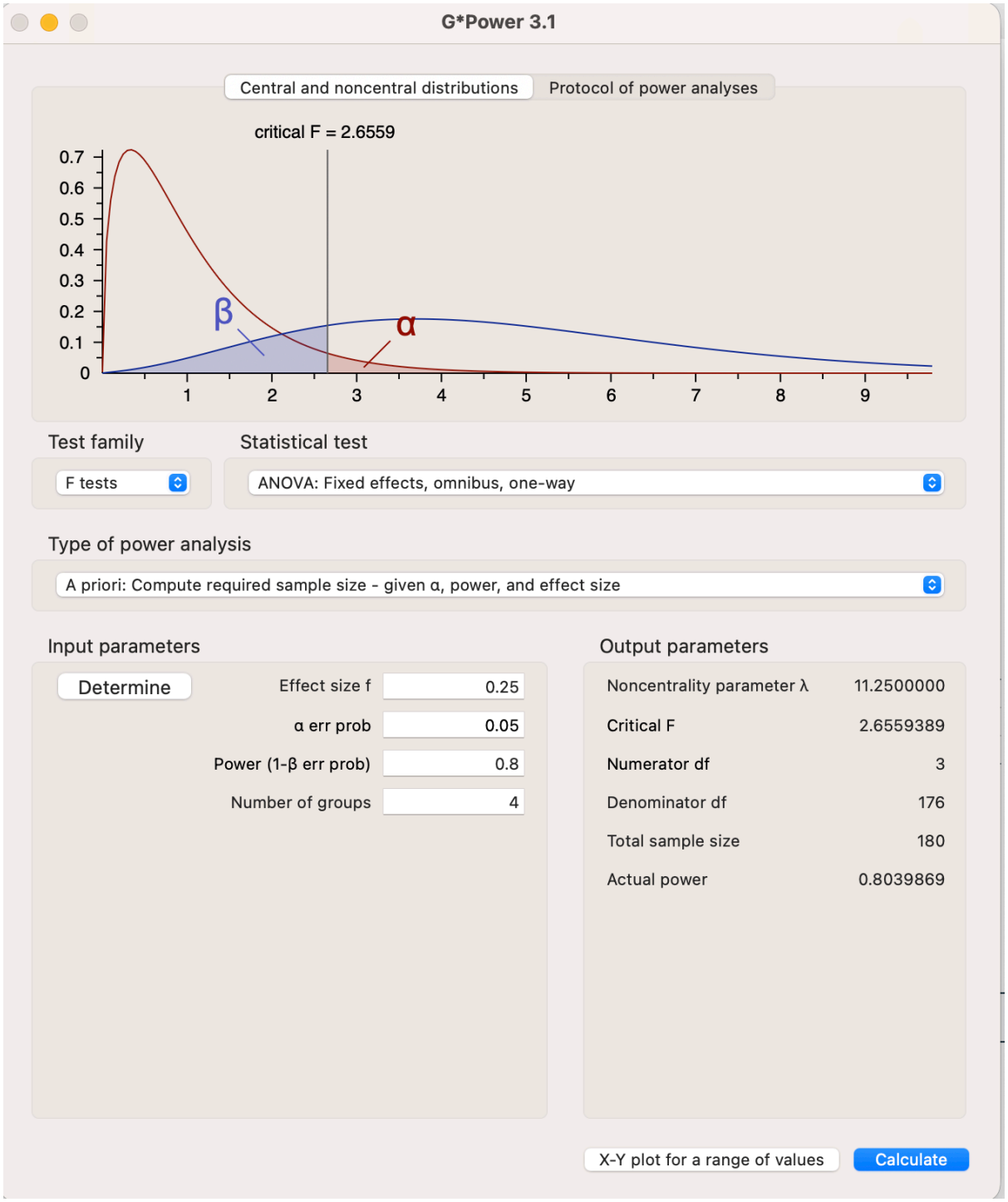


**Figure E3.**

*Mann Whitney U Test G* power calculation*

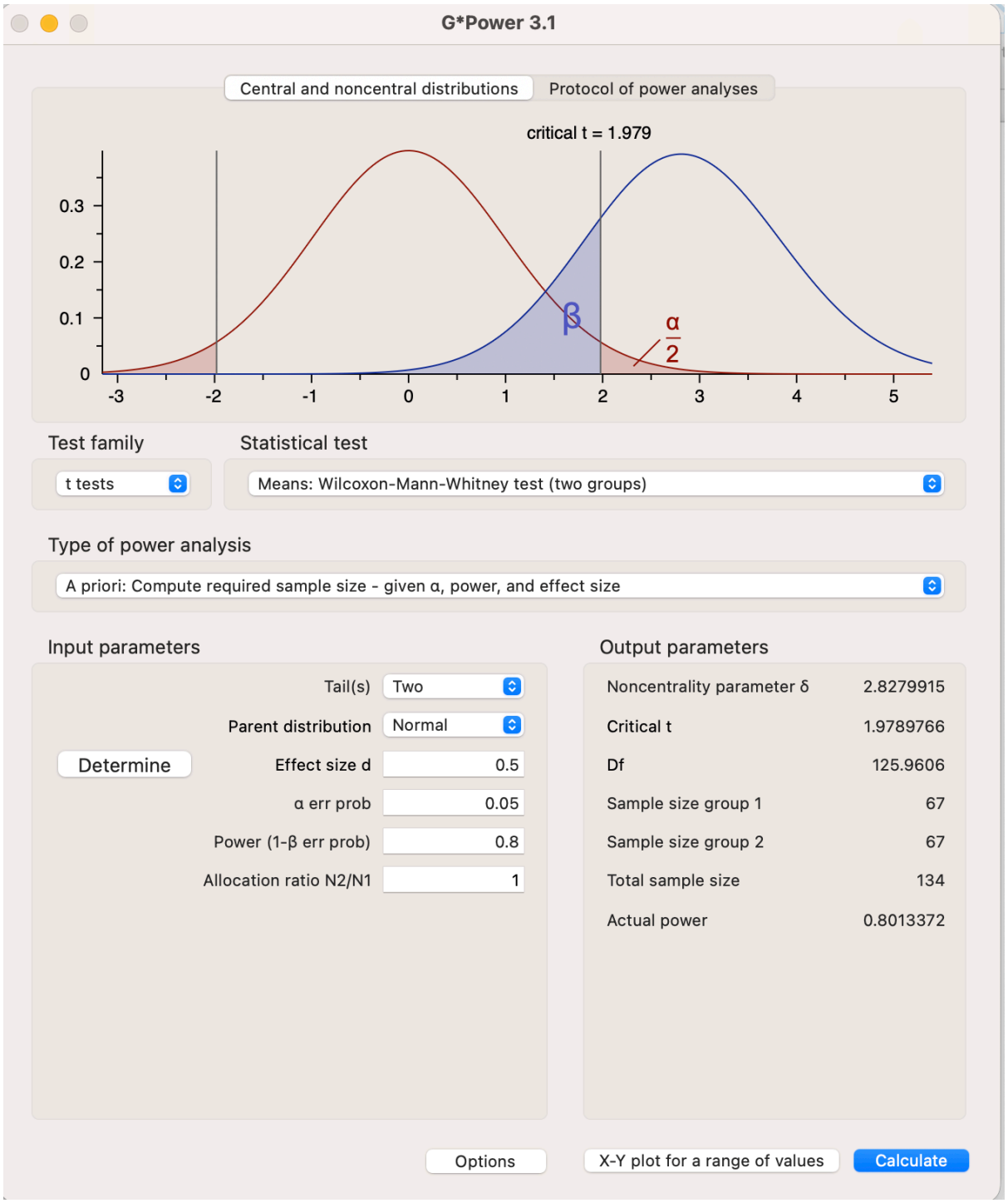
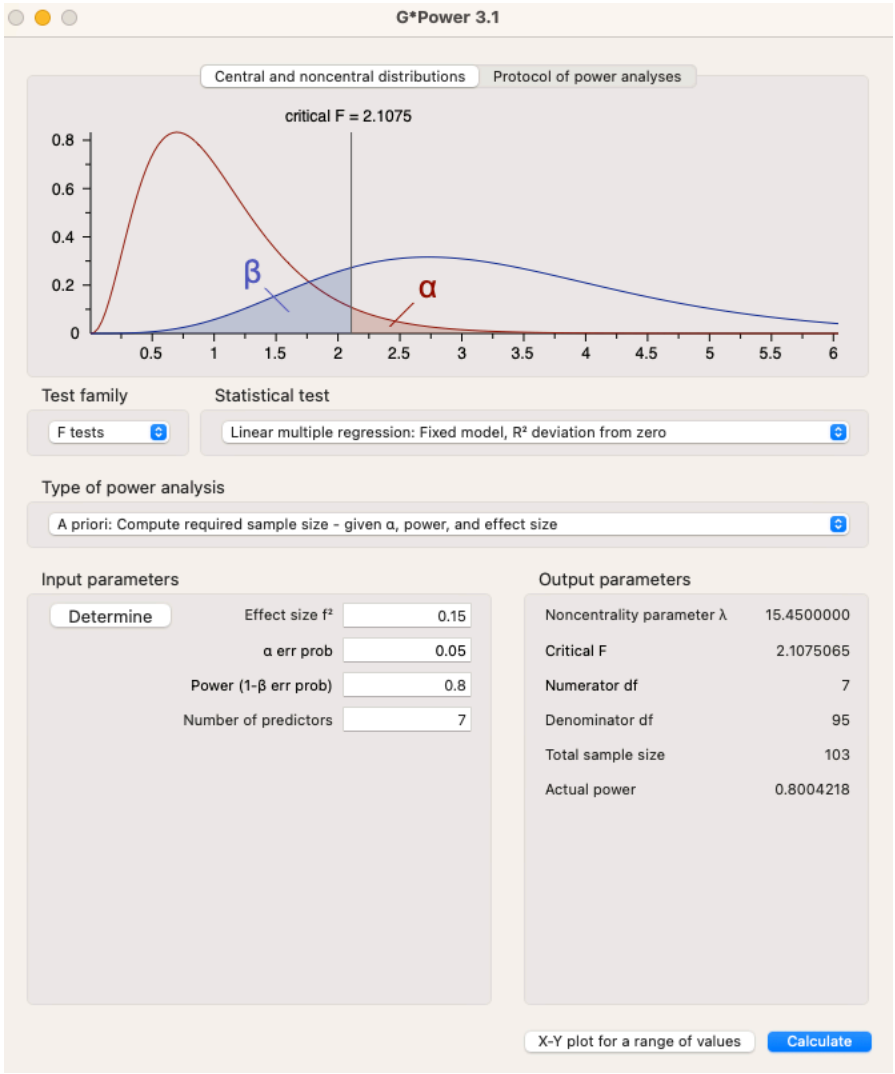


**Figure E4.**

*Multiple regression G* Power calculation*



## Appendix F

## Non-normal distribution data

**Figure F5.**

*Histogram displaying the distribution for the Total MISS-HP score*

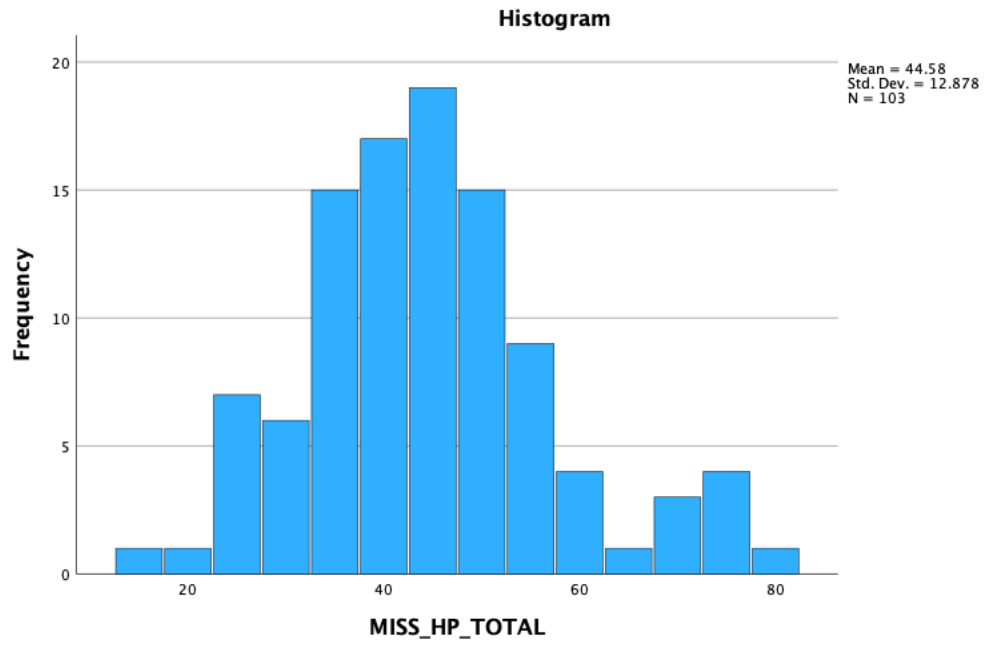



**Table F3.**

*Tests of normality: Kolomogorov-Smirnov and Shapiro-Wilk*

| | Kolmogorov-Smirnov | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|
| | Statistic | df | sig | Statistic | df | sig |
| MISS-HP total | .104 | 103 | .008 | .967 | 103 | .012 |

## Appendix G

## Participation Information Sheet

University of East Anglia

### Participant Information Sheet

### Exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

This information sheet will provide you with information about this study to help you to decide whether you would like to take part.

**What is this study about?**

Previous research has largely focused on moral injury in physical health nurses and health care workers. Moral injury can be defined as both the emotional and cognitive responses to following events that violate a person's moral or ethical code. This study aims to explore whether Registered Mental Health Nurses are impacted by moral injury and if factors are contributing to this.

**What will the study involve for me?**

You will be asked to complete an online survey which will ask questions about you, for example, age and ethnicity. You will also be asked about your current role; for example, whether this is an inpatient or community role and the population you work with (e.g., adult, child and adolescent services, and forensic). You will then be asked a series of tick box questions about moral injury, mental health, and various factors such as perceived staffing levels. The survey will take approximately 10 minutes to complete.

**Who is running the study?**

Lauren Powell a Postgraduate Researcher, Norwich Medical School, University of East Anglia will be the lead researcher on this study.

**Are there any benefits in taking part?**

Through taking part in this study, we hope to develop an understanding of moral injury in mental health nurses, as well as any working conditions which impact on moral injury.

**What are the possible disadvantages of taking part?**

You will be asked to think about difficult times such as, feeling betrayed or witnessing something which goes against your morals. These topics may be upsetting and/or cause you distress. Below there is information for support, this will be shown again following the completion of the survey.

**Signposting for further support**

If the contents of this study have caused upset, please consider seeking support from your GP or other services signposted below.

**Mind**

mind.org.uk

Telephone: 0300 123 3393
The Mind InfoLine can help you find specialist services in your area.

**Samaritans**

www.samaritans.org

Open 24 hours a day, 365 days a year.

Telephone: 116 123

**Shout**

www.giveusashout.org

For immediate support text 'SHOUT' to 85258

Open 24 hours a day, 365 days a year.

**Do I have to take part?**

No, you do not have to take part, the survey is voluntary. If you begin completing the survey and wish to withdraw you can simply exit the survey without submitting your answers, and your information will not be included.

University of East Anglia

**What will happen to my information?**

By consenting to participate, you are agreeing for your data to be used for the purpose of this research study. If you choose to withdraw, your information will not be included in the study. If you complete and submit your survey, then you will not be able to withdraw from the study due to all data being anonymous. All data which is collected will be stored in compliance with the Data Protection Act (2018) and the University of East Anglia Research Data Management Policy (2019).

**Can I find out the results of the study?**

You can have a copy of the overall results of the study. You can request this through emailing lauren.powell@UEA.ac.uk. A copy will be provided once the study is complete.

**What if I have a complaint or concerns about the study?**

If you wish to make a complaint about the research, then please contact Professor Sian Coker, Deputy Head of Department Clinical Psychology and Psychological Therapies and Programme Director, ClinPsyD (s.coker@uea.ac.uk). Professor Coker is not directly involved or linked to the research in any way. Alternatively, you may contact the lead researcher on lauren.powell@UEA.ac.uk.

This study has been granted ethical approval by UEA FMH Ethics Board ETH2425-0176 & ETH2425-1874.

By ticking this box, I consent to taking part in this study and I understand that I can withdraw consent at any point prior to submission by closing the browser.

## Appendix H

## Debrief sheet

University of East Anglia

**Debrief Information Sheet**

**Thank you for taking the time to complete this survey.**

Please share this study with other mental health nurses.

We hope as a result of taking part in this study, we can develop an understanding of moral injury in mental health nurses and what factors may contribute to this.

If you feel you require further support following the completion of this study, please see the resources signposted below.

**Signposting for further support**

If you are feeling upset from the contents of this study, please consider seeking support from your GP.

**Mind**

mind.org.uk

Telephone: 0300 123 3393
The Mind InfoLine can help you find specialist services in your area.

**Samaritans**

www.samaritans.org

24 hours a day, 365 days a year.

Telephone: 116 123

**Shout**

www.giveusashout.org

For immediate support text SHOUT to 85258 available 24 hours a day, 365 days a year.

You have the right to receive feedback about the overall results of the study. You can request this through emailing me on lauren.powell@UEA.ac.uk, you will receive this once the study is complete.

Version 1.0 24.01.25

University of East Anglia

If you have further questions about the study, you can contact me via email lauren.powell@UEA.ac.uk.

Thank you for your participation. You may now close your browser.

Version 1.0 24.01.25

# Appendix I

## Ethical Approval

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

**Study title:** Exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

**Application ID:** ETH2425-0176

Dear Lauren,

Your application was considered on 10th March 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

This approval will expire on **30th October 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

**Study title:** Exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

**Application ID:** ETH2425-1874 (significant amendments)

Dear Lauren,

The amendment to your sttudy was considered on 1st April 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

This approval will expire on **30th October 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

**Study title:** Exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

**Application ID:** ETH2425-2473 (significant amendments)

Dear Lauren,

Your amendment to your study was considered on 4th July 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

This approval will expire on **30th October 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

**Study title:** Exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

**Application ID:** ETH2526-0077 (significant amendments)

Dear Lauren,

Your amendment to your study was considered on 26th August 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

This approval will expire on **30th October 2026**.HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS syste

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

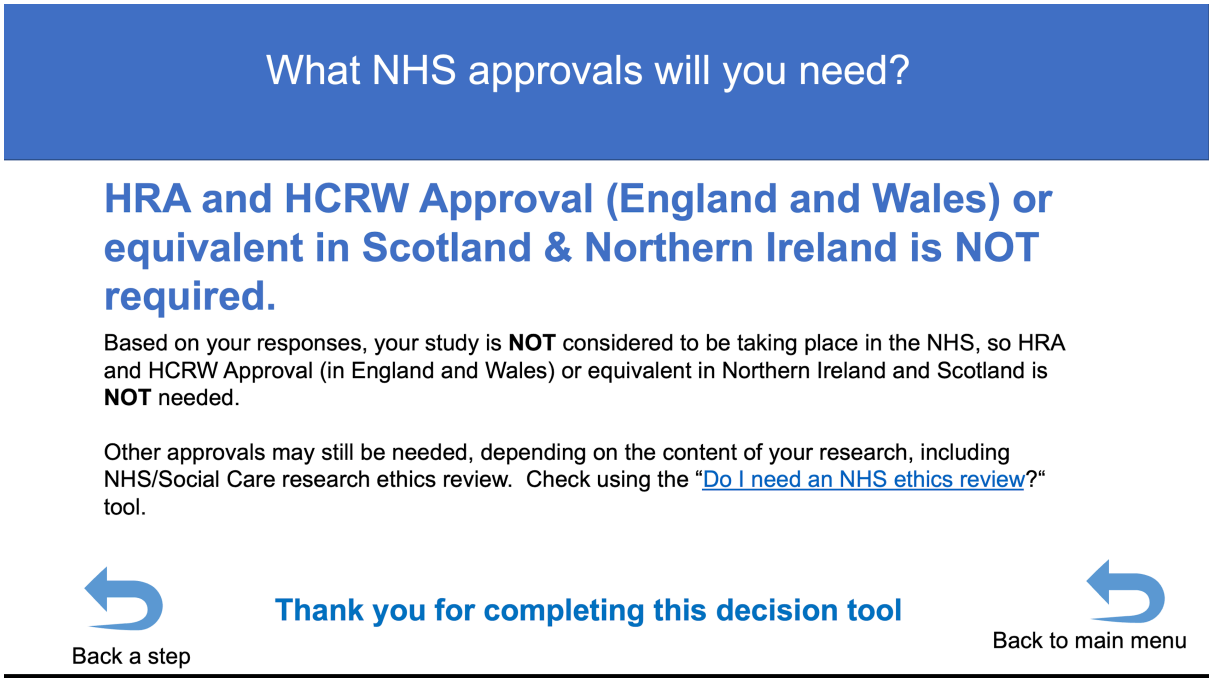
On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

**Appendix J**

**HRA decision tool confirmation**



## Appendix K

## Moral Injury Symptom Scale -healthcare professionals version (MISS-HP)

**Moral Injury Symptoms Scale – Healthcare Professionals Version** (MISS-HF) ©

*The following questions **may be difficult**, but they are common experiences of busy healthcare professionals.* They concern your experiences on your job as a health professional and **how you are feeling now**. Try to answer every question. Circle a single number between 1 and 10 for indicating how much you personally agree or disagree with each statement.

1. **I feel betrayed by other health professionals whom I once trusted.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

2. **I feel guilt over failing to save someone from being seriously injured or dying.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

3. **I feel ashamed about what I've done or not done when providing care to my patients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

4. **I am troubled by having acted in ways that violated my own morals or values.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

5. **Most people with whom I work as a health professional are trustworthy.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

6. **I have a good sense of what makes my life meaningful as a health professional.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

7. **I have forgiven myself for what's happened to me or to others whom I have cared for.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

8. **All in all, I am inclined to feel that I'm a failure in my work as a health professional.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

9. **I sometimes feel God is punishing me for what I've done or not done while caring for patients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

10. **Compared to before I went through these experiences, my religious/spiritual faith has strengthened.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Strongly disagree | | Mildly disagree | | Neutral | | Mildly agree | | Strongly agree | |

11. Do the feelings you indicated above cause you significant distress or impair your ability to function in relationships, at work, or other areas of life important to you? In other words, if you indicated any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not at All □ Mild □ Moderate □ Very Much □ Extremely

**Scoring**:
Reverse score items 5-7 and 10, and then add up to produce a total score (range 10-100). Higher scores indicate greater moral injury.
Scores of 36 or higher are 84% sensitive and 93% specific for identifying MI symptoms causing moderate to extreme problems with family, social, and occupational functioning, and therefore require clinical attention.

© Koenig HG, Mantri S, Lawson J (2020). Moral injury symptoms scale for healthcare professionals: the MISS-HP. Durham, North Carolina: Duke University Center for Spirituality, Theology and Health. No permission required for use. No fee required for use.

**Cite as**: Mantri, S., Lawson, J. M., Wang, Z., & Koenig, H. G. (2020). Identifying moral injury in healthcare professionals: The Moral Injury Symptom Scale-HP. Journal of Religion and Health, *59*(5), 2323-2340.

**Appendix L**

**Generalised Anxiety Disorder-7 (GAD-7)**

# Generalised Anxiety Disorder Assessment (GAD-7)

## Instructions:

Please read each statement and select from "Not at all" to "Nearly every day" to indicate how much the statement applied to you over the past two weeks.

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1 | Feeling nervous, anxious or on edge | **0** | **1** | **2** | **3** |
| 2 | Not being able to stop or control worrying | **0** | **1** | **2** | **3** |
| 3 | Worrying too much about different things | **0** | **1** | **2** | **3** |
| 4 | Trouble relaxing | **0** | **1** | **2** | **3** |
| 5 | Being so restless that it is hard to sit still | **0** | **1** | **2** | **3** |
| 6 | Becoming easily annoyed or irritable | **0** | **1** | **2** | **3** |
| 7 | Feeling afraid as if something awful might happen | **0** | **1** | **2** | **3** |

## Developer Reference:

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092-1097.

**Appendix M**

**Patient Health Questionnaire – Depression (PHQ-9)**

# Patient Health Questionnaire - Depression (PHQ-9)

## Instructions:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1 | Little interest or pleasure in doing things | **0** | **1** | **2** | **3** |
| 2 | Feeling down, depressed, or hopeless | **0** | **1** | **2** | **3** |
| 3 | Trouble falling or staying asleep, or sleeping too much | **0** | **1** | **2** | **3** |
| 4 | Feeling tired or having little energy | **0** | **1** | **2** | **3** |
| 5 | Poor appetite or overeating | **0** | **1** | **2** | **3** |
| 6 | Feeling bad about yourself — or that you are a failure or have let yourself or your family down | **0** | **1** | **2** | **3** |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | **0** | **1** | **2** | **3** |
| 8 | Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | **0** | **1** | **2** | **3** |
| 9 | Thoughts that you would be better off dead or of hurting yourself in some way | **0** | **1** | **2** | **3** |

## Developer Reference:

Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues.

## Appendix N

## Bespoke single item questions

How old are you?

Do you consider yourself to have a religion or spirituality?

- ◯ Yes
- ◯ No

What is your relationship status

- ◯ Single
- ◯ Married
- ◯ In a relationship
- ◯ Prefer not to say

What is your ethnicity?
If you do not wish to answer please type prefer not to say.

What is your gender?

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to say
- ◯ Other

If other please specify below.

How long have you been a registered mental health nurse?
Please specify years and months.

Where do you currently work?

- ✓ Please select an option
- Inpatient
- Community
- Other

If other please specify below.

What population do you currently work with?

- ◯ Children and Adolescents (0-18)
- ◯ Youth (18-25)
- ◯ Adults (25-65)
- ◯ Older adults (65+)

Please specify if working in a specialist population e.g., Forensic, Perinatal, Pain clinic

How long have you worked in your current role?
Please specify years and months.

Do you work full time or part time hours?

- ◯ Full time
- ◯ Part time

Are you currently employed as a permanent or agency staff member?

- ○ Permanent
- ○ Agency

Have you completed any additional therapy training e.g DBT, CBT, CAT?

Do you have caring responsibilities?
A carer is *anyone who gives unpaid care to a family member, partner or friend who could not cope* without their suppo

- ○ Yes
- ○ No
- ○ Prefer not to say

Where did you complete your training?

- ○ United Kingdom
- ◉ Abroad

If abroad, please state what country you completed your training in.

What is your current pay banding

- ✓ Please select an option
- Band 5
- Band 6
- Band 7
- Band 8a
- Band 8b
- Band 8c
- Band 8d
- Band 9

ne Surveys

In the last two weeks did you take your allocated breaks?

Clear selected

| | Everyday | Most days | Occasionally | Almost never | Never |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

How do you perceive your staffing levels in the team your working in?

Clear selected

| | Always fully staffed | Most days fully staffed | Occasionally fully staffed | Almost never fully staff | Always short staffed |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

Do you feel adequately supported by the following people?

Clear selected

| | Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| Supervisor | ○ | ○ | ○ | ○ | ○ |
| Colleagues | ○ | ○ | ○ | ○ | ○ |
| Line manager | ○ | ○ | ○ | ○ | ○ |
| Family | ○ | ○ | ○ | ○ | ○ |
| Friends | ○ | ○ | ○ | ○ | ○ |

How much over the last two weeks did you work over your contracted hours?
Please specify minutes or hours.

Do you feel that you have had adequate resources to deliver what you believe to be satisfactory care?

Clear selected

| | Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

53. Have you ever experienced aggression from a service user?*

| | Never | rarely | sometimes | Often | always |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

54. Have you felt that you have received inappropriate referrals or admissions to your team in the last two weeks?*

| | Never | rarely | sometimes | Often | always |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

55. In the last two weeks how often have you disagreed with discharging a service user from your team?*

| | Never | rarely | sometimes | Often | always |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

56. Do you feel that your current responsibilities match the level of power you feel you have in the team?*

| | Never | rarely | sometimes | Often | always |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

Are you considering leaving the profession of mental health nursing?

- ○ Yes
- ○ No
- ○ Maybe
- ○ Prefer not to say

## Appendix O

## Advertising poster

**Are you a Registered Mental Health Nurse?**
Please volunteer for this study exploring predictive factors and associated outcomes of moral injury in Registered Mental Health Nurses employed in the National Health Service (NHS).

University of East Anglia

**What is this research about?**

Previous research has largely focused on moral injury in physical health nurses and health care workers. Moral injury can be defined as both the emotional and cognitive responses to following events that violate a person's moral or ethical code. This study aims to explore whether Registered Mental Health Nurses are impacted by moral injury and if any factors are contributing to this.

**What will participation involve?**

You will be asked to complete an online survey which will take approximately 10 minutes to complete.

**Can I participate?**

If you are over 18 and a registered mental health nurse working in the NHS, you can take part in this study. You are also able to take part if you have gained additional qualifications such as, Cognitive Behavioural Therapy or Dialectical Behavioural Therapy, as long as you are still currently a registered mental health nurse.

**Want to know more?**

Please e-mail me at lauren.powell@UEA.ac.uk if you would like to know more about this research or have any questions. Scan the QR code to be taken to the survey or follow the link https://app.onlinesurveys.jisc.ac.uk/s/uea/mi

Version 1.0 24.01.25

## Appendix P

## Process of code development and refinement for systematic review

The below tables demonstrate the process of which codes were developed and refined to form the final themes and subthemes of the systematic review.

**Table P4.**

*Initial coding and emergent themes*

| Emergent themes and subthemes | Initial coding |
|---|---|
| Consequences of moral distress, injury | |
| Doubting professional practice | decisional capacity around food left staff questioning their role and balancing patient choice with when it is appropriate to intervene |
| | Distress as a result of self doubt around decision making and their practice |
| | doubting whether the right action had been taken or whether the restraint could have been avoided |
| | Experiencing moral distress and questioning practice after an unexpected death of a patient |
| | Increase in staff feeling guilty and doubting themselves around decision making around discharge in covid-19 |
| | insufficient time made nurses doubt their quality of assessments |
| | Making high risk decisions without an evidence base left psychiatrist's feeling anxious and uncertain often feeling like made the wrong decision |
| | making yourself small to justify behaviours (restraints) driven by the system |
| | Patients over stepping boundaries and not knowing what to do |
| | Questioning risk management decision making following a service user completing suicide |
| | Questioning what is appropriate and reasonable reactions on a professional level, creating anxiety and panic when there is uncertainty |
| | whether it is the right thing to do and living with the decision |
| | Questioning whether they put their patient and unit at risk resulted in moral distress |
| | Questioning whether they want to be restraining patients |
| | The experience of moral distress resulted in professional questioning 'is the best I can do' |

| | |
|---|---|
| Emotional experiences of moral distress | Care becoming isolated and disconnected leaving nurses feeling alone and isolated |
| | Casual workers feeling more like a machine than a person resulting in disconnect and distress |
| | Experiencing self-condemnation when mental health nurses fail to care for patients resulting in moral distress and guilt |
| | experiencing shame and guilt when unable to protect patients and nurses from verbal and physical aggression, often blaming self perceiving that they should have acted differently to prevent it |
| | Feeling angry and dishonest with self due to the use of restraint going against values |
| | Feeling ashamed to be a nurse after care fell below what was expected |
| | Feeling discomfort, guilt, bad conscience and a feeling of inadequacy when unable to protect staff and patients during mental or physical violence |
| | feeling disgusted and that it is intolerable not to have sufficient time to spend with patients |
| | feeling frail, empty, numb and tired needing to create a shield between self and surroundings |
| | Feeling frightened of making a wrong decision and refusing a service that someone needs |
| | Feeling hopeless about the future and feeling unable to influence the delivery of the service feeling bound by the decisions of the trust and government |
| | Feeling like a bad person after engaging in mechanical restraints |
| | Feeling overwhelmed with sadness as a result of work impacting on being present as a parent |
| | Feeling uncomfortable and anxious with the possibility of missing something when going from face to face to telephone support |
| | Feeling uneasy and sad when coercive action is difficult for the patient resulting in moral distress |
| | Finding it difficult to tolerate and feeling helpless in not being able to prevent the impact of overeating |
| | Finding work conditions intolerable |
| | Moral distress impacting negatively on both professional and personal life resulting in feelings of guilt, self doubt, frustration, anger, sadness, inadequacy, loss of meaning, isolating themselves, emotional numbness and physical health difficulties |
| | Moral distress leading to feelings of demotivation, burnout, discouragement, anguish, powerlessness and helplessness |
| | nurses experiencing anxiety, guilt, disappointment and stress which result in sleep problems after providing psychiatric care |
| | Nurses experiencing shame and guilt after restraining |
| | Nurses feeling neglected in an emotionally demanding job and professional code meaning they are not able to meet their own basic needs or |

| | |
|---|---|
| | provide good quality care |
| | Pressure of senior staff, lack of supportive supervision, blame and bullying culture left professionals feeling shame and guilt around poor quality of care |
| | Staff blaming themselves after disruptive behaviour (verbal and physical threats) wondering what they could of done to prevent this |
| | Staff feeling guilty about not being able to fulfil their role |
| | Staff felt guilty and helpless about their inability to deliver usual care standard and felt responsible for service users resulting in anxiety |
| | Staff felt guilty that they were unable to offer specialist services due to service prioritisations |
| | the impact of moral injury leaving nurses feeling emotionally tired and dented |
| | The reduction in peer support increasing anxiety due to not be able to talk through difficult circumstances |
| Personal cost of moral distress | Ethical sensitivity to respond to those receiving care with respect and empathy and this quality being a precursor to moral distress |
| | Moral distress as a result of accumulation of observing ineffective patters of responding to adolescent or team behaviours |
| | moral sensitivity in psychiatric nurses leads to moral distress |
| | Pressure to achieve a high standard of care resulting in a personal cost to the nurse |
| | Professionals attempted to mitigate harmful effects by increasing their workload resulting in feelings of burnout |
| | Staff felt a moral obligation to their team resulting increased work demands |
| | Struggling to maintain boundaries at home with the level of demand |
| personal value conflicts | Being complicit in a decision which the psychologist did not agree with resulting in service user suffering |
| | Conflict around feeling that restraints are harmful and necessary and can cause moral harms just by observing others being restrained |
| | Conflict between holding responsibility on shift and feeling unable to direct the team to not restrain a patient |
| | Conflict between nurses feeling responsible for supporting participants to be involved in decision making and loyalty towards the system |
| | Conflict between patient participation and reality of choosing the quickest solution |
| | Conflicts around higher thresholds and not being proactive with the ethos and philosophy of the service early intervention |
| | Conflicts around professionals' duty and the emotions caused when using restraints |
| | Disparity in patient care resulted in frustration and questioning why |
| | Fear of getting into trouble for maintaining professional obligations |

| | |
|---|---|
| | Feeling compelled to provide care which conflict with beliefs, ethics and professional standards resulting in moral distress |
| | Feeling fearful of being labelled by others as a problem, having your practice called into question or being intimidated by others through yelling or exclusion from the group |
| | Feeling frustrated and conflicted about whether to continue challenging or to leave the work place |
| | Feeling like a 'jailer' going against professional training of caring |
| | Feeling morally conflicted about increasing risk in service user presentation and lack of action within the system, whilst worrying about the consequences of speaking up |
| | Feeling morally obligated to act whilst scared about becoming a alienated from the team |
| | Feeling conflicted about benefits of being able to disengage quickly from work difficulties when home and becoming cold and blase |
| | Following senior staffs decision despite disagreeing due to feeling there was no choice |
| | Going against own beliefs to apply restraints to avoid conflict with team members |
| | Having two conflicting roles, a carer and punisher, controller |
| | it is impossible to refuse to restrain due to this being an inevitable part of the role |
| | Its difficult to participate in treatment that nurses do not believe in which results in moral dilemma |
| | not able to be the ideal psychologist |
| | Nurses feeling squeezed between patient wishes, families wishes and doctors orders when unable to limit social media |
| | Protecting others through the use of restraints came at a cost as it was felt this was not a moral way to act resulting moral injury |
| | Seeing mechanical restraints going against values of being peaceful |
| | Values and beliefs differing from the institution (workplace) and acting against this resulting in a breach of contract |
| | Values conflicting with expectations of co-workers and other systems involved in the youths care resulting in moral distress |
| Responses to moral distress | Comprising morality and ethics as a result of only providing care to reduce own stress levels rather than the intention to reduce the young persons distress resulting in feeling upset and selfish |
| | Experiencing physical symptoms such as headaches when holding more responsibility within the context of being understaffed |
| | moral distress impacting on sleep, want to socialise and thinking about work |
| | When confronted with ethical problems psychiatric nurses did not act which resulted in nothing changing |
| | when unable to meet own standards participants choose to resign, avoid personal involvement in distressing situation or do what is believed |

| | |
|---|---|
| | to be in the patients best interest no matter what |
| Helpful and unhelpful ways of dealing with moral distress injury | |
| Coping mechanisms | Becoming desensitised to restraints as a coping mechanisms to moral injury |
| | building trust and listening to patients helps them to accept treatment and reduces moral distress |
| | Developing coping mechanisms to be able to work in contradictory and harmful situations |
| | Dialogue with representative professional bodies was to check whether they had acted in accordance with standards of practice |
| | Family and friends were used for emotional support when dealing with moral distress |
| | Holding colleagues accountable and sharing the workload reduced moral distress and guilt |
| | Hopelessness that nothing will change and there is no point in discussing it |
| | learning from senior nurses about moral and professional behaviours |
| | managerial support in reducing staff shortages and meeting the needs and demands of nursing reduces moral distress |
| | managing own emotional regulation helped reduce moral distress when dealing with violence from patients |
| | needing to compensate for other colleagues mistakes or lack of work to prevent patients rights from being violated and reduce feelings of guilt & moral injury |
| | Needing to distance ones self to be able to cope with the restraint |
| | needing to pick the battles to not be destroyed by it and continue helping others |
| | needing to take a day off or go on sick leave due to work challenges and ethical dilemmas increasing and impacting on their ability to do a good job |
| | normalisation as a defense mechanism for moral and ethical distress |
| | Patient participation was seen to be dependent on individual practitioners professional convictions |
| | placing own values and professional code above the needs of the organisation to prevent suffering and moral injury |
| | Professionals develop and involuntary (unconscious) mechanisms and conscious strategies to reduce distress at a moral level from using restraints |
| | Receiving psychological support to help nurses cope with moral distress |
| | Reduction of distress, reflection and becoming desensitised over time to a once morally distressing situation |

| | |
|---|---|
| | religious beliefs help nurses to act on their duties and avoid unethical actions reducing moral distress |
| | reporting and following up on morally injurious events was a coping mechanism |
| | Separating work from home life as a coping mechanism |
| | Shifting from individualist view to a wider systemic context allowed for a more realistic picture of where change could be enacted |
| | Some nurses found talking with a paster or priest helpful coping strategy when dealing with moral challenges |
| | Support was validating when the other person 'got it', the moral distress was acknowledge and normalised |
| | Talking about leaving or leaving as a result of unresolved moral distress |
| | talking with colleagues helped nurses to cope with moral distress and supported them to find their work meaningful and worthwhile |
| | The option to leave the role provided incentive for staff to continue working in the role |
| | Using communication to cope with moral distress |
| | Using dialogue to make sense of their experiences with supervisors, peers, co-workers, professional bodies, friends and family |
| | using peer support to cope with moral distress and seeking further supervision when moral distress remained unresolved |
| | Using reflection to counteract morally distressing situations |
| | Using supervision to protect ethical practice reducing moral distress |
| | using the support of other psychologist to reassure what is considered good and competent practice |
| Shifting responsibility | Believing that responsibility of coercive treatment sits with the doctors and that they are only following orders |
| | Capacity assessment is seen as tick box exercise which absolved clinicians of responsibility of dealing with the ethical dilemma |
| | Coercive measures taking place due to lack of resources, used in routine practice, were legally questionable or staff did not agree with resulted in moral distress |
| | Colleague support helped with guidance and options from past experiences which created moral distress |
| | Shifting responsibility of the behaviour on to the state to reduce moral emotional distress |
| Sources of moral injury | Moral distress caused by use of coercive or restrictive interventions |
| | Anti-psychotic and coercive treatments are seen as necessary evils and nurses find it emotionally stressful to be on the receiving end of patients despair in connection with treatment |
| | balancing the restrictions and patients autonomy but feeling that sometimes it is not restricted enough as it is putting health in jeopardy |

| | |
|---|---|
| | Experiencing guilt, remorse, impotence, frustration and out range when using restraints with no alternative measures |
| | Experiencing moral distress when coercive measures could have been avoided |
| | feeling personally responsible for motivating patients to stay voluntarily combined with time pressures meant nurses rely on pressure/persuasion |
| | Feeling trapped and not able to refuse to restrain |
| | Feeling unsure when it is appropriate to use coercive measures and having to tolerate higher levels of challenging and violent behaviour |
| | finding mechanical restraints the most unpleasant thing about the job and feeling bad and dire after restraining |
| | Harming the dignity of people and ruining their life when using restraints as a professional |
| | jeopardising the therapeutic relationship through the use of restraints |
| | Moral dilemma caused by pressure to keep patients and staff safe whilst using as little coercion as possible |
| | moral dilemma of not taking responsibility away from service users and seeing the impact obesity is having on the wider health care system whilst feeling under scrutiny by CQC |
| | Moral distress due to needing to seclude patients in unexpected events of violent behaviours |
| | Perception that restraints are part of psychiatry and not wanting to restrain |
| | Questioning the moral and ethical elements of restraint |
| | Use of coercion when the situation could have been resolved with better staffing was a source of moral distress |
| | Using coercive measures resulted in string negative emotions, decreased appetite, rumination and doubt about one's own morals leading to moral distress |
| | Worrying about the traumatic impact of restraints and needing colleagues to support to complete the restraint |
| Providing inadequate care | anxiety and worry about not providing 'decent care' resulting in patient being secluded |
| | Being unable to provide treatment and worrying about patient safety |
| | failure to be present was attributed to high workload, lack of time causing fatigue and insecurity which in turn may lead to being unable to meet patients needs |
| | Feeling conflicted about following COvid-19 restrictions and leaving vulnerable clients without care |
| | Feeling like failing the service user due to not being able to moderate food |
| | Feeling unable to live up to the requirements of nurse patient relationship resulted in moral distress |

| | |
|---|---|
| | Finding it hard to provide other aspects of the job (recovery, hope, relationships) which does not involve medication |
| | Increase in severity of mental health conditions left practitioners feeling on edge and resulted in guilt and the focusing on risk and safety rather than treatment |
| | Later stages of COvid-19 psychiatrist witness deterioration in service users mental health whilst feeling unable to help them due to service restrictions |
| | Moral injury experienced as the result of professionals feeling they were letting the service users down resulting in feeling dissatisfied in the care they were offering |
| | Not being able to assess in line with pre-covid-19 referral criteria |
| | Not being able to work on the root cause of the difficulty due to system constraints |
| | Nurse experiences moral distress when unable to provide the patient with adequate time |
| | observing mistakes and working with underactive colleagues were sources of moral distress |
| | Participants felt they were delivering substandard of care which didn't feel right in Covid-19 |
| | Peer support worker unable to provide support due to similar experiences |
| | Professionals moral distress was the result of an perceived or actual inability to maintain safety |
| | psychiatric nurses feeling unable to engage in a behaviour to stop patients leaving the hospital or stop administering unrequested medication |
| | Reducing the service due to Covid-19 and feeling that some service users were not receiving support |
| | Remote consultations causing significant doubts about adequacy of care |
| | Restrictions left staff feeling they were not providing effective care and finding this difficult |
| | undignified care where individual needs are not met result in nurses experience frustration and distress resulting in them not taking personal responsibility |
| | Witness inadequate care and feeling unable to find a solution results in only focusing on the care you can provide |
| | Witnessing patients go without medication for days and receive inadequate treatment leads to moral distress |
| | Witnessing patients socially disgrace themselves but feeling unable to prevent it |
| | witnessing unjustifiable conduct which could escalate into dangerous situations from both professional and unskilled staff |
| Raising concerns and feeling invalidated | Feeling unable to voice concerns or disagreements about decisions is a source of moral distress |
| | Feeling hurt after raising misconduct and being met with anger |

| | |
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| | Feeling unable to raise concerns due to being dismissed or there being inaction |
| | Feeling unable to raise concerns due to power dynamics and needing to continue working with the colleague |
| | Feeling unheard and uncared for when reporting concerns resulting in not disclosing the distress |
| | Feelings of frustration, anger, powerlessness was a result of moral distress being dismissed on a personal level |
| | Finding it difficult to raise racism and implicit bias towards patients |
| | Invalidating support for moral distress included feeling silenced and feeling that there was no hope for change that the situation could be prevented or managed differently in the future |
| | learnt helplessness impacting on others speaking out against unethical practice |
| | Patient participation being limited and nurses feeling that it is important but patients are treated like packages and are not being heard |
| | regretting raising unethical practices due to conflict with supervisor |
| Risk and feeling unsafe resulting in moral distress | Dilemma around the risk of infection, legalities of isolating servicer users and delays in responding to emergencies due to time taken to don PPE |
| | Due to the changes to CMHT staff felt their practice was not as safe as it was pre-pandemic |
| | Feeling thrown in the deep end and feeling that lack the competency to support the service user |
| | Peer support worker overstepping boundaries resulting in moral distress |
| | psychiatric health care assistants feeling unsafe impacting on their ability to fulfil their role |
| | Reliance on telephone calls led to fear about unsafe discharges and feeling that this was not best nursing practice |
| | Remote consultations becoming a source of stress leading to retirement |
| System and organisational constraints resulting in moral injury | |
| Ethical tension between care, risk, and responsibility | Growing qualms about being part of a system which is deemed not good enough |
| | institutional and hierarchical constraints led to moral distress for peer support workers due to limited agency, and high empathy towards patients |
| | Moral distress was the result of complex health care system, intra- and interpersonal factors, resource allocation issues, legal parameters and |

| | |
|---|---|
| | multiple government systems involvement |
| | Principles of care being overlooked to emphasise the safety management and personal risk |
| | Tension of being responsible at a community and society whilst accepting ones moral choices |
| | Trying to balance the risk of transmitting Covid-19 and delivering adequate care to service users |
| Gaps in services and care resulting in moral distress | Experiencing moral distress when patients and families are not able to access support from other providers which you have no control over |
| | institutional constraints causing moral distress due to not promoting person centered values and being punitive to vulnerable young people which results in feeling frustrated and resentful to the organisation |
| | Observing treatment being ineffective and knowing that the servicer user's length of stay is being impacted by external factors |
| | Psychiatrist feeling pressure to cover the systemic failures and gaps in services |
| Impact of being short staffed | Being understaffed, missing breaks and working late resulted in comprised care and low staff morale |
| | Due to shortages of staff the functions of the CMHT were reduced often resulting in staff working longer hours and not taking annual leave to address capacity issues |
| | Expectation to do duties that are not in line with own role due to short staffing and feeling criticised by management |
| | inadequate staffing and untrained staff impacted on patients in need of heightened care due to risk |
| | inadequate staffing, high patient turn over and administrative tasks impact on nurses time which impacted on ability to build patient relationships |
| | Missed essential care due to inappropriate staffing levels resulting in aggression and violence |
| | Service users missing out on legal entitlement (section 17 MHA) due to their being no staff to escort them which impacts on their recovery and discharge |
| | Working overtime to compensate for frequent turnover and shortages of nurses and psychiatrists |
| Inadequate resources | Contradictory messages contributing to moral distress where expectations by employer or coworker were contradicted by their actions |
| | Inadequate resources (time and staff) meaning that patients cannot be spared much time |
| | inadequate resources and cuts to funding leading in understaffing and not able to provide sufficient care due to missing things |

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| | inadequate resources, understaffing, unable to take annual leave leading to increased pressure feeling intolerable |
| | inadequate structural spaces negatively impact on workers experience which is a barrier in caring effectively |
| | insufficient time lead to moral distress resulting in a bad conscious, feelings of inadequacy and feeling that they are failing their patients |
| | lack of funding results in inadequate resources and understaffing |
| | lack of hospital beds, lack of time, harmful ward environment and a high workload led to feelings of inadequacy and moral distress |
| | lack of resources impacted on nurses ability to give patients care they needed |
| | limited resources (time and space) resulted in nurse quitting inpatient psychiatry due to frustration about the care provided |
| | moral distress as a result of inadequate resources both material and professional results in improvisation of care and criticism from other professionals due to going above capacity |
| Poor communication | Mistrust towards senior management and the advice offered feeling unacceptable |
| | Moral distress as a result of a lack of consensus in the team, different approaches and structural deficiencies with internal and external providers |
| | poor communication at both patient and colleague level was a cause of moral distress |
| | poor communication between management and the team can result in moral distress |

**Table P5.**

*Refinement of emergent themes and subthemes*

| **Theme** | **subtheme** |
|---|---|
| Consequences of moral distress, injury | Doubting professional practice |
| | Emotional experiences of moral distress |
| | Personal cost of moral distress |
| | personal value conflicts |
| | Responses to moral distress |
| Helpful and unhelpful ways of dealing with moral injury | Coping mechanisms |
| | Shifting responsibility |
| Sources of moral injury | Moral distress caused by use of coercive or restrictive interventions |
| | Providing inadequate care |
| | Raising concerns and feeling invalidated |
| | Risk and feeling unsafe resulting in moral distress |
| System and organisational constraints resulting in moral injury | Ethical tension between care, risk, and responsibility |

| | |
|---|---|
| | Gaps in services and care resulting in moral distress |
| | Impact of being short staffed |
| | Inadequate resources |
| | Poor communication |

**Table P6.**

*Final themes and sub-themes*

| **Themes** | **Subthemes** |
|---|---|
| Psychiatric professionals feeling powerless to change a morally distressing system | |
| Consequences of moral injury | Feeling conflicted and experiencing distress |
| | Work related exhaustion or resign |
| Helpful and unhelpful ways of dealing with moral injury | Emotionally distancing or sharing the burden |
| | Shifting responsibility |
| Individual sources of moral injury | Balancing risk, boundaries and safety for self and others |
| | Moral distress caused by use of coercive or restrictive interventions |
| | Providing inadequate care |

| | |
|---|---|
| | Raising concerns and feeling invalidated |
| System and organisational constraints resulting in moral injury | Gaps in services and care resulting in compromised care |
| | Inadequate resources |
| | Poor communication across multiple levels |

## Appendix Q

## Verbatim extracts from studies with applied codes

**Table Q6.**

*Verbatim extracts from studies with applied codes*

| Theme | Subtheme | Raw data |
|---|---|---|
| System and organisational constraints | Gaps in services resulting in compromised care | "Mental health care occurs in a complicated system alongside social determinants of health, and PHAs felt the challenges it created during an inpatient admission." |
| | | "When you look at a patient, they may come in for problem. But in reality, problems B, C, and D are all really making problem A worse. And if we would work on those, we could really get problem A under control." |
| | | There was a general consensus among PHAs that length of stay was not determined by clinical need but other external factors. Psychotic patients awaiting the transition to long-term care in a less restrictive setting were" |
| | | "just being kept for a very long time. And we know, as humans, that they would certainly be better off not being locked on the unit for four to five or more months, on the same medication regimen that's not really working" |
| | | I understand the need to protect the core service if you like, but it's been hard to send mixed messages about our referral criteria. To other services, for a very long time, we've been saying, if you even suspect psychosis, talk to us, you know, we want to know about it, liaise with us. And then at the moment, people are referring to us, and we're saying we won't even assess a lot of those referrals. And referrers are confused by that, I think. And I can understand why. (CBT therapist, Early intervention in psychosis service)" |

Many psychiatrists and care coordinators felt that the therapeutic function of their role was particularly compromised in favour of ‘case management’, pointing to the moral content of these prioritisation decisions. Staff felt guilty that they were not able to refer service users to the necessary specialist services because these were no longer operational, they described service users as being in a ‘holding pattern’, rather than being supported to make improvements."

The medicalisation approach of care for psychiatric patients has overlooked the principles of ‘care’ in the context of nursing and consequently the emphasis seems to have shifted more towards safety management and personal risk. (David, Diary)

"Institutional constraints are one of my primary stressors, I find that institutional constraints do not promote person centred values, but rather are punitive to a group of vulnerable, damaged young people that are in need of inspiration, hope and innovation guided care. The lack of such things makes me extremely frustrated and resentful to the organisation. (Marcus, Diary)."

"This shift in perspective is seen in Anita’s discussion of having her moral distress “dismissed.”"

"It was dismissed in the overall picture cause he just went home and then back to his drug use and it’s all falling apart. And—but that’s the system, that wasn’t people. That wasn’t any one individual.. . .Part of my distress in that case was that I knew exactly what was going to happen.. . . in reality, the system didn’t allow for anything else to happen." "When they moved from speaking about the incident in terms of their own actions to speaking about the incident in the broader context of the team, unit, agency, or health care system, they had a more realistic picture of where they could enact change."

"Additionally, poor collaboration with external care providers, such as social services or outpatient care units, resulted in prolonged patient stays and re-admissions."

"Olof, physician: [It’s morally distressing] when patients and families do not get what they need and are entitled to from other care providers that I have no control over, such as outpatient care and social services.

| | |
|---|---|
| | "Although the COVID-19 pandemic presented clinical challenges unlike anything experienced in their professional careers, participants also described how these pressures were accentuated by preexisting systemic failures. For example, some participants talked about how, historically, clinical responsibility fell on consultant psychiatrists without a concomitant mechanism of responsibility or accountability on senior management to provide the resources necessary to deliver services. Thus, a culture had developed in which the system was kept going through reliance on (and exploitation of) the goodwill of psychiatrists and their team:" "'There's a culture where [it] falls on the consultant to cover that gap and to say I'm just going to keep going here' (Oisín, urban area, Male , General adult psychiatrist).)." |
| Inadequate resources | "Being the only staff nurse on ward is a huge responsibility for such complex unwell patients, having to do all nursing jobs on top of assisting others to due lack of staff and missing breaks, staying late in work to catch up on paperwork to name but a few issues, leaving staff morale very low on ward as everyone is always exhausted and over worked." |
| | "Compromised safety of both patients and staff were frequently identified. Respondents described injury and missed essential care. Self-harm was identified as a specific issue when one-to-one care was not possible, along with de-escalation of violence and aggression:" |
| | "Staff and patients have been injured on my ward, due to inappropriate staffing levels. Staff are unable to do personal care and spend the 1:1 time needed to support and de-escalate patients. As a result, agitated patients escalate, and can have aggressive outbursts." |
| | "We get berated if we submit Datix forms about dangerous staffing levels and we often work with no managers on shift and just one qualified nurse. We also are expected to do the duties that would be expected of a ward clerk and are constantly criticised by management as they feel we are lazy and not performing. It's a terrible situation." outcomes for patients |

"Poor staffing levels where I work often leads to my patients having poor outcomes, either through not having up to date care plans or paperwork, but also that they engage in challenging behaviour including serious ligatures and assaultive behaviour, which in turn creates a vicious cycle." "Nurses frequently pointed to being unable to provide one-to-one care, despite this being essential not only to avoid incidents but to progress in patient recovery and work towards discharge:"

"One of the most concerning (and frequently cited) aspects of patient outcomes and missed care was the omission of escorted leave. Under Section 17 of the Mental Health Act; people who are detained are legally entitled to leave from the ward; in fact, this is a vital aspect of recovery and discharge:"

"Sometimes patients detained under the Mental Health Act are denied escorted S17 leave because there are no staff available to escort them. This means they are missing out on a vital part of their recovery/ rehabilitation."

“As the rooms are small, they tend to be overcrowded”. All this couldcause «growing qualms about being part of a sys-tem I do not find good enough».

"participants described that frequent staff turnover and shortages of nurses and psychiatrists disrupted care continuity. To compensate for this shortage, participants reported that working overtime had become commonplace." "Anna, physician: Time and experience are so important. When the organisation is under pressure, experienced staff do not stay, the risks and pressure on us who dare to stay increase. [It is important to actually provide] reasonable conditions for experienced staff to stay—and new ones to dare to stay until they become experienced."

"Staff also described a sharp increase in patients with eating disorders as a growing contributor to moral distress, reporting feelings of unpreparedness and substantial resource gaps."

"Untrained personnel and inadequate staffing made task delegation and follow-up of suicidal patients, patients in need of seclusion or with heightened risk of violence difficult. Untrained personnel may neither understand the gravity of situations nor feel the same kind of responsibility as the permanent staff:"

"I have seen patients under permanent watch where the personnel are sitting with the door slightly ajar focusing on their mobile phone, while the patients are in bed with the duvet over their heads. (I4)"

The workers considered that the MD in daily work is associated with insufficient and inadequate structural conditions because the facility provided for care was not prepared as per the characteristics of the service. Therefore, the bad distribution of spaces, constraints, and composition of hazardous materials in the structure was recurrent in the statements:" "This is a house that has been transformed into a center, and we don’t have a legal structure to meet our demand. (P1)" "Our space has much glass. We already had a problem with patients who freaked out and got hurt [...] I see this as a negative point in our space because of our demand. (P2)" "Also, the inadequate spaces limit the holding of workshops, negatively interfering with workers’ experience, which is an obstacle towards developing their activities, as follows:" "Because of our structural difficulties, we sometimes cannot provide the work effectively, the way we should. (P6)

Fewer staff were available to carry out certain CMHT functions. In order to redress workforce capacity issues, staff reported working longer hours and not taking their annual leave." "we have had a lot of staff deployed back into the teams and it's mostly been the case because we've, we've been struggling and there have been real safety concerns around patient safety due to a lack of staffing(Respondent 11)."

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| | time was described as a valuable asset that was typically lacking due to shortage of nursing staff, overcrowding, high patient turnover, and administrative tasks. The following statement by participant2 illustrates how having enough time was perceived as a matter of prioritizing being with patients, and thus essentially under nurses' and assistant nurses' control:" "participant2 illustrates how having enough time was perceived as a matter of prioritizing being with patients, and thus essentially under nurses' and assistant nurses' control: It was a Sunday evening at five minutes to eight….I was thinking that I should write something, but then I saw through the window a girl just getting back from leave. Well, now I have a choice. I either make three notes for tomorrow's rounds or I go and talk to her. I chose her, and then I complimented myself for choosing her over the computer. You have those choices all the time that you have to make." Failure to be present was typically attributed to a high workload and lack of time, causing fatigue and lack of concentration, but also to insecurity and a failure to appreciate the importance of relationships |
| Poor communication across multiple levels | Contradictory Messages most often took the form of stated expectations by the employer or co-workers that were directly contradicted by their actions. Participants described several ways in which Contradictory Messages, that ranged from blatant to subtle, were conveyed and either verbally or non-verbally. This same force, if used on the inpatient unit, would result in a formal reprimand from the supervisor, because it was unsafe for the youth, yet it seemed fine in the ED." "There's inconsistencies or incongruences across the systems where you're expected to act in different ways.. . . it becomes distressing right. . . you're not sure. . . on one hand it's okay to do that here in Emerge [ED] but it's not okay to do that at treatment. . . you know, it's hard" In these situations, participants attributed an increase in their experience of moral distress to co-workers' contradictory actions. As one participant explained, she felt "set-up" by the team when she followed the care plan and other team members did not." |

The subtheme captures the problems encountered due to a lack of consensus within teams, differences in treatment approaches, and structural deficiencies in collaboration with internal and external care providers. Participants frequently pointed out disagreements among team members (commonly with physicians), concerning the best care strategies for patients, leading to emotional friction and dissatisfaction. A major influence on moral distress was a sense of not being able to voice disagreements or concerns about decisions perceived as detrimental to patients" "Nils, psychiatric aide: [On sources of moral distress]Conflicts with physicians. Difficult to cooperate regarding the patient's needs.

"The experience of suffering also happens when there is no dialogue between management and the team, as they point out the importance of professionals' participation indecisions that directly influence their work dynamics:" "A manager has to share a few things, especially when it will directly interfere with teamwork. [...]we come to know some things too late, and there's nothing we can do about them. (P5)"

Weakness in establishing proper communication at the level of patients and colleagues was stated by psychiatric nurses as one of the causes of moral distress. Psychiatric nurses stated that when they strengthen communication, they felt fewer levels of moral distress. the strategy of "Team participation" was used by psychiatric nurses to establish professional communication with colleagues. "

"This culture, combined with a perception that some senior management did not appreciate the complexities of service delivery, created a breeding ground for excessive strain on consultant psychiatrists." "in addition to having to constantly adapt to the sheer speed and volume of information incoming at the early stages of the pandemic, logistical and clinical uncertainties were compounded by inconsistent and sometimes conflicting guidance and instruction issued by senior management within the Health Service Executive (HSE). A perception that HSE guidance was conflicting with World Health Organization (WHO) guidelines often gave rise to a general sense of mistrust that trickled down to team members. Regular meetings organised by senior management that were intended to be a source of reassurance and support often became divisive and a source of frustration for many participants. In the absence of reliable guidance or instruction from senior management, participants realised that they would need to take matters into their own hands and make decisions at a local level based on 'best instinct' (Finn, rural area). In some cases, participants actively had to fight to ensure that senior management understood the extreme risk that COVID-19 posed to those in their care:" "'Initially there was a big meeting in the service and they [management] were trying to […] highlight what services needed to be most focused on, and […] if there was a big COVID outbreak, which services could sort of shut down or be rationed, if you like, so that they could preserve the acute. And at the initial meeting our own service was put way down the list…and I had an apoplectic fit at the meeting, and said, "You cannot do this […] these patients are the most vulnerable, the most at risk, and you know, most likely to die from COVID, so to say that we're not going to provide services, it's just absolutely outrageous"' (Mairead, rural area, female psychiatry of old age)."

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| | | "There was also a sense of fatalism about the possibility of services being able to meet future demand owing to both strained relationships with senior management and a perceived lack of clarity over how decisions were being made in resource allocation:" "'I'm effectively working seven days a week, at the moment, because of increased demand, because of the pandemic. And this has been flagged to management, time and time again but I suppose, it's just "get the work done" … we've applied for additional resources and we haven't got them'(Roisin, urban area, Female, child and adolescent psychiatrist). " |
| | Balancing risk, boundaries and safety for self and others | "Pervasive safety concerns of not only the patient the PHA was speaking to, but all others on the unit, including themselves, influenced interactions with patients." "I would equate it to if you were a therapist and were sitting doing therapy with somebody, but you were in a really big room. [.] And right behind you, a guy just kept walking [.],and shadowboxing behind the back of your skull. Trying to conduct therapy with this person would be impossible because you'd be so worried about your own safety."" "All PHAs interviewed had witnessed or experienced violence towards themselves or other staff members." "I have a friend, a nurse. We started the same time.one year and one month. Maybe four or five times he got beat up because he is the only male nurse on the floor." "At times, PHAs are required to work while feeling unsafe" |
| Individual sources of moral injury | | ""Sometimes I'm like scared of the situation because like I think the patient is undermedicated or the patient is out of control." |

"Other dilemmas focused on trying to balance the need to control infection risk with the need for human contact in inpatient settings. Staff explained the difficulties of providing therapy or conducting necessary assessments with service users whilst wearing PPE. Staff also raised concerns about being able to react to emergencies rapidly because of the time taken to don PPE, and even once they had they reported some service users were startled or distressed by their appearance. In some cases, for example, service users with Covid-19 who did not agree with self-isolation protocols were, nevertheless, confined to their rooms. These measures put pressure on service users as well as staff, at times resulting in reported increased levels of distress and aggression, possibly due to frustration. In some services, frontline staff raised concerns about whether this form of restriction was ethically or legally defensible as part of care; emergency ethics committees were convened to address these and other pandemic-related dilemmas. Again, evidence of moral injury was a feature of these accounts."

The inability to see aspects of non-verbal communication (i.e. body language, gestures) and to physically observe a service user's home environment created concerns about relying on telephone interactions."

"we have a lot of patients whose only contact now with teams is on the telephone or via video in some form, and for a lot of our patients that's not enough to maintain safety or to offer a safe service (Respondent 11)"

"Reliance on telephone calls created uncertainty about discharging service users from their caseloads. This was compounded by a fear that service users may perceive this as further rejection at a time when there was less social support than usual."

"I've just written up a visit that, well a call, that I did yesterday, it was 15 min long and normally I'd be with them for like half an hour and she's very anxious and she doesn't really like talking over the phone, so, I think I'm only getting half the story with that(Respondent 19)."

"for me it's not really the best nursing practice just to ring someone up and go 'I've been coming out for the last two years but no I'm too busy' or 'now I've got too many people', so or even if they are settled or generally they are ready for discharge I think it's really impersonal just to do it over the phone(Respondent 16)."

"we're not we're not really discharging anybody at the minute. It's not particularly safe to do that if you can't assess them properly(Respondent 19).

"It should be noted that instances may arise where overinvolvement and an inclination to assist others may inadvertently result in conflictual situations, or alternatively the transgression of boundaries within the relationship." "(…) I went a bit too far. I wanted to use my contact with the estate agent to recommend that person to a patient who was really worried about his house and didn't know what to do with it and was thinking of selling it… then I saw the aggression in the patient's sister's eyes, so I backed off. (M1_day ward_full time_5years' work experience)]"

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| | "There were concerns that switching to remote forms of care might cause some patients to become disengaged, particularly older individuals with a low level of information technology (IT) literacy and those with profound intellectual disabilities. As the pandemic wore on, initial technical issues were resolved and the possibilities associated with remote care provision were seen by some in a more positive light (e.g. extending services to geographically distant areas). However, it is worth noting that in the case of at least one senior psychiatrist, the expectation that remote forms of work would likely be incorporated into the provision of care in psychiatric services in the future prompted decision to retire earlier than she might have otherwise" "'It will be an ongoing source of stress and I decided to retire…I mean I would be going to retire, sooner or later anyway, but I just decided, no, it's not for me […] it's too difficult […] the spontaneity has gone out of the job' (Orla, rural area female, General adult psychiatrist)." |
| Use of coercive or restrictive interventions leading to moral injury | Many of the interviewees felt obliged to tolerate more challenging – even violent – behaviour then they previously had done. Restraints and coercion were no longer used until the risk of violence was imminent. Even so," "«It is difficult to know when we actually should use coercion. We try and try and try again all the measures at our disposal to avoid tight-holding or belts. When the patient in spite of this goes on and on and on ... You get to a point when this is enough [has to be stopped]. But you don't want to use coercion. After-wards one may think what is right? What is wrong?»." "«Where to draw the line? When does it become dangerous? When someone throws something in the wall? You never know if he'll attack someone else next time. There is a lot of frustration that is not turned against us, but someone who is screaming and yelling and perhaps throws chairs around is rather threatening. These situations affect us ...»." "Several interviewees said they often felt personally responsible for motivating patients to stay in hospital and accept treatment. However, when pressed for time their communication tended more towards persuasion or pressure than motivation:<br>I should say that it took me a long time before I was able to do it myself [...] I needed someone else to be there, in case something happened. I don't know, I thought: "this is going to be traumatic for everyone." [A2. Group A – 4:646]" |

"I think that it's iatrogenic... and even so I use containment in those cases without... I mean, I wouldn't want to, but if I ask the supervising specialist, they are going to tell me that I should contain them, and that psychiatry [...] is like that. Today in the Community of Madrid, it's like that. [M19. Group C – 4:949]"

There's no escape, because you can't choose not to do it. Of course you have to do it. I'd like not to be here, but I have to be here. [P12-E10. Group B – 4:537/8]

I think they harm the dignity of the person. Literally, they are ruining that person's life. [P17. Group C – 4:1165]

Ethical dilemmas about coercive measures "Marianne, nurse: The first time I tube-fed are strained patient, I had a surreal feeling of being in a horror movie set in a mental hospital, and I was one of the bad guys." "Some participants described the work with coercive measures as particularly morally distressing. These participants experienced strong negative emotions and found working with coercive measures difficult. They described how it had a negative impact on their private life in forms of stress symptoms, difficulty sleeping, decreased appetite, ruminations and doubts about one's own morals." "Fredrik, nurse: [The work of coercive measures results in] that you, sometimes, feel hopelessness and lose commitment. That you sometimes take work home with you and dwell on traumatic coercive measures in an unhealthy way that leads to poorer recovery [for yourself]."

"Further, situations when coercive measures had to be used but could have been avoided were seen as especially morally distressing. For example: coercive measures that were triggered by staff; that took place routinely; did not lead forward in treatment; were consequences of lack of resources; were legally questionable; or that staff did not agree with. This also included situations where coercive measures lead to negative treatment effects, such as spoiling the alliance with the patient or reinforcing self-harm." " Anders, psychiatric aide: [It's morally distressing] when there are coercive measures because the staff has failed to listen to the patient and when the staff "triggers" a situation that could have been avoided. Unfortunately, this happens quite often."

"the interviewees found that patients tend to be more gravely ill with more use of synthetic drugs and lower threshold for physical violence than a few years ago. This is combined with fewer seclusion rooms and fewer staff. This made episodes of threats and violence more prolific:" "It is very difficult, it is the patients' safety and the staff's safety, while there is a continuous pressure to use as little coercion as possible – that is perhaps our greatest moral dilemma. (I2)"

"Coercive treatment was mainly characterised as necessary and a caring measure towards patients who suffered greatly, self-harmed or were threatening. Anti-psychotic medication was understood as an important part of treatment during acute psychiatric phases and as a necessary evil. Yet, the interviewees found it emotionally stressful to participate in coercive measures even when convinced that the patient needed the treatment, and draining to be on the receiving end of patients' despair, anger and frustration in connection with treatment:"

"Use of coercion when the situation could have been otherwise solved if better staffed or the unit's routines had been more focused on individual patients' needs made the nurses uncomfortable. One related how he found it morally stressful when a patient who needed to be freed from straps was left too long due to the unit's routines. The use of coercion was also difficult if disruptive behaviour was caused by a co-worker's personality or communication style."

"Dire. I feel very bad…it is one of the things, well I think the most unpleasant thing, in this job… Impotence. I feel frustrated(P1). (female, acute mental health, MHN, age 29, 2 years qualified) "

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| | "Our final theme is broken trust. The therapeutic nurse– patient relationship (TNPR) is a core aspect of mental health nursing and participants felt that MR jeopardized this, especially the trust element." "The patient loses the confidence that he had in you, it is a very aggressive measure, you are taking away a right that he has, at that moment I think that it [trust]is completely broken(P3). (Male, acute mental health, MHN, age 32, 8 years qualified) " "I think that the alliance that the patient has with you isn't going to be the same… The patient no longer has so much confidence in you, loses confidence, doesn't tell you everything he thinks(P4).( Male, acute mental health, MHN, age 32, 8 years qualified) " "The therapeutic alliance requires collaboration and partnership which is at odds with the paternalism of MR. The weakening of this alliance due to MR use was also a concern." "… it is negative, it is something that distances the patient from the health personnel…containment [MR]will never strengthen the therapeutic bond,(P2). Female, acute mental health, MHN, age 31, 5 years qualified) " "The imbalance in the level of restrictions was seen as conflicting with the professional obligation to provide a reasonable standard of care:" "So I know in a secure unit we have a Duty of Care and it's a balancing act and I think this is the problem with yeah [. . .] sometimes it's not restricted sometimes enough and it's putting their erm health in jeopardy (Donald occupational therapy technical instructor)." "In our culture of heavy scrutiny, heavy litigation, CQC is coming and having a look at your least restrictive practices and whether they are being implemented and followed to a tee. We on one side we are being pulled towards ''Do not take responsibility, give the patient the responsibility' 'And on the other side um the wider community, the [. . .] healthcare system it's all being impacted on (Hana Mardi associate specialist )." |
| Providing inadequate care | Participants described being confronted by multiple challenges and dilemmas arising from the pandemic. Some of these centred on their perceived inability to care for people in the way they felt would serve their needs, or providing care that they perceived as sub-standard and that didn't "feel right". " |

"Another personal pressure is I'm in this job because I want to help people and I've felt really like held back from that… the message at the beginning was don't see clients, and I, kind of, really understood that. I've been taking the Covid really seriously in terms of like not going to supermarkets… but I felt really conflicted that we were leaving some very, very vulnerable clients without care. (CBT therapist, Early intervention in psychosis service)"

A distinctive feature of the accounts of participants was the evidence of moral injury linked to staff feeling that they were letting service users down and that people were suffering deeply as a result. Participants reported feelings of deep dissatisfaction with the support they were able to provide for service users during the pandemic. One worry was that individuals with mental health difficulties would be left feeling isolated and without support and care; staff were deeply concerned about service users who were experiencing reductions or withdrawals of care."

"That's one of the things that this job isn't about just medical stuff, it isn't just about care coordination, it's about recovery, relationships, hope, building something, and that's a lot harder at the minute. (Senior care coordinator, Early intervention in psychosis service)"

One of the nurses had furthermore witnessed 'unjustifiable' conduct that could escalate into dangerous situations both from unskilled extras and professional staff.

Most participants identified that the experience of moral distress began after an event that involved safety.

If nurses felt they had not lived up to the requirements of the nurse/patient relationship, they began Experiencing Moral Distress."

""“It seems that I did not provide decent care for the patient. I felt fear and anxiety every time I had to separate the violent patient in the seclusion room. I was not happy with the work. I felt anxiety all the time, and I am worried that the same situation might happen again (Case 22, page 1, lines 11 - 15, 20 -21)."

participant expected that the patient would be treated as holistically as possible by the team members. The participant knew that she could not help the patient, who needed IV fluid or medicine injection. However, the participant only provided bedside nursing care, including adjusting the patient's position appropriately and with warmth. In this situation, the participant was anxious about active treatments for safety." "“Once I had the experience of referring a psychiatric patient to another hospital due to the physical problems of the patient. I could not prescribe treatments like medicine and IV fluid. I could not help the patient in this regard. I knew that the patient needed IV fluid or water, but I could not give it to the patient. The patient's blood pressure began dropping. I just generally had to look after or keep them warm in an appropriate position. I felt a great deal of anxiety that the patient might not be safe (Case 24,page 1, lines 21 - 25).”"

The nurses found that this, in combination with reduced number of beds in psychiatric units, had resulted in the patients currently admitted being more ill than, say, ten years ago. They experienced a greater tendency to physical violence, like scratching, kicking, blows and strangle-holds as well as serious verbal threats." "“We endure more challenging situation for longer than we perhaps should sometimes, with unrest, threats and destruction lasting for a long, long time.”" "The unpredictability and feelings of constantly «being on tenterhooks» were described as draining. Having potentially very violent patients moving freely among unsuspecting or anxious patients while they were waiting for transfer to a security unit was also seen as problematic. " "One of the nurses characterised the scenarios that could be played out on the ward as “limitless and surrealistic”." "Unfortunate episodes created an apprehensive mood on the ward and were hard on vulnerable patients and made them retire to their rooms. This made it difficult for the nurses to offer the kind of therapeutic and beneficial environment they needed. Several interviewees described feelings of guilt when unable to safeguard patients who were mentally or physically attacked by co-patients. As a consequence, the nurses' focus tended to shift from treatment and care to risk evaluation and safety." "“When people are howling in the corridors and the ward is in a chaos and alarms go off left and right,patients often want us to

lock their door, but this we can-not do as we are responsible for them. But I do under-stand them …" an interviewee said. "Such conditions are unworthy".

"Freer access to social medias through being allowed to keep their mobile phones on the ward made it possible for psychotic patients to socially disgrace themselves:" ""Our hands are tied until they have crossed the line, like when the patient has ruined a relationship, sent their employer nude pictures, for instance". Such actions maybe difficult for the family, too, particularly the patients' children: "One thing is to disgrace oneself, but you have the family setting which may be totally on the breaking point"."

"One of the nurses said that her greatest moral challenge at work was to witness how obviously psychotic patients had to wait for days without medicines and adequate treatment. She felt that many of her colleagues agreed with her, but she was one of the very few who discussed this with the leadership."

"Lars, nurse: [I experience moral distress] when I feel that a patient needs my time in a way that I cannot give, because many others need it at the same time."

"During COVID-19, several changes were made to the delivery of services. Face-to-face visits to support people with mental health issues in their own home were suspended unless service users were in crisis or required depot injections. There were a number of facets to this restriction which affected CMHT staff. CMHT staff were unfamiliar and uncomfortable with rationing their services to selected service users. Visiting, listening and talking to service users was at the heart of how they typically performed their role in the community."

"we were asked to draw up a vulnerable service user list for all four teams where teams and team managers could get together and actually identify those service users who were most at risk (Respondent 11)."

"we were only obviously told at first that we would, kind of like, only do, sort of, urgent and emergency visits, you felt as if, kind of like, those patients that sort of needed regular support, even though they sort of weren't having any sort of you know relapse, you were kind a like, I felt I wasn't supporting them, that there was a higher risk of like their sort of relapsing (Respondent 17)."

time with service users all ran counter to staff training and their moral values. All of these factors resulted in the delivery of a very different service to usual which CMHT staff suggested was a less effective service.\" " It's quite difficult really, it's not the same job that it was before and I don't think it's as effective as it was before (Respondent 19)."

CMHT staff struggled with their desire to continue to provide a service to service users at the same time as reducing the risk of transmitting COVID-19 to their own family members. For many staff, this produced a unique set of emotional conflicts." "a lot of my anxiety comes from because obviously, I'm the one who's going shopping and looking after other people within my household and my mum…I'm going to a vulnerable patient and I think, it really gives you a conflict (Respondent 05)." "While some service users had good social support pre-pandemic from family and friends, others were socially isolated and relied on visits from CMHT staff for social interaction. It was perhaps not surprising that CMHT staff were concerned about these socially isolated service users who were not deemed to be high risk but who, nevertheless, were

sustained by the contacts they had with the team." "but I think people are starting to become more unwell and you're not noticing the signs as quickly as you were. So people are getting worse before you actually realise what's happening and then the hospitals are full, people are having to wait a week or more or something to get a bed before they can start to get better (Respondent 19)." "As a result of the changes to the way in which CMHT staff were required to work, staff reported feeling that the support they could offer was not as safe as before the pandemic."

"I've been dealing with some pretty tough stuff recently. A psychologist asked me to take on a patient who came here with depression after her mother passed away. Another asked me to work with a woman who doesn't want to take care of her mother. And me in all this–I have a mother with Alzheimer's, so it was a bit of a challenge. One weekend, I sat down and cried to myself. Because I want to help them, but I'm trying to make sense of it all by caring for my mother, who I love. It was such a shock to my system. It's difficult when it touches on my personal life, like my mother or father, or the mental crisis of losing my job, or the friend who left me when I started to get sick. These things come back to me when I'm working with patients. (F6_mixed setting_part-time_2 years' work experience)"

"In other instances identified as moral distress, the inability to provide assistance was attributed to institutional constraints, specifically the position of PSWs within the team. The low position of PSWs within hierarchical medical teams has-been identified as a source of frustration due to the limited agency and high empathy towards patients."

"It means that nurses could not perform any suitable behaviour when they wanted to stop patients leaving the hospitals after troubles or stop administering unrequested medication.

"Think (.) deep down [. . .] from experience. I know when patients have said to me like ''I don't like the way I look. I'm too big. I cannot get any clothes that fit me'' and (.) it's like (.) is somebody failing, that's somebody failing them! I don't know. [. . .] I think [. . .] if we moderate some things and potentially it would end this vicious circle. (Donald, occupational therapy instructor)."

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| | Working with underactive colleagues and observing the mistakes of colleagues were among the factors that caused moral distress to psychiatric nurses. |
| | Failure to be present was typically attributed to a high workload and lack of time, causing fatigue and lack of concentration, but also to insecurity and a failure to appreciate the importance of relationships, |
| | "Heather expressed distress that many of her fellow nurses seem to have given up: They've just kind of given up on things they should be doing, I guess. And maybe that is their way of dealing with their, you know, their own stress. Maybe they feel too intimidated to go out there. Maybe they're just burned out and maybe this is just their way of dealing with it. For the most part there's very few of the nurses that talk to their patients. And you know, they won't come out of that office no matter what and, that's very frustrating … How do you, how do you, you know, get your colleagues to do their job, basically? So I just, I don't see any answer, I just make sure that I look after my patients and spend my time with my patients. But it's very sad." |
| | The later stages of the COVID-19 response, which in turn put pressure on psychiatrists as they were dealing with higher workloads and higher levels of distress. At the same time, lockdowns also meant that nonpharmacological interventions, such as social prescribing, were no longer available. In this context, participants described the double burden of witnessing a regression in the mental health of many of their patients while at the same time feeling impotent to help them because of a narrowing of therapeutic options:" |
| | "'the huge problem in managing basic mental health problems is at the moment […] a lot of those […] recovery tools are simply not available. You feel incredibly limited in what you can do' (Cillian, urban area, male, general adult psychiatrist)." |
| Raising concerns and feeling invalidated | "If I see something wrong with like care from like a nurse.am I going to report that if I have to like work with the person the next 10 days, and there's a power dynamic on top of it?" (participant not identifiable in data) " "“Seeing coworkers do something you know is wrong. And institutionally, because of the power structure, not being able to say anything. |

"Structural racism and implicit bias toward patients by some clinical staff members were repeatedly noted." "“No one is being mistreated. But there are times when there is a difference, you can see the difference between the staff and the patient in terms of the way they talk to them, the tone of voice.”" "Had she not been [a] Black woman. I think that she would have probably gotten better treatment for that.”" "That we’ve certainly seen with certain staff members or doctors or residents, different reactions to young homeless Black males in particular, as opposed to other patients.” " "PHAs struggled with how to address this disparity within the institution and the hierarchy" "How do you say this person is purposefully treating this patient worse or more aggressively because of their race, but they’re not racist? They don’t mean to be doing it. They don’t realize.”"

"Staff felt unable to raise concerns about staffing, and those that did described a culture of dismissal or inaction. The effect of this management style appeared to heavily impact morale; respondents described facing incredible levels of risk, with little sense of protection or support from the organization:"

Several interviewees were seriously contemplating changing jobs. They had tried to speak up about problems like understaffing that could lead to inadequate patient care, but their complaints had neither been validated nor led to any change."

These types of invalidating responses, particularly from supervisors, left the participant feeling like there was no hope for change or that the situation could be managed differently or avoided in the future" "“She doesn’t really allow for moral distress. . . I mean, there just isn’t the place or a time for her to allow that. . . it’s like suck it up and move on. . .so what do you do? You just don’t talk to her then.” " "About half the participants experienced feeling silenced when they tried to talk about the incident and in these instances, they described being silenced, directly and indirectly, by co-workers and management alike. Being silenced occurred when participants were excluded from the clinical team.

James described that, in the agency he works in, the clinical team develops the care plan for an adolescent, and if others not on the clinical team had concerns or disagreed with the care plan,

there was no formal mechanism for participating in the discussion."

"When participants spoke about having a shared emotional space, they were actually talking about the listener connecting with the distress the participant was experiencing related to the incident. Often, the purpose of seeking out dialogue was not to problem solve the situation; instead it was about making sense of the situation. In the shared emotional space, the participant and listener could examine the factors that influenced the incident, and the complexity of the situation became evident." " When their experience was dismissed on a personal level, they expressed frustration, anger, and powerlessness to create change. When participants experienced being dismissed on a systems level, they expressed feeling helpless and hopeless.

[Pointing out misconduct directly] and [Receiving anger and being hurt]. " "It means that when a nurse confronted ethical problems in a clinical situation and she pointed out the misconduct to another nurse, the nurse became angry. The nurse who pointed out the misconduct was very hurt.

"At the team discussion of this review, Heidi acknowledged that she would have to administer certain tests, as no one else had the required credentials. To this, her supervisor responded," ""I won't let you do that. I don't think you'd be able to do THAT!" He said it just like that, just kind of this cynical little, "let you do THAT!" I knew that ethically I could not be a part of something that was knowingly not living up to the regulations. [But] I should never have said anything; it's one of those times when you go, "Why did I know what I know, and why didn't I just shut up?""

RUTH )"This is all you got, work with it," so you do work with it or say, "No I'm not going to." She said she repeatedly raises the issue:" "There is no soundproofing and I brought it up to the agency and said, "It's not ethical for me to practice with no soundproofing. I can hear the person clear as day, everything they're saying, in the next office. How do you think my clients feel when they're sitting there and they can hear the conversation next door?" "Just because I want it

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| | | documented in the minutes. I know I will get the same answer and I know nothing is going to happen about it. People will nod their heads in agreement and outside the meeting say, “That’s a good point that you brought up,” but they won’t speak out. I do. What happens is that a lot of people see that nothing ever happens [regarding] what’s spoken up [about]so why bring [it] up? Or there’s even pressure not to speak out. There ends up being a kind of learned helplessness. You can’t get enough solidarity for people to do some kind of job action that would make a difference. Like everyone saying, “We’re not going to see clients until we have soundproofing in this building.” If we all agreed to do that, something would happen" |
| | | Jean, too, now keeps her distress within. She has gone repeatedly to the administrators at her institution, only to be told to do her best. She feels unheard; believes they don’t care about her or her patients." |
| | Feeling conflicted and experiencing distress | "Though generally accepting that the pandemic had forced difficult decisions, many participants reported great discomfort with how services had been prioritised, as well as the way competing demands on services that remained open were managed. In a bid to reduce the risk of Covid transmission, and ensure adequate staffing levels in inpatient settings, many secondary mental health services had either been forced to shut or were operating with tightened admission criteria. Some participants believed that higher thresholds for admission were at odds with the ethos and philosophy of their ser- vice; others felt that the prioritising of some services over others undermined the proactive and preventative work that is key to early intervention." |
| Consequences of Moral injury | | "When I leave the ward with ladies in the same clothes they have been in for days because I or the other staff haven't had the time to spend with them I feel ashamed to be a nurse." |
| | | "I am a single mother of a 12 year old boy, he has recently transitioned to secondary school. I cannot remember the last time I finished a shift on time, Nor can I remember the last time I finished and had the energy to give my son the positive attention he deserves….. I feel exhausted when I get home. As I write this, I feel overwhelmed with sadness…." |

While some respondents reported having supportive managers, others described a sense of frustration, resentment and mistrust. Descriptions ranged from poor responses to concerns, a lack of supportive supervision and a culture of blame and bullying. Respondents felt the pressure of high standards from senior staff without the support needed to achieve this; resulting in feelings of shame, guilt, and poor care quality:"

"Edward described feeling inferior and constrained by a senior's decision and appears to experience moral distress."

"'The challenges I faced were ethical, having a duty of care I find it hard to actively let a patient self-harm in such a harmful manner but at the same time I felt I had no choice but to follow the senior member of staff's lead.' (Edward, Diary)."

" Helene also describes a sense of powerlessness to provide compassionate care in this account of an interaction with a patient." "I went in she was crying her eyes out so I went to sit and de-escalate and talk to her and they told me to come out (.) they were like right we've seen she's alive (.) and I was SHOCKED I didn't even know what to say (.) I'm being told by my nurse in charge we've seen she's alive come out (.) I could have spent two minutes talking to her (.)calming her down and then she would have gone to sleep (.)whereas instead she continued crying and I was upset (Helene, Interview)."

Marcus acknowledges his motivation as individualistic and battles with his compromising sense of morality and ethics, as he attempts to maintain his identity and self-esteem. While Marcus's personal motivations are altruistic and patient-centred, the environment alters his perception and subsequent behaviour; Marcus is effectively becoming institutionalized. Consequently, Marcus is emotionally exhausted and therefore struggles to interact with patients for motivations beyond individualistic gain, which results in Marcus experiencing feelings of guilt and reduced personal accomplishment."

"Although, no self-harm occurred which I was very happy about, I did have some feelings of ambivalence about the outcome. Although it was positive, I was aware that unlike my usual motivations for supporting a young person which includes being caring, compassionate and

empathetic for the young person suffering, I offered the support to avoid increasing my stress levels and ultimately I felt that was a selfish action. This has made me feel very upset with myself, because I am always so happy with my intentions which have always been based on altruism and a genuine desire to alleviate young people's suffering. (Marcus,Diary)"

tended to feel guilty when patients became aggressive or violent and the safety of patients and/or nurses was threatened. This made her feel that she should have acted differently, it was her fault, and she should have prepared herself better. This kind of self-criticism – even guilt and shame – was often mentioned in connection with the use of coercion or inability to prevent aggressive behaviour and violence."

"Feeling Caught in Conflicting Values emerged as participants were able to identify how their own values around taking care of adolescents conflicted with the expectations of co-workers, the agency, or other systems involved in the care of the youth. Just the number of agencies, such as child protective services or the justice system, involved in the ongoing care of an adolescent contributed to conflicting values."

any of the examples they shared were subtle and indirect and included being fearful of being labelled by others as a problem, having your practice called into question, or being intimidated by others through yelling, or exclusion from the group."

"Another participant said he felt frustrated when they provided care for the VIP patients. They felt why they have to give special care to the VIP patients. All patients should treated equally in the same hospital. However, the participant had to provide nursing care for the VIP patient first while other patients had to wait for the nursing treatment, which caused frustration among the participants for this unreasonable responsibility. Since all patients equally receive the same nursing care, there should be fair treatment for all patients."

"“In my opinion, the healthcare professional codes of conduct or regulations pronounce that we, as nurses, have to provide care for all patients equally. We cannot choose a specific patient for care. I feel frustrated. However, I have to do it. I always ask myself why I have to do (Case 9, page 1, lines 13 - 16).”"

I am stressed while taking responsibility in the shifts. There are many psychiatric conditions including depression, delusion, and aggressive behaviours. When the patient’s behaviour is aggressive, he or she will be restrained by our team. Sometimes, I think that it’s not appropriate for patients, for we could also talk to them to calm down. But I could not tell the team to follow my instructions, so I felt quite stressed (Case 33, page 1, lines 4 - 9).”"

The experiencing self-condemnation refers to the mental health nurses undergo the feeling of failure to care for patients while they know they should do. Some stories illustrate how the participants feel guilt and what they should do. Most participants shared such experiences which led to their moral distress through a sense of guilt. " ""At first, I felt guilty because I wanted to do my best in the situation, but it was getting worse, so I thought it was my fault. I tried to comfort the family members by making them feel good, so I took them to another room (Case 1, page 3, lines 23 - 25)" "Another narrative is that of a participant’s experience with guilt after helping a patient with severe respiratory problems. The patient was physically and mentally aided with the use of medical equipment which was sometimes impossible because of the patient’s severe physical health problems and the inadequacy of the equipment in question. The patient then had to be referred to another hospital that night. The patient unexpectedly died on the way before arriving at the hospital. After these events the participant asked herself what had happened and

why had the patient died. The nurse knows that such things can happen any time, but still felt guilt for over a month. However, the participant employed strategies to cope with the negative feelings by talking and consulting team members and looking for ways to help the other patients. The participant's moral distress decreased like that of another participant below." "“I feel guilty for a month as it affected my work. When the patient was admitted to the ward, his other physical symptoms could not be coped with and later the patient had to be sent to a general hospital for the treatment of physical health problems (Case 16, page 2, lines 9 - 11).

"Although restraining or coercive measures at times were necessary, using them often left the nurses with a very unpleasant feeling: Even though they were not directly criticised for having used restraints or coercion, the nurses could experience defeat and shame."

"«In the morning [after having worked the weekend] you sit together with all the doc-tors and healthcare staff and have to defend the use of restraints. You feel defeated and perhaps a little ashamed for having had to use such measures». "

Several of the nurses were furthermore upset by the lack of attention paid to violence from patients and how this also made health carers suffer. The interview-ees expressed discomfort, guilt, bad conscience, and a feeling of inadequacy when unable to protect patients and staff during episodes of mental and/or physical violence. " "Time, competency, and experience were seen as decisive for being able to recognise signals in time to deescalate dangerous situations. However, this is «difficult when the unit is full to capacity». The ward's architecture and size were also seen as a hindrance for less use of restraints or coercion:

Among other things, they speak of the application of restraints against their own criteria in order to avoid conflicts with the team, the workplace hierarchy or the fear of institutional repercussions."

"As a general norm, I feel very angry and dishonest with myself with respect to the values that I have, the ideas that I have, and the person that is contained. [E15. group C – 4:1092]

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| | Quotes from author |
| | "Ethical dilemmas: this code describes the conflicts between principles such as beneficence and autonomy or freedom and safety. The residents highlight that tensions exist between what they consider to be their professional duty and how they feel during the practice of mechanical restraint" |
| | ".we are trained to care... and suddenly, we realize that we are carrying out a social role. [...] I feel like a jailer... You say, really I'm doing the job of a prison guard, without having studied to be one. [A1. Group A – 4:629-38] |
| | Two opposing roles appear: the figure that provides care and the figure that controls/punishes. The escape from this conflict is the incorporation of the belief that restraints are un undesirable but inevitable part of their work and that it is impossible to refuse to carry them out." |
| | "It is interesting that, although considering restraints to be effective, necessary and even therapeutic, when focusing on the consequences in the people who are restrained, the residents recognize that the impact is generally negative, describing psychological, physical, moral and behavioural harms that can be inflicted even just by observing others being re- strained. |
| Work related exhaustion or resign | "I think it's important to say that we had a suicide of a patient a month after he was discharged. And so it was really tricky and I felt… I think it's tricky because you start kind of reviewing your decisions. I know it was a month before… it was a month after he was discharged so a lot of things could have happened, but you always question, like, was he really ready, were things in the community really ready for this kind of risk management. (Trainee psychiatrist, Inpatient ward)" |
| | "staff reported high levels of worry about service users who were not able to receive the care they needed. For example, staff in inpatient settings were anxious about their decisions to discharge service users into already stretched community services, and feared service users would deteriorate or in the worst case, die by suicide. In the event of the tragic news of a service user dying by suicide, staff reported a guilt and self-doubt about their decisions to discharge |

service users."

"Many participants reported personal efforts to mitigate the potentially harmful effects of changes in care provision. For example, several members of staff continued to contact service users who, assigned to the ‘low risk’ category, and had been told that they needed to proactively call services if they needed support. Staff also made the case for seeing service users who they perceived to be particularly vulnerable face-to-face rather than using remote technologies. These additional tasks led to staff taking on considerably more work, exacerbating feelings of burnout

The pressure to achieve the very high standards of care expected was often, however, associated with a personal cost to the nurse.

"High standards demanded as part of their professional registration, influence nurses’ own thought processes when making sense of their positions. These data indicate that for many respondents' work-related exhaustion had impacted on their own health, private lives and that of their families, as they tried to provide the best possible care required, no matter what:"

"I am a single mother of a 12 year old boy, he has recently transitioned to secondary school. I cannot remember the last time I finished a shift on time, Nor can I remember the last time I finished and had the energy to give my son the positive attention he deserves….. I feel exhausted when I get home. As I write this, I feel overwhelmed with sadness…."

Nurses don't feel prioritized or cared for in an emotionally demanding job where they feel, due to the demands of the code they work under, they are not able to meet their own basic needs let alone provide good quality care."

Human nature is to react but on a professional level can we? (.)and what's appropriate and reasonable?. . . so I get really anxious unless I'm 100% certain that's the right stage or if I haven't dealt with it before you can panic that perhaps you aren't doing the right thing and then if you leave them are you not caring for them so I can get quite nervous about it (.) obviously you've got the risk to them and then you've got to live with it (.) I think it can be really daunting (Lucy, Interview)."

"Thus, there was an obvious dissonance between these nurses' claim of not bringing their work home with them and what often occurred. Several interviewees admitted that although they tried not to mull over work when at home, they often felt " 'tired and grumpy when I get home and I need to sleep' (N27.) "while one really would have wanted to go for a run or be among friends, just have fun, one lacks the strength, becomes without initiative' (N6). " "Others admitted that the thoughts 'kind of pop up' even when off duty because 'there are some things that stick with you'."

N14 said she often felt frail, empty and tired when she got home from work, that she created a shield between herself and her surroundings and felt emotionally numb and that she was losing her role in her own life. Her way of coping was to fill her private life with good and beautiful things. N11 coped with feelings of work-related inner disquiet and inability to sleep by trying to make herself physically exhausted by working-out, or periodically taking sleep medication. "

N9 found that when 'it is difficult to know what is the best thing to do, your hands become clammy. . . that is a stressor'." "Tension headache was another rampant bodily symptom. N5 tended to develop headaches on days when she knew they were short staffed, which meant that she would have to shoulder extra heavy responsibilities.

"In most cases participants described incidents that impacted on their ability to keep the adolescent patient safe and led to experiencing moral distress. The experience of moral distress triggered the participant to ask him or herself the question "I

"That’s a safety issue, so there’s my responsibility, to keep the patient safe . . . so the distress for me was. . . did I . . . was I really. . . did I put my patient and our unit at risk? (Jay)"

And it put me in distress because I doubted my practice, I doubted my decisions, I doubted what I had done with this patient” (Jay). "

"One of the threads that ran through the experience of moral distress when participants experienced Obstructed Learning was the repetitive nature of the incidents. The moral distress created by these incidents did not occur in the moment, but over time, as participants were a part of, or observed, the same ineffective pattern of responding to adolescent or team behaviours. Emma lamented that although this youth was brought in approximately every six months, there seemed to be no attempt to change this ineffective pattern: " "Emma told a disturbing story of excessive force being used to bring a youth in for treatment when he becomes ill “you just have to mention this individual’s name and you know how it’s going to be for him.” If we know all that, then can we not talk about another way to do this?”"

Another narrative is that of a participant’s experience with guilt after helping a patient with severe respiratory problems. The patient was physically and mentally aided with the use of medical equipment which was sometimes impossible because of the patient’s severe physical health problems and the inadequacy of the equipment in question. The patient then had to be referred to another hospital that night. The patient unexpectedly died on the way before arriving at the hospital. After these events the participant asked herself what had happened and why had the patient died. The nurse knows that such things can happen any time, but still felt guilt for over a month. However, the participant employed strategies to cope with the negative feelings by talking and consulting team members and looking for ways to help the other patients. The participant’s moral distress decreased like that of another participant below." "“I feel guilty for a month as it affected my work. When the patient was admitted to the ward, his other physical symptoms could not be coped with and later the patient had to be sent to a general hospital for the treatment of physical health problems (Case 16, page 2, lines 9 - 11).”"

participants later experience psychological problems including disappointment, anxiety, guilt, and stress after providing psychiatric care. One of the physical problems is the loss of sleep. One of the participants shared stories of when caring for patients with severe physical problems. The participant in the study sought to provide optimal care by monitoring vital signs and keeping the patients safe despite the limitations of medical equipment. However, the patients still experienced severe symptoms and were sent to another hospital. After work, the participants had problems putting themselves to sleep for they were still concerned about the patients' physical symptoms of.

As the participants said:" "“At night I cannot sleep well. I doze and wake up all night. I am worried about the symptoms of the patient. It's normal for me to take everything seriously. Some nights, I dream about the patient. I always want patients to be in a good condition” (Case 27, page 1, lines 20 - 22)."

"It's not at all pleasant... not at all. They are moments that make you ask yourself if you really want to be doing this. Because it's really hard...[A3. Group A - 4:20]

We rationalize, we normalize [...] But you are aware that... you make yourself small to justify that you can't change such a huge system [...] I repeat to myself “this is crazy,” never more aptly stated, but… I at least go in that direction, I move toward normalizing what isn't normalizable. [P17. Group C – 4:1112-15-18]"

The interviewees' moral sensitivity seems to be both a premise for and cause of moral distress although they held divergent views and had different experiences of moral concerns.

Time was described as essential for giving quality acute psychiatric care: time to reassure patients; to supervise secluded patients; and for therapeutic conversations, motivation, relationship building and clinical assessments. Potential suicide or self-harm were basic worries and were experienced as a great responsibility. Inadequate time for therapeutic conversations made the interviewees doubt the quality of their own assessments:" "'It doesn't help much to check on someone sitting on her bed 20 times during a shift if you don't have time to figure out what goes on inside her head' (I6)."

"Others described feelings of frustration, anger, sadness, inadequacy and loss of meaning. Some felt mentally tired, without initiative and wanting to pull away from social settings when off duty:"

"'I create a kind of shield between me and my surrounding' (I14). " "Several interviewees said they experienced emotional numbness and feeling fragmented. Others talked about being emotionally 'flat', cold and empty: " "It isa little scary, really, that I am a little cold, am able to not think about it. How humane is one then, basically?'(I13).

Moral distress was also seen as causing high blood pressure and problems sleeping: "I have been on sick leave due to stress, got high blood pressure. I sometimes feel that I cannot breathe, that no-one listens'(I4). "

This category shows the feelings arising from the experiences of Moral Distress in CAPS among them: demotivation, burnout, discouragement, anguish, powerlessness, and struggle, asper the following statements:" "... We get demotivated, we fall into the pressure to-perform routine, and there is no way back. (P6) It's the weariness, discouragement; it's a constant pressure to perform... it is tiring, you know?(P6)"

"In common with their commitment to service users, there was a widely held belief that staff had a 'moral obligation' to their team which was reflected in comments such as"

it means that some psychiatric nurses did not do anything when they confronted ethical problems, thus there was no change.

"The effects of the moral injury endured outside of work and is characterized by participants "taking work home" with them." "… when it touches you gradually take cases to your home, in the end you still resent and say I am not physically tired, but I am emotionally, it's making a dent(P1). (female, acute mental health, MHN, age 29, 2 years qualified) "

Involvement in MR left participants with residual feelings of doubt. "…at the beginning I felt bad for a few days, wondering whether I had done everything right, if I could have done something else to avoid it(P10). Female, acute mental health, MHN age 27, 2 years qualified) "

"The participants empathised with the difficulty of making lifestyle changes, acknowledging that unhealthy decisions were a part of human nature as well as recognising that staff did not always lead by example. The situations where patients who were deemed as having mental capacity continued to make dangerous choices despite being made aware of the risk resulted in bewilderment with the appropriate time and level of intervention, leaving staff questioning their role and the potential consequences of their actions:" "So then do staff have a right to intervene? Or does because he still has capacity and he has choice that he will eat that even though it will make him extremely unwell? [. . .] So at what point does Good Samaritan outweigh staff being autocratic and not being able to, you know, give your patient choice, rights, independence and freedom? (Barry Gaff Health care assistant )."

"When unable to meet their own standards, participants might also choose to resign themselves to the situation and 'do the best you can under the circumstances', try to avoid personal involvement in distressing situations, or persist in doing what they believed was in the patient's best interest no matter what (e.g. prioritize being with patients over completing administrative work or going against ward rules and routines)."

Ruth saw her options as either stay the same and do what I'm doing, however wrong; become more action oriented; or decide to change careers and do something different and say, "That's enough." She indicated that she finds a further dilemma in her options of staying or going. Just because you aren't able to bring about changes, does that mean you give up, or do you push harder, and at what point is pushing harder [going to help and there will be] that breakthrough?" RUTH " can keep going if I think I am making a difference, but if I feel that I'm not—I have to stop walking into a brick wall. (CLEO)" "Well, why am I working here?" This is not a place where I have the freedom to work ethically and really work with the ethics that I have. Then this is not a place for me. (HEIDI)" "I worked in a place where the funding was being misused, and that meant that people needing help were being denied service, and so I drew that to the attention of some people in charge and then when nothing happened, I quit. I had to leave because I just felt I could not be there with such a misuse of funds and such exploitation and such denial.

(UKNOWN)"

"It is absence of respect that distresses Nicole. This young aide, with only a brief orientation program to prepare her for giving care, recognizes that respect is essential to ethical practice. It is what she would want if she were a patient. Nicole feels empathy for the persons in her care; she resists responding to them as problems to solve, messes to clean. She demonstrates a receptivity and an attentiveness to the suffering of others. This responsiveness, this willingness to engage in a meaningful way with those in our care seems a necessity. It underlies what has been termed ethical sensitivity, what educators of health professionals strive to develop and support in their students. It may be, however, that this quality is a key precursor of moral distress."

Participants described the emotional turmoil surrounding having to make high-risk decisions that affected both patients and staff without any evidence base as to the correct course of action. With shortages of personal protective equipment (PPE), participants spoke of their fear of leading both staff and patients into a situation" "'We have these long-term residents who are particularly vulnerable […] we felt early on that if the coronavirus got into any of these residential places […] it could be fatal for quiet a few people […]That was a big thing at the beginning, you know, uncertainty […] Not knowing what was going on, maybe some of the decisions you made turned out very quickly to be wrong decisions, but you kind of had to get on with it anyway […] it was a funny time […] anxiety was very common' (Finn, rural area, male, consultant psychiatrist) "

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| | Disruption of professional connectedness "Participants described sense of alienation that arose from the directive to work from home. For some participants, the transition to remote forms of care was marked by a constant struggle to maintain the boundaries between work and home life and the jarring nature of finding themselves as mental health professionals dealing with emotional distress of patients from the environment of their own home:" "'It was very hard to keep boundaries, you are dealing with these problems, these psychiatric problems in your own home and people were sending you emails after hours […] and your phone was beeping all the time […] I got totally overwhelmed'(Orla, rural area female, General adult psychiatrist).). |
| Emotionally distancing or sharing the burden | "However, in periods with inadequate staffing, and when work challenges and ethical dilemmas seemingly were piling up, some interviewees could find it necessary to take a day off or even go on sick leave. They realised that they were unable to do a good job without a respite when physically and mentally exhausted:" "You work with problems all the time; you cannot have problems yourself. You have to be rested and fresh' (N12).<br>On her ward they discussed ethical dilemmas on a near daily basis. Even if something could have been done differently, it did not necessarily mean that it was done wrong. " "For some, discussing moral challenges with a pastor/priest or in a mentoring group was a helpful coping strategy. The latter was a setting where all kinds of themes could be discussed, and the nurses felt free to" 'talk about how it affects us' (N3).<br>I do not bring anything home with me, absolutely not'(N8). Even if there were a lot of things she disapproved of or saw as problematic at work, 'I do not bother to bring it home with me'." "N6 claimed that she was quite 'flink' (good at) leaving her thoughts concerning work at work. Even so, some evenings, when in bed, she would think about certain episodes and wonder what she could have done differently. "<br>"Thus, there was an obvious dissonance between these nurses' claim of not bringing their work home with them and what often occurred. Several interviewees admitted that although they tried not to mull over work when at home, they often felt " 'tired and grumpy when I get home and I need to sleep' (N27.) "while one really would have wanted to go for a run or be among |

friends, just have fun, one lacks the strength, becomes without initiative' (N6). " "Others admitted that the thoughts 'kind of pop up' even when off duty because 'there are some things that stick with you'."

freedom to be this candid about thoughts and feelings was not common on all the wards, though. For some, the knowledge that they could quit their job somehow seemed to be an incentive to stay on.

dialogue could be formal or informal, and those the participants sought out for dialogue included supervisors, peers/co-workers, professional bodies, and friends and family, in that order. "

"James explained: I mean, you know, you go in there with your concerns and your fears and you lay it out on the table.. . . You know, it's like, "Oh, well, we can't change anything. Too bad that happened.". . . So I don't even bother with those."

"Noelle put it this way: "I still do need to be checked in terms of I need to talk . . . and I think it protects our practice, it makes us ethical practitioners.

Dialogue with representatives of professional bodies was self-initiated and often rooted in the participant's desire to know that he or she had acted in accordance with the Standards of Practice;

whereas, when participants spoke with friends or family, it was to use them as a sounding board and gain emotional support."

"Participants discussed validation and described being validated and being invalidated by the person whom the participant sought out for dialogue. Three elements were needed: the other person needed to "get it," the moral distress needed to be acknowledged, and it needed to be normalized. When asked what advice participants had for nurses who experienced moral distress, the most common response was to "talk to someone who gets it."'

"If participants had a negative experience of dialogue, they were not able to view the incident from a broader perspective of the factors that contributed to the safety incident and could not satisfactorily answer the question “Is this the best I can do?” For these participants, Resolution meant they either left the unit or agency, or talked about leaving." "Jay captures these sentiments as she struggled to understand if she took the right actions “b

"In this study, the participants mentioned the need concerning administrative support in the form of understanding and listening held annually at the nurses' psychological support center. This kind of support can help participants deal with situations that lead to moral distress. Receiving support on enhancing skills and knowledge, understanding and suggestions are very important issues to help the mental health nurses cope with moral distress to provide quality care to the patients and family members. As one participant said:" ""It will be beneficial to nurses if they provide a channel for listening and psychological support. The nurses will have an opportunity to suggest and support needed. If the nurses are ignored to psychological support, they may not be able to provide care for patients effectively” (Case 29, page 6,lines 21 - 23)."

I think over time you distance yourself from it. I’m not sure if normalizing or distancing yourself from it is the same in this case, but it’s like you distance yourself from something, I guess the same way that an oncologist distances themselves from death and things like that, you take some distance. [M14. Group C – 4:1120]"

"I think that all that ethical and moral part, as you spend more time in the residency, it’s not that you forget it, but it’s like the process of indicating a physical restraint becomes more automatic, I don’t know if it’s a defense mechanism, to not feel... Because I felt really bad the first year of the residency and now, it’s not like I like it or anything, but I don’t feel as bad as a I did the first year. [...] The first day it was like “how terrible, I’m going to awful every time,” and the truth is that now, sadly, I don’t feel as bad as I did at the beginning. [M13. Group B – 4:300-519]"

If mechanical restraint generates emotional distress and dissonant experiences at the moral level, and yet the residences experience that there is no way of refusing to use them (in the context of safety, hierarchy and fear of consequences), it is understandable that in order to work

in this contradictory and harmful situation, different adaptation processes take place. T

participants describe changes over time in their feelings (the restraints cause them less distress), their thought processes (they reflect less regarding restraints), and their actions, which they define as a habituation to mechanical restraints, a desensitizing in their reactions and an automatization in their indication."

The professionals recognize the development of involuntary (unconscious) mechanisms as well as conscious strategies and actions to reduce the distress generated by the application of mechanical restraints in their work. Among them, they describe distraction mechanisms, mechanisms of distancing themselves from the emotional experience (intellectualization-negation-normalization) and mechanisms for venting/emotional expression."

"Morally challenging situations made the nurses reflect on their actions and choice of coping strategies, a mental activity they saw as important to counteract violation of their patients' dignity when possible.

" when we are a little overwhelmed, we get together. We have our weekly meeting where we share our problems, do our users' case studies and distribute them so we can balance things out here. (P2)"

"professionals point to the communication in team meetings, and the informal dialogues between them, as essential mechanisms to cope with moral distress they experience, "

"... the mechanism had very cool moments with the psychologist, we talked a lot about it because I explained to her right the situation and she contributed a lot for me to deal with these situations... (P5)"

Separating work from pe

CAPS nursing professionals use their ability to leave work-related issues to be resolved and discussed in the workplace so that they do not adversely affect their family environment as their strategy to cope with moral distress." "... when I leave home, I leave my problems there, and when I leave here, I try to leave the problems here, because if we don't, we end up mixing things up. (P2)"

"... as a professional, I solve what I can solve within the workplace. (P7)" "... we try to separate a little bit because if we take it home, bring it from home; it gets very complicated. But as I told you, early on, I had many problems absorbing other people's suffering. Nowadays, I can separate this, and it's no longer affecting me. (P5)"

"Consulting among staff and understanding each other] or [Consulting with supervisors and no change because of hospital systems"

"Sometimes when nurses consulted among the staff regarding moral distress, they understood well each other, but sometimes they consulted supervisors and ethical problems were not resolved.

you do what you have to do and it's over, you desensitize to this kind of thing… I have been desensitizing myself, although there are certain MRs that continue to affect me as much as at the beginning(P9). (female, acute mental health, MHN, age 23, 2 years qualified) "

"“Following up and reporting” the event that caused the moral distress was one of the psychiatric nurses' coping strategies against moral distress. "

“When I see my colleague doesn't act on her duties and I cannot warn him/his or make a mistake, I have to compensate my colleague's mistake or lack of work to prevent the patients' rights from being violated and guilty feeling... for example, I change the drug that mistake or do his/her duties...”"

"In this regard, participant No. 8 stated: “The case method assignment is a better method. Because every nurse is responsible for her work and must be accountable and no one cannot ignore her/his duty... And the workload is not for one person... when all patients care was done, moral distress and guilty feeling do not occur...”"

"Use violence in dealing with aggressive patients, which psychiatric nurses have described as one of the causes of moral distress. Psychiatric nurses by “strengthening anger management skills” as a coping strategy tried to decrease moral distress. " "Participant No. 4 stated in this regard: “I try to control myself when the patient is aggressive and sometimes even says ugly things to the nurses... I used to get angry and I could not control myself, but now I tell myself that the patient has a psychotic problem... I am her nurse and I should not be angry… I take a deep breath and try to calm down...”"

"Participant No. 5stated in this regard: “The most important thing for our patients is to listen to them...When I talk to my patient and he trusts me and accepts the treatment, I feel very good... This is a great way to reduce our moral distress.”" “Empathy with the patient” "Participant No. 8 stated in this regard: “If we put our nurses in the place of the patient, we will never experience moral distress... I have to treat my patient as a member of my family... Understand his situation... Support him...”"

"Participant No. 6 stated in this regard:“ The support of managers is very important... when Merton supports nurses... Tries to meet the needs and demands of nurses... eliminates the shortage of staff… Cares about the opinions of nurses... “Well, the nurses do their job properly and do not underestimate, nor do they suffer from moral distress...”" "Participant No. 2 stated: “Managers can support nurses and prevent moral distress by creating an environment where nurses’ opinions are valued and nurses’ knowledge and experience are not ignored.”

"Commitment to religious beliefs "They emphasized that religious beliefs and Islam commitments can help them to act on their duties and avoid unethical actions." " participant No. 11 stated: “We are Muslims. Who believe to “Halal and Haram” and to acquire “Halal income,” don’t ignore her/his duties… it is a Deterrent factor to moral distress”" "participant No. 12 stated:“ Belief on God and her monitoring on our actions causing to act on our professional duties and prevent moral distress…Violating the rights of patients is an unethical action and causes divine punishment.”"

"Participants typically perceived acting morally and being professional as being one and the same. " "Participant 3 described how he came to adopt this view of nursing when he first started working in psychiatric inpatient care: It was one of my mentors, a senior nurse, when I started working at the mental hospital. When he arrived to the acute ward in the morning, he would go around and unlock all the belts, and he would say, ‘This is not decent’, and that’s something I sort of picked up...that you can do other things."

"I never revealed to anyone there that it was me. And I didn’t feel that I needed to reveal it to anyone because I felt that my intervention had solved the problem. But clearly this was an exceptional situation that required intervention, and we seemed to be unable to provide that intervention within the regular mechanisms available to us. I have my own obligations as a psychologist. I felt I have my own professional obligations to myself first and second to my organization that I belong to. So if I had not done anything, and if this had created a situation where this person continued to suffer, I feel I would have been in violation of my professional ethics."

"There are some things you let go of, but there are things that you go to the wall for. I read a poster that there is a special place in hell for people who at times of injustice remain neutral. And that’s probably too good for them.[But] you choose your battles, and it’s better to do some good than waste all your energy in a battle that is doomed to fail, in a battle you cannot win. And so you give to those you can, and you have to back off from the other stuff. At least I have to back off from it because otherwise I could help no one. I think I would be destroyed by it. (CLEO)"

"Heidi described being supported and reaffirmed in her conception of good and competent practice by colleagues outside her agency and through attendance at psychology conferences. As with other disciplines, however, colleagues can be supportive during times of moral distress, or they can make it worse."

Shifting the responsibility

"Some interviewees coped with participating in treatment with which they disagreed by seeing themselves as loyal cogs in the machinery – as ‘part of the system’ – or by ‘just doing as [the physicians] have decided’"

"N10 put it, ‘It is no problem for me that others have decided what I am to do, like giving coercive medication. I am no doctor, I cannot prescribe anything, I am to administer it’." " Furthermore, ‘I can say that I will not give this, but then one of my colleagues will have to do it’ (N2)"

In cases where participants successfully worked through the experience of moral distress, they came to recognize how their actions were influenced by the larger context of a complex health care system, intra- and interpersonal factors, resource allocation issues, legal parameters, and multiple government systems involvement."

For example, participants looked to colleagues to provide them with guidance or options from their own past experience in dealing with issues that created moral distress

"Theory helps me a lot. Thinking philosophically helps me to process it and put myself in a role of saying there’s a part that isn’t my responsibility, there’s a part that isn’t me 100% the exercising agent, I’m exercising the invisible hand of the State, I’m the exercising hand of the social, the social has made use of me in the same way as it has made use of the police. [A1. Group A – 4:630]

For example: coercive measures that were triggered by staff; that took place routinely; did not lead forward in treatment; were consequences of lack of resources; were legally questionable; or that staff did not agree with. This also included situations where coercive measures lead to negative treatment effects, such as spoiling the alliance with the patient or reinforcing self-harm." "

Responsibility lay with the physician and that they themselves only followed orders. One said that she still regretted not having refused to coercively administer medicines which she and others felt should have been postponed. However, she admitted that she probably still today would not have refused to follow doctor’s orders."

"Others felt that their role was outlined in their professional code of practice to act in the patient's best interest and experienced inner conflict from the inability to fulfil this duty."
"Capacity assessment was thought to be lacking objectivity, not accounting for wider societal impacts of an individual's unwise decisions and that the process "has almost become a tick-box exercise" (Hana Mardi Associate specialist) used to absolve the clinician from the responsibility of dealing with the ethical dilemma by observing some degree of the patient's understanding of the risks associated with their decision and their ability to communicate those risks."

Failure to assume personal responsibility because of ward culture or lack of resources results in undignified care, where the individual needs of the patient are not met, further adding to nurses' and assistant nurses' difficulties in assuming personal responsibility. Difficulties in assuming personal responsibility and providing dignified nursing care cause nurses and assistant nurses to experience frustration and distress."