Moral Distress within Clinical Psychology.

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Abstract

This thesis explores the phenomenon of moral distress within the field of clinical psychology, a concept originally rooted in nursing but increasingly recognised across healthcare disciplines. Drawing on a scoping review and empirical research, the study investigates the correlates and predictors of moral distress within the UK clinical psychology workforce. The review identifies key contributors to moral distress, including ethical dilemmas, power imbalances, institutional limitations, and socio-political pressures that inhibit practitioners from acting in accordance with their moral or professional values. A quantitative approach was employed, comprising inferential analysis of survey data from a substantial dataset of 200 clinical psychologists and trainees. The results indicated significant positive correlations between moral distress, stress, and the intention to leave the profession. In contrast, moral distress was negatively correlated with job satisfaction. Notably, subscales measuring the frequency of moral distress were significant predictors of increased stress levels, reduced job satisfaction and intent to leave. With trainees reporting higher satisfaction and lower intent to leave than qualified psychologists. Age was negatively associated with levels of moral distress and job satisfaction, and positively associated with intent to leave, indicating that younger individuals reported higher distress, while older individuals reported lower satisfaction and greater turnover intentions. Women reported significantly higher average levels of distress on the level of distress subscale. Findings underscore the importance of addressing both individual and structural sources of moral distress and call for ethical, cultural, and systemic reforms. The thesis contributes to a growing discourse on the moral complexities faced by mental health professionals and highlights implications for training, policy, and clinical supervision.Moral Distress within Clinical Psychology.

Chapter 1. Introduction

This chapter introduces the central concept of moral distress and examines its significance within the field of clinical psychology. It begins by situating psychological practice within the broader political, economic, and systemic landscape of UK healthcare, before outlining key ethical foundations, tensions in psychological work, and culminates in the theoretical and empirical development of moral distress as a construct.

1.1 Political and economic context of care and mental health.

Understanding the concept of moral distress and its operation within the profession of clinical psychology requires first situating it within the political and economic context of care and mental health in the UK. Over the past century, the UK's healthcare system has experienced significant political shifts and economic transformations, leading to a persistent tension between the care envisioned in policy, expected by the public, and realities of what can be delivered in practice. Moreover, these political and economic conditions play a critical role in shaping individual and collective wellbeing.

1.1.1 Political and economic shifts in mental health care.

Neoliberal economic policies have reshaped the landscape of UK welfare and mental health provision by shifting responsibility from the state to the individual (Burns, 2015; Macintyre et al, 2018). Initiated during the Thatcher era and continuing across successive governments, these reforms emphasised market-driven solutions and introduced privatisation across public services, including healthcare (Elliott, 2016). In mental health, this shift has been marked by the commodification of distress and the increasing influence of private providers (Pilgrim & Bentall, 1999). Although mental illness accounts for approximately 28% of the total disease burden in the UK, only 13% of NHS spending is allocated to mental

health (JRF, 2022). This funding gap reflects not only systemic underinvestment but also the marginalisation of mental health within broader neoliberal welfare restructuring.

Building on these neoliberal foundations, the post-2010 austerity programme intensified pre-existing inequalities and deeply impacted mental health service delivery. Cummins (2018) argues that austerity has served as a political project aimed at permanently shrinking the welfare state, rather than a temporary economic necessity. His analysis highlights how cuts to welfare and local government services have undermined community-based care, increased mental health-related distress, and reinforced a biomedical model that neglects social determinants. Similarly, Kiely (2023) shows that while national spending on mental health has risen since 2016, many local services have faced real-terms reductions, leading to unequal access. He identifies three key trends: rising coercion in inpatient care, the imposition of conditionality in community settings, and the abandonment of those who do not meet thresholds for either low-intensity or crisis interventions. These trends illustrate how austerity has restructured services not only by reducing funding but by reshaping care around risk management, employability, and exclusion.

Beyond service provision, austerity has eroded the broader welfare infrastructure that protects mental health. Welfare reforms—including a 20% reduction in benefits—have exacerbated poverty, housing insecurity, and social exclusion (Barr et al, 2016; Beatty & Fothergill, 2016). These reforms disproportionately affected marginalised populations, including disabled people and low-income workers (Centre for Welfare Reform, 2015). Kiely (2024) adds to this critique by showing how voluntary-sector mental health services have become sites of "entrepreneurial conditionality," where clients are subtly required to engage in labour-like tasks to retain access to support. This shift reframes care as contingent on

productivity, embedding neoliberal values even in spaces once defined by mutuality. Together with rising living costs and insecure employment—including zero-hour contracts and the growing "working poor" (JRF, 2016)—these dynamics reveal how austerity has not only failed to stimulate growth (Kirkup, 2013) but has intensified the very conditions that give rise to mental distress.

1.1.2. Inequality and social determinants of mental health

Research highlights the sociological determinants of well-being, linking economic inequality to poorer health outcomes (Marmot, 2010; Wilkinson & Pickett, 2009). Economic insecurity, housing instability, overcrowded and/or polluted living conditions, and food poverty have been identified as significant contributors to the decline in mental health (Assari et al, 2016; Elliott, 2016; Silva et al, 2016). Furthermore, structural violence and systemic marginalisation exacerbate mental health disparities, particularly among vulnerable populations (Hatzenbuehler & Phelan, 2013; Rafferty et al, 2015).

Additionally, the COVID-19 pandemic exacerbated existing inequalities, significantly affecting education, employment, household living standards, and overall well-being (Banks & Xu, 2020; Mind, 2020). Lockdowns, social distancing, and economic instability contributed to rising mental health concerns, particularly among vulnerable groups, including young adults, older adults, and racialised communities (Blundell et al, 2021). It is projected that 10 million people in the UK will require mental health support in the next three to five years (Mental Health Foundation, 2021). According to NHS England (October 2024), NHS mental health services in England treated a record 3.8 million people in the preceding year—an increase of one fifth compared to the previous year—indicating a significant rise in both demand for and access to services. These record figures strongly suggest that earlier

projections are being fulfilled and reflect a continuing upward trend in mental health service utilisation.

1.1.3. Systemic pressures and workforce challenges.

Despite policy commitments, including the NHS Five Year Forward View (2014), there has been limited improvement in service delivery (Garratt & Laing, 2022). Workforce expansion targets remain unfulfilled, with one in seven psychology posts unoccupied (British Psychological Society [BPS], 2022). Service shortages, staffing crises, and long waiting times continue to undermine the accessibility and quality of mental health care (British Medical Association [BMA], 2018b).

The reduction in mental health services has led to an increased reliance on crisis services and involuntary treatment under the Mental Health Act (Gilburt, 2021). Many psychology services continue to operate within outdated and inadequate facilities (Care Quality Commission, 2022), placing clinicians in a position where they must compromise the quality of care. NHS rooms are often perceived as suffocating, unwelcoming, or unhygienic, which stands in stark contrast to the therapeutic values that clinicians strive to uphold. Additionally, staff shortages, high workloads, and burnout contribute to high turnover rates (Buchan et al, 2019).

Psychological professionals face increasing caseloads with limited support, resulting in high levels of stress and burnout (Harris & Griffin, 2015). A 2018 survey reported that 87% of NHS workers experienced declining morale due to workplace stress (Unite, 2018), while 52% of mental health professionals stated they were too overwhelmed to provide adequate care (BMA, 2021).

There is a growing body of evidence indicating that reductions in funding for NHS staff wellbeing programmes have significant negative consequences for workforce health, service delivery, and economic sustainability. Qualitative research has shown that financial constraints and a reluctance to invest in staff wellbeing are key barriers to implementing and maintaining effective support services (Quirk et al, 2018). Such cuts have been linked to increased stress, sickness absence, and staff turnover, collectively costing the NHS billions in avoidable expenditure (Daniels et al, 2022).

Economic modelling suggests that the annual cost of poor staff wellbeing—including presenteeism, sickness absence, and recruitment pressures—exceeds £12 billion (Daniels et al, 2022). Conversely, targeted investment in wellbeing services could yield savings of up to £1 billion annually. Evidence also emphasises the limitations of individual-level interventions, such as mindfulness or resilience training, when delivered without accompanying systemic reforms. A recent review concludes that system-level changes—such as protected breaks, improved working conditions, and senior leadership support—are essential to sustainably improve staff mental health (Brand et al, 2024). The broader implications for patient care are also considerable, as staff wellbeing has been directly linked to patient safety and experience (Sizmur and Raleigh, 2018). These findings underscore the importance of sustained, structural investment in NHS staff wellbeing as both a moral and operational imperative.

Workforce shortages remain a critical challenge, with many staff leaving due to poor working conditions and limited career advancement opportunities (BPS, 2022; Lavender,

2019). Despite the government's Psychological Professions Workforce Plan (2019), meaningful improvements in workforce retention have yet to materialise (BPS, 2022). The emphasis on recruitment rather than retention further destabilises service provision, worsening continuity of care (Varcoe et al, 2012).

1.2 Ethics of healthcare and psychology.

An essential additional lens for understanding the concept of moral distress within clinical psychology is the ethical foundations of healthcare, and how these inform key ethical tensions in psychological practice. Healthcare is underpinned by intrinsic moral, political, and ethical tenets, which are enacted and brought into focus through the various ethical dilemmas encountered in the everyday work of clinical psychologists.

1.2.1 Ethical foundations in healthcare

For the purposes of this thesis, morality refers to the principles distinguishing right from wrong. Ethical frameworks and rules support judgements regarding moral behaviour. Ethical practice is at the core of health and the caring profession (Kimball, 2018). The early rationalist foundations of healthcare ethics emphasise the intrinsic moral dimensions of medical practice, and advocate a universal, logical and deductive approach (Kohlberg, 1969; Piaget, 1932). The Hippocratic Oath has historically framed beneficence and non-maleficence as core ethical duties, shaping medical professionalism. Rawls (1971) expands ethical discourse by framing healthcare as a matter of distributive justice, advocating for equitable access to medical resources. Beauchamp and Childress (1994) formalise ethical decision-making in healthcare through four principles: autonomy, beneficence, non-maleficence, and justice.

While early ethical models focused on principles, real-world abuses exposed critical shortcomings in healthcare ethics.

Ethical principles within clinical practice have been significantly shaped by historical instances of unethical conduct. The Tuskegee Syphilis Study (Kampmeier, 1974), in which misinformation and the denial of treatment were weaponised against Black men in America, highlighted systemic racism in healthcare and underscored the critical importance of non-maleficence and informed consent. Similarly, the case of O'Connor v Donaldson (1975) emphasised the right to refuse institutionalisation; Donaldson was confined to a psychiatric hospital for 15 years without appropriate treatment, despite posing no risk to himself or others. This case reinforced the principle of autonomy and the rights of individuals with mental health difficulties. Furthermore, Riese v St Mary's Hospital (1987) involved an involuntarily hospitalised patient contesting forced medication; the California court ruled that even patients under involuntary commitment retain the right to refuse psychotropic medication unless deemed to lack capacity. This case strengthened the emphasis on capacity assessments and informed consent within psychiatric treatment. In the UK, the Mental Health Act (amended in 2007) introduced legal frameworks governing the involuntary detention and treatment of individuals with mental disorders in England and Wales. The Act sought to balance beneficence with respect for autonomy and the principle of least restrictive care, while also raising ongoing ethical debates regarding coercion, human rights, and procedural safeguards.

Traditional bioethical models, rooted in rationalist, individualistic, and universalist assumptions have been increasingly critiqued for their inadequacy in addressing the relational, emotional, and contextual complexities of mental health care (Bloch & Green, 2006; Hummelvoll & Severinsson, 2001). Dominant Western frameworks tend to marginalise collectivist and interdependent worldviews, failing to account for how cultural, systemic, and

power-laden factors shape ethical experiences in practice (Prompahakul & Epstein, 2020; Sue, 2010).

1.2.2 Clinical Psychology as an ethical practice

Clinical psychologists routinely navigate the complexities and challenges inherent in psychological practice (Rønnestad, & Skovholt, 2003). Within the NHS, clinical psychologists hold a pivotal role at the intersection of mental health care and ethical practice. As core members of mental health services, they are responsible for the assessment, diagnosis, and delivery of evidence-based interventions across a broad spectrum of psychological difficulties. The ethical dimensions of this work are especially pronounced given the complexity and diversity of the populations served—ranging from individuals with chronic mental health conditions and trauma histories to vulnerable groups such as children and those with cognitive impairments, or adults with physical health needs and/or disabilities.

Clinical psychology is a regulated profession in the UK, overseen by the Health and Care Professions Council (HCPC), with the title “Clinical Psychologist” being legally protected under the Health Professions Order 2001. Notably, while the title “Clinical Psychologist” and other specialist designations such as “Counselling Psychologist” and “Educational Psychologist” are protected, the term “Psychologist” alone is not subject to statutory regulation. Similarly, titles such as “therapist” or “counsellor” are unregulated and may be used by individuals without formal registration. This distinction carries significant implications for professional accountability, the maintenance of ethical standards, and public confidence in psychological services.

The foundations of ethical dimensions in clinical psychology are rooted in psychoanalytic traditions (Summers, 2022), they pertain to the therapeutic relationship, with an emphasis on client autonomy, dignity, and empowerment. Key thinkers have shaped this discourse through existential, humanistic, and psychoanalytic frameworks. Frankl (1946) highlights the ethical role of meaning-making in suffering, positioning therapy as a space for constructing purpose. Rogers (1961) frames therapeutic ethics around autonomy, authenticity, and unconditional positive regard. In contrast, Lacan (1959) challenges normative ethics, proposing that psychoanalysis must engage with unconscious desire rather than reinforce societal norms. These perspectives collectively underscore therapy as a morally complex practice rooted in layers of human subjectivity.

In preparing for this multifaceted role, trainees encounter a range of ethical challenges. Bhola et al. (2015) provides seminal work in understanding the significance of ethical dilemmas. This research identified that the most salient dilemmas were related to confidentiality and boundary management during training. Trainees also commonly report concerns regarding their perceived competence. Moreover, the role involves navigating broader ethical considerations around power dynamics and the promotion of client autonomy.

Confidentiality is a foundational but not absolute principle in psychological practice. Practitioners must balance ethical and legal duties, particularly in cases of imminent harm, abuse disclosures, or court orders. Risk and confidentiality present complex dynamics in psychological practice, clients may disclose troubling or potentially risky behaviours, whether historical or intended. Embedded within this tension is the need to make nuanced decisions about whether to prioritise safeguarding and risk management protocols or to uphold the client's autonomy and right to confidentiality.

Professional regulatory bodies provide ethical frameworks to support practitioners in navigating complex situations, grounded in principles such as non-maleficence, dignity, integrity, and professional responsibility. Psychological ethics draw on bioethical principles while also addressing the relational and subjective nature of mental health care. Core values outlined in the APA (2017) and BPS (2021) codes include autonomy, beneficence, non-maleficence, justice, and fidelity. However, it remains unclear to what extent interpretations of ethical codes and responses to dilemmas are consistent across cultures, with some research suggesting cross-cultural similarities (Slack & Wassenaar, 1999), while other studies report notable differences depending on cultural or subcultural context (Leach & Harbin, 1997, Zhao et al, 2012). Concerningly, a deeper examination of the principles-based approach to ethics—commonly upheld in clinical psychology reveals the limitations of a such an approach. Bhola et al. (2015) emphasise that ethical codes function primarily as reference points and are insufficient for navigating the complex and often ambiguous realities of healthcare. Trainees frequently encountered ethical dilemmas marked by uncertainty, particularly when existing guidelines lacked clarity or failed to account for cultural nuance.

The principle of "do no harm" is further complicated by the broader responsibilities of clinical psychologists. As Patel (2003) argues, the role extends beyond alleviating psychological distress to actively addressing and challenging its underlying social and structural causes. This perspective places an additional, quasi-activist role upon psychologists, beyond their therapeutic responsibilities. Such a view invites critical exploration of how engagement with social activism intersects with experiences of moral distress. It would be valuable to examine whether the added responsibility to challenge structural oppression intensifies moral distress or alternatively, offers a form of ethical agency that may mitigate feelings of compromise and helplessness. Exploring these dimensions

could deepen understanding of the nuanced ways systemic advocacy shapes clinicians' moral and emotional experiences within complex healthcare environments.

Notably, many mental health trusts in the UK are increasingly adopting a preventative approach to mental health, which aligns more closely with a commitment to systemic and institutional change. Regardless of where individual psychologists position themselves within this ongoing discourse, such developments call into question the adequacy of a purely principles-based ethical framework, which often dominates within healthcare systems.

1.2.3 Power, race and epistemic justice.

Clinical psychologists are trained to consider principles of social justice, systemic awareness, and empowerment, and the BPS (2019) has stated "its commitment to promote equality, diversity and inclusion and to challenge prejudice and discrimination, and actively promotes a culture of equality, diversity, and inclusion within our discipline". Notably, the forthcoming 2024 draft BPS Accreditation Standards for Clinical Psychology place *"equality, equity, anti-discrimination, and inclusivity"* at the core of professional training, positioning these values as a foundational standard of the standards wheel (British Psychological Society, in press). This framing underscores the profession's ethical commitment to social justice and structural awareness, and further highlights the tension faced by psychologists when systemic constraints inhibit the enactment of these principles in practice.

However, ethical practice exists within complex relational and systemic contexts. Patel (2003) offers a profound reflection on the ethical foundations and power dynamics inherent within clinical psychology. In particular, she highlights a cultural narrative that often positions the psychologist as the "expert" and the client as the passive "recipient"

of knowledge and healing. Such dynamics can contribute to clients feeling disempowered and may be experienced as deeply wounding, especially by individuals from marginalised groups. Furthermore, this narrative can risk disempowering the client, but also risks promoting an individualistic view of the psychologist, failing to acknowledge their position within a broader system that is often highly restrictive—shaped by policies, legislation, frameworks, and organisational structures. It neglects to consider the wider systemic and community context in which the psychologist operates. Further, Clinical psychologists may experience internal tension between being perceived as both empathic carers and authoritative experts. This duality can foster identity insecurity, which in turn may heighten sensitivity to experiences of moral failure when systemic or client-related obstacles impede their practice (Schubert et al, 2023). Importantly, Patel (2003) argues that psychological practice cannot be separated from the broader societal and structural forms of oppression inherent in power dynamics. Supporting this view, Anderson (2012) critiques the myth of power neutrality in psychotherapy, arguing that ethical practice requires the explicit recognition and navigation of power imbalances.

The implications of these dynamics are not abstract. Bhola et al. (2015) highlight how power dynamics and social discourse can play a significant role in psychological sequelae. Trainees identified themes such as dual relationships, gift-giving, and client disclosures, reflecting the ways in which even well-intentioned actions—whether from the client or the therapist—may reinforce relational hierarchies embedded within social norms and biases.

These concerns are compounded when considering how power operates structurally. The ethical commitments for Clinical Psychologists exist within a profession shaped by structural racism and enduring power imbalances (Mortimer, 2022; Ong, 2021).

Despite increased discourse around inclusion, clinical psychology in the UK remains a predominantly white profession in both workforce and epistemological orientation. Training continues to prioritise Eurocentric, Western, and individualistic conceptions of distress and wellness, which often emphasise personal responsibility, self-regulation, and normative standards of functioning, while marginalising other ways of knowing (Fernando, 2017; Wood & Patel, 2017). Critical Race Theory (CRT) provides a useful lens for understanding these dynamics, highlighting how racism operates systemically rather than through isolated incidents (Delgado & Stefancic, 2023). Racial disparities persist across multiple domains: from the underrepresentation of racially minoritised professionals and their experiences of epistemic exclusion in training (Prajapati et al, 2019), to racialised coercion in service access and care pathways (Nazroo, Bhui, & Rhodes, 2020). An understanding of moral distress in clinical psychology is incomplete without considering the role of race, particularly how institutional racism and cultural invalidation can create conditions that conflict with psychologists' ethical values. Addressing moral distress, therefore, requires not only attention to individual ethics but also structural analysis of race and power within the profession (Kline, 2014; Patel, 2013).

The structural nature of power also shapes how distress is conceptualised and responded to. Expressions of distress may sometimes be interpreted through a diagnostic or formulaic lens that prioritises adjustment to the status quo, and in particular capitalist outomces of wellbeing e.g. getting back to work. These frameworks risk overlooking the social or political origins of suffering. Drawing on Foucault’s (1977) analogy and adaptation of Bentham’s (1787) design of the Panopticon – psychologists, positioned as both observers and arbiters of normative behaviour - may inadvertently contribute to a form of internalised surveillance, whereby individuals come to monitor and regulate their own thoughts and

emotions in alignment with cultural and social discourse. This dynamic can risk pathologising legitimate dissent or expressions of resistance to dominant models of wellbeing, particularly when distress is linked to experiences of marginalisation or systemic injustice. When distress is pathologised without considering the cultural, social, or historical context, it may contribute to organisational abuse and violence. This represents a form of epistemic injustice (Barker et al, 2023; Sakakibara, 2023), where the client's voice is silenced or misinterpreted, denying them the opportunity to have their lived reality recognised and validated. In this way, therapy can inadvertently reinforce marginalisation rather than promote healing. While therapy can certainly support political agency, empowerment, and resilience, it is important to remain critically aware of the profession's role in shaping what is deemed 'healthy' or 'acceptable' behaviour—and whose voices may be silenced in the process.

Taken together, these intersecting dynamics reveal the systemic constraints within which psychologists operate. Clinical psychologists operate within settings in which broader societal and institutional norms and structures are at play. These systems may themselves perpetuate forms of oppression and can restrict psychologists from fully enacting the therapeutic values in which they have been rigorously trained. Without ongoing critical reflection, psychologists risk becoming instruments of these systems, inadvertently reinforcing conformity rather than fostering liberation and empowerment. This presents a significant, exhausting and painful ethical tension to navigate; more concerningly, it becomes potentially dangerous and harmful to both clients and professionals when left unacknowledged. Such dynamics may act as a potent source of moral distress, in which clinical psychologists may feel emotionally burdened and ethically compromised by the

demands of systems that restrict their ability to practice in accordance with their professional and personal values (Austin, 2007; Hamric, 2012).

1.2.4. Relational, virtue and care ethics.

Traditional bioethical models have increasingly been critiqued and supplemented by humanistic approaches, such as care ethics (Noddings, 1984) and virtue ethics (MacIntyre, 1981), which foreground empathy, moral character, and the quality of therapeutic relationships. These models position ethics as dynamic and responsive, rather than rigid or prescriptive. Cultural humility (Tervalon & Murray-Garcia, 1998) has been proposed as a more flexible alternative to cultural competence, highlighting the need for continuous self-reflection and responsiveness to power dynamics. Such frameworks align with the inherently relational and negotiated nature of mental health ethics.

Theorists argue that ethical practice unfolds within moral communities (Austin, 2007), where practitioners continually navigate tensions between institutional norms, therapeutic values, and personal convictions. Moral distress arises when professionals are constrained from acting in accordance with their ethical beliefs due to systemic or organisational pressures (Jameton, 1984). This phenomenon is particularly salient in mental health settings, where dilemmas related to autonomy, risk, coercion, and limited resources are pervasive (Hem et al, 2014; Jansen & Hanssen, 2017).

Recent developments in moral psychology also underscore the role of emotion, intuition, and social context in ethical decision-making (Greene, 2015; Haidt & Graham, 2007; Kahneman, 2002). Moral Foundations Theory and Morality-as-Cooperation (Curry, 2016) propose that moral reasoning is shaped by evolutionary and cultural dynamics. In

clinical contexts, such frameworks help illuminate how professionals weigh competing moral obligations—such as fairness, care, and loyalty—particularly in multidisciplinary teams and shared decsion-making processes (Curry et al, 2019a, 2019b).

Healthcare professionals are regulated by differing ethical standards across disciplines, leading to potential interprofessional conflicts (Landau, 2000). In the UK, clinical psychologists are accountable to the Health and Care Professions Council, yet the British Psychological Society remains highly influential. Variations in ethical codes and institutional expectations can create moral dissonance—particularly in high-pressure environments such as inpatient units, where nurses often face ethical challenges with limited autonomy (Falcó-Pegueroles et al, 2016; The Nuffield Trust, 2020).

Despite growing recognition of cultural influences on moral judgement and distress, empirical exploration of these dimensions remains limited (Hong, 2023). There is a pressing need for ethical models in mental health care that integrate universal principles with a nuanced understanding of culture, power, and relationality. Such frameworks must evolve to reflect the lived complexity of ethical practice in contemporary, pluralistic societies.

It is important to acknowledge that, regardless of how psychologists engage with ethical processes and the debates and tensions inherent in the role, they are required to engage in ongoing reflection. Clinical psychologists must consider whether their work sustains or challenges oppression. This consideration provides essential context for the current research. This is often a complex and multi-layered process requiring ongoing critical self-awareness.

1.3 Moral distress

The concept of moral distress has been discussed for over four decades (Jameton, 1984), primarily within healthcare contexts, and has gained increasing relevance across professional disciplines, including clinical psychology. This section explores the evolution of moral distress as both a theoretical and practical construct. It considers how definitions have developed over time, how moral distress relates to concepts like moral injury and the crescendo effect, and how contemporary frameworks conceptualise it as a dynamic, multidimensional experience shaped by individual and systemic factors. Together, these subsections provide a foundation for understanding the complexity of moral distress and its significance within mental health professions.

1.3.1 Evolution of concept

Moral distress emerged as a term rooted in the nursing profession, particularly in relation to powerlessness and lack of authority. The term was first introduced by philosopher Andrew Jameton in 1984 within the context of nursing ethics, who noticed that nurses were facing ethical challenges without sufficient authority to act upon them. In Nursing Practice: The Ethical Issues, Jameton defined moral distress as the psychological conflict experienced "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984).

In the early 2000s, researchers began to operationalise the concept of moral distress in response to growing recognition of limitations within the original definition (Corley, 2002; Hanna, 2004). As the field progressed, several conceptual gaps were articulated. Notably, scholars raised concerns that moral distress was often conflated with the psychological or emotional distress that may result from it (McCarthy and Deady, 2008), prompting a shift in focus towards its specifically ethical dimensions. Debates have emerged regarding what

constitutes the 'right' course of action, with Campbell et al. (2016) questioning whether constraint is a necessary precondition for moral distress and emphasising the potential role of value conflict or moral ambiguity as alternative or contributing factors. Building on this, Campbell et al. also highlight the dynamic and temporal nature of moral distress, marking a shift from early linear models to more fluid conceptualisations that recognise it as an unfolding ethical process. Authors also called for greater specificity in identifying the constraints on moral action, noting that such constraints may be located both internally (within the individual) and externally (within institutional or systemic contexts) (Austin et al, 2005; Musto and Rodney, 2016). Given the complexity and multiplicity of these perspectives, scholars have underscored the ongoing conceptual ambiguity surrounding moral distress and the need for further theoretical refinement (Fourie, 2017).

From the mid-2000s onwards, the conceptualisation of moral distress began to diversify, with definitions increasingly incorporating ethical, relational, and systemic dimensions. Wilkinson (2004) outlined moral distress as a psychological disequilibrium when a moral decision isn't followed by matching moral behaviour, adding a behavioural and emotional dimension to Jameton's seminal work. Hanna (2004) positioned moral distress within contexts where a moral good is recognised but perceived to be threatened, harmed, or violated, thus shifting the emphasis from constraints to moral values themselves. Austin et al. (2005) maintained a focus on constraints but highlighted how they impede moral choices and actions, reinforcing the external pressures shaping ethical decision-making. Nathanial (2006) introduced the notion of moral "pain," describing the psychological and relational suffering that arises when individuals participate—whether through action or omission—in behaviour they perceive as morally wrong due to real or perceived constraints. In the late 2000s and into the 2010s, further definitions reflected increasing conceptual complexity and a broader

multidisciplinary engagement with the phenomenon. Crane et al. (2015) conceptualised moral distress as psychological suffering linked to involvement in, or failure to prevent, actions that transgress personally held moral or ethical beliefs. Barlem and Ramos (2015) highlighted the experience of powerlessness within "micro-spaces" of institutional dynamics, which erode moral sensitivity and obstruct moral deliberation. Similarly, Campbell et al. (2016) framed moral distress as arising from negative self-directed emotions that result from one's perceived involvement in morally undesirable situations. Together, these perspectives illustrate the evolution of moral distress from a narrowly defined, constraint-based concept to a multifaceted phenomenon encompassing internal conflict, systemic forces, and emotional consequences.

In tracing the evolution of the concept of moral distress, it is noteworthy that no single, universally accepted definition exists. Definitions vary considerably, often reflecting differences in emphasis on emotional responses, the types and sources of constraints, and the nature of the perceived moral transgression (Musto & Rodney, 2018). A consistent theme throughout the literature is the need to distinguish psychological or emotional distress from moral distress, in order to preserve the ethical significance and conceptual integrity of the term. Authors call for greater specificity in what makes distress inherently moral. The disciplinary influence of nursing has likely shaped the early definitions of moral distress. Musto and Rodney (2018) highlight that, although contributing factors in nursing frequently stem from a lack of decision-making authority, physicians may experience moral distress precisely because they bear responsibility for the ethical decisions they make (Austin et al, 2008). Consequently, differences inherent to each profession may account for variations in how moral distress is experienced. This is further supported by Williamson et al. (2020), who examined potentially morally injurious events and argued that such events are shaped by

organisational culture, highlighting the tension between combat-related and civilian value systems. These contrasts underscore the importance of considering professional context when conceptualising moral distress. An important development in the evolution of moral distress is the shift from its original focus on the nursing profession to its recognition as a phenomenon experienced across a range of healthcare disciplines. This broadening of scope reflects the diverse ethical tensions encountered by practitioners when they are unable to act in accordance with their moral judgements. While this more inclusive approach enhances the relevance of the concept, it also adds complexity to the ongoing challenge of establishing a clear and operationalised definition of moral distress.

Additionally, moral distress has been recognised in humanitarian and global health settings, where practitioners face acute resource scarcity, overwhelming need, and ethically fraught decisions, such as determining who receives care during crises. These are not hypothetical dilemmas but daily realities for healthcare workers in disaster zones, refugee camps, and in conflict areas, where structural violence and political constraints severely limit humanitarian response (Simm, 2021). In such contexts, moral distress arises not only from constrained agency but also from witnessing systemic injustice and operating within ethically compromised frameworks (Gotowiec and Cantor-Graae, 2017). This highlights moral distress as a global phenomenon shaped by inequality, violence, and loss, extending beyond professional disciplines or national contexts.

While constructs such as burnout (Amiri et al, 2024), and compassion fatigue (Kabunga et al, 2024) are well-established within healthcare literature, they do not sufficiently capture the moral and ethical dimensions inherent in the work of healthcare professionals. Moral distress, by contrast, centres on the experience of ethical compromise—

specifically, the distress that arises when individuals are unable to act in accordance with their core moral or professional values due to systemic or institutional constraints. This emphasis on moral agency and ethical dissonance is particularly salient in professions grounded in care, justice, and human dignity. As such, moral distress provides a vital analytic lens through which to examine the moral and emotional burdens experienced by practitioners operating within ethically complex environments.

1.3.2 Moral injury, the crescendo effect, and related terms

Distinguishing between moral distress and moral injury is crucial, as these terms are often used interchangeably in the literature, despite referring to distinct phenomena. Both are increasingly recognised as interrelated yet conceptually separate experiences within healthcare contexts. Moral distress, originally conceptualised by Jameton (1984), arises when professionals are constrained from acting in accordance with their ethical beliefs, leading to emotions such as frustration, guilt, and powerlessness (Epstein & Hamric, 2009). In contrast, moral injury refers to deeper and more enduring psychological difficulties and mental health issues that occur when individuals perpetrate, witness, or fail to prevent actions that transgress their core moral values (Dean et al, 2019; Litz et al, 2009). Additionally, while the concept of moral distress originated within healthcare contexts, moral injury was initially introduced through narratives of military veterans. While moral distress is typically situational, contextual, and dynamic—often dissipating once the constraint is removed—moral injury involves a profound moral disorientation or rupture of identity, frequently accompanied by shame, loss of trust, or spiritual crisis (Griffin et al, 2019; Mantri et al, 2021). Recent tools, such as the Moral Injury and Distress Scale (Borges et al, 2023), offer more nuanced means of identifying these constructs, enabling differentiation between normative, situationally congruent emotional responses of moral distress and the clinically

significant moral harm that constitutes moral injury. Clear conceptual distinction is essential not only for informing appropriate psychological intervention but also for guiding organisational change to address systemic contributors to both phenomena (Riedel et al, 2025).

Epstein and Hamric (2009), drawing on their research with nurses and physicians, propose a model in which repeated experiences of moral distress lead to an accumulation of "moral residue"—the lingering feelings of moral compromise and value violation that persist after the immediate situation has passed. They describe a phenomenon termed the *crescendo effect*, wherein unresolved morally distressing experiences compound over time, intensifying the emotional impact and raising the baseline for future experiences of moral distress. Dean et al. (2023) extend this conceptualisation by suggesting that moral injury may develop as a cumulative consequence of repeated, unresolved moral distress, thereby reinforcing models such as the crescendo effect. Together, these perspectives highlight the importance of attending to the root causes of moral harm—namely, morally distressing events—as they play a significant role in the long-term impact on the wellbeing of healthcare practitioners.

Further, the evolving definitions of moral distress and moral injury have led to the development of various related terms—such as "moral stress", "guilt without cause", "moral courage", "moral resilience", and "moral engagement"—frequently used in the literature on ethical challenges in healthcare (Ducharlet et al, 2021; Giwa et al, 2021; Hebert, 2020). While these terms reflect different facets of moral experience, their precise interrelationships remain unclear. Research in this field must demonstrate critical awareness of the entanglement of terms that has emerged.

1.3.3 Current Understanding

Contemporary understandings of moral distress have evolved to reflect its dynamic and multifaceted nature. Fourie (2015) emphasises that the concept remains in development and has increasingly expanded beyond its origins in nursing. It is now widely recognised that moral distress affects a broad range of healthcare professionals and should be understood as a phenomenon that transcends disciplinary boundaries. The experience of moral distress is shaped by the unique ethical frameworks and professional contexts within each discipline.

Morley et al. (2017) sought to clarify moral distress by identifying its necessary and sufficient conditions through a systematic review and narrative synthesis of 152 papers. From an in-depth analysis of 34 key studies, they proposed a refined framework in which moral distress comprises three essential components: a moral event, psychological distress, and a direct causal link between the two. A moral event may involve moral judgement, conflict, or dilemma, which evokes cognitive and emotional responses such as guilt, frustration, and powerlessness. When these responses are directly attributable to the moral event, the experience constitutes moral distress.

While Morley et al. (2017) offer a comprehensive and inclusive definition of moral distress—centering on a moral event, psychological distress, and the causal link between the two—this conceptualisation may still be critiqued for its emphasis on the *individual experience* of distress. Although the framework recognises moral events such as dilemmas or conflicts, these are often situated within broader organisational or systemic contexts. In line with arguments from other scholars (e.g, Epstein & Hamric, 2009; Peter et al, 2004), moral distress should also be understood as arising from structural constraints, hierarchical power dynamics, or conflicting institutional values that inhibit ethical action. Morley et al.'s model

serves as a useful foundation, that preserves the ethical dimension and systemic context of moral distress while linking it to the resultant psychological impact.

Earlier definitions emphasised external constraints, such as institutional hierarchies and resource limitations, which prevent ethical action. However, more recent accounts have expanded to include internal constraints—like fear or self-doubt—which acknowledge that moral distress may arise even in the absence of overt external obstacles. This evolution reflects a growing recognition of the complexity of moral experience in healthcare practice.

Additionally, the relational and institutional contexts in which healthcare professionals operate are increasingly recognised as central to understanding moral distress. Rather than being seen as solely an individual phenomenon, moral agency is now understood as socially and contextually situated. Professionals are embedded in networks of structural conditions—such as cultural norms, policy frameworks, and interpersonal dynamics—that both shape and constrain moral action (Musto and Rodney, 2018). This marks a shift away from traditional notions of agency as autonomous and individualistic, towards a relational perspective in which agency is enacted within, and inseparable from, specific social contexts (Musto and Rodney, 2018). Within this framing, structures—such as institutional cultures, professional hierarchies, and economic systems—do not simply impose limits on action; they also generate the conditions under which moral reasoning and response become possible. Moral agency and structural forces thus exist in a state of mutual constitution, whereby even small acts of resistance or moral expression can influence broader systems, and those systems in turn shape the scope of moral possibilities. This dynamic interplay not only informs how moral distress manifests, but also how it may be negotiated, reframed, or transformed over time. Such a view aligns with Sewell's (1992) theory of the reciprocity between structure and

agency, as well as Austin's (2007) conceptualisation of healthcare settings as inherently moral communities. Framing moral distress in this way underscores its variability across professional sectors—for instance, distress in the military may arise from obligations to follow orders that conflict with personal ethics, whereas in psychology or social work it may stem from institutional barriers to ethical care.

In summary, moral distress is now conceptualised as a product of individual, relational, and structural dynamics. A comprehensive understanding must account for both internal and external constraints, recognise the relational nature of moral agency, and consider the broader socio-political structures that influence ethical practice. Addressing moral distress requires interventions at multiple levels, including individual education on moral resilience, supportive leadership, and systemic reforms that promote ethically sustainable workplace environments.

1.3.4 Recent empirical contributions

Recent doctoral theses have explored moral distress in both clinical psychologists and mental health professionals in the UK.

Sprigings (2021) qualitatively explores moral distress (MD) among 14 clinical psychologists in UK NHS adult mental health services. Through thematic analysis of interviews, three themes emerged: *Being in Services*, *Power*, and *Professional Identity*, highlighting tensions between professional values and systemic constraints. Participants reported ethical conflict stemming from managerialism, resource limitations, and policy-driven care, often impacting wellbeing and lead to exhaustion. The study underscores moral distress as a significant but under-recognised phenomenon, shaped by institutional power and misalignment with

professional identity, and calls for systemic reform and integration of moral distress discourse into training, supervision, and policy.

Mortimer (2022) examines moral values, racial attitudes, and clinical decision-making among 450 UK mental health professionals using a mixed-methods design. Grounded in the Morality-as-Cooperation framework, the study utilised the Measure of Moral Distress for Healthcare Professionals (MMD-HP) and Colour-Blind Racial Attitudes Scale, alongside varied vignettes. High levels of moral distress were reported, with colour-blind racial attitudes linked to biased clinical decision-making, mediated by values such as deference and group loyalty. The findings suggest that whiteness and dominant racial discourses shape clinical decision-making. Mortimer extends the concept of moral distress to include structural racism and calls for anti-racist practice, moral and racial reflexivity, and structural change within mental healthcare.

1.4. Efficacy and Measurement.

1.4.1 Measures

One of the most widely used instruments is the Moral Distress Scale (MDS) (Corley et al, 2001), which assesses ethical dilemmas frequently encountered in clinical settings by measuring the frequency and level of distress on a Likert scale. The original 38-item MDS, was used to assess moral distress in intensive care nurses. Hamric et al. (2012) revised and shortened this measure to enhance its applicability across a broader range of healthcare professionals (HCPs) and acute care clinical settings. The resulting 21-item instrument, known as the Moral Distress Scale–Revised (MDS-R), comprises six versions: adult-nurse,

adult-physician, adult-other, paediatric-nurse, paediatric-physician, and paediatric-other. The MDS-R has been widely employed in empirical studies and has demonstrated sound reliability and validity (Allen et al, 2013; Dodek et al, 2016; Lamiani et al, 2017; Penny et al, 2016; Trotochaud et al, 2015; Whitehead et al, 2015).

The Measure of Moral Distress for Healthcare Professionals (MMD-HP) provides a new iteration of the MDS (MDS-R), it evaluated distress alongside intent to leave in 653 healthcare professionals (Epstein et al, 2019) and has been utilised to assess distress during the COVID-19 pandemic (Donkers et al, 2024). This revised version develops the measure further by providing a summative score, and introducing a factor loading structure, allowing for more comprehensive assessments of moral distress levels across different healthcare populations.

Other tools have been developed to address specific aspects of moral distress. The Moral Distress Thermometer (MDT) provides a rapid, single-item assessment using a 0–10 scale (Wocial & Weaver, 2013). The Ethical Conflict in Nursing Questionnaire – Critical Care Version (ECNQ-CCV) positions moral distress along a continuum that includes related constructs such as moral uncertainty and moral dilemmas, offering a more nuanced understanding of the ethical challenges faced by healthcare professionals (Falco-Pegueroles et al, 2013). Additional instruments, such as the Ethical Climate Questionnaire (ECQ) and the Critical Incident Technique, help identify specific moral distress triggers by examining the ethical climate of an organisation. The Professional Quality of Life (ProQOL) Scale measures burnout, which can overlap with moral distress, providing further context for understanding the well-being of healthcare professionals.

Qualitative approaches, including interviews, ethical dilemma scenarios, and reflective journals, remain integral to moral distress research, offering a richer, more context-sensitive perspective. However, there are no standardised instruments or guidelines for investigating moral distress in qualitative research. The study by McAndrew et al. (2018) highlights inconsistencies in how moral distress is measured, noting variations in how distress is experienced across different research contexts. The lack of standardisation in measurement instruments complicates cross-study comparisons and limits the generalisability of findings. Nevertheless, these quantitative and qualitative methods play a crucial role in measuring moral distress, establishing its prevalence, and informing interventions to support healthcare professionals.

1.4.2 Critique of Measures

Despite their widespread use, measuring moral distress remains challenging due to persistent conceptual ambiguities and ongoing debate about the validity and effectiveness of existing measures. The MMD-HP is one of the most frequently used tools in healthcare settings (Orgambídez et al, 2025). It includes statements related to ethical dilemmas commonly encountered in clinical environments, with respondents rating the frequency and level of their distress on a Likert scale. However, scholars such as Kolbe and de Melo-Martin (2023) argue that existing instruments fail to capture the complexity of moral distress. A key concern is their inability to distinguish between legitimate and illegitimate constraints on healthcare professionals' moral agency. Current tools, including the MDS and its various iterations (MDS-R, MMD-HP), do not adequately differentiate between moral discomfort, and moral distress, nor do they account for institutional and interpersonal factors that shape ethical decision-making. Additionally, Kolbe and de Melo-Martin (2023) question whether reported instances of moral distress accurately reflect clinical and logistical realities,

thereby undermining the reliability of these measures. They also raise concerns about whether the distress being measured is genuinely moral in nature or merely psychological or emotional discomfort arising from non-moral factors.

These critiques align with findings from McAndrew et al. (2018), who highlight inconsistencies in the use and interpretation of moral distress measurement tools. Some studies report moral distress as predominantly moderate to high, while others indicate variability based on demographics, years of experience, and unit type. The lack of standardised instruments limits the comparability of findings across different settings, making it difficult to draw definitive conclusions about the prevalence and impact of moral distress. Furthermore, conceptual ambiguity hinders efforts to determine whether moral distress should be the primary target for intervention. Without a clear definition and understanding, strategies to mitigate moral distress may be misguided or ineffective. Morley et al. (2017) stressed the need for a more precise and consistent definition to guide both empirical research and practical applications. Their work contributes a foundational framework that facilitates a clearer understanding of moral distress, encouraging the development of targeted interventions and supportive workplace cultures.

In response to these critiques, Wocial (2023) defended the validity of existing instruments, emphasising their evolving nature and continued relevance. While acknowledging their limitations, Wocial argued that these tools have contributed valuable insights and incorporated real-world feedback, demonstrating their ongoing utility in moral distress research. Kolbe and de Melo-Martin (2023) continue to call for more precise and context-sensitive tools, stressing that current measures often fail to determine whether reported instances of moral distress arise from legitimate ethical concerns or personal biases.

The study by McAndrew et al. (2018) similarly advocates for refining existing tools and developing more comprehensive instruments that integrate both qualitative and quantitative components.

An additional challenge for measures to overcome in moral distress research is the issue of self-selection bias (Krosnick, 1999). It is plausible that individuals experiencing the most severe or chronic forms of moral distress may be the least likely to participate in research due to emotional exhaustion, burnout, or disengagement. This could result in an underestimation of the true extent and severity of moral distress in the workforce, particularly among those most affected. As such, findings may disproportionately reflect the experiences of individuals who retain sufficient capacity or institutional support to engage with research.

The discourse surrounding the conceptual ambiguity and resulting scientific challenges of moral distress is both rigorous and insightful, prompting the academic community to consider the extent to which the experience can be measured and quantified—and, if so, whether it is an appropriate target for elimination.

1.4.3 Research opportunities

To enhance the reliability and applicability of moral distress measurement, further testing and validation of existing tools are necessary, particularly in relation to their ability to predict patient and family outcomes. The development of standardised, multi-dimensional instruments that account for institutional, psychological, and ethical dimensions of distress could improve research replicability and inform more targeted interventions. Conceptual clarity is therefore essential for ensuring that moral distress measures effectively capture the

ethical challenges faced by healthcare professionals and support meaningful changes in clinical practice.

1.5. Predictors and correlates of moral distress.

Moral distress in healthcare settings arises from a combination of individual, clinical, and systemic factors that contribute to ethical dilemmas and emotional strain among healthcare professionals. Beyond the legal and policy constraints that often shape decision-making, moral distress frequently emerges in environments characterised by conflicting demands, a lack of collaboration, and organisational pressure. These factors are compounded by systemic issues, such as inadequate staffing, overwhelming caseloads, and financial constraints, all of which exacerbate the experience of moral distress among healthcare workers (Forde & Aasland, 2008; Morley et al, 2021).

1.5.1 Systemic and organisational factors

Moral distress in healthcare settings does not occur in a vacuum; rather, it emerges from the confluence of institutional, systemic, and workplace-specific factors. Legal frameworks, organisational policies, and broader socio-political agendas often restrict healthcare professionals' ability to act in alignment with their ethical values, giving rise to ethically challenging situations. For instance, restrictive abortion legislation has placed obstetricians in morally distressing circumstances, where they are unable to provide care they consider appropriate and safe (Turk, Claymore, Dawoodbhoy, & Steinauer, 2024). Similarly, healthcare workers must contend with institutional imperatives to reduce coercive interventions—such as physical restraint—while also ensuring safety and therapeutic integrity in high-risk settings (Jansen et al, 2022). These tensions reveal how ethical decision-making is deeply embedded within political contexts and societal norms, making moral practice a function of not only individual judgment but also collective, cultural forces.

Organisational culture further mediates the expression and impact of moral distress. Factors such as interprofessional conflict, lack of collaboration, and inadequate managerial support have been consistently associated with increased moral distress among healthcare professionals (Deady & McCarthy, 2010; Musto, Rodney, & Vanderheide, 2015; Webber et al, 2015). Systemic issues such as inadequate staffing (Corley et al, 2005b), high administrative burdens, and overwhelming caseloads (Whitehead et al, 2015) create environments in which professionals are routinely required to prioritise equally urgent tasks, often under resource constraints (Kälvemark et al, 2004). These demands, coupled with the imperative to control costs (Sporrong, Holland, & Arnetz, 2006), can compromise care quality and amplify ethical conflict. Such conditions are particularly pronounced in high-stress environments like intensive care units and emergency departments, where the interplay between operational stress and moral distress becomes acute (Clark et al, 2021; Dodek et al, 2019).

The systemic nature of workforce distress is further reflected in evidence of widespread workplace hostility. A recent UK parliamentary report on burnout in health and social care found that NHS staff frequently encounter bullying, harassment, and abuse, with 30.3% of Black and racially minoritsed staff and 27.9% of White staff reporting such experiences (House of Commons Health and Social Care Committee, 2022). Despite this, perceptions of discrimination and abuse have remained static, suggesting a professional culture that valorises resilience while failing to address its structural causes. Such conditions risk reframing ethical distress as individual weakness, thereby compounding moral distress and eroding psychological safety within clinical settings.

A key determinant of how moral distress is experienced within these systemic constraints is the ethical climate of the organisation. Morley et al. (2017) emphasise that ethical environments that restrict autonomy or limit moral agency intensify the risk of distress. When professionals are repeatedly unable to act in accordance with their values, this misalignment contributes to emotional exhaustion, disengagement, and reduced job satisfaction—factors that, over time, impact retention and the effectiveness of the workforce. The organisational ethical climate thus plays a pivotal role not only in the emergence of moral distress but also in shaping its longer-term consequences.

In parallel, occupational well-being is a critical mediating factor in the experience of moral distress. Positive work environments—characterised by adequate resourcing, supportive leadership, and effective communication—can act as buffers, helping professionals to cope with the emotional and ethical complexities of care delivery (Plouffe et al, 2023). Conversely, where support is lacking, particularly in terms of peer collaboration and managerial responsiveness, healthcare professionals may feel isolated in their ethical reasoning and emotionally overwhelmed (Deady & McCarthy, 2010; Musto et al, 2015). Organisational commitment to staff well-being, including spaces for emotional processing and reflective practice, is therefore essential in mitigating the effects of moral distress and sustaining staff integrity.

Moreover, the ethical infrastructure of a workplace—reflected in its culture, norms, and opportunities for ethical reflection—has significant implications for both moral distress and job satisfaction. An ethical work environment allows healthcare workers to engage openly with moral dilemmas, bolstered by institutional support and shared ethical frameworks. Corley et al. (2005) argue that such environments enable professionals to better

navigate ethically fraught scenarios, reducing the incidence and severity of moral distress. Further, Borhani et al. (2012) suggest that ethical cultures correlate positively with nurse job satisfaction, reinforcing the broader organisational benefits of fostering ethical awareness and responsiveness.

Leadership and supervision also serve as key leverage points in addressing moral distress. Supportive supervisory relationships provide professionals with guidance and validation, enabling more confident ethical decision-making. As Nuttgens and Chang (2013) highlight, strong supervisory support can attenuate the emotional burden associated with ethical conflicts. In contrast, inadequate supervision and poor managerial responsiveness to ethical concerns have been shown to exacerbate moral distress (Musto et al, 2015). Effective leadership involves not only logistical coordination but also the emotional labour of recognising and responding to moral complexity, thereby fostering a psychologically safe and ethically resilient workforce.

1.5.3 Clinical situations

Among the most frequently discussed triggers of moral distress in the literature is the perception of poor-quality patient care (Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004). Healthcare professionals experience distress when they witness or are compelled to participate in inadequate treatment, particularly in high-stakes scenarios such as end-of-life care and decisions regarding life-sustaining treatments. This distress is heightened when there is ambiguity surrounding the patient's wishes or concerns about their quality of life. Additionally, prolonged patient suffering and diminished quality of life, without the means to alleviate it—whether due to clinical limitations, policy constraints, or resource scarcity—further contribute to moral distress among healthcare providers.

An additional layer of complexity emerges in psychological work across both forensic and clinical settings, where engaging therapeutically with individuals who have committed morally abhorrent acts—such as violent and/or sexual offences—presents significant emotional and ethical challenges for psychologists. Moral distress in this context can arise not only from external constraints but from the internal dissonance between professional responsibilities and personal moral values. Clinicians are often required to show empathy and therapeutic commitment to clients whose actions may evoke disgust, fear, or anger, resulting in psychological strain.

Engaging with clients whose behaviours or histories may evoke strong moral revulsion—such as those involving cruelty, exploitation, abuse, or violence, can elicit profound discomfort for healthcare professionals. These internal reactions, while often unspoken, may include disgust, anger, or fear, and can disrupt the therapeutic stance of neutrality and unconditional positive regard (Knoll and James, 2009). When such reactions are incongruent with professional expectations to remain empathic and nonjudgemental, it is possible that professionals experience an ethical dissonance that mirrors the broader construct of moral distress. In these instances, the source of distress is not necessarily institutional or procedural, but internal, a conflict between one's moral identity and the therapeutic obligations of care. These ideas further underscore the notion that therapeutic work is inherently moral in nature.

A further tension arises in the context of NHS guidance (NHS England, 2021), which rightly seeks to protect staff from abusive and discriminatory behaviour from the public. While such policies are essential for safeguarding staff wellbeing, they may sit uneasily

alongside the therapeutic expectation that psychologists engage empathically with clients who express views or behaviours that are morally challenging, abusive, or offensive. This creates a complex clinical dilemma: on the one hand, professionals are required to uphold standards of empathy, non-judgement, and therapeutic engagement, while on the other, they must navigate organisational boundaries that limit tolerance of abusive or discriminatory expressions. The coexistence of these demands may itself be a source of moral distress, as clinicians negotiate the line between professional responsibility and personal or institutional protection.

Emerging literature suggests that therapists who encounter morally objectionable clients may respond with emotional distancing, avoidance, or even subtle forms of disengagement, potentially impacting the quality and consistency of therapeutic work (Betan et al, 2005; Linn-Walton & Pardasani, 2014). These reactions, when unacknowledged or unsupported, may contribute to burnout, vicarious traumatisation, or compromised clinical judgement. In this way, moral distress in psychological practice can be rooted not only in systemic constraints but also in the moral ambiguity of human relationships themselves.

Barros et al. (2020) found that forensic psychologists and psychiatrists working with sex offenders often adopt emotional distancing strategies, such as indifference, to manage this discomfort. However, these responses were associated with increased vicarious trauma and disrupted beliefs about trust and safety, particularly among less experienced professionals or those without prior therapy. Defence strategies also correlated with greater psychological disruption, suggesting that unresolved moral conflict may heighten vulnerability to trauma. Similarly, Baum and Moyal (2018) conducted a systematic review revealing that male therapists reported higher levels of vicarious trauma than their female counterparts,

particularly in relation to cognitive disruptions around intimacy, trust, and self-esteem. This research indicates that moral distress in forensic settings can manifest as emotional disengagement, trauma-related symptoms, and shifts in worldview.

1.5.4 Individual factors

Individual resilience is another important factor that can buffer the effects of moral distress. Resilience refers to an individual's ability to cope with and adapt to stress, adversity, and challenging situations, including ethical dilemmas (Spilg et al, 2022). In the NHS, a culture of resilience often pressures healthcare workers to endure systemic failings without showing signs of distress. Conolly, (2022) explores how this expectation, particularly during the pandemic, led NHS nurses to internalise guilt and psychological distress, as they felt they were "not resilient enough" to cope with the ethical and emotional challenges of their roles. This has lead to a ubiqiotousness and valorisation of 'resilience' within healthcare (Tan, 2022), often overlooking the lasting effects of difficult workplace conditions. By focusing on individual resilience, healthcare systems may neglect the systemic factors contributing to stress and burnout, reinforcing the status quo rather than addressing the root causes.. This is not to suggest that individual resilience is without merit; in fact, healthcare workers with high levels of resilience are generally better equipped to manage moral distress and preserve their emotional well-being when facing ethical challenges. Clark et al. (2021) found that resilient emergency department nurses were more likely to engage constructively with workplace challenges, thereby reducing the impact of moral distress or mitigating it entirely. Resilience alone cannot fully eliminate moral distress the systemic and clinical contexts that give rise to moral distress, it serves as a protective factor that enables individuals to cope more effectively with the emotional and ethical challenges they encounter in the workplace.

In addition to resilience, several individual-level factors, including personal beliefs and values, locus of control, decision-making autonomy, and professional experience—have been implicated in the experience of moral distress among healthcare professionals. Clinicians with strongly held personal values may be particularly vulnerable when systemic barriers inhibit ethical action (Beadle et al, 2024). Similarly, an individual's locus of control—the extent to which they perceive events as being within or beyond their control—plays a moderating role. Evidence suggests that healthcare workers with an external locus of control, who view themselves as powerless in influencing outcomes, may experience heightened moral injury, particularly when encountering ethically compromised systems or policies (Singhal and Chukkali, 2023). This sense of powerlessness can erode agency and exacerbate psychological distress, especially in environments where practitioners are expected to deliver care that conflicts with their ethical standards.

Autonomy in clinical decision-making also appears to be a key determinant of moral distress in some professions. Research has demonstrated that reduced professional autonomy is significantly associated with higher levels of moral distress, as it undermines practitioners' capacity to make ethically sound decisions in line with their clinical judgement (Abdolmaleki et al, 2018). This is particularly salient in highly structured or risk-averse healthcare systems, where institutional priorities may override individual ethical reasoning. Determining the role of autonomy in moral distress is more complex. As outlined, interdisciplinary differences suggest that autonomy can function both as a constraint, particularly for nurses, and as a burden, as seen in the ethical responsibilities carried by psychiatrists (Austin et al, 2003, 2005, 2007).

Furthermore, levels of experience and professional confidence have been shown to increase vulnerability to morally distressing situations. Novice practitioners, including newly qualified nurses and trainee psychologists, often report greater vulnerability to moral distress due to a lack of clinical confidence, limited authority, and uncertainty about how to navigate ethical complexity within hierarchical systems (Kovanci and Atli Özbaş, 2025). In contrast, experienced professionals may draw upon a more robust ethical framework and practical knowledge to manage or mitigate distress, although they too are not immune to its effects. As clinicians progress in their developmental stage, role changes often expose them to greater decision-making responsibilities, such as navigating resource allocation and service constraints, meaning that while their ethical frameworks and coping strategies may be more robust, the complexity and potential moral weight of their decisions also increases. These findings underscore the complex interplay between individual psychological characteristics and structural dynamics in shaping the intensity and frequency of moral distress in healthcare contexts.

Moral distress has been consistently linked to adverse physical and mental health outcomes, including emotional, psychological, and physical symptoms (AACN, 2020; Christodoulou-Fella, 2017; Fard et al, 2020). Emotional reactions such as frustration, anger, shame, and guilt are frequently associated with moral distress (Corley, 2002; Rushton, 2022). Nurses experiencing moral distress often report feelings of emotional detachment from themselves and others (Hanna, 2004). Physically, moral distress is associated with symptoms such as muscle aches, headaches, heart palpitations, insomnia, neck and abdominal discomfort, and weight fluctuations (Delfrate et al, 2018; De Villers & DeVon, 2013; Rushton, 2022). Mental health complications linked to moral distress include depression, secondary post-traumatic stress disorder (PTSD), anxiety, sleep disturbances, social

difficulties, suicidal ideation, emotional numbness, and a reduction in empathy (Christodoulou-Fella, 2017; Hamaideh, 2014; Lamiani et al, 2017). Empirical evidence demonstrates that higher moral distress scores are strongly associated with increased psychiatric morbidity, as measured by validated instruments (Christodoulou-Fella et al, 2017), underscoring the significant predictive role of moral distress in nurses' mental health (Azizi et al, 2015; Hamaideh, 2014; Ohnishi et al, 2010).

1.6. Interventions for moral distress.

Moral distress has been linked to burnout, reduced job satisfaction, and increased turnover among healthcare professionals (Amos & Epstein, 2022). Given its significant consequences, researchers have explored various interventions aimed at reducing moral distress. These interventions can be broadly categorised into education-based interventions, facilitated discussions, structural, and organisational interventions, and mixed-method approaches.

1.6.1 Education-based interventions

Education-based interventions are among the most commonly implemented strategies to address moral distress. These interventions typically involve workshops, training sessions, and seminars designed to enhance ethical knowledge, coping skills, and moral reasoning. Systematic reviews indicate that educational interventions can lead to reductions in moral distress, though their effectiveness is often limited without concurrent organisational support (Morley et al, 2021). A review by Amos and Epstein (2022) found that education-based programmes had some success in improving participants' understanding of moral distress and ethical decision-making, yet most studies lacked strong evidence of statistically significant reductions in distress levels. Similarly, Morley et al. (2021) reported that while some

educational interventions demonstrated positive effects, many studies were methodologically weak, with small sample sizes and a lack of control groups.

1.6.2 Facilitated discussions and ethics rounds

Facilitated discussions, such as ethics debriefing sessions, moral distress consultations, and multidisciplinary ethics rounds, have been employed to create spaces for healthcare professionals to openly discuss ethical dilemmas and moral distress experiences. Wocial et al. (2024) examined the effectiveness of facilitated ethics conversations, which involved structured, guided discussions about ethical challenges in clinical practice. Their findings suggested that while moral distress levels did not significantly decrease, participants reported psychological benefits, a sense of community, and improved moral agency. Other studies have suggested that ethics rounds provide emotional support and help clinicians develop ethical coping strategies, though their effectiveness is often difficult to measure quantitatively (Morley et al, 2021).

1.6.3 Structural and organisational interventions

Given that moral distress is often caused by systemic barriers such as understaffing, high workload, and hierarchical decision-making structures, some interventions have focused on organisational changes rather than individual coping strategies. Structural interventions include policy changes, ethical climate improvements, and leadership support for ethical decision-making. Amos and Epstein (2022) noted that organisational-level interventions were the least studied but potentially the most impactful (Hamric & Epstein, 2017; Reilly and Jurchak, 2017, Saeedi et al, 2019, Sporrong et al, 2007). High turnover rates and burnout associated with moral distress highlight the need for institutional commitment to improving ethical climates, staff support, and decision-making autonomy.

1.6.4 Mixed-method and multicomponent approaches

Given the complexity of moral distress, some studies have explored multifaceted interventions that combine education, ethics discussions, and institutional changes. Wocial et al. (2024) implemented a two-phase intervention where participants engaged in both facilitated ethics conversations and public reporting of aggregate moral distress scores. This approach aimed to foster transparency and ethical dialogue within the workplace. While the quantitative measures did not show statistically significant reductions in moral distress, qualitative feedback suggested improvements in ethical awareness and team cohesion. This aligns with Morley et al. (2021) review, which identified intervention bundles as a promising approach, particularly when tailored to specific institutional contexts.

1.6.5 Limitations and critiques.

Despite the growing focus on interventions for moral distress, several limitations persist. Importantly Kolbe and De Melo Martin (2022) express concern that interventions aimed at relieving or resolving moral distress may shift focus from the structural and systemic sources of the distress to the individual's psychological response.

Many studies suffer from small sample sizes, lack of control groups, and methodological inconsistencies, making it difficult to draw firm conclusions about effectiveness (Amos & Epstein, 2022; Morley et al, 2021). Additionally, moral distress is a subjective and context-dependent phenomenon, requiring interventions that are flexible, individualised, and embedded within organisational structures. Future research should prioritise longitudinal studies, randomised controlled trials, and interventions that integrate both individual and systemic approaches to mitigating moral distress in healthcare settings.

The evidence indicates that no single intervention is sufficient to comprehensively address moral distress, thereby supporting the view that moral distress is a variable experience across different disciplines and contexts. Education-based interventions and facilitated discussions provide valuable tools for ethical awareness and coping, but their impact is limited without organisational-level changes. Structural interventions, though less studied, hold the greatest potential for long-term reduction of moral distress by addressing its root causes. Moving forward, multicomponent interventions that integrate education, ethics discussions, and systemic reforms may offer the most effective strategy for supporting healthcare professionals in ethically challenging environments.

1.7 Systematic reviews

Most research on moral distress to date has focused on the nursing profession, with Lamiani et al. (2017) estimating that 71% of studies in this area involve nurses. A substantial proportion of this literature concentrates on palliative care and the complex decision-making processes associated with it (Austin, 2007; Corley, 2002; Hamric, 2000; Tiedje, 2000). Although moral distress originated as a concept within nursing, it has also been explored among physicians, pharmacists, and occupational therapists, particularly within acute physical healthcare settings (Førde & Aasland, 2008; Schwenzer & Wang, 2006; Sporrong et al, 2006).

The systematic reviews by Orgambídez et al. (2025) and Salari et al. (2022) collectively underscore the significant prevalence and impact of moral distress among healthcare professionals, particularly nurses. Orgambídez et al. (2025) demonstrate a robust and statistically significant correlation between moral distress and emotional exhaustion,

identifying moral distress as a key contributor to burnout within the framework of the Job Demands-Resources model. Salari et al. (2022), meanwhile, offer a global perspective on the frequency and severity of moral distress in nursing, highlighting its widespread occurrence and association with organisational constraints, inadequate support, and ethical conflicts. Both reviews emphasise that unresolved moral distress can lead to adverse outcomes for individual well-being, professional retention, and quality of patient care. Importantly, they advocate for systemic responses—such as ethical leadership, enhanced staffing, and institutional support structures—to foster moral resilience and mitigate the damaging effects of sustained moral conflict in healthcare environments.

Despite increasing attention to moral distress, there remains a relative lack of research on how it is experienced by healthcare professionals within mental health settings and in non-nursing professions, making this an under-explored area in the current literature (Rodney, 2017; Sanderson et al, 2019). In response to this gap, a scoping review was undertaken to synthesise and critically appraise the existing evidence on moral distress among mental health professionals.

1.8 Systematic scoping review

1.8.1 Review aims and questions

I conducted a systematic scoping review, following Arksey and O'Malley's (2005) framework. The review mapped the breadth and nature of the literature, identified key concepts, and highlighted evidence gaps. I used systematic methods, including a comprehensive search, predefined inclusion and exclusion criteria, and quality appraisal, to ensure transparency and rigour.

The aims of this review were, broadly, to summarise and understand the research base around moral distress in mental health settings. An additional aim was to understand how moral distress is defined in the literature, in response to the conceptual ambiguity identified in the existing research base. As such, the research questions are as follows:

1. What is known from the existing literature about moral distress in mental health settings?
2. How does the existing literature about moral distress in mental health settings define the phenomena?

1.8.2 Methodology

The aim of this review is to summarise the breadth of the research base on moral distress in mental health settings and to assess the extent and quality of the available literature. For this purpose, I conducted a scoping review. This approach is well-suited for mapping the research landscape while identifying key concepts, recurring themes, and gaps in the literature. Scoping reviews are particularly advantageous for fields that are less established, as they allow for an exploration of diverse methodologies and findings without the rigid criteria required by systematic reviews (Pham et al, 2014). Additionally, scoping reviews facilitate the identification of neglected areas of research, aligning closely with this review's objective of highlighting what is missing in the existing literature.

1.8.2.1 Article Selection

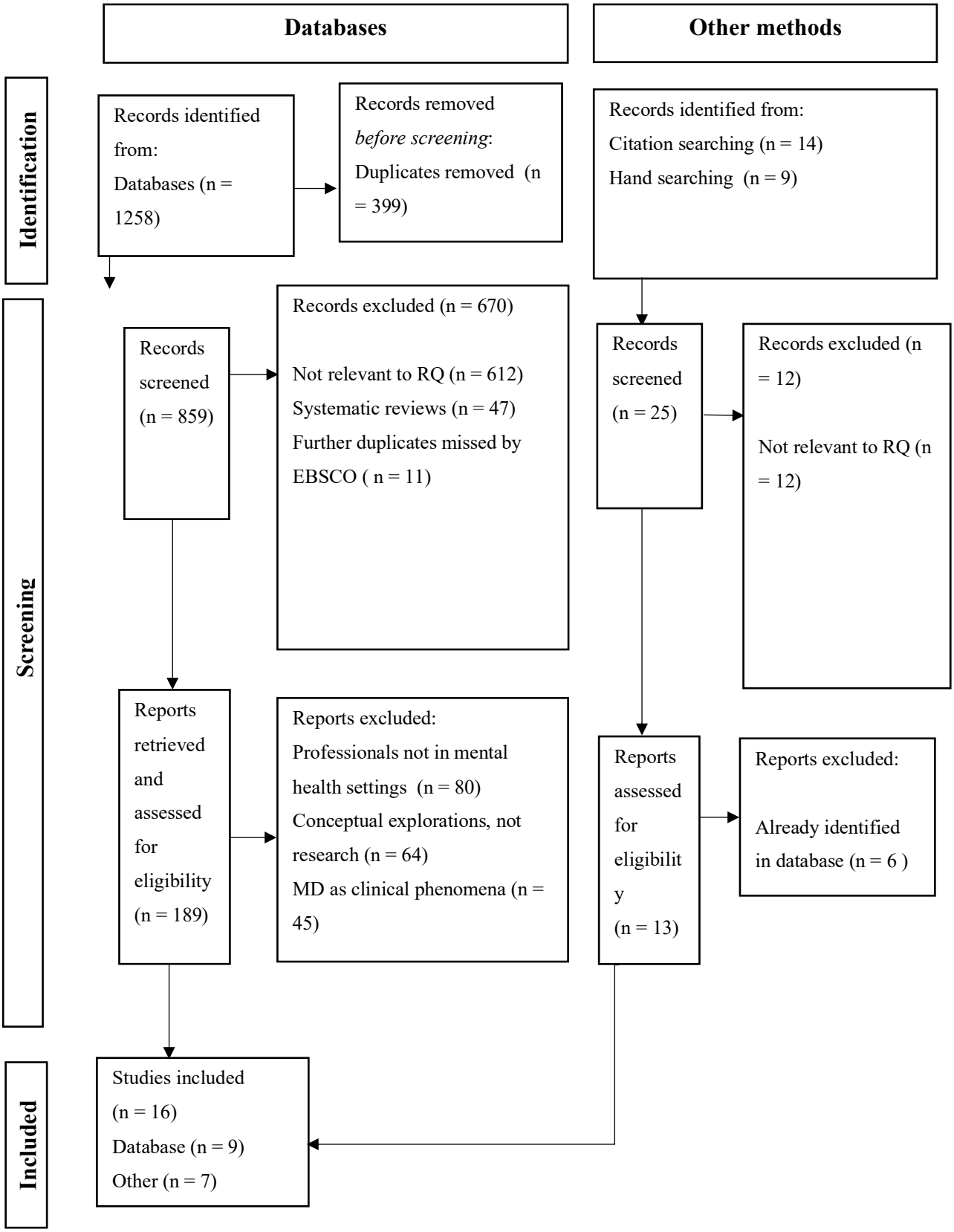
This review developed search terms for the systematic literature search to focus on moral and ethical concepts, as well as to identify a representative sample of professionals within the mental health workforce. I applied these terms both independently and in combination to enhance the breadth and depth of the search results. Moral distress was the

phenomena of interest, due to ambiguity of terms. Moral distress was described using “moral injury” “distress”, “stress”, “damage”, “residue” or “suffering”. The strand of “mental health professionals”, “mental health nurse”, “therapists”, “psychiatrist”, or “psychologist” was added to elicit studies describing the experience of moral distress within these work settings and roles. The only limiter added was to limit the language to English. I used meta-databases Ebscohost, APA Psychinfo, APA Psycharticles, CINAHL Ultimate, and MEDLINE Ultimate were searched. This search returned 1258 records, 399 records were removed as duplicates, leaving 859 records that were screened, and a further 158 retrieved and assessed for eligibility. Figure 1 shows complete database search strategy in line with PRISMA guidelines, and illustrates additional methods taken to obtain records.

The majority of studies excluded were irrelevant to the review question. These studies were not examining moral distress, or were not examining it in an occupational context or were examining it outside the mental health field. Exhaustive reasons for exclusion can be found in Figure 1.

Figure 1.

PRISMA Flow diagram.



1.8.2.2 Inclusion criteria

This review developed the inclusion criteria post hoc as familiarity with the literature base increased. Criteria were then systematically applied to all citations to assess their relevance. The inclusion criteria focused on the study type and the characteristics of the population sample. The following criteria were used: A) Studies were qualitative, quantitative or both (empirical). B) Participants were mental health professionals. C) Studies explore moral distress from the perspective mental health professionals D) Studies explore moral distress within mental health settings. E) Experiences were examined from an occupational rather than a clinical perspective. F) Reports were in English. Systematic reviews were excluded from the final selection as they synthesise existing studies rather than present original data, which could lead to duplication or overlap in findings. However, they were reviewed and utilised as supplementary sources to inform the identification and screening of relevant primary studies, and were subsequently subjected to citation searching.

1.8.2.3 Design

The methodological framework for conducting a scoping review was guided by Arksey and O'Malley's (2005) seminal six-stage process. These stages include: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, (5) collating, summarising, and reporting the results, and an optional stage (6) consulting with stakeholders. The review created a spreadsheet was created to examine each studies aims, methods, measures, populations, and key findings. Afterwards this spreadsheet was used to summarise and group results according to a thematic organisational framework. To enhance rigor and transparency, additional insights were drawn from Levac, et al. (2010), who provided key refinements to the original framework. These enhancements emphasise transparent reporting and assessing quality of the studies.

I selected the Mixed Methods Appraisal Tool (Hong et al, 2018) to systematically evaluate the quality of each study. This tool is specifically designed for reviews that incorporate qualitative, quantitative, and mixed-methods research, offering a comprehensive framework for appraising diverse study designs. The Mixed Methods Appraisal Tool provides a structured and transparent assessment process, ensuring consistency and rigor in evaluating methodological quality across different types of studies. These frameworks ensured a robust and comprehensive approach to the review process. A thematic review was not selected, as its sole focus on identifying and organising themes would not sufficiently address this review's broader aim of evaluating the scope of the research base. However, thematic organisation remains an element of a scoping review, despite not being its primary objective. Adopting a scoping approach allows for a comprehensive synthesis, integrating thematic insights while assessing the research landscape.

1.8.3 Numerical Analysis

Table 1 provides a frequency summary of all the locations, populations, and research methods used in each study.

1.8.3.1 Geographic Distribution

The studies span various geographic regions, with the majority conducted in high-income countries. Three studies were conducted in Canada, all by the same research team (Austin et al, 2003, 2005, 2008), indicating a notable contribution from this group rather than a broader national trend. Europe also features prominently, with contributions from Ireland (Deady & McCarthy, 2010), Sweden (Lützén et al, 2010), Norway (Jansen et al, 2020, 2022), England (Hemmington, 2023), and Italy (Delfrate et al, 2018). Additionally, research from the Middle East (Hamaideh, 2014; Tavakol et al, 2022), Asia (Ando & Kawano, 2016;

Ohnishi, 2010), South America (Bruggmann et al, 2023), and Cyprus (Christodoulou-Fella & Middleton, 2017) reflects an increasing global recognition of the issue. However, disparities in representation remain, as certain regions, particularly Africa, are underrepresented in the literature.

1.8.3.2 Populations Studied

The studies investigate moral distress across various mental health professional groups. Psychiatric nurses are the most frequently studied population, appearing in nine studies (e.g, Deady & McCarthy, 2010; Jansen et al, 2020). Other mental health professionals, including psychologists (Austin et al, 2005), psychiatrists (Austin et al, 2008), and approved mental health professionals (Hemmington, 2023), are examined but underrepresented in the literature. Sample sizes vary significantly, ranging from small, qualitative cohorts (e.g, Hemmington, 2023, with four participants) to larger quantitative studies, such as Ohnishi (2010), with 264 psychiatric nurses. This range in participant demographics provides a broad perspective on moral distress but also suggests a need for standardised population sampling in future research.

1.8.3.3 Research Methods

Qualitative approaches dominate the literature, with hermeneutic phenomenology being a popular choice (Austin et al, 2003, 2005, 2008). Thematic analysis is another common method, as seen from Jansen et al. (2020, 2022) and Tavakol et al. (2022). Quantitative designs, including cross-sectional surveys (e.g, Bruggmann et al, 2023; Hamaideh, 2014) and correlational analyses (e.g, Delfrate et al, 2018; Lützén et al, 2010), account for a smaller proportion. Mixed-method studies, such as Ando and Kawano (2016), provide a comprehensive understanding by combining qualitative insights with quantitative

rigor. This methodological variety underscores the complexity of moral distress and the necessity for multidisciplinary research approaches.

Table 1

Summary of locations, populations, and research methods in studies selected.

Aspect	Count	Percentage (%)
Geographic Distribution		
Canada	3	18.75%
Norway	3	18.75%
Japan	2	12.5%
Sweden	1	6.25%
Jordan	1	6.25%
Cyprus	1	6.25%
Italy	1	6.25%
Iran	1	6.25%
Ireland	1	6.25%
Brazil	1	6.25%
England	1	6.25%
Population Sample		
Mental Health Nurses	8	50%
Mixed Psychiatric Nurses	4	25%
Psychologists	1	6.25%
Psychiatrists	1	6.25%
Psychiatric Professionals	1	6.25%
AMHPs	1	6.25%

Research Methods		
Qualitative	10	68.75%
Quantitative	6	37.5%

1.8.3.4 Aims and significant findings

Across the studies, recurring themes emerge amongst the aims and findings of each study. This allowed the analysis to group studies together aligned by their common aims and findings. It should be noted that some of these studies belong to more than one group, highlighting the multifaceted nature of moral distress and the interplay between individual and systemic factors. Table 2 presents a detailed summary of the studies, organised according to their respective aims and findings.

Table 2

Summary of studies on moral distress in mental health professionals, grouped by aims.

Study	Moral Distress Sources	Psychological Impact	Organisational & Environmental Factors	Coping Mechanisms & Responses
Austin et al. (2003)	•			
Austin et al. (2005)	•			
Austin et al. (2008)	•			
Deady & McCarthy (2010)	•			
Ohnishi et al. (2010)			•	
Lützen et al. (2010)			•	
Ando & Kawano (2016)				•
Hamaideh (2014)		•		
Christodoulou-Fella & Middleton (2017)		•		
Delfrate et al. (2018)		•		
Jansen et al. (2020)	•			
Jansen et al. (2022)				•
Jansen et al. (2022)			•	
Tavakol et al. (2022)			•	
Hemmington (2023)				•
Bruggmann et al. (2023)			•	

Firstly, a group of studies emerged that aimed to explore the sources of moral distress among mental health professionals, using predominantly qualitative methods like semi-structured interviews (Austin et al, 2003, 2005, 2008; Jansen et al, 2020). Studies consistently identify systemic barriers and ethical dilemmas as root causes of moral distress among mental health professionals. Common systemic issues include resource shortages, such as inadequate staffing, insufficient funding, and limited access to necessary tools, which leave professionals unable to provide the quality of care they value and lead to feelings of helplessness and frustration (Austin et al, 2003; Jansen et al, 2022). Role conflicts further exacerbate distress, as professionals, including psychiatrists and psychologists, struggle to reconcile their values with institutional demands, such as balancing patient care with public safety (Austin et al, 2005, 2008). Additionally, ethical dilemmas are particularly pronounced in acute psychiatric settings, where professionals face conflicts between minimising coercion and ensuring safety, creating moral ambiguity and unease (Jansen et al, 2020).

A second group of studies aimed to assess the psychological impact of moral distress, through quantitative cross-sectional surveys, often using well established scales. This research linked moral distress to burnout, emotional exhaustion, and secondary traumatic stress. Quantitative research, such as Hamaideh (2014) and Delfrate et al. (2018), demonstrates moderate positive correlations between moral distress and burnout, with predictors including income level, caseload, and experience, though job satisfaction showed little correlation. Christodoulou-Fella and Middleton (2017) further associate unresolved moral distress with secondary traumatic stress symptoms, including anxiety, guilt, and mental fatigue. These findings underscore the emotional impact of recurring ethical challenges and the perceived lack of organisational support.

A third group emerged in which the research aimed to explore the impact of organisational and environmental factors on moral distress, this group employed a mixture of method's to achieve this such as cross-sectional surveys and category analyses (Lützén et al. (2010); Ohnishi et al, 2010; Tavakol et al, 2022). The research highlights that organisational barriers, such as inadequate staffing, poor communication, and bureaucratic policies, exacerbate moral distress. Conversely, supportive work environments, characterised by ethical leadership, open communication, and team support, can mitigate distress and enhance coping. Key findings emphasise that the workplace's moral climate plays a crucial role in either alleviating or intensifying moral distress.

A fourth group of research focused on coping mechanisms and responses to moral distress, primarily using qualitative designs. Jansen et al. (2022), Ando and Kawano (2016), and Hemmington (2023) explored how mental health professionals manage moral distress. Findings reveal that proactive strategies, such as consulting colleagues, seeking leadership support, and engaging in ethical reflection, are effective in mitigating distress. In contrast, emotionally avoidant strategies—where professionals detach from their work—can provide short-term relief but negatively impact long-term job satisfaction and patient care. Organisational culture and team dynamics play a significant role in determining the availability and effectiveness of these coping strategies. The studies primarily utilise qualitative interviews, with Hemmington (2023) incorporating ethnographic analysis of Mental Health Act assessments.

1.8.5 Critical appraisal of the literature

1.8.5.1 Quality of Qualitative Evidence

The qualitative literature on moral distress in mental health professionals primarily employs hermeneutic phenomenology, thematic analysis, and ethnographic approaches to explore the lived experiences of nurses, psychologists, psychiatrists, and Approved Mental Health Professionals (AMHPs). These methodologies are well-suited for capturing complex ethical dilemmas and systemic constraints influencing moral distress. However, the quality of these studies varies significantly in terms of methodological transparency, data collection rigour, and analytical depth.

Several studies (Austin et al, 2003, 2005, 2008) apply hermeneutic phenomenology, an appropriate approach for understanding subjective experiences of moral distress. However, these studies often lack detailed methodological reporting, particularly regarding sample size, participant selection, and data saturation. Thematic development is described, but the process of coding and theme identification remains unclear, limiting the reliability and validity of findings. In contrast, Jansen et al. (2020, 2022) and Tavakol et al. (2022) demonstrate greater methodological rigour by employing Braun and Clarke's thematic analysis and conventional content analysis, respectively, ensuring a structured and transparent approach to coding and theme development.

Data collection methods vary in adequacy. Many studies rely on semi-structured interviews (Deady & McCarthy, 2010; Jansen et al, 2020, 2022; Tavakol et al, 2022), allowing for rich, personal narratives. However, sample sizes varied considerably, with some studies including small samples (e.g, Deady & McCarthy, 2010; n= 8), which limits generalisability. Across all studies, it was unclear how representative the samples were —

particularly as self selection bias, may mean the most distressed individuals might not have participated at all. In contrast, Hemmington (2023) adopts a longitudinal ethnographic approach, combining field observations, semi-structured interviews, and recorded Mental Health Act assessments, providing deep contextual insights into AMHPs' moral distress.

Overall, the qualitative evidence on moral distress in mental health professionals is of mixed quality. High-quality studies (Jansen et al, 2020, 2022; Tavakol et al, 2022) employ multiple validation techniques, such as peer debriefing, member checking, and expert consultations, strengthening their credibility. In contrast, studies like Austin et al. (2003, 2005, 2008) do not explicitly discuss validation procedures, making their findings less methodologically robust. Future research should prioritise larger, more representative samples, clearer reporting of analytical methods, and enhanced validation techniques to strengthen the evidence base. Table 3 presents a comprehensive and detailed evaluation of the quality of qualitative studies on moral distress within mental health professions.

Table 3

Evaluation of the quality of qualitative studies on moral distress within mental health professions.

Study	Study Type	1.1 Qualitative approach appropriate?	1.2 Data collection adequate?	1.3 Findings derived from data?	1.4 Interpretation substantiated?	1.5 Coherence between sources, collection, analysis, and interpretation?	Overall Quality Summary
Austin, Bergum & Goldberg (2003)	Qualitative	Yes. Uses hermeneutic phenomenology to explore mental health nurses' lived experiences of moral distress.	Partially. Interviews conducted but lacks details on sample size, structure, or participant selection.	Partially. Identifies themes of systemic constraints but lacks clarity on theme development.	Yes. Includes direct quotes but does not explain coding or validation.	Partially. Themes align with research focus but methodological transparency is limited.	Provides valuable insights but lacks transparency in methodology, reducing reliability.
Austin et al. (2005)	Qualitative	Yes. Uses hermeneutic phenomenology to explore psychologists' moral distress.	Yes, but vague details. States psychologists were interviewed but does not specify sample size, structure, or data saturation.	Partially. Identifies themes (e.g, team conflicts, institutional demands) but lacks detail on how themes were derived.	Yes. Includes participant quotes but does not fully explain the analytical process.	Partially. Maintains consistency between focus, collection, and findings, but weak methodological transparency reduces reliability.	Provides useful insights into psychologists' moral distress but lacks methodological clarity.
Austin et al. (2008)	Qualitative	Yes. Uses hermeneutic phenomenology to explore psychiatrists' moral distress.	Yes, but lacks details. One-on-one interviews were conducted but sample size, structure, and	Partially. Identifies themes like patient safety vs. public safety	Yes, with limitations. Includes quotes but lacks explicit theme	Partially. Aligns with phenomenological approach but lacks transparency.	Provides insights into psychiatrists' moral distress but missing methodological

			saturation are unclear.	tensions but does not detail the coding process.	derivation explanation.		details limit credibility.
Deady & McCarthy (2010)	Qualitative	Yes. Uses a qualitative descriptive approach appropriate for early-stage research.	Yes. Semi-structured interviews asking participants to describe distress and coping, following Pope & Mays (2000).	Yes. Analysis follows a rigorous process, including external consultation.	Yes. Uses numerous quotes to support themes.	Yes. Clear flow between research questions, data sources, methods, and analysis.	High-quality study with clear methodology, but a small sample size limits generalisability.
Ando & Kawano (2016)	Qualitative	Yes. Uses qualitative analysis to explore psychiatric nurses' responses to ethical dilemmas.	Yes. Open-ended written responses allow subjective experiences, though richer data could come from interviews.	Yes. Identifies seven themes through qualitative content analysis.	Yes. Provides detailed descriptions and quotes but lacks deeper exploration of underlying factors.	Yes. Strong coherence between data collection, analysis, and interpretation.	High-quality study but would benefit from richer data collection methods.
Jansen et al. (2020)	Qualitative	Yes. Uses in-depth interviews to explore moral distress in acute psychiatric nurses.	Yes. Conducted 16 interviews with rigorous thematic analysis.	Yes. Identifies key themes (coercion, resource constraints, violence exposure) with strong data support.	Yes. Provides participant quotations ensuring themes are well-grounded.	Yes. Strong methodological coherence from collection to analysis.	High-quality study with strong methodological rigour and well-supported interpretations.

Jansen et al. (2022)	Qualitative	Yes. Explores nurses' coping mechanisms for moral distress in psychiatric settings.	Yes. Uses 16 interviews and 3 focus groups, strengthening reliability.	Yes. Identifies three coping themes, supported by participant quotes.	Yes. Integrates narratives with theoretical concepts like moral resilience.	Yes. Coherent structure aligning research question, data, and findings.	Well-executed study, though deeper exploration of psychological coping mechanisms would enhance findings.
Jansen et al (2022)	Qualitative	Yes. The study uses content analysis to explore how cultural and political ideals cause moral distress in acute psychiatry, which is appropriate for an exploratory and interpretive research aim.	Yes. Data were collected via semi – structured interviews with 12 multidisciplinary staff from acute psychiatric wards, a method well-suited for capturing rich, in-depth experiences of moral distress. Interviews were audio-recorded and transcribed verbatim.	Yes. The analysis followed Braun and Clarke's thematic approach. Themes were clearly identified and grounded in the data through direct participant quotations, suggesting systematic derivation.	Yes. Interpretations are supported with ample quotations and contextual explanations, clearly linking participant narratives to the study's key themes (e.g, individualism, efficiency ideals).	Yes. There is strong alignment between the research questions, interview content and findings. The methods and interpretation are consistent and clearly described.	High quality. This study demonstrates strong coherence and rigor in its use of qualitative methodology. The design, data collection, and interpretation are well-aligned and adequately justified, producing credible insights into moral distress in acute psychiatry.
Tavakol et al. (2022)	Qualitative	Yes. Uses content analysis to explore moral distress in Iranian	Yes. Semi-structured interviews (n=12), purposive sampling, and	Yes. Identifies seven categories and 20	Yes. Uses extensive quotations, peer debriefing, and	Yes. Strong coherence between objectives, methods, and analysis.	High methodological rigour, providing strong insights into moral

		psychiatric nurses.	data saturation ensured.	subcategories of distress.	member checking to validate findings.		distress in an Iranian context.
Hemmington (2023)	Qualitative	Yes. Uses ethnographic methods to explore AMHPs' moral distress.	Yes. Combines interviews, field observations, and recorded Mental Health Act assessments.	Yes. Identifies themes of identity crisis, systemic constraints, and political aspects of AMHP work.	Yes. Substantiated with extensive participant narratives and theoretical integration.	Yes. Strong coherence between sources, collection, and interpretation.	High-quality ethnographic study providing in-depth insights into AMHPs' moral distress.

1.8.5.2 Quality of Quantitative Non-Randomised Evidence

The quantitative non-randomised studies on moral distress in mental health professionals focus on assessing prevalence, intensity, and correlates of moral distress using validated psychometric scales. While these studies provide valuable empirical data, their quality varies based on sampling representativeness, confounder control, and completeness of outcome data.

Several studies have reported strong internal consistency for the measures used to assess moral distress and related constructs. Ohnishi et al. (2010) found that the internal consistency of their instrument, as measured by Cronbach's alpha, was greater than 0.70. Similarly, Hamaideh (2014) reported an internal consistency reliability of 0.89 for the whole scale. Christodoulou-Fella and Middleton (2017) demonstrated good internal consistency, with Cronbach's alpha coefficients of 0.893 for the moral distress frequency scale and 0.941 for the level of distress scale. Delfrate et al. (2018) also reported excellent psychometric properties, with the revised scale achieving a content validity index (CVI) of 0.89 and a Cronbach's alpha of 0.93. These findings suggest that the tools employed, such as the Moral Distress Scale (MDS), Maslach Burnout Inventory (MBI), and Secondary Traumatic Stress Scale (STSS), demonstrate robust measurement reliability across different studies. However, sample representativeness is a key limitation. Many studies rely on convenience sampling (Bruggmann et al, 2023; Hamaideh, 2014; Ohnishi et al, 2010), which limits generalisability to broader mental health professional populations. Additionally, some studies have small sample sizes (e.g, Lützén et al, 2010, n=49), further reducing statistical power and external validity.

Completion rates vary across studies, and it can be challenging to obtain large datasets. This is likely due to the length and complexity of some measures, which often incorporate multiple dimensions and may lead to participant fatigue, boredom, and subsequent dropout. Studies such as Delfrate et al. (2018) have achieved high response rates (80%), ensuring sufficient data for robust analysis. In contrast, others, such as Christodoulou-Fella and Middleton (2017), reported a lower response rate (57.2%), increasing the risk of non-response, and self-selection bias and potentially limiting the validity of conclusions drawn about the sample. Studies typically statistically control for some demographic factors, such as age, gender, education, and clinical setting (Delfrate et al, 2018; Hamaideh, 2014), which could limit conclusions that can be drawn regarding moral distress and its correlates, particularly regarding social and demographic factors.

Despite these limitations, the studies provide useful observational data on moral distress in psychiatric settings, with some exhibiting moderate to high methodological quality due to validated instruments and strong response rates (Delfrate et al, 2018; Ohnishi et al, 2010). However, future research should consider probability sampling, larger sample sizes, and more robust confounder adjustments to enhance the reliability and generalisability of findings. Table 4 presents a comprehensive and detailed evaluation of the quality of quantitative non-randomised studies on moral distress within mental health professions.

Table 4

Evaluation of the quality of quantitative non-randomised studies on moral distress within mental health professions.

Study	Study Type	3.1 Representative sample?	3.2 Appropriate measurements?	3.3 Complete outcome data?	3.4 Confounders accounted for?	3.5 Exposure occurred as intended?	Overall Quality Summary
Ohnishi et al. (2010)	Quantitative	Partially. 391 psychiatric nurses from six Japanese hospitals, but convenience sampling limits generalisability.	Yes. Uses validated MDS for Psychiatric Nurses (MDS-P) and MBI-GS.	Mostly. 73.9% response rate, with 91.3% of responses used for analysis.	Partially. Controls for gender, hospital type, and experience, but lacks advanced confounder control.	Yes. Observational study measuring naturally occurring moral distress.	Moderate-quality study with validated tools but limited confounder control.
Lützén et al. (2010)	Quantitative	Underpowered. Small sample (n=49) from Swedish mental health nurses, limits representativeness.	Yes. Uses validated HECS, MSQ, and WRMS scales.	Unclear. 49/100 surveys returned, but missing data not reported.	Partially. Some demographic controls, but no advanced statistical adjustments.	Yes. Measured natural workplace moral stress.	Low to moderate quality due to small sample and unclear data completion.
Hamiadeh (2014)	Quantitative	No. Convenience sample (n=130) from a single psychiatric hospital, which limits generalizability to broader MHN	Yes. Used validated instruments: Moral Distress Scale for Psychiatric Nurses (MDS-	No indication of missing data.	No. Multivariable regression identified predictors of moral distress (burnout,	Yes. As a self-reported survey with no intervention, the measurement	Moderate quality - Despite strong analysis and validated measures, the single-site convenience

		population in Jordan	P), Maslach Burnout Inventory, and Job Satisfaction Scale		education, income, caseloads), indicating adjustment for confounders.	was applied consistently.	sample limits generalisability.
Christodoulou-Fella & Middleton (2017)	Quantitative	Yes. The study targeted all mental health nurses (MHNs) in Cyprus's public sector (N=360), with clear inclusion/exclusion criteria and a response rate of 57.2% (n=206)	Yes. Validated instruments were used: a modified Moral Distress Scale (MDS), Secondary Traumatic Stress Scale (STSS), GHQ-28 for mental distress, and Jefferson Empathy Scale	Yes. Out of 360 eligible nurses, 206 completed the survey. A 57.2% response rate is within acceptable thresholds for survey research, and analysis included only complete responses.	Yes. The analysis controlled for gender, age, education, rank, and intention to quit. Mediation analyses were also conducted	Yes. As a cross-sectional survey with self-reported exposure and outcome, no deviations in exposure were possible. Instruments were applied uniformly	High quality. The study used representative sampling, validated measures, accounted for confounders, and had complete data, ensuring strong methodological rigor.
Delfrate et al. (2018)	Quantitative	Partially. Four hospitals in Milan, but limited regional generalisability.	Yes. Uses validated MDS-PItarev and MBI scales.	Mostly. 80% response rate, with some missing burnout scale data.	Partially. Controls for age, gender, experience, but lacks advanced statistical methods.	Yes. Observational study.	Moderate to high quality with validated tools and strong response rate but partial confounder control.
Bruggmann et al. (2023)	Quantitative	Yes. Sample (n=173) drawn	Yes. The study used the	Yes, All 173 participants	No. Although the study	Yes. Exposure (moral distress)	Moderate quality. The

	from 12,294 potential MHNs across Brazil's Psychosocial Care Network using quota sampling for regional representation	EDME-Br-SM, a validated scale adapted for mental health settings, with reported psychometric validation processes including CVI and expert review	completed the online questionnaire. No mention of missing data or dropouts	presents stratified analysis by demographic variables, there is no use of multivariable adjustment or control for confounders in analysis	was assessed via a validated online tool with fixed administration; no indication of unplanned changes in exposure	study used validated tools and had broad geographic coverage, but lacked control for confounders, limiting internal validity.

1.8.6 Organisational framework

When collating, summarising, and reporting results, Arksey and O'Malley (2005) suggest organising the literature in a thematic framework. As part of the review's aims, and in light of the existing conceptual ambiguity and associated research challenges surrounding moral distress, the organisational framework sought to clarify the definitional boundaries of moral distress within the research literature. The definition given and methods used to measure moral distress became a central lens through which each study was reviewed.

Moral distress has been conceptualised in varying ways across the literature on psychiatric and mental health professionals. The definitions provided in the research can be categorised into three main perspectives: (1) moral distress as psychological or emotional discomfort, (2) moral distress as a conflict between ethical awareness and external constraints, and (3) moral distress as a result of systemic or cultural factors. Table 5 presents a comprehensive summary of the definitions and measurement approaches employed in each study.

Table 5

Summary of definitions and measures approaches in each study.

Study	Definition of Moral Distress	Measures Used
Austin et al. (2003)	Knowing the morally right action but being unable to act due to constraints.	Semi-structured interviews
Austin et al. (2005)	Psychological discomfort when unable to act ethically.	Semi-structured interviews
Austin et al. (2008)	Distress from thwarted moral choices and actions.	Semi-structured interviews
Deady & McCarthy (2010)	Being seriously compromised as a moral agent.	Semi-structured interviews
Ohnishi et al. (2010)	Feeling constrained from acting ethically due to barriers.	Moral Distress Scale (MDS) (Japanese version)
Lützen et al. (2010)	"Moral stress" from being unable to act morally.	Moral Sensitivity Questionnaire &

		Perceived Moral Distress Scale
Ando & Kawano (2016)	Psychological discomfort when unable to act ethically.	Semi-structured interviews
Hamaideh (2014)	Psychological disequilibrium when unable to act ethically.	Moral Distress Scale (MDS)
Christodoulou-Fella & Middleton (2017)	Psychological distress due to institutional constraints.	Moral Distress Scale-Revised (MDS-R)
Delfrate et al. (2018)	Constraints preventing ethical actions, leading to distress.	Moral Distress Scale-Revised (MDS-R) & Maslach Burnout Inventory
Jansen et al. (2020)	Emotional and psychological discomfort from external constraints.	Semi-structured interviews
Jansen et al. (2022)	Internal struggle when prevented from acting ethically.	Semi-structured interviews

Jansen et al. (2022)	Moral distress shaped by cultural/political influences.	Semi-structured interviews
Tavakol et al. (2022)	Emotional suffering from external limitations on ethical actions.	Semi-structured interviews
Hemmington (2023)	Ethical conflicts due to systemic pressures.	Semi-structured interviews, ethnographic component
Bruggmann et al. (2023)	Psychological discomfort in response to ethical dilemmas.	Moral Distress Scale-Revised (MDS-R)

The first perspective defines moral distress as a psychological discomfort, emotional suffering, or internal struggle arising when professionals are unable to act according to their moral values due to external barriers. Austin et al. (2003, 2005, 2008) describe moral distress as the emotional turmoil that results from being unable to perform what is perceived as the ethically appropriate action. Other researchers, including Deady and McCarthy. (2010) and Ando and Kawano. (2016), similarly characterise moral distress as the experience of being morally compromised, leading to distress and psychological disequilibrium. More recent studies (Jansen, et al, 2020; Tavakol et al, 2022) reinforce this interpretation by highlighting how psychiatric professionals experience moral distress as an internal ethical conflict and its resultant psychological distress. Studies that conceptualise moral distress in this manner consistently employ qualitative methods, such as semi-structured interviews, to capture the experience.

The second perspective frames moral distress as a cognitive and ethical dissonance between recognising the right course of action and being unable to execute it due to professional, legal, or institutional constraints. Authors Ohnishi et al. (2010) and Hamaideh. (2014) argue that moral distress emerges when psychiatric professionals perceive an ethical obligation yet face workplace or Blom systemic pressures that prevent action. In this conceptualisation of moral distress, the link between the distress and constraint is the defining feature. Similarly, Lützén et al. (2010) conceptualise moral distress as a function of "moral stress," wherein professionals are acutely aware of ethical challenges but lack the autonomy or resources to address them. This conflict-based perspective is also evident in Christodoulou-Fella and Middletons. (2017) work, which fames moral distress as resultant from systemic constraints that inhibit ethical decision-making. Studies emphasising the cognitive conflict aspect of moral distress often employ quantitative methods, utilising tools

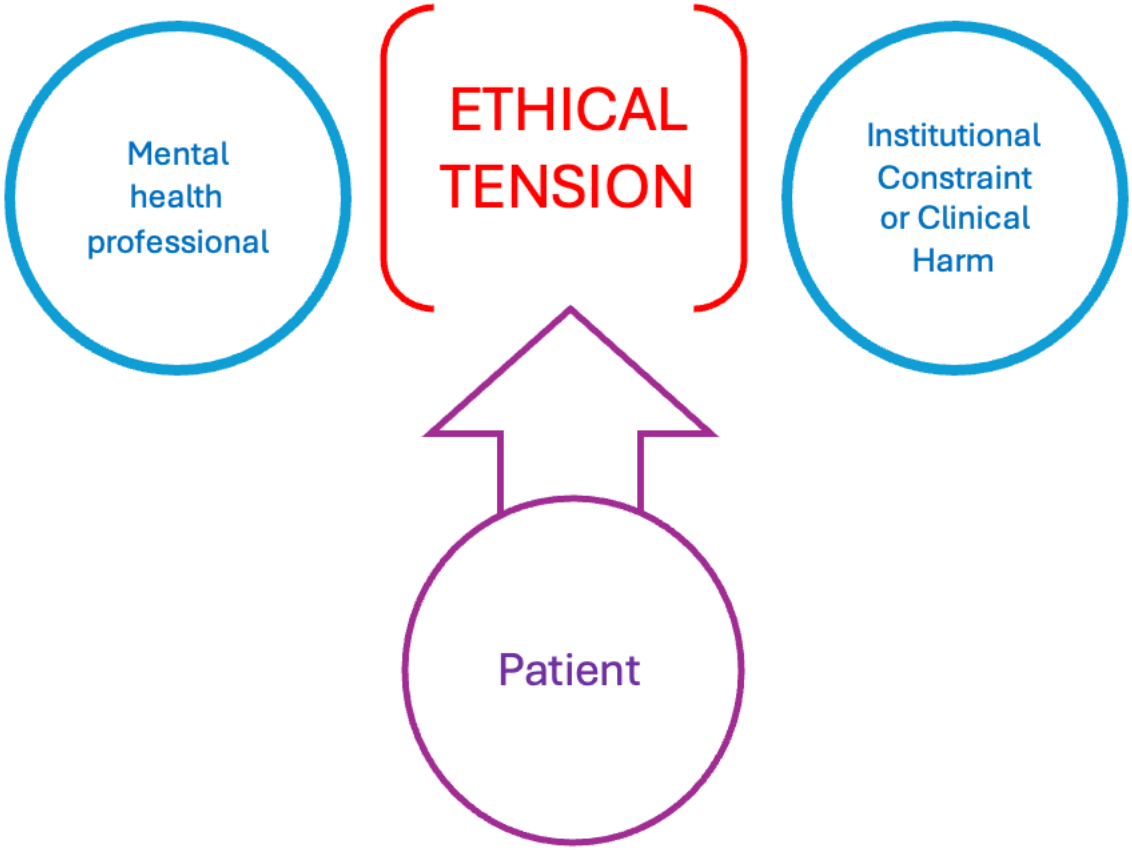
such as the Moral Distress Scale-Revised (MDS-R), the Moral Sensitivity Questionnaire (MSQ), and the Perceived Moral Distress Scale (PMDS) to measure it.

A third perspective emphasises the role of systemic, political, and cultural factors in shaping moral distress. Rather than viewing moral distress solely as an individual emotional response or cognitive conflict, researchers such as Jansen et al. (2022) argue that broader cultural and political influences dictate the ethical dilemmas faced by psychiatric professionals and the features of the distress that follows. Similarly, Tavakol et al. (2022) suggest that moral distress is embedded within structural conditions, such as power imbalances, policy restrictions, and cultural norms, which shape ethical tensions in clinical practice. These researchers primarily employ qualitative methods to assess their definitions of moral distress, with Hemmington. (2023) incorporating an ethnographic approach to provide deeper insight into the lived experience of this phenomenon at an organisational level.

These diverse conceptualisations informed the development of a tentative model for defining moral distress (Figure 2.). It is evident from this review that constraints giving rise to individual distress, as well as the tension between them, are key defining features of moral distress, aligning with Morley's (2017) conceptualisation. In response to criticism regarding what renders such distress inherently ethical (Musto & Rodney, 2018), I introduce an additional component to the definition: the patient. This inclusion seems intuitive, given the inherently ethical nature of healthcare practice (Austin, 2007), I argue here that the patient serves as the driving force of the ethical component because they evoke the humanistic values healthcare professionals are trained in. However, it does restrict the applicability of the definition to healthcare professions, a limitation that is appropriately acknowledged in the title.

Figure 2.

A Model for Defining Moral Distress in Mental health professionals.



This definition illustrates that moral distress in psychiatric and mental health care is a multifaceted and complex phenomenon, emerging in the complex interplay between individual experiences and systemic structures. While some researchers focus on the emotional and psychological toll of moral distress, others highlight the institutional and cultural constraints that shape ethical dilemmas in mental health care settings. Understanding these diverse perspectives is crucial for advancing research initiatives and developing interventions that effectively address both the individual and structural dimensions of moral distress in mental health settings.

1.8.7 Research opportunities

While the existing literature offers a valuable foundation for understanding moral distress within mental health settings, significant theoretical and empirical gaps remain. To

date, most research has concentrated on qualitative explorations of the experience and sources of moral distress among mental health nurses, particularly in high-income countries such as Canada, Norway, Japan, and various parts of Europe. These studies often emphasise subjective accounts of ethical challenges, emotional responses, and coping mechanisms, with a smaller number of quantitative studies examining associations between moral distress and variables such as burnout, job satisfaction, and intent to leave (e.g, Bruggmann et al, 2023; Delfrate et al, 2018; Hamaideh, 2014). Nurses remain the most frequently studied professional group, with relatively fewer studies focused on psychologists, psychiatrists, or other mental health professionals.

One notable omission in the moral distress literature is the role of Self-Determination Theory **(**Ryan, and Deci, 2000**)**, which posits that the fulfilment of basic psychological needs—autonomy, competence, and relatedness—is critical to wellbeing and job satisfaction. Within the ethically complex and often resource-constrained environments described in qualitative accounts of moral distress (e.g, Jansen et al, 2020; Tavakol et al, 2022), these needs may be systematically undermined. A theoretical lens grounded in SDT could help explain how organisational climates contribute to or mitigate the experience of moral distress, and whether the frustration of these needs mediates its impact on wellbeing and retention.

Similarly, the constructs of personal values and value congruence offer fruitful avenues for further investigation. Arieli et al. (2020) highlight the influence of individual values on behaviour and affect at work, while Edwards and Cable (2009) demonstrate that alignment between personal and organisational values predicts job satisfaction, organisational commitment, and reduced turnover. It is plausible that value incongruence contributes to, or compounds, the distress experienced by professionals who are repeatedly asked to act against

deeply held principles. Yet to date, such variables remain largely unexplored in empirical research on moral distress within mental health professions.

Another important conceptual development relates to the distinction between moral distress and moral injury. While both constructs describe psychological harm in response to ethical conflict, moral injury extends beyond the constraints of action that characterise moral distress, encompassing deeper existential themes such as betrayal, shame, and violations of core moral identity. Research in military contexts suggests that moral injury may be a distinct or more enduring and severe form of ethical suffering (Zasiekina et al, 2023). Exploring whether moral injury explains additional variance in outcomes such as job satisfaction or psychological stress, over and above moral distress, could offer new insights into how professionals internalise and are affected by moral adversity. It may also clarify the conceptual boundaries between these two frameworks, providing a richer understanding of ethically driven occupational distress.

In summary, although moral distress research in mental health settings has grown in recent years, its theoretical scope remains relatively narrow. Incorporating variables from broader organisational and psychological research may offer a more comprehensive account of how professionals experience and respond to ethical challenges.

1.8.8 Conclusion

This scoping review highlights the breadth and complexity of moral distress among mental health professionals, identifying key themes, methodological approaches, and gaps in the literature. The findings indicate that moral distress is defined by the systemic context it arises within, individual distress it evokes and the tension between the two. The research is

predominantly qualitative, with few quantitative studies, and no large-scale studies identified in the review. Psychiatric nurses are over-represented compared to other mental health professionals. Geographically, high-income countries dominate the literature, with underrepresentation from lower-income regions. Despite increasing recognition of moral distress in mental health settings, inconsistencies in definitions and measurement approaches persist. Future research should prioritise standardised assessment tools, explore underrepresented professional groups and regions, and examine organisational strategies to mitigate distress.

1.9. Rationale, aims & research questions.

This thesis focuses on moral distress rather than broader constructs in occupational health, in order to explicitly capture the ethical tensions and dissonance that underpin the psychological challenges faced by clinical psychologists.

Despite growing recognition of the impact of systemic and organisational factors on practitioner wellbeing, there remains a notable lack of empirical, quantitative research specifically addressing moral distress within UK mental health services. While the concept of moral distress has been explored in nursing and medical literature internationally, and has gained increasing traction in psychological discourse, the UK evidence base (particularly within Clinical Psychology) remains underdeveloped. Existing studies have largely focused on qualitative insights or have originated from international contexts with different healthcare structures, such as the US. Consequently, there is limited understanding of the prevalence, frequency, and psychological consequences of moral distress within the specific operational and ethical landscapes of UK mental health services.

This gap is particularly salient in the context of escalating pressures within the NHS, including workforce shortages, high service demand, and policy-driven changes under austerity. These systemic constraints often place Clinical Psychologists in ethically compromising positions, where they may be unable to practise in accordance with their professional values, thereby fostering conditions for moral distress. Yet, the lack of robust, quantitative data makes it difficult to substantiate these concerns, identify affected groups, or plan interventions.

The present research is directly relevant to the discipline of Clinical Psychology. By quantitatively examining the frequency and impact of moral distress among Clinical Psychologists and trainees working in the UK, this study addresses a clear gap in the literature and contributes to a developing field. Understanding how moral distress interacts with workplace factors such as job satisfaction, psychological stress, and intent to leave the profession has crucial implications for workforce retention, service sustainability, and the quality of client care. The study also aligns with the profession's ethical imperatives to promote practitioner wellbeing, uphold standards of care, and advocate for systems-level change.

To date, no quantitative research has explored the relationship between moral distress, job satisfaction, stress, and turnover intentions among UK Clinical Psychologists. While qualitative studies have begun to examine moral distress in UK contexts—for example, research with British Approved Mental Health Professionals (AMHPs; Hemmington, 2023) and doctoral work with Clinical Psychologists (Spriggings, 2021)—quantitative evidence remains absent. Existing quantitative studies on moral distress in mental health settings have focused predominantly on psychiatric or mental health nurses in countries such as Canada

(Austin et al, 2003), Japan (Ohnishi et al, 2010), Jordan (Hamaideh, 2014), Italy (Delfrate et al, 2018), and Brazil (Bruggmann et al, 2023). Although some of these studies have examined related outcomes, including burnout (e.g, Delfrate et al, 2018; Hamaideh, 2014; Ohnishi et al, 2010) and job satisfaction (Hamaideh, 2014), none has investigated this combination of variables within the UK Clinical Psychology workforce. The present study therefore offers a novel quantitative investigation of moral distress, job satisfaction, stress, and intent to leave among 200 Clinical Psychologists working in the UK.

Aims of the Current Research

The overarching aim of this study is to address the empirical gap by examining moral distress in Clinical Psychology within a UK context using quantitative methodology. Specifically, the study seeks to explore moral distress and its associations with job satisfaction, psychological stress, and intentions to leave the profession. It also aims to identify whether certain demographic or professional variables (e.g, age, gender, role) are linked to differing experiences of moral distress.

Research Questions

1. What are the relationships between moral distress, job satisfaction, perceived stress, and intent to leave the profession?

2. Do demographic or role-related factors (e.g, age, gender, qualification status) influence the levels or impact of moral distress?

Hypotheses

Drawing on theoretical frameworks of moral distress (Morley, et al 2017), guided by the literature review and empirical findings, the following hypotheses were proposed:

H1: Higher levels of moral distress will be associated with lower job satisfaction.

H2: Higher levels of moral distress will be associated with higher levels of perceived psychological stress.

H3: Higher levels of moral distress will be associated with stronger intentions to leave the profession.

These hypotheses reflect established links between moral distress and practitioner wellbeing outcomes observed in other healthcare disciplines and aim to test whether similar patterns exist within UK Clinical Psychology.

Chapter 2. Methodology

This methodology chapter outlines the research design, methods, and ethical considerations for investigating the impact of moral distress on Clinical Psychologists, focusing on its relationship to job satisfaction, stress, and intent to leave. It justifies the use of a quantitative approach to generate generalisable data for evidence-based interventions. The epistemological framework adopts a pragmatist stance, balancing practical utility with theoretical depth, while personal reflexivity is acknowledged to minimise bias. The chapter also details the research design, data collection, and analysis methods, and addresses ethical considerations. Finally, it outlines the strategy for disseminating the findings within academic and professional communities.

2.1 Justification of methods, epistemological framework and personal reflexivity

2.1.1 Justification of methods

The scoping review highlighted a scarcity of quantitative research on moral distress within mental health professions, particularly outside of nursing, and underscored the need for clearer measurement of its predictors and outcomes. While moral distress has been more

extensively explored through qualitative methods, there remains a shortage of generalisable data that can inform workplace interventions. In response, this study adopts a quantitative approach to systematically investigate the relationships between moral distress, job satisfaction, stress, and intent to leave among Clinical Psychologists. This design enables statistical analysis across demographic and professional variables, addressing key gaps in the evidence base and supporting the development of targeted, data-informed strategies.

A key advantage of quantitative methods is their ability to produce statistically robust findings that can inform NHS stakeholders, policy-makers, and workforce managers in typically larger samples than qualitative studies. By applying validated self-report measures, this research aims to establish prevalence rates, examine predictive relationships, and generate data-driven insights that can inform evidence-based interventions. The structured nature of quantitative data collection also ensures consistency and replicability, allowing for comparisons with existing research across different healthcare disciplines.

However, it is acknowledged that a quantitative approach has limitations. While it enhances generalisation and scalability, it may not capture the full depth of personal experiences associated with moral distress and standardised instruments may not fully account for workplace-specific complexities. Additionally, by prioritising measurable outcomes, there is a risk of focusing on short-term solutions rather than engaging with the broader theoretical underpinnings of moral distress. To mitigate these challenges, this study incorporates validated measures to ensure reliability and consistency while situating findings within the wider context of healthcare practice.

2.1.2 Epistemological Framework

Epistemology refers to the underlying belief systems that shape our understanding of reality and the ways in which knowledge is acquired. When adopting an epistemological stance, researchers make definitive claims about how knowledge is constructed, interpreted, and validated. These beliefs form the foundation of research design, influencing data collection methods, analysis strategies, and the interpretation of findings. In psychological research, two dominant epistemological positions—relativism and positivism, present distinct limitations (Paranjpe, 1993). Relativism affords equal weight to all interpretations of reality, creating challenges in evaluating the validity of findings. In contrast, positivism prioritises empirical evidence and objective measurement, often reducing complex psychological phenomena to quantifiable variables. Both perspectives, in isolation, risk oversimplifying the research process: relativism by lacking criteria for validity and positivism by failing to capture the subjective complexity of human experiences.

Given these limitations, this study adopts a pragmatist epistemological stance, which acknowledges that knowledge is dynamic, negotiated, and shaped by its practical implications. Pragmatism prioritises the function and utility of knowledge over rigid adherence to a single methodological paradigm (Morgan, 2007, Dewey, 1929).

When exploring quantitative data on moral distress within the role of clinical psychology, a pragmatist approach is particularly well-suited due to its emphasis on practical relevance and methodological flexibility. Moral distress is a complex and multifaceted construct, often defined and experienced differently across contexts, roles, and individuals. While qualitative methods provide rich, detailed accounts of moral distress, their findings often lack generalisability and empirical weight in influencing policy and workplace

interventions. By applying quantitative methods, this research aims to translate the concept of moral distress into actionable insights, enabling healthcare organisations to assess risk factors, monitor workforce well-being, and improve evidence-based interventions.

Pragmatism enables researchers to utilise structured, empirical data without being constrained by the need for a universally agreed-upon definition of moral distress. Instead, it encourages a focus on how moral distress is operationalised in practice—such as through standardised scales or frequency measures—and how it manifests within the day-to-day experiences of clinical psychologists. This allows for the quantification of distress-related variables (e.g, *MD Frequency, MD level of distress*, impact on job satisfaction, stress or intent to leave) while remaining sensitive to the contextual and subjective nuances that may influence these responses.

Moreover, by adopting a pragmatist lens, the research can prioritise actionable insights that are meaningful for practitioners, services, and policymakers. For example, identifying statistically significant predictors of distress may inform organisational change or targeted support, even if the underlying theoretical debates about the nature of moral distress remain unresolved. In this way, pragmatism supports a research agenda that is both empirically rigorous and practically oriented, bridging the gap between numerical findings and the complex, value-laden realities of clinical psychology practice.

2.1.3 Personal Reflexivity

The researcher's background and experiences inevitably shape the research process, including the framing of questions, the interpretation of findings, and the application of results. As a queer, 30-year-old woman from the North of England who has worked in mental

health for over a decade and is currently training to be a Clinical Psychologist, I bring both lived and professional experience to this study. My understanding of the complexities of working within healthcare systems, alongside my awareness of structural and systemic barriers within the profession, informs my interest in moral distress as a critical issue for psychologists and healthcare staff.

However, as a person who has personally experienced moral distress at work, it is important to acknowledge the potential for bias in shaping the research focus, the interpretation of results, and the conclusions drawn. My professional and personal experiences may lead to assumptions about the prevalence or impact of moral distress that differ from those of participants with different experiences. To mitigate these risks, I have engaged in critical reflection and regular supervision throughout the research process, ensuring that my interpretations remain rigorously examined and grounded in the data. Additionally, maintaining a transparent and structured analytical approach—including the use of validated measures and statistical analysis—helps to minimise subjectivity and enhance the reliability of the findings.

On reflection, I recognise that my decision to adopt a quantitative design was also shaped by my developmental stage as a researcher, although this was not fully apparent to me at the time of choosing methods. In retrospect, I can see that, having personally experienced moral distress within healthcare contexts, I may have lacked the confidence and reflexive skill required to interview fellow Clinical Psychologists in a way that would fully protect the integrity of their narratives. While qualitative methodologies could have offered valuable insights and are well-suited to co-constructing meaning when researcher and participants share lived experience, I judged myself more able, at this stage, to work with the structure

and distance afforded by quantitative methods. This reduced the risk of unintentionally influencing participants' accounts and enabled me to focus on generating findings that were both rigorous and trustworthy. Although this reflection is necessarily post hoc, it highlights how methodological choices are not only epistemological but also shaped by the researcher's developmental trajectory and their sense of responsibility in representing others' experiences.

By recognising these potential influences, this study maintains a commitment to objectivity, reflexivity, and critical engagement with the data. The goal is not to validate personal experiences but to generate findings that are empirically robust, applicable to wider populations, and capable of informing real-world improvements in healthcare practice.

2.2 Participants

201 participants were recruited (M_{age} = 34.13, *SD* =9.17, range: 23 to 66 years). Full comprehensive summaries of demographic descriptive information are presented in Tables 6 and 7. Racial identity was not disclosed by 34 participants (17.3%).

Table 6

Racial Distribution of Participants.

Race	Frequency	Percentage (%)
White British	120	59.7%
White European	8	4.0%
White Irish	6	3.0%
White Other	7	3.5%
Black British	7	3.5%
Mixed	8	4.0%
Asian	7	3.5%

Hispanic/Latino	1	0.5%
Iranian	2	1.0%

Table 7

Gender Distribution of Participants.

Gender	Frequency	Percentage (%)
Woman	165	82.5%
Man	30	15%
Non-binary	4	2%
Gender fluid	1	0.5%

Participants were asked a series of questions that to clarify their current role, area of work, setting and income within the field of psychology. The majority of participants were trainee clinical psychologists (46%), which likely reflects the income distribution, with the most common bracket being £20,000–£40,000 (37.8%). Most worked in adult mental health (36.3%) and were based primarily in community settings (58.7%), consistent with typical trainee placements in UK mental health services. A comprehensive summary of the distribution of roles within the sample is provided in the following (Tables 8-11).

Table 8

Role Distribution of Participants.

Role	Frequency	Percentage (%)
Trainee Clinical Psychologist	92	46%
Clinical Psychologist	57	29%
Assistant Psychologist	21	11%
Psychotherapist	14	7%

Psychological Wellbeing Practitioner (PWP)	6	3%
Counselling Psychologist	3	2%
Clinical Associate Psychologist	1	1%
Trainee Psychological Wellbeing Practitioner	1	1%

Table 9.

Area Distribution of Participants

Area	Frequency	Percentage (%)
Adult mental health	73	36.3%
Combination of populations	49	24.4%
Specialist	36	17.9%
Children and families	19	9.5%
Older adult	12	6%
Learning disability	6	3%
Other	4	2%

Table 10.

Seting distribution of Participants

Setting	Frequency	Percentage (%)
Community settings	118	58.7%
Combination of settings	47	23.4%
Inpatient settings	20	10%
Other	10	5%

Social services	2	1%
Educational settings	2	1%

Table 11.

Income distribution

Income bracket	Frequency	Percentage (%)
<£20,000	3	1.5%
£20,000-£40,000	76	37.8%
£40,001-£60,000	46	22.9%
£60,001-£80,000	36	17.9%
£80,001-£100,000	21	10.4%
>£100,000	17	8.5%

2.2 Design

To address the research aims and objectives, a quantitative approach was adopted to examine the relationships between moral distress, job satisfaction, stress, and intent to leave among Clinical Psychologists. This study seeks to build upon prior research by applying a structured, data-driven approach to systematically assess how different dimensions of moral distress relate to key occupational outcomes.

To investigate these relationships, a cross-sectional survey design was employed. Participants completed self-report questionnaires measuring moral distress (including its frequency and level of distress), job satisfaction, stress, and intent to leave. Analyses were conducted to determine whether moral distress is a predictor of stress, job satisfaction, and intent to leave. Subscales and factor structures were incorporated into the analysis to enhance

understanding of the associations. This approach allows for an in-depth exploration of how moral distress may relate to workforce well-being and retention, helping to address key questions about whether specific sources of moral distress are more strongly linked to negative occupational outcomes.

Careful consideration was given to the sequencing of measures presented to participants. Measures of moral distress frequently position items relating to intention to leave at the end of the survey. However, following discussion and reflection with my supervisor, we agreed that this ordering could introduce a priming effect. To minimise the risk that reflecting on moral and ethical practice at work might artificially inflate intentions to leave, I made the choice to separate the constructs more distinctly. This decision was made to enhance the validity of any subsequently observed relationships. As such, participants first responded to questions concerning their intention to leave, alongside other role-related factors such as overtime, salary, and remote working, prior to completing items assessing moral distress in the workplace. This choice aimed to ensure more authentic and natural responses from the participants.

By employing validated self-report measures and statistical modelling, this study generated empirically robust findings that contribute to the understanding of moral distress in Clinical Psychology. The structured nature of the quantitative approach ensures that findings are replicable, comparable, and applicable to workforce planning within healthcare settings, including the NHS. The insights gained from this research can provide evidence-based recommendations for interventions and future research aimed at reducing the negative impact of moral distress and supporting Clinical Psychologists in maintaining their job satisfaction.

2.3 Procedure

The study employed purposive sampling to target specific groups, including clinical psychologists in training within DClinPsy programmes at British universities nationwide, assistant psychologists, and qualified psychologists. Assistant Psychologists were included due to their direct involvement in service delivery. Although not professionally qualified, they often provide one-to-one support, contribute to assessments and formulations, and are embedded within multidisciplinary teams. Their proximity to clients and daily exposure to systemic and ethical challenges render their perspectives highly relevant to the study of moral distress. The British Psychological Society (BPS, 2022) acknowledges that assistant psychologists contribute to assessment, formulation, and therapeutic work, often within ethically complex and resource-limited settings.

Recruitment was facilitated through social media advertisements, flyers (see Appendix A), and emails, which served as accessible platforms to convey the study's aims and engage potential participants. The link to the online survey was provided through these communications. Social media channels, including Facebook groups for pre-qualified and qualified clinical psychologists, and Twitter, were also utilised to extend the reach. Snowball sampling further encouraged participants to share study details within their professional and personal networks.

The software Qualtrics was used to collect the survey data. Participants were first presented with an information sheet outlining the study's purpose, potential risks, and data privacy measures. Participants indicated their consent by ticking a box on the online form before proceeding with the study.

Participants completed a series of self-report questionnaires, which included demographic questions regarding age, gender, ethnicity, and occupation, as well as questions about their role, job setting, area of work, overtime, remote working and income. After this participants were required to rate their likelihood and consideration of leaving their current role or reducing their working hours in the near future.

Additionally, they completed the MMD-HP, the Perceived Stress Scale, and the Job Satisfaction Scale. These questionnaires are designed to assess the frequency and distress levels associated with moral dilemmas in clinical practice, stress experienced over the past week, and overall job satisfaction. The expected time for completion was approximately 10 minutes.

Participants were informed of their right to withdraw from the study at any time without penalty. Any data already collected will be destroyed upon completion of the thesis.

2.4 Measures

2.4.1 Moral Distress Scale

The Moral Distress Scale (MDS) was originally developed to assess moral distress among critical care nurses (Corley et al, 2001) and has since become the most widely used measure of moral distress within the nursing profession.

To extend its applicability beyond critical care settings and across diverse healthcare disciplines, the Moral Distress Scale was revised by Hamric et al. (2012), resulting in the development of the Moral Distress Scale–Revised (MDS-R). This instrument was subsequently refined by Epstein et al. (2019), culminating in the Measure of Moral Distress

for Healthcare Professionals (MMD-HP), which offered an expanded item pool and provided a useful factor loading structure. The four-factor captures the complex, multilevel nature of moral distress in clinical settings. System-level root causes refer to organisational constraints such as inadequate staffing, limited resources, and administrative pressures that impede ethical practice. Clinical root causes at the patient level involve ethically troubling care decisions, such as administering non-beneficial treatment or withholding information from patients. Team-level root causes are divided into two subcategories: compromises to integrity, including bullying, fear of retribution, and pressure to conceal ethical violations; and issues in team–patient/family interactions, such as poor communication, inadequate informed consent, and inconsistent messaging. This structure underscores the interplay between systemic, interpersonal, and clinical factors in generating moral distress.

This study employed the MMD-HP to assess levels of moral distress. The measure presents 27 clinical situations that may provoke moral distress, including scenarios such as witnessing dishonesty to patients, pressures to administer unnecessary treatments, resource limitations, and fear of retaliation for speaking up. Participants are asked to rate each item on two dimensions using a 5-point Likert scale: the frequency with which they have encountered the situation (ranging from 0 = never to 4 = very frequently) and the level of distress it causes (ranging from 0 = none to 4 = very distressing). If a situation has never been experienced, respondents are required to indicate how distressing they believe it would be.

The factor structure was utilised to streamline the measure and ensure a manageable survey completion time. I sought permission from the authors (Epstein et al, 2019) to access and use the MMD-HP (Appendix B); see Appendix C for the correspondence. For the present

study, the MMD-HP has been adapted for use with Clinical Psychologists. The adapted version consists of 18 items divided into two subscales: frequency of moral distress and level of distress experienced. To this end, the three to five highest-loading items from each relevant factor were retained, while lower-loading items were removed. This process resulted in a final selection of 18 items, with 9 items redacted. A full summary of amendment made, itemised through each factor is provided in Table 12.

Table 12

Summary of redactions.

Factor	Item Retained	Item Redacted
1. System-level root causes	16, 17, 19, 23,	4, 7, 18
2. Clinical root causes at patient level	2, 1, 3, 8, 22	5, 10
3. Team-level root causes: compromises to integrity	21, 20, 11, 25	12
4. Team-level root causes: team-patient/family interactions	15, 14, 9, 26	13, 24

Additionally, I completed minor wording changes to some item descriptions. The wording of the items has been kept as close as possible to the original scale to facilitate comparisons with existing research while aiming to improve readability, reduce completion time, and help mitigate attrition. Certain questions were also refined to enhance relevance and contextual accuracy for the role of clinical psychologists.

Table 13

Summary of adapted item descriptions.

Item	Adapted Description	Original Description
1	Witness health care providers being dishonest to a patient or family.	*Witness healthcare providers giving "false hope" to a patient or family.*
2	Follow lines of treatment I believe are not in the best interest of the patient.	*Follow the family's insistence to continue aggressive treatment even*

		though I believe it is not in the best interest of the patient
6	Be pressured to avoid taking action when I learn that a colleague has made a medical error and does not report it.	*Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it*
17	Experience compromised patient care due to lack of resources.	*Experience compromised patient care due to lack of resources/equipment/bed capacity.*

2.4.2 Job Satisfaction Scale

The study utilised the Job Satisfaction Scale to assess levels of job satisfaction. scale was originally developed for use across a wide range of occupational groups (Macdonald and Maclntyre, 1997). This scale was constructed from an initial pool of 44 items reflecting aspects of job satisfaction, which were administered to 885 working adults in Ontario across diverse occupations. The items assessed employees' positive feelings towards their job and workplace, including job satisfaction, perceived recognition, job security, and overall sentiment about working at the company (e.g. "I feel good about my job", "I receive recognition for a job well done"). The scale asks participants to respond on a 5-point Likert scale ranging from 'Strongly disagree' to 'Strongly agree.'

In more recent years, the scale has been employed to assess wellbeing among software engineers during the COVID-19 pandemic (Russo, Hanel, & Van Berkel, 2024). The four items with the highest factor loadings were retained, and the scale demonstrated high internal consistency (Cronbach's $\alpha = .85$). The current study employed this factor structure, utilising these four items as part of the analysis.

2.4.3 Perceived Stress Scale

The current study assessed stress using a four-item version of the Perceived Stress Scale (Cohen, 1988), a widely used measure of the extent to which individuals perceive situations in their lives as stressful. The scale asks participants to indicate how often they experienced particular thoughts or feelings related to stress during the past week (e.g, “In the last week, how often have you felt that you were unable to control the important things in your life?”; “In the last week, how often have you felt confident about your ability to handle your personal problems?”). Responses are provided on a 4-point scale ranging from 1 (Never) to 4 (Very often). The scale has demonstrated good internal consistency (α = .80; Russo, Hanel, & Van Berkel, 2024) using a four-item factor structure which again, was employed for use in the current study.

No amendments were made to the Job Satisfaction and Perceived Stress scales. Both scales are relatively brief, facilitating a shorter completion time for participants.

2.4.5 Reliability of Measures

The reliability and internal consistency of the measures were assessed using Cronbach’s alpha. Previous research on the MDS-R reported Cronbach’s alpha values ranging from 0.67 to 0.88, demonstrating acceptable to high reliability (Hamric et al, 2012). Content validity was established through expert evaluation, with four moral distress experts achieving 88% interrater agreement on primary and secondary root causes of moral distress. Full agreement was reached for 19 out of 21 items, leading to further refinement of item wording.

For the present study, Cronbach’s alpha was computed separately for each subscale of the MMD-HP, for the overall scale, for each Moral Distress factor (Epstein et al, 2019), and

for measures of job satisfaction, stress and turnover intentions. The scale overall (*MD Average*) demonstrated strong reliability (α = .92). The frequency subscale (*MD Frequency*) demonstrated strong internal consistency (α = .90), as did the *MD Level of Distress* subscale (α = .95). The Moral Distress factor structure showed good internal consistency: *Systemic factors* (α = .83), *Clinical Factors* (α = .77), *Team integrity Threats* (α = .79), and *Team interaction breakdown* (α = .82). Measures of stress (α = .80) and job satisfaction (α = .83) also exhibited high internal consistency, as did intentions to reduce hours (α = .87) and intentions to change jobs (α = .90), indicating reliability in assessing these constructs within the sample of Clinical Psychologists.

2.5 Analysis

The data analysis process was conducted using SPSS, involving both descriptive and inferential analyses. The process involved several key steps: computing variables, conducting descriptive statistical analyses, reviewing the descriptive findings, assessing reliability, testing assumptions, and carrying out inferential statistical analyses. These steps ensured the robustness and validity of the analysis, enabling accurate interpretation of the data.

A composite item scores were created by multiplying the frequency and level of distress (Epstein et al, 2019). To obtain an overall composite score of moral distress, the composite item scores were added together. Reliability analysis was then performed on each variable using Cronbach's alpha to ensure internal consistency. Descriptive statistics including means, standard deviations, and ranges, were calculated for each variable to summarise central tendencies, distribution and variability.

Following this, inferential analyses were conducted, including Pearson's correlations to assess relationships between variables, independent t-tests to compare differences between

groups, regression analysis to examine the influence of predictor variables, and mediation analysis to explore the potential causal pathways between moral distress and other workplace factors.

2.7 Ethical considerations

Ethical approval for this study was granted by the School of Health and Social Care Ethics subcommittee at the University of Essex on 01.12.23 (Appendix D). The participant information sheet (Appendix E) was shared with all participants upon expressing interest in the study. This sheet included details about the study, its aims, the voluntary nature of participation, the right to withdraw, and information on data management. Consent was obtained online using tick-box fields prior to participation (Appendix F).

Email addresses were provided only by participants who expressed interest in a potential qualitative phase of the study; however, following the decision to discontinue this phase due to resource and time constraints, the ethics application was amended accordingly and approved, all collected email data were securely destroyed in line with data protection protocols.

The anonymous quantitative data was stored in the researchers Qualtrics account, then downloaded to the researchers University of Essex Box account, accessible only to the researcher and supervisor, Paul Hanel. All files were protected with password security, and the data was deleted upon completion of the thesis. The consent form specifies that once published, anonymised data cannot be destroyed.

The findings will be summarised and shared with participants upon request and made available in the University of Essex repository.

Chapter 3. Results

3.1 Descriptives

The descriptive statistics and distributional characteristics of each variable were examined to assess assumptions for inferential analyses. These descriptives are presented in Table 14. The distribution of *MD Frequency* was positively skewed, indicating that while most participants reported experiencing moral distress infrequently, a smaller number reported experiencing it very frequently. In contrast, *MD Level of Distress* was negatively skewed, suggesting that the majority of participants experienced high levels of distress in response to ethical scenarios, with relatively few reporting low-intensity experiences. The average composite score (*MD Average*) had a central distribution. It should be noted that 24 participants did not complete the level of distress subscale, resulting in a reduced sample size (N = 173) for *MD Average*.

Table 14.

Descriptive Statistics

Variable	N	Mean	Median	SD
MD Average	173	136.00	123.00	62.09
MD Frequency	197	37.68	36.00	11.50
MD Level of Distress	173	61.01	64.00	16.84
Stress	200	10.49	10.00	3.16
Job Satisfaction	200	13.45	14.00	3.38
Intent to leave	199	5.24	4.00	3.19

Intent to reduce hours	199	3.91	2.00	2.49
System Factors	185	41.83	36.00	23.21
Clinical Factors	184	32.10	30.00	14.62
Team Integrity Threats	182	34.73	31.00	19.88
Team Interaction Breakdown	186	34.41	30.00	17.96

The descriptive statistics for the *MD average* were compared with recent studies employing the same scale. Boulton et al. (2023) reported a median composite score of 108 among 227 intensive care unit healthcare professionals. Matthews et al. (2023) found a mean composite score of 123 in a sample of 139 healthcare professionals working in paediatric oncology. Furthermore, Beltrán-Aroca et al. (2024) reported a mean composite score of 127.3 in a cohort of 566 healthcare professionals.

Additionally, means and standard deviations for each item are presented in Table 15. The highest scoring items related to themes of resource scarcity, continuity of care, and power hierarchies, exemplified by items such as “Experience compromised patient care due to lack of resources,” “Watch patient care suffer because of a lack of provider continuity,” and “Work within power hierarchies in teams, units, and my institution that compromise patient care.”

Table 15.

Item Descriptives

Item description	**N**	**Mean**	**SD**
Experience compromised patient care due to lack of resources.	198	12.21	6.74
Watch patient care suffer because of a lack of provider continuity.	199	12.03	6.30
Work within power hierarchies in teams, units, and my institution that compromise patient care.	195	9.97	7.31
Witness low quality of patient care due to poor team communication.	197	9.84	5.91
Have excessive documentation requirements that compromise patient care.	194	8.61	6.84
Fear retribution if I speak up.	190	8.36	6.52
Follow lines of treatment I believe are not in the best interest of the patient.	196	8.10	4.22
Be required to care for more patients than I can safely care for.	192	7.93	5.62
Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	189	7.09	4.79
Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	190	6.94	6.00
Participate on a team that gives inconsistent messages to a patient/family.	190	6.65	5.40
Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	187	6.08	4.25

Be required to work with abusive patients/family members who are compromising quality	192	6.08	4.10
Feel unsafe/bullied among my own colleagues.	187	6.05	4.63
Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.	189	5.74	4.39
Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.	189	5.60	3.95
Witness health care providers being dishonest to a patient or family regarding patient care.	198	5.26	2.50
Be pressured to avoid taking action when I learn that a colleague has made a medical error and does not report it.	186	4.52	3.23

3.2 Correlations between variables

Correlations were examined between moral distress, measured as an overall composite score (*MD Average*), through its subscales (*MD Frequency* and *MD Level of Distress*), through its factor structure (*System factors, Clinical factors, Team integrity threats, team interaction breakdown*) and with job satisfaction, stress, intent to leave and intent to reduce hours (Table 16).

I conducted one-tailed Pearson correlations between *MD Average* and each outcome variable (job satisfaction, stress, and intent to leave), in line with directional hypotheses (H1–H3), which predicted that higher levels of moral distress would be associated with poorer outcomes. For all other variables, including *MD Frequency* and *MD Level of Distress* , two-tailed significance values were retained, as these measures were not explicitly specified in the hypotheses and are therefore considered exploratory.

As hypothesised, *MD average* was positively correlated with stress ($r = .40$, $p < .001$) and negatively correlated with job satisfaction ($r = -.46$, $p < .001$), indicating that higher moral distress is associated with increased stress and lower job satisfaction. *MD average* was significantly associated with intent to leave ($r = .14$, $p = .035$). Analysing moral distress through its individual subscales revealed distinct patterns of association. *MD Frequency* demonstrated positive correlations with stress ($r = .41$, $p < .001$) and negative correlations with job satisfaction ($r = -.51$, $p < .001$). It was also significantly associated with intent to leave ($r = .20$, $p = .005$), indicating that more frequent experiences of moral distress is linked to turnover intentions. *MD Level of Distress* was positively correlated with *stress* ($r = .20$, p

= .003) and negatively correlated with job satisfaction (r = −.16, p = .036), it was not significantly associated with intent to leave (r = .01, p = .884).

Stress was significantly negatively correlated with job satisfaction (r = −.45, p < .001) and positively correlated with intent to leave (r = .21, p = .003), suggesting that higher stress levels are linked to lower job satisfaction and an increased likelihood of considering leaving. Job satisfaction was also significantly negatively correlated with intent to leave (r = −.33, p < .001), reinforcing its role as a key determinant of turnover intentions.

Additional negative correlations were observed between age and *MD Level of Distress* (*r* = −.20, *p* = .008), suggesting that younger individuals may experience higher levels of distress in response to morally distressing events. Age was also negatively correlated with job satisfaction (r = −.22, p = .002) and positively correlated with intent to reduce hours (r = .25, p <.001), indicating that older individuals may experience lower job satisfaction and are are more likely to reduce hours.

Overtime working patterns demonstrated several significant relationships with moral distress, stress, and job satisfaction. Greater overtime was associated with higher levels of *MD Frequency* (r = .36, p < .001) and *MD Average* (r = .32, p < .001), suggesting that those working beyond their contracted hours report experiencing moral distress more frequently. A positive correlation was observed between overtime and stress (r = .25, p = .002), indicating that working more hours than contracted is linked to increased psychological strain. In contrast, a significant negative correlation was found between overtime and job satisfaction (r = –.24, p = .003), reflecting lower satisfaction among those reporting longer working hours. These findings align with broader patterns in the data and suggest that exceeding contracted

work hours may contribute to a cascade of occupational stressors, including heightened exposure to morally distressing events and reduced professional fulfilment.

Table 16

Correlational table between all variables

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
1.	Age	1	-	-	-	-	-	-	-	-	-	-	-
2.	Overtime		1	-	-	-	-	-	-	-	-	-	-
3.	MD Average	.01	.32**	1	-	-	-	-	-	-	-	-	-
4.	MD Frequency	.07	.36**	.91**	1	-	-	-	-	-	-	-	-
5.	MD Level of Distress	-.20**	.06	.65**	.33**	1	-	-	-	-	-	-	-
6.	System factors	.11	.26**	.86**	.76**	.53**	1	-	-	-	-	-	-
7.	Clinical factors	-.07	.21**	.84**	.75**	.65**	.65**	1	-	-	-	-	-
8.	Team integrity threats	.05	.23**	.85**	.76**	.56**	.58**	.63**	1	-	-	-	-
9.	Team interaction breakdown	-.05	33**	.86**	.79**	.54**	.60**	.70**	.62**	1	-	-	-
10.	Stress	-.13	.25**	.40*	.41**	.20**	.31**	.36**	.31**	.34**	1	-	-
11.	Job Satisfaction	-.22**	-.24**	-.46*	-51**	-.16**	-.38**	-.27**	-.46**	-.35**	-.45**	1	-
12.	Intent to leave	.08	.05	.14*	.20**	.01	.11	.05	.17*	.13	.21**	-.33**	1
13.	Intent to reduce hours	.25**	.07	.05	.12	-.02	.12	-.00	.02	.00	.04	-.16*	.38**

Note. MD = Moral distress. ** denotes significance at the two-tailed level; * denotes significance at the one-tailed level.

3.3 Regression Analysis

A series of multiple regression analyses were conducted to assess how different dimensions of moral distress are associated with work-related outcomes. In total, 12 regression models were computed, representing the combination of three moral distress measures and four dependent variables (3 × 4). Each set of regressions focused on a different dependent variable: (1) job satisfaction, (2) stress, (3) intent to leave, and (4) intent to reduce working hours. For each outcome, three separate regression models were run to assess the predictive value of different aspects of moral distress. These included: (1) the overall *MD average*; (2) *MD Frequency* and *MD Level of Distress* ; and (3) the four identified moral distress factor scores (*System factors, Clinical factors, Team integrity threats*, and *Team interaction breakdown*). This approach allows for a comprehensive understanding of how moral distress, both in its overall totality and specific dimensions, contributes to job satisfaction, stress, intent to leave, and intent to reduce working hours.

The *Moral Distress (MD) Average* variable was entered as a predictor in separate regression analyses for job satisfaction, stress, intent to leave, and intent to reduce hours (Table 17). The regressions for job satisfaction, ($F(1, 171) = 45.35$, $p < .001$, $R^2 = .210$), and stress ($F(1, 171) = 32.22$, $p < .001$, $R^2 = .159$) were statistically significant, with each model accounting for 21% of the variance in job satisfaction and 15.9% of the variance in stress. *MD Average* was a significant predictor for both job satisfaction (B= -.03, β = -.46, p< .001) and stress (B= .02, β = .40, p = <.001). The regressions predicting intent to leave and intent to reduce hours were not statistically significant.

Table 17

MD Average – Regression table

	Job Satisfaction				**Stress**				**Intent to leave**				**Intent to reduce hours**			
	B	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*
MD Average	*-.03*	-.46	*.00*	*<.001***	*.02*	*.40*	*.00*	*<.001***	*.00*	*.14*	*.00*	*.069*	*.00*	*.05*	*.00*	*.522*
***F*-value**	*45.35*				*32.22*				*3.36*				*.41*			
Degrees of freedom	*1, 171*				*1, 171*				*1, 170*				*1, 170*			
R²	*.210*				*.159*				*.019*				*.002*			

Note. MD: Moral distress, ** denotes statistically significant results.

MD Frequency and *MD Level of Distress* variables were entered as predictors in separate regression analyses for job satisfaction, stress, intent to leave, and intent to reduce hours (Table 18). The regression analysis for job satisfaction as dependent variable was significant ($F(2, 170) = 30.06$, $p < .001$, adj. $R^2 = .253$), with the model accounting for 25.3% of the variance in job satisfaction. The regression for stress as dependent variable was significant ($F(2, 170) = 19.41$, $p < .001$, adj. $R^2 = .176$), with the model accounting for 17.6% of the variance in stress. The regression for intent to leave as dependent variable was also significant ($F(2, 170) = 3.40$, $p = .036$, adj. $R^2 = .027$), with the model accounting for 2.7% of the variance in intent to leave. The regression predicting intentions to reduce working hours was not statistically significant ($F(2, 169) = 1.384$, $p = .253$, adj. $R^2 = .004$).

It is noteworthy that *MD Frequency* emerged as a significant predictor of job satisfaction ($B = -.15$, $\beta = -0.51$, $p < .001$), stress ($B = .11$, $\beta = 0.40$, $p < .001$), and intent to leave ($B = .06$, $\beta = 0.21$, $p = .010$), whereas the standardised coefficients for *MD Level of Distress* were not significant. This suggests that the frequency of morally distressing events is a stronger predictor of job satisfaction, stress, and turnover intentions than the perceived intensity of those experiences.

Table 18

MD Frequency & Level of Distress - Coefficient table

	Job Satisfaction				**Stress**				**Intent to leave**				**Intent to reduce hours**			
	B	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*
MD Frequency	*-.15*	*-.51*	*.02*	*<.001***	*.11*	*.40*	*.02*	*<.001***	*.06*	*.21*	*.02*	*.010***	*.03*	*.13*	*.02*	*.102*
MD Level of Distress	*.00*	*.01*	*.01*	*.907*	*.01*	*.07*	*.01*	*.334*	*-.01*	*-.06*	*.02*	*.474*	*-.01*	*-.06*	*.01*	*.435*
F Value	*30.10*				*19.41*				*3.40*				*1.38*			
Degrees of freedom	*2, 170*				*2, 170*				*2, 169*				*2, 169*			
Adj. R^2	*.253 (p<.001)*				*.176 (p<.001)*				*.027 (p=.036)*				*.004 (p=.253)*			

Note. MD: Moral distress, ** denotes statistically significant results.

System factors, Clinical factors, Team integrity threats, and *Team interaction* breakdown were entered as predictors in regression analyses, with job satisfaction, stress, intent to leave, and intent to reduce hours as dependent variables (Table 19). The regression model predicting job satisfaction was significant, ($F(4, 168) = 13.48$, $p < .001$, adj. $R^2 = .225$) indicating that the model accounted for 22.5% of the variance in job satisfaction. Examination of the coefficients revealed that System factors (B= -.04, β =-.25 , p =.009) and *Team integrity threats* (B= -.06 β = -.32 , p =.001) were significant predictors of job satisfaction. The regression model predicting stress was significant ($F(4, 168) = 7.89$, $p < .001$, adj. $R^2 = .138$), with the predictors collectively accounting for 13.8% of the variance in stress. However, none of the individual factors were significant predictors in the model, which may indicate that the predictive value lies in their combined effect.

The regression model predicting intent to leave was not significant ($F(4, 167) = 1.73$, $p = .145$), nor was the model predicting intent to reduce hours ($F(4, 167) = 1.09$, $p = .363$). This suggests that, when examining the factor structure of moral distress, these variables hold more predictive value for job satisfaction and stress, rather than in predicting intent to leave or intent to reduce hours.

Table 19

MD Factor structure – Regression table

	Job Satisfaction				**Stress**				**Intent to leave**				**Intent to reduce hours**			
	B	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*	*B*	*β*	*SE*	*p*
System Factors	*-.04*	*-.25*	*.01*	*.009***	*.01*	*.10*	*.01*	*.343*	*.01*	*.08*	*.02*	*.486*	*.02*	*.22*	*.01*	*.049*
Clinical Factors	*.03*	*.13*	*.03*	*.226*	*.04*	*.16*	*.03*	*.151*	*-.04*	*-.18*	*.03*	*.137*	*-.02*	*-.12*	*.02*	*.337*
Team integrity threats	*-.06*	*-.32*	*.02*	*.001***	*.02*	*.10*	*.02*	*.321*	*.03*	*.16*	*.02*	*.135*	*.00*	*.00*	*.01*	*.996*
Team interaction breakdown	*-.02*	*-.09*	*.02*	*.401*	*.02*	*.11*	*.02*	*.340*	*.02*	*.10*	*.02*	*.403*	*-.01*	*-.05*	*.02*	*.663*
F Value	*13.48*				*7.89*				*1.73*				*1.09*			

Degrees of freedom	*4, 168*	*4, 168*	*4, 167*	*4, 167*
Adj. R^2	*.225(p<.001)*	*.138 (p<.001)*	*.017 (p=.145)*	*.002 (p=.363)*

Note. MD: Moral distress, ** denotes statistically significant results.

Notably, the regression analyses revealed that moral distress—particularly its frequency—was a significant predictor of job satisfaction, stress, and intent to leave. These findings prompted the researcher to explore a mediation model, between *MD Frequency* and intent to leave.

3.4 Mediation Analysis

The mediation analysis was guided by consistent findings across correlation and regression analyses, which identified *MD Frequency* as a significant predictor of job satisfaction, stress, and intent to leave. Notably, *MD Frequency* was the only moral distress variable to significantly predict intent to leave in the regression models. Job satisfaction and stress were also significantly associated with *MD Frequency*. Intent to reduce hours was not significantly predicted by any moral distress variable, offering limited justification for its inclusion. Based on these findings, the mediation model was designed to explore potential mechanisms underpinning the relationship between *MD Frequency* and intent to leave.

A parallel mediation model (PROCESS Model 4; Hayes, 2022) was conducted, specifying *MD Frequency* as the independent variable and intent to leave as the dependent variable. Job satisfaction and stress were included together as mediators to examine their potential mediating roles in this relationship. This model allowed for the investigation of direct and indirect effects, clarifying how *MD Frequency* may influence psychologists' intention to leave through its impact on occupational wellbeing.

The model revealed that *MD Frequency*, stress, and job satisfaction significantly predict intent to leave ($R^2 = .110$, $F(3, 195) = 7.92$, $p < .001$) indicating that 11.3% of

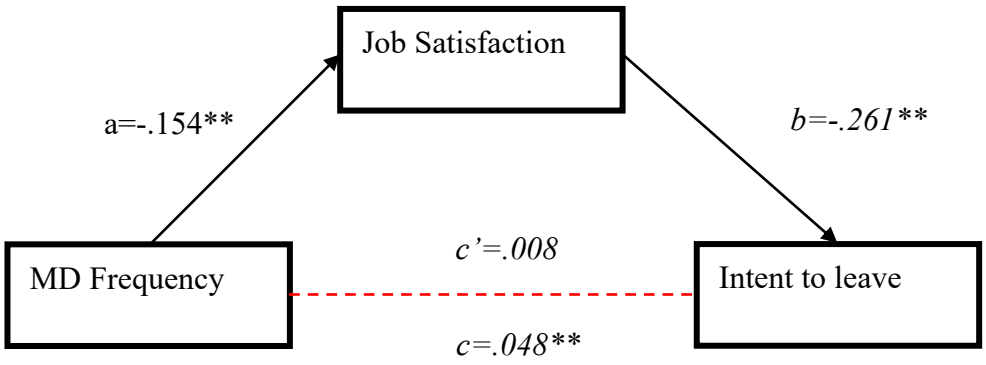
variance in intent to leave is accounted for by the model. Upon examining the coefficients job satisfaction emerged as a significant predictor (b = -0.26, SE = 0.08, t = -3.32, p = .001, 95% CI [−0.42, −0.11]). While stress (b = 0.07, SE = 0.08, t = 0.94, p = .349, 95% CI [−0.08, 0.23]) and *MD Frequency* did not (b = 0.08, SE = 0.02, t = 0.34, p = .733, 95% CI [−0.04, 0.05]).

The direct effect of *MD Frequency* on intent to leave was not significant (b = 0.01, p = .733, 95% CI [−0.38, 0.05]). However, a significant indirect effect of *MD Frequency* on intent to leave via the combined mediators was observed (b = 0.05, BootSE = 0.02, 95% CI [0.02, 0.08]). This effect was primarily driven by job satisfaction (b = 0.04, BootSE = 0.01, 95% CI [0.02, 0.07]), whereas the indirect effect through stress was not significant (b = 0.01, BootSE = 0.01, 95% CI [−0.01, 0.03]). These findings suggest that the association between *MD Frequency* and intent to leave operates predominantly through its negative impact on job satisfaction rather than stress.

The analysis supports an indirect mediation model, in which *MD Frequency* influences intent to leave through job satisfaction rather than a direct effect, as shown in Figure 3. *MD Frequency* significantly predicts job satisfaction, which in turn predicts intent to leave, while the direct effect of *MD Frequency* on intent to leave becomes non-significant. This highlights job satisfaction as a key mechanism linking *MD Frequency* to turnover intentions.

Figure 3

Mediation model



3.5 Mean differences in gender and role

Independent samples t-tests were conducted to examine whether the mean levels of moral distress, job satisfaction, stress, and intent to leave differed between men and women. Results showed that women reported on average significantly higher levels of distress on the *MD Level of Distress* subscale compared to men, ($t(166) = -3.03$, $p = .003$, $d = -.65$). No other significant differences were observed, for a complete summary of the results, see Table 20.

Table 20

Gender differences between variables.

Variable	Men		Women		*t*	*p*	Cohens' d
	M	*SD*	*M*	*SD*			
MD Average	134.38	86.77	135.73	57.57	-.10	.920	-.02
MD Frequency	39.57	14.89	37.13	10.91	1.03	.303	.21
MD Level of Distress	51.81	19.36	62.55	16.10	-3.03	.003**	-.65
System Factors	44.24	27.85	41.09	22.52	.66	.509	.13

Clinical Factors	29.37	18.13	32.26	14.00	-.94	.347	-.20
Team Integrity Threats	29.24	23.24	35.76	19.38	-1.60	.112	-.33
Team Interaction Breakdown	34.31	24.03	34.30	16.83	.004	.997	.001
Stress	10.43	3.19	10.48	3.20	-.07	.947	-.01
Job Satisfaction	14.17	3.52	13.37	3.36	1.19	.235	.24
Intent to leave	6.10	3.09	5.04	3.20	1.67	.096	.33
Reduce hours	4.03	2.41	3.93	2.54	.20	.841	.04

Note. MD: Moral distress.

Independent t-tests were also conducted to examine whether trainees and qualified clinical psychologists differed in their levels of moral distress, job satisfaction, stress, intent to reduce hours, and intent to leave. Results showed that trainees reported on average significantly higher job satisfaction compared to qualified psychologists, ($t(147) = -2.58$, $p = .011$, $d = -.44$). Additionally, trainees reported on average significantly lower intent to leave than qualified psychologists ($t(146) = 2.46$, $p = .015$, $d = .42$). Lastly, trainees reported on average significantly lower intent to reduce hours than qualified psychologists ($t(146) = 3.48$, $p < .001$, $d = .59$). While it is expected that trainees are less likely to leave due to the context of doctoral training in the UK, these differences underscore potential disparities in the work-related experiences of trainees and qualified psychologists. No other significant differences were observed. For a complete summary of the results, see Table 21.

Table 21

Role differences between variables.

Variable	Trainees		Qualified		*t*	*p*	Cohens' d
	M	*SD*	*M*	*SD*			
MD Average	132.29	60.58	148.32	64.50	1.43	.155	.26
MD Frequency	37.25	10.47	39.91	12.21	1.41	.161	.24
MD Level of Distress	60.70	16.66	61.70	14.62	.35	.728	.06
System Factors	40.42	23.26	47.26	25.17	1.63	.053	.29
Clinical Factors	33.19	14.73	32.60	14.26	-.23	.409	-.04
Team Integrity Threats	32.87	17.88	37.69	21.30	1.42	.079	.25
Team Interaction Breakdown	33.82	17.47	38.23	18.32	1.42	.079	.25
Stress	10.79	2.94	10.05	3.30	-1.42	.078	-.24
Job Satisfaction	14.02	2.78	12.67	3.60	-2.58	.005	-.44
Intent to leave	4.43	3.07	5.74	3.28	2.46	.015	.42
Reduce hours	3.53	2.37	5.02	2.79	3.48	<.001	.59

Note. MD: Moral distress.

Chapter 4. Discussion

4.1. Summary of findings

This doctoral thesis explored the relationships between moral distress and key occupational outcomes, including job satisfaction, stress, and turnover intentions among clinical psychologists.

The Moral Distress Average mean score in this study was 136.00 (SD = 62.09), exceeding the mean scores reported in recent studies, such as those involving paediatric oncology professionals (mean = 123) (Matthews et al. 2023). While these findings suggest that clinical psychologists may experience moral distress at a higher level, differences in sample characteristics, settings, and measurement contexts mean direct comparisons should be held cautiously. Items receiving the highest ratings on the scale related to compromises in patient care due to resource scarcity, continuity of care, and power hierarchies, highlighting important challenges inherent to mental health practice.

Significant relationships were observed between moral distress and key outcome variables. Moral distress (*MD Average*) was positively associated with stress and negatively associated with job satisfaction, and was significantly related to intent to leave. *MD Frequency* correlated positively with stress and intent to leave, and negatively with job satisfaction. *MD Level of Distress* also showed a positive relationship with stress and a negative relationship with job satisfaction, but no significant association with intent to leave. Stress was negatively related to job satisfaction and positively related to intent to leave. Job satisfaction was negatively associated with intent to leave. Additionally, age demonstrated modest associations, with older participants reporting lower *MD Level of Distress*, lower job satisfaction, and a higher intent to reduce working hours. Overtime was linked to higher

moral distress (Average and Frequency) and stress, and lower job satisfaction, suggesting that working beyond contracted hours may contribute to increased psychological strain and reduced professional fulfilment.

Moral distress (*MD Average*) significantly predicted job satisfaction and stress, but not intent to leave or intent to reduce hours. When both frequency and level of distress were included in the model, *MD Frequency* emerged as a significant predictor of job satisfaction, stress, and intent to leave. Neither *MD Frequency* nor *MD Level of Distress* significantly predicted intent to reduce hours. Additionally, examining different types of moral distress revealed that system factors and team factors (involving threats to personal integrity) significantly predicted job satisfaction and stress, however none of the four moral distress factors significantly predicted intent to leave or intent to reduce working hours.

Job satisfaction was found to mediate the relationship between *MD Frequency* and intent to leave. Specifically, higher frequency of moral distress predicted lower job satisfaction, which in turn predicted greater intent to leave. Stress did not significantly mediate this relationship.

Independent T-Tests indicated that women scored on average significantly higher on levels of distress (*MD Level of Distress*) than men. Regarding role differences, trainees reported significantly higher job satisfaction and lower intent to leave compared to qualified psychologists. No significant differences were found between trainees and qualified psychologists on moral distress or stress.

4.2. The Mediating Role of Job Satisfaction

The current study identified job satisfaction as a mediator between the frequency of moral distress and turnover intentions among clinical psychologists. This suggests that moral distress does not predict the desire to leave the profession, but rather contributes to a decline in job satisfaction, which in turn increases the risk of departure.

4.2.1. Theory of Structure and Agency

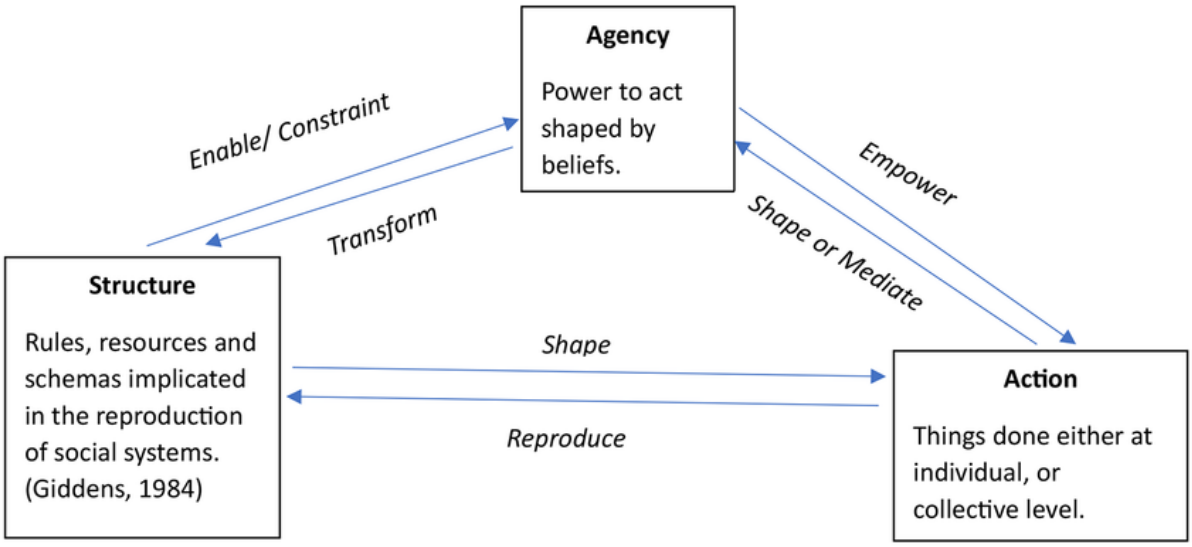
Sewell's (1992) structural theory of agency offers valuable insights for interpreting the findings of the current research. Sewell offers a reworking of structuration theory (Giddens, 1984) and proposes that structures are both the medium and the outcome of social action, composed of schemas (cultural rules) and resources (symbolic and material). In contrast to more deterministic accounts within classical social theory, Sewell argues that while structures may constrain agency, individuals possess the capacity to reinterpret schemas and improvise, thereby enabling social transformation.

Healthcare professionals may be conscious of structural changes, policy revisions, or shifts in team dynamics that have stemmed from ethically challenging experiences. The presence of competing values and interpretive schemas within healthcare systems reflects the diverse moral standpoints that practitioners bring to their roles. Acts of resistance, reinterpretation, and creative improvisation by professionals may be attempts to challenge, navigate, or transform constraining structures. Sewell's model suggests that it is precisely through these iterative exchanges between systemic forces and individual agency that change occurs.

This dynamic interplay is illustrated in Figure 4. Within this framework, frequent experiences of moral distress may reflect structural conditions that inhibit moral agency—for example, rigid organisational policies or insufficient resources. When individuals are able to act in accordance with their values, this exercise of agency may contribute to higher job satisfaction. Conversely, repeated constraints on moral action may diminish satisfaction and increase the likelihood of leaving the role.

Figure 4

Theory of Structuration (Sewell, 1992)



This theoretical lens offers a compelling way to conceptualise the mediating role of job satisfaction in the relationship between moral distress and workplace outcomes. Sewell's framework suggests that the ability to act in alignment with one's values contributes to a sense of empowerment and re-negotiation of existing structures. In this context, lower *MD Frequency* may reflect greater opportunities to exercise moral agency, thereby enhancing job satisfaction and reducing the desire to leave the profession. Conversely, when individuals frequently experience moral constraints - captured by higher *MD Frequency* - their capacity

for value-driven action is restricted, potentially diminishing job satisfaction and increasing intent to leave. Thus, job satisfaction may serve as a psychological mechanism through which moral distress exerts its impact on workforce retention.

Critique

While Sewell's theory provides a valuable conceptual framework for understanding the current findings, it does not fully account for the exchange of resources between individual agents and structures. There is limited consideration of how symbolic or material resources—such as financial compensation or professional recognition - are negotiated between practitioners and institutional systems. In healthcare contexts, individuals may experience declining job satisfaction over time, despite continuing to contribute to outcomes valued by the broader system. This asymmetry suggests that a more complete model would benefit from a fuller theorisation of resource flows between structures and agents, particularly in relation to motivation, reward, and the sustainability of moral agency.

4.2.2. Job Demands-Resources (JD-R) model

The Job Demands-Resources (JD-R) Model (Demerouti et al, 2001) is a widely recognised framework within occupational health psychology, offering a comprehensive lens through which to examine the exchange of resources within professional healthcare environments. This model conceptualises burnout as arising from the interaction between job demands and resources. The authors define job demands as the physical, social, or organisational aspects of work that require sustained physical or mental effort and are therefore associated with certain psychological and physiological costs, such as exhaustion. Conversely, job resources are described as physical, psychological, social, or organisational factors that serve to facilitate the achievement of work goals, mitigate the impact of job

demands and their associated costs, and/or promote personal growth and development. Central to the model are two concurrent processes: the health impairment process, wherein excessive job demands contribute to strain and burnout; and the motivational process, whereby ample job resources enhance work engagement, motivation, and commitment, thereby supporting employee wellbeing.

This framework is particularly relevant when morally distressing events are conceptualised as a specific form of psychological job demand, which demand sustained emotional and cognitive effort and are frequently associated to adverse psychological and health-related outcomes (AACN, 2020; Christodoulou-Fella, 2017; Fard et al, 2020). This is consistent with literature that associate higher frequencies of moral distress with reduced job satisfaction and elevated levels of stress. An increased frequency of morally distressing experiences is likely to heighten the cumulative emotional burden over time.

Furthermore, the JD-R model supports the notion that repeated exposure to high job demands, whether due to their frequency, duration, or intensity, is associated with negative occupational outcomes. This aligns with the present findings, which suggest that the frequency of morally distressing events may be a particularly salient predictor of workplace outcomes. It also mirrors evidence that older clinical psychologists report lower job satisfaction, suggesting that job demands may accumulate across a career span, particularly in the absence of sufficient resources to buffer their effects. Beyond its emphasis on the exchange of resources within workplace dynamics, the theory also encourages critical reflection on how systemic factors, such as austerity measures, may undermine individual wellbeing within healthcare settings over time. Additionally accumulated experience could foster resilience in navigating ethically complex situations. In this context, reduced job

satisfaction later in one's career may reflect a wider range of contributory factors beyond moral distress alone. Through this model, moral distress can be conceptualised as an organisational rather than solely an individual issue. In this regard, potential interventions are likely to be most effective when they focus on 'resource-based' approaches, rather than targeting individual responses.

4.2.3. Ethics and identity theories

While structural and occupational health models offer some explanatory power, the findings may be more meaningfully understood through theories rooted in ethics, identity, and justice within healthcare. Specifically, the crescendo effect, organisational justice theory, and professional identity theory provide a more targeted lens through which to interpret the mediating role of job satisfaction.

The crescendo effect (Epstein & Hamric, 2009) posits that moral distress, when unresolved, leaves a lingering psychological residue that accumulates over time. This cumulative burden intensifies clinicians' emotional responses to subsequent ethical challenges, even those of comparatively lower severity. Within this framework, frequent experiences of moral distress are not isolated incidents but form part of a broader trajectory of growing ethical dissonance and emotional fatigue. This study's finding that increased *MD Frequency* is associated with lower job satisfaction may reflect this escalating effect. As clinicians are repeatedly placed in ethically compromising situations—such as being unable to provide appropriate care due to service constraints—moral residue accrues, gradually eroding their sense of purpose, efficacy, and emotional resilience. Over time, this accumulation may contribute to a sustained decline in job satisfaction, making the prospect of leaving the role increasingly appealing as a means of moral self-preservation.

The study indicates that older clinicians report lower job satisfaction compared to trainees, it is important to note that this may reflect the accumulation of professional experience and its associated challenges, such as increased moral distress and ethical dissonance, rather than age itself being the sole determinant. This finding supports the crescendo effect. With years of experience, the cumulative psychological residue from unresolved ethical dilemmas may deepen clinicians' sense of dissonance and diminish their emotional resilience and experience a decline in job satisfaction compared to trainees who are still navigating the initial stages of their professional identity development. In this sense, the prolonged exposure to ethical challenges over time may contribute more significantly to job satisfaction than age alone.

Organisational justice theory (Greenberg, 1987) refers to individuals' perceptions of fairness in workplace procedures, outcomes, and interpersonal treatment. This framework helps to clarify how systemic and institutional practices can impact clinicians' wellbeing. When clinicians experience moral distress, it is often in the context of organisational decisions that constrain their ethical practice—such as service eligibility criteria, premature discharge policies, or excessive administrative burden. If these constraints are perceived as procedurally unjust (e.g, imposed without consultation), distributed unfairly (e.g, harming clients disproportionately), or accompanied by poor communication (e.g, lack of transparency or empathy), they may lead to a sense of organisational betrayal. Such perceptions of injustice may represent a potential mechanism through which moral distress diminishes job satisfaction, heightens occupational stress, and contributes to intentions to leave the profession or reduce working hours. This perceived injustice may exacerbate the emotional impact of moral distress but also undermines trust in the institution and diminishes job

satisfaction. Further research would be needed to understand the role of perceived justice and organisational betrayel in moral distress. In this context, the mediating role of job satisfaction reflects a breakdown in the perceived ethical climate of, and trust in the organisation, which prompts clinicians to disengage and consider exiting the profession.

Finally, professional identity theory (Adams et al, 2006) offers a psychologically grounded explanation for why job satisfaction is so vulnerable to moral distress. The theory posits that individuals derive a sense of meaning, coherence, and self-worth from alignment between their professional role and personal values; when this alignment is disrupted—such as when ethical practice is compromised—identity conflict can emerge, undermining job satisfaction. Clinical psychologists typically enter the profession with a strong internalisation of ethical principles, a commitment to client-centred care, and a desire to make meaningful contributions to mental health (Baker and Nash, 2011). When their ability to practise in accordance with these values is routinely compromised, their professional identity may come under threat. Recurrent moral distress can result in identity dissonance, whereby clinicians no longer recognise their work as consistent with the values they associate with their role and training. This dissonance is likely to foster a sense of alienation, disengagement, and loss of professional meaning. Thus, the mediating role of job satisfaction may reflect not just emotional fatigue, but a deeper erosion of ethical and professional coherence.

Taken together, the crescendo effect, organisational justice theory, and professional identity theory offer a multi-layered explanation for why job satisfaction mediates the relationship between moral distress and turnover intentions. While the crescendo effect highlights the cumulative emotional toll of unresolved moral conflict, organisational justice theory points to the role of systemic fairness in shaping clinicians' perceptions of their work

environment. Professional identity theory adds a deeper psychological dimension, illustrating how repeated ethical compromise can erode a clinician's sense of purpose and alignment with their professional role. These frameworks converge in suggesting that moral distress undermines the emotional, relational, and identity-based foundations of job satisfaction. It is this erosion—rather than the frequency of moral distress alone—that ultimately increases the likelihood of leaving the profession. By integrating emotional, organisational, and identity-based perspectives, these theories collectively support the interpretation of job satisfaction as a central mechanism through which moral distress influences retention.

Practical Applications

These theoretical perspectives suggest that efforts to improve retention and wellbeing in clinical psychology must address not only external demands but also the internal ethical and identity-related consequences of moral distress. From a practical standpoint, services should prioritise mechanisms that reduce the accumulation of moral residue, promote organisational justice, and protect professional identity. For instance, regular facilitated ethical reflection groups may help clinicians process morally distressing experiences before they accumulate into chronic dissatisfaction. Enhancing procedural and distributive justice—such as through transparent decision-making processes, staff involvement in policy development, and clear rationales for clinical pathways—can restore trust and fairness. Additionally, reinforcing professional identity through meaningful supervision, values-based leadership, and opportunities for clinicians to shape service delivery may buffer the corrosive impact of moral distress. Such interventions are likely to have a positive impact on job satisfaction and, in turn, reduce the risk of turnover by reconnecting clinicians with the ethical foundations of their work.

4.2.4. Self determination theory.

Self-Determination Theory (SDT; Ryan & Deci, 2000) provides a useful lens through which to interpret the present findings, particularly the observed relationships between moral distress, job satisfaction, and turnover intentions. SDT posits that optimal motivation and wellbeing are contingent on the satisfaction of three basic psychological needs: autonomy, competence, and relatedness. Conversely, the active frustration of these needs leads to demotivation, diminished wellbeing, and increased withdrawal behaviours. Within the context of clinical psychology, the experience of moral distress can be conceptualised not merely as an absence of need fulfilment but as an ongoing pattern of need thwarting (Vansteenkiste & Ryan, 2013), which has more corrosive implications for motivation and workforce retention.

From an SDT perspective, autonomy is frustrated when systemic and organisational constraints prevent psychologists from acting in alignment with their professional and moral values. This goes beyond limited flexibility in practice, amounting instead to situations where psychologists feel compelled to deliver care that conflicts with their ethical commitments; for instance, discharging clients prematurely due to service thresholds or adhering to restrictive treatment protocols. Competence is similarly undermined when high caseloads, bureaucratic processes, and inadequate resources prevent practitioners from exercising their skills effectively. Importantly, this is not only an erosion of perceived efficacy but a thwarting of psychologists' ability to achieve valued therapeutic outcomes, intensifying the experience of moral compromise.

The UK context provides further illustration of these dynamics. Within the NHS, austerity-driven funding cuts, extended waiting lists, and target-driven initiatives such as

Improving Access to Psychological Therapies (IAPT) can directly curtail professional autonomy by narrowing the scope of practice (Clark et al. 2018; Cummins, 2018). At the same time, the chronic understaffing of services undermines competence, as psychologists are unable to meet demand or provide interventions consistent with best practice. Relatedness, meanwhile, is challenged by overstretched services that leave limited time for peer support, reflective practice, or meaningful supervisory engagement. While training cohorts and supervisory structures often provide a strong sense of belonging (Bhola et al., 2015), thereby meeting relatedness needs, qualified psychologists may experience increasing isolation as systemic pressures erode opportunities for connection.

These temporal differences across career stages are particularly significant. Trainees' higher levels of job satisfaction and lower intent to leave may be explained by the satisfaction of relatedness needs through strong supervisory relationships and peer belonging. SDT suggests that such need fulfilment fosters intrinsic motivation, which may buffer against the negative effects of moral distress. However, the gradual and cumulative frustration of autonomy and competence across years of practice may contribute to amotivation among more experienced psychologists. This helps explain why older participants in the present study reported lower job satisfaction and higher turnover intentions despite experiencing comparable or lower levels of distress. In this sense, the accumulation of need thwarting may be central to understanding the temporal trajectory of motivation in clinical psychology.

SDT also provides a theoretically grounded framework for considering practical interventions. Protecting autonomy might involve increasing psychologists' involvement in service-level decision-making, promoting flexible working arrangements, and embedding values-based leadership. Supporting competence requires attention to caseload management,

access to continuing professional development, and recognition of clinical expertise. Enhancing relatedness could be achieved through structured peer supervision groups, cross-disciplinary forums, and mentoring schemes. Such initiatives should not be seen as peripheral supports but as core levers for sustaining intrinsic motivation and retention. By situating these findings within SDT, it becomes clear that interventions to address moral distress must operate at both structural and relational levels if they are to meaningfully enhance workforce sustainability.

Finally, SDT can be usefully integrated with other theoretical frameworks already applied in this thesis. The Job Demands–Resources (JD-R) model aligns closely with SDT, as job resources can be understood as conditions that facilitate need satisfaction, while job demands are often sources of need frustration. Similarly, identity theories complement SDT by highlighting how thwarted autonomy and competence not only undermine motivation but also destabilise professional identity, reinforcing the sense of moral dissonance. Taken together, these perspectives offer a multidimensional account of the ways in which moral distress intersects with motivation, identity, and wellbeing in the clinical psychology workforce.

4.3 Gender Differences in Moral Distress

In the present study, although the composite *Moral Distress Average* score did not differ significantly by gender, the average *MD Level of Distress* score was significantly higher among female participants. The finding that women scored significantly higher on levels of moral distress compared to men aligns with previous research using the MMD-HP. Beltrán Aroca et al. (2024) reported significantly higher moral distress among female healthcare professionals, and Matthews et al. (2023) similarly found that female participants

had a higher mean MMD-HP score (127.1) than male participants (83.6). Monrouxe et al. (2015) found that female healthcare students were significantly more likely than males to report experiencing moral distress. However, the authors suggest that these differences may reflect gendered response styles, not necessarily true differences in distress levels. They propose that men may under-report distress to conform to social expectations of emotional resilience, whereas women may be more open to acknowledging distress due to broader patterns of socialisation.

In addition to these gendered reporting styles, Mortimer (2022) found that men had significantly higher group loyalty scores compared to women, suggesting that men may be more inclined to align with institutional norms or hierarchies. This tendency could influence how moral distress is experienced or reported. Greater group loyalty might buffer or suppress the expression of moral dissonance, potentially contributing to the gender differences observed in moral distress scores.

While these differences may reflect broader societal norms, the gender disparities in moral distress warrant further exploration of gendered motivations for entering clinical psychology and the role of emotional labour in shaping moral distress experiences.

Baker and Nash (2011), explored the gendered motivations and career trajectories of female clinical psychology trainees in the UK. The authors highlighted that women's attraction to the clinical psychology field is often shaped by a range of personal and societal factors, particularly their identification with emotional distress and the desire to alleviate suffering. This finding may provide a insight for understanding the heightened distress levels observed among women in the current study.

Baker and Nash (2011) highlight five central narratives that encapsulate the diverse motivations of women entering the field of clinical psychology. One of these is the desire to "make a difference", where trainees are primarily driven by the aspiration to have a positive impact on individuals' lives and contribute meaningfully to society. Another narrative, "waiting for what I want", reflects a focus on achieving personal career goals, with an emphasis on aligning professional life with personal aspirations. Some trainees are attracted to the "idealisation of challenge", viewing the profession's inherent challenges as opportunities for personal growth and professional development. Additionally, there is a group of trainees who "identify with distress", drawn to the emotional aspects of the work and motivated by personal empathy or experiences of psychological suffering, aiming to alleviate distress in others. Lastly, some trainees reflect on the "acknowledgment of power and privilege", demonstrating a critical awareness of the societal power dynamics and privileges that come with the profession, which shapes their approach to clinical practice. This seminal work challenges assumptions about gendered career choices, suggesting that women's interests in the field are diverse and not shaped by societal gender norms such as the 'nurturing matriarchal' archetype that is often referred to in discussions about gender these narratives are often extremely personal and shaped by core individual values. This collectively underscore the varied and complex motivations that guide women into clinical psychology, highlighting the interplay of personal values, professional ambitions, and societal factors in shaping career decisions within the field.

When considering these themes in light of the current findings, it is intuitive that women would find instances of moral distress particularly difficult, more so than their male counterparts. The motivations driving women into clinical psychology contrast sharply with

the experience of moral distress. For those drawn to the field by the desire to make a difference, relish the challenges of effecting change, or embody critical awareness of power dynamics, witnessing or participating in an event that undermines these values would naturally be profoundly distressing. Similarly, for those who identify with the pain of suffering with mental health, and those who have endured systemic failings – to encounter situations that conflict with professional and personal values may feel especially challenging. Thus, moral distress, in this context, strikes at the core of the very motivations that initially led these women into the profession.

More broadly, Hochschild's (1983) highlights the disparate nature of emotional labour between genders. She argues that women are more likely to occupy roles that require the management of emotions, with gender shaping the emotional demands placed on individuals in the workplace. This dynamic is evident in the current sample, where the majority of participants were women. Women are socialised to assume a greater share of emotional labour, expected to be more emotionally available, empathetic, and expressive, expectations that can permeate both professional and personal spheres (Dean et al, 2022). This tendency may be particularly pronounced in clinical psychology, where empathy and emotional engagement are central to the practice. The higher levels of moral distress experienced by women may reflect the emotional strain inherent in the profession. This strain could be particularly pronounced for women who are more likely to internalise societal expectations of care and empathy, which could contribute to heightened emotional and psychological distress when faced with moral conflicts in the workplace.

In sum, research suggest that gender plays a significant role in shaping the motivational and emotional experiences of clinical psychologists. Further research is needed

to explore the relationship between gender and moral distress, particularly with regard to gender diversity, which remains underrepresented in the clinical psychology workforce and in research (Caswell and Baker et al, 2008). These findings highlight the importance of exploring and addressing gendered experiences in clinical psychology training and practice.

4.4. Age differences in moral distress

Older, qualified psychologists reported lower levels of job satisfaction and lower *MD Level of Distress* compared to their younger or pre-qualified clinical psychologists. They also reported significantly higher intent oto leave. In contrast, younger psychologists scored higher on the *MD Level of Distress* subscale of the MMD-HP, indicating that they experience a greater intensity of distress when faced with morally distressing events. Although these findings may initially appear contradictory, they become more coherent when considered alongside potential explanations and relevant theoretical perspectives.

According to Super's Life-Span, Life-Space Theory (1990), career satisfaction evolves across distinct stages of professional development. Early-career psychologists, situated in the Exploration and Establishment phases, are typically more enthusiastic and engaged as they form their professional identity. This phase involves exploring career options, engaging in education and training and forming a vocational identity. This may explain the higher reported job satisfaction among younger or pre-qualified psychologists. However, this same developmental phase may also render these professionals more vulnerable to the emotional impact of morally distressing events. They may be less prepared for, or acclimatised to, such experiences, which could account for the higher levels of distress reported on the MMD-HP.

In contrast, older clinical psychologists are more likely to occupy the Maintenance stage, they may face diminished opportunities for professional growth and advancement, potentially leading to feelings of stagnation, burnout, reduced job satisfaction, and an increased intent to leave the profession. Furthermore, within Clinical Psychology, reflective practice, ongoing professional development, and critical self-awareness are central and actively promoted (Hughes and Youngson, 2009). A reduced sense of engagement with these processes may contribute to feelings of demoralisation. The cumulative impact of prolonged exposure to systemic pressures—such as funding constraints and bureaucratic demands—may further intensify these challenges.

Generational Work Values Theory (Twenge et al, 2010) provides additional insight into these age-related differences. Younger generations (e.g, Millennials and Generation Z) tend to prioritise autonomy, flexibility, and personal fulfilment in the workplace, values that are reflective of the natural life stage these professionals are at. While these values may initially enhance job satisfaction and drive ambition, they can also lead to heightened distress when organisational environments fail to meet these expectations, particularly in ethically challenging contexts. Moreover, the finding that trainees reported higher job satisfaction and lower intent to leave than qualified psychologists—despite comparable levels of moral distress—may reflect the protective function of early-career idealism. This initial optimism, common during the formation of professional identity, may buffer individuals from disengagement. However, repeated exposure to unresolved ethical tensions and systemic barriers over time may erode this idealism, contributing to reduced satisfaction and an increased desire to leave the profession (Epstein & Delgado, 2010).

Conversely, older generations (e.g, Generation X and Baby Boomers) are often more institutionally loyal but may become increasingly disillusioned by persistent systemic inefficiencies. When their capacity to effect meaningful change is limited, moral distress may be experienced in a more chronic or existential manner, contributing to decreased job satisfaction and a desire to leave. These differences in priority may underlie the variations observed in job satisfaction. Further exploration of these factors could provide deeper insight into how age-related priorities, both in the workplace and personally, influence the experience of moral distress.

Older, qualified psychologists often face additional contextual pressures beyond ethical challenge exposure. One such factor may be the increasing shift toward portfolio careers, that is, combining multiple roles (e.g. clinical work, research, teaching, consultancy) rather than a single organisational employment. Portfolio working can offer autonomy and variety, but also introduces instability, role fragmentation, and greater demands for self-management (Clinton, 2006). In mid- to late-career, maintaining a portfolio of roles may become more burdensome: the cognitive load of juggling contracts, maintaining income, boundary negotiation, and administrative complexity might reduce overall job satisfaction and contribute to decisions to reduce hours or depart entirely.

Another relevant factor is retirement planning and institutional incentives. Some psychologists may approach the statutory or expected retirement age, prompting reflection on career sustainability, workload reduction, or transitions into emeritus roles (Vilela et al., 2023). The anticipation of diminishing returns or fewer opportunities for advancement can feed into a sense of stagnation during Super's Maintenance phase. Furthermore, generational differences in financial security, pension entitlements, and life-stage responsibilities (e.g. elder care, health concerns) can also influence decisions to scale back or leave the profession.

A life-span perspective (Zacher et al., 2021) encourages seeing these trajectories as evolving interplay between individual resources, roles, and work demands across time. In that sense, older psychologists may be less distressed by acute moral events (lower MMD-HP scores) not because they are impervious, but because prolonged exposure has led to habituation, emotional distancing, or even disengagement. Over time, the emotional salience of ethically distressing events may dampen, while structural frustrations and systemic constraints exert a more pervasive, chronic influence on satisfaction.Thus, the observed pattern - younger psychologists reporting higher distress intensity, but older ones reporting lower satisfaction and greater intent to leave - may be explained by an interaction of career stage, portfolio working pressures, retirement/exit planning, and emotional adaptation to moral challenges.

In sum, experienced psychologists are likely to have encountered a cumulative burden of stressors over time, including systemic challenges such as funding cuts, bureaucratic constraints, and complex ethical dilemmas. Career plateauing is also important to consider, as mid- to late-career professionals often face fewer developmental opportunities and may experience a sense of stagnation. In contrast, early-career psychologists are typically engaged in the formation of their professional identity and may approach their work with greater enthusiasm and optimism. This idealistic phase may render younger, pre-qualified clinical psychologists more vulnerable to morally distressing experiences, potentially intensifying the emotional impact of such events and the pain they carry. These theories suggest that age-related differences in job satisfaction and moral distress may be shaped by both career stage and generational values. Interventions aimed at improving retention and wellbeing in the

psychology workforce should therefore remain aware of these differing needs and experiences.

4.5 Symbolic Interpretations

Beyond demographic patterns, the emotional and ethical dimensions of moral distress can also be illuminated through symbolic and historical frameworks, offering a deeper understanding of how clinicians experience and carry the burden of moral distress in practice.

4.5.1 Jungs Wounded Healer

Jungian archetypes represent universal, symbolic patterns embedded within the collective unconscious, manifesting in recurring motifs across cultures and professions (Jung, 1959). Among these, the wounded healer archetype is particularly pertinent to healthcare professionals. It depicts healers who carry their own psychological, emotional, or moral wounds—wounds that simultaneously motivate their caregiving and shape their vulnerabilities (Hillman, 1997). The wounded healer embodies a paradox: the capacity to heal others while grappling with internal suffering. In mythology, this is epitomised by Chiron, the centaur who could heal all but not himself.

The present study's findings offer empirical resonance with this archetype within the context of clinical psychology. Moral distress—conceptualised here as an internal 'wound'—emerges when clinicians encounter ethical constraints that hinder practice in accordance with their values. These unresolvable tensions, often tied to systemic barriers and resource limitations, precipitate moral injury and psychological suffering. Strong associations between moral distress and elevated stress, diminished job satisfaction, and increased intent to leave illustrate the emotional toll of such dissonance. This mirrors the dual reality of the wounded healer: like Chiron, clinical psychologists demonstrate skill in supporting others whilst enduring their own moral and emotional pain (Schilpzand et al, 2018).

Importantly, however, recent empirical literature encourages a more nuanced understanding of this archetype. Cruciani et al. (2024) argue that while the wounded healer framework provides a compelling narrative of adversity transformed into therapeutic insight, it risks pathologising therapist motivation if taken in isolation. Not all psychotherapists report significant early trauma or dysfunction; motivations are diverse and often include self-oriented and altruistic drivers such as intellectual curiosity, personal growth, and a desire to help others. To better encapsulate this complexity, Cruciani and colleagues propose the concept of the 'healing healer', which reflects not only the presence of wounds but also the active pursuit of self-development and ethical, engaged care. Unlike the static image of the archetypal sufferer, the healing healer encompasses both the therapist's internal journey and their capacity to transform suffering into wisdom and sustained practice.

Similarly, van Oosterzee et al. (2024) highlight that therapists' career narratives are shaped not only by adversity, but also by positive formative experiences. Their qualitative study with experienced Dutch therapists revealed that motivations often evolve over time, encompassing early caring dispositions, inspiring role models, and personal experiences with therapy. While many therapists acknowledged painful histories—including aversive childhood experiences—these were frequently interwoven with themes of resilience, empathy, and meaningful connection. This narrative flexibility challenges the idea of an inherent or fixed woundedness and instead positions the therapist's identity as a dynamic product of both personal and professional development.

The present findings further support this view. Gender and professional role nuances emerged, with women reporting higher levels of moral distress. Though this may reflect

broader socio-cultural dynamics; Cruciani et al. (2024) suggest that women are more likely to experience early parentification and internalise care-taking roles, potentially increasing vulnerability to moral harm when systemic failures impede ethical practice.

Furthermore, Cruciani et al. (2024) draw an essential distinction between “healing healers” and impaired professionals. While the former harness personal suffering to enhance therapeutic connection, the latter may be compromised by unresolved trauma that impairs clinical work. This distinction underscores the importance of reflective practice, supervision, and personal therapy—not only to mitigate burnout and vicarious trauma but to support the constructive integration of personal experience into clinical wisdom.

In sum, the wounded healer remains a powerful metaphor for understanding the moral and emotional labour of clinical psychologists. Yet it should not be viewed as a singular or static identity. The findings suggest that internal wounds—such as moral distress—may indeed drive deeper empathy, insight, and meaning-making, but only when embedded within reflective and supportive systems. Rather than valorising suffering, the field must recognise the transformative potential of these wounds alongside the structural conditions that exacerbate or alleviate them. As such, the study affirms not only the relevance of the wounded healer, but also the need for its conceptual expansion to accommodate contemporary understandings of therapist motivation, growth, and resilience.

4.5.2 The Nightingale Legacy

Although Florence Nightingale is most famously associated with nursing rather than psychology, her legacy as a pioneering healthcare reformer offers a rich symbolic lens through which to understand the moral distress experienced by clinical psychologists.

Traditionally revered as a figure of resilience, ethical integrity, and systemic critique (Bostridge, 2008), Nightingale embodies the tension between caregiving ideals and the institutional constraints that frustrate their realisation—a tension central to the phenomenon of moral distress.

Recent scholarship underscores the multidimensionality of Nightingale's legacy. Conte et al. (2024), in their critical discourse analysis of public portrayals across podcasts and YouTube, identify five dominant themes: the legendary caregiver, the feminist reformer, the statistician and data scientist, the public health innovator, and the STEM contributor. Each of these thematic representations offers valuable symbolic parallels to contemporary clinical psychologists.

As a legendary caregiver, Nightingale represents the ethical and emotional burden borne by those committed to patient welfare despite systemic inadequacies—an experience mirrored in the narratives of psychologists within this study, who reported distress when unable to practise in accordance with their values. Her portrayal as a feminist heroine, who subverted Victorian gender norms to pursue autonomous professional work, resonates with the gendered dynamics in clinical psychology, where emotional labour and ethical dilemmas are often underacknowledged or feminised.

Moreover, Nightingale's role as a statistician and reformer—emphasising data-driven advocacy and public health policy—challenges reductive perceptions of caring professionals as passive or purely affective. Her use of the Rose Diagram to expose systemic failures (Conte et al, 2024) symbolises the potential for clinicians to channel distress into evidence-informed critique and institutional change. In this way, moral distress becomes not merely an

index of personal suffering but a moral barometer signalling the need for structural transformation.

This reading is supported by Breigeiron et al. (2021), who argue that Nightingale's Environmental Theory remains strikingly relevant in the context of COVID-19. Their study outlines ten dimensions of contemporary nursing practice shaped by Nightingale's principles—ranging from hygiene and work organisation to ethics and leadership. Among these, the emphasis on physical and mental wellbeing, ethical responsibility, and professional training offers further parallels with the findings of the present study, particularly the documented relationship between moral distress, stress, and reduced job satisfaction. Nightingale's own physical and emotional sacrifices, as documented historically, echo these findings and underscore the personal toll of unresolved ethical strain.

"When I am no longer a memory, just a name, I hope my voice may perpetuate the great work of my life." (Nightingale, as cited in Bostridge, 2008)

Symbolic resonance is deepened by Nightingale's aspiration for enduring impact. Her words express a profound commitment to legacy, not for personal recognition, but to sustain ethical and systemic transformation. Similarly, research shows that a desire to make a meaningful difference is a central motivator for many entering clinical psychology, particularly women (Baker & Nash, 2011). This vocational drive, to alleviate suffering, promote justice, and shape the systems in which clients live echoes the values Nightingale championed. Yet, as this study reveals, such idealism often clashes with institutional barriers, giving rise to moral distress when psychologists cannot practise in line with their core values. In this light, Nightingale's voice offers both a historical echo and a contemporary imperative:

to honour the vision that draws many into this work, and to ensure that the systems surrounding them do not silence it.

Nightingale's enduring influence as a reformer, who sought to transform not only patient care but the very structures in which it occurred, supports the conclusion that addressing moral distress requires systemic intervention. Just as she challenged the status quo of 19th-century military hospitals, so too must contemporary services examine the organisational and cultural conditions that constrain ethical practice in psychology.

In sum, Nightingale's symbolic legacy provides a historically grounded, multidimensional framework for interpreting moral distress—not merely as a personal affliction but as a response to deep systemic incongruities. Her example invites reflection on the ethical labour of psychologists and inspires a more transformative vision: one that seeks to reconfigure the conditions in which care is delivered.

4.5. Critique of methodology and design

The sample comprised 200 pre-qualified and qualified clinical psychologists, providing a substantial dataset for examining relationships between key variables within this professional group. This represents a key strength of the research, as the shorter completion time helped reduce drop-out rates and facilitated the collection of a larger dataset — a notable achievement given the scarcity of larger-scale studies in the existing literature.

The present research offers several key advantages for the field. Although the validity of the MMD-HP remains a topic of debate, the measures utilised in this study provide robust and reliable assessments of moral distress, stress, and job satisfaction. As a well-established

instrument, the MMD-HP benefits from a degree of content validity, as it has been widely used to assess moral distress in healthcare professionals. Its extensive use in research lends support to its content validity, as it encompasses key aspects of moral distress as experienced in clinical settings. However, concerns persist regarding how accurately it captures the construct (Kolbe and de Melo-Martin, 2023). Despite criticisms, the measure's established presence in the literature suggests that it remains a valuable tool for examining moral distress and its occupational consequences.

The research employed multiple layers of inferential analysis, contributing to a comprehensive understanding of the relationships between variables. Beginning with correlational analyses to establish associations, the study then utilised regression analyses to assess the predictive power of each variable, ultimately informing the development of a mediation model. This stepwise approach provided a nuanced understanding of the interrelationships between key constructs. The structured and systematic analytical process ensured a reasoned, logical, and replicable approach to data analysis.

The study employed a cross-sectional design, which not only restricts the ability to establish causal relationships but also limits inferences regarding how these relationships evolve over time. Longitudinal research would be necessary to assess how moral distress influences workplace factors and turnover over an extended period.

It is also important to acknowledge the potential underestimation of moral distress within this study. Clinical psychologists experiencing the most severe levels of stress or moral distress may have been less inclined to participate, owing to time constraints or the emotional toll involved. This potential self-selection bias suggests that the sample may not

fully represent those most affected, which could result in an attenuation of the observed associations.

Additionally, while statistical analyses offer valuable insights in a field with limited quantitative research, qualitative methods could have provided a richer understanding of the lived experiences of moral distress. Qualitative interviews, in particular, could have helped contextualise morally distressing events and provided a deeper exploration of the subjective impact of moral distress alongside the quantitative findings. These limitations are outlined to encourage a nuanced and critical interpretation of the data.

An important limitation to acknowledge is the lack of representation within the sample. The themes identified have been drawn primarily from the experiences of white, cisgender women. Although this reflects broader trends within the Clinical Psychology profession, it is important to remain critically aware of the reasons this lack of representation persists. This is particularly relevant when examining a phenomenon so closely tied to occupational experiences that are deeply affected by structural racism (Mortimer, 2022; Ong, 2021). Any conclusions we draw from this dataset should hold this critical awareness. While decolonisation efforts have been implemented across DClinPsy training programmes in the UK, the representation of racially and gender-diverse clinical psychologists remains limited (Caswell and Baker et al, 2008, Scior et al, 2007). Additionally, systemic barriers continue to impede the participation of individuals from racialised and gender-diverse backgrounds in research, further contributing to their under-representation.

Racial identity was not included in the quantitative analysis due to the use of an open-text response format, which allowed participants to self-identify in their own terms rather

than selecting from a predefined list. This approach aimed to promote inclusivity and avoid the limitations of standard tick-box categories, which often oversimplify complex and nuanced identities. However, the variation in responses meant the data could not be reliably coded for statistical analysis. This represents a limitation, particularly in light of research by Mortimer (2022), which highlights how racial attitudes can shape clinical decision-making. As such, future research should consider mixed-method approaches that can both honour identity complexity and support meaningful analysis of racialised experiences.

Additionally, as the study was conducted in the UK, the findings may not be directly generalisable to clinical psychologists in other healthcare systems. Cultural and systemic differences in healthcare environments are likely to shape the experience of moral distress in distinct ways. For instance, the highest rated items in the scale related to a lack of provider continuity and lack of resources. However, cultural differences may influence which items healthcare professionals perceive as most distressing.

In sum, while the study demonstrates methodological rigour and contributes valuable insights into moral distress among clinical psychologists, its limitations—particularly in relation to sampling, representation, and design—highlight important considerations for future research. Addressing these issues through more inclusive, longitudinal, and mixed-method approaches will be essential to deepening our understanding of this complex phenomenon.

4.6. Implications of the research

This study underscores the need to view moral distress not as a personal pathology, but as a response rooted in systemic and organisational contexts. Recognising it as a sign of

moral sensitivity, rather than weakness, shifts the focus from individual resilience to structural reform. Accordingly, the findings support practice interventions that reduce ethically challenging situations and foster ethical support, alongside research that further clarifies moral distress as a construct and evaluates systemic, reflective approaches to mitigation.

4.6.1. Practice Implications

The findings of this study underscore the need for targeted interventions to mitigate the impact of moral distress in healthcare settings, particularly by reducing the frequency of ethically challenging situations. However, it is crucial to interpret these recommendations with caution, as ongoing debate persists within the field regarding whether moral distress itself should be considered a direct target for intervention. Kolbe and de Melo-Martin (2023) caution against framing moral distress as an individual pathology, highlighting the risk of obscuring systemic ethical failings. This critique gains further weight when considering the possibility that some practitioners may, over time, come to recognise their complicity in harmful practices (Witkowski, 2015). This raises important questions about the role of retrospective ethical awareness in shaping either disillusionment or growth following experiences of moral distress or injury, particularly among more experienced psychologists. Consequently, the occurance moral distress might reflect a moral sensitivity, strength, and a deep commitment to the ethical values one would hope to find in those entrusted with the provision of care. To assume otherwise risks pathologising the clinician rather than critically examining the systemic conditions in which they are required to practice and interventions that target individual resources and ‘resilience’ culture may inadvertently cause clinicians to adapt to injustice dulling their moral sensitivity and critical resistance.

It is important to distinguish between addressing individual responses to morally distressing events and tackling their root causes, while also recognising the challenge of balancing a compassionate response for individuals who understandably find such situations distressing. Rather than desensitising individuals to morally incongruent situations or eradicating any distress that accompanies such situations, interventions should prioritise the development of appropriate support mechanisms. Additionally, fostering ethical structures and processes can help clinicians navigate ethical challenges, engage meaningfully with moral dilemmas, and maintain both their professional integrity and moral sensitivity.

The finding that *MD Frequency*, rather than level of distress, was predictive of negative workplace outcomes offers a clear rationale for prioritising structural and systemic interventions.Additionally, the finding that system-level and team-related forms of moral distress—particularly those involving threats to personal integrity—were significant predictors of job satisfaction and stress further supports the case for structural and systemic interventions as more impactful avenues for change. It is not solely the degree of distress that undermines wellbeing, but the repeated exposure to ethically compromising situations and the types of situations from which they arise. This suggests that individual coping strategies, while important, are inherently limited in their capacity to mitigate harm. Efforts to support clinicians must therefore extend beyond emotional management and target the conditions that allow such dilemmas to persist. Interventions that reduce the recurrence of morally distressing events, through ethical governance, workload reform, and supportive team cultures, are likely to be more effective in sustaining clinician wellbeing over time.

Given the strong association shown in the current research between *MD Frequency* and workplace factors, organisations should consider implementing structured ethical

decision-making frameworks to support clinicians in navigating moral dilemmas more effectively. Strengthening institutional support through clear ethical guidelines, reflective practice opportunities, and access to ethics consultation services may help mitigate distress. Additionally, fostering open and transparent team communication, alongside interdisciplinary collaboration, could alleviate some of the systemic pressures contributing to moral distress (Fantus et al, 2023). These measures have the potential to not only reduce the frequency of morally distressing events but also create a more supportive and ethically resilient work environment.

Improving job satisfaction is another key strategy for mitigating the negative consequences of moral distress, particularly in relation to employee retention. Since job satisfaction was found to mediate the relationship between moral distress and turnover intentions, targeted efforts to enhance workplace conditions could reduce attrition rates. Improving supervision quality, and oppurtunities for professional development has been shown to increase staff retention and decrease burnout (Martin et al, 20221). Additionally, health personnel experiencing higher workloads are approximately half as likely to report job satisfaction compared to those with balanced workloads (Wulansari, Murti, & Tamtomo, 2023). It is imperative to examine workload pressures both individually and systemically, and promote fair and sustainable working conditions across healthcare settings. Organisational efforts should consider workload management strategies and mental health support, as job dissatisfaction is often predicted by burnout (Rifin and Danaee, 2022) and emotional exhaustion (Lee and Ashforth, 1996; Seidler et al, 2014). Regular supervision, space for moral reflection, and explicit training in managing aversive countertransference are essential in helping psychologists navigate these ethically complex encounters with resilience and integrity. Supporting clinicians through supervision, reflective practice, and training that

explicitly addresses moral and emotional complexities is crucial for sustaining ethical and effective therapeutic engagement. By fostering a workplace culture that prioritises staff wellbeing, clinical settings may improve nurse retention but also enhance the overall quality of psychological care provided to clients (Twigg & McCullough, 2013) and possibly mitigate long term consequence of moral distress.

Additionally, the study's findings suggest that younger psychologists and women experience higher levels of moral distress, indicating the need for tailored support strategies for these at-risk groups. Mentorship programmes that pair early-career psychologists with more experienced professionals could offer guidance in managing ethical dilemmas and coping with workplace challenges. Peer support groups and reflective practice spaces may also serve as valuable resources, providing clinicians with opportunities to share experiences, process distress, and develop adaptive coping strategies. Organisational policies should further consider the unique challenges faced by women in clinical psychology, particularly in relation to gendered workplace expectations and emotional labour. Exploring these disparities through organisational interventions may help create a more equitable and supportive professional environment for all clinicians.

4.6.2. Theoretical and research implications

The findings contribute to the ongoing refinement of moral distress as a theoretical construct, particularly in distinguishing between frequency and level of distress. The results suggest that these dimensions may have distinct effects on workplace outcomes, reinforcing the argument that they should be examined separately in both research and practice. *MD Frequency* emerged as a predictor of workplace factors and turnover intentions, rather than distress intensity. This suggests that frequency of events related to structural and systemic

dynamics, rather than just the subjective experience of distress, play a critical role in shaping professional wellbeing. Future research should explore whether interventions targeting frequency (such as structural and policy changes) differ in effectiveness from those addressing intensity (such as emotional coping strategies, or wellbeing support). A clearer conceptualisation of moral distress may enable more precise intervention development and enhance the ability of organisations to address its root causes.

This study also reinforces existing occupational health models, particularly those that position job satisfaction as a key mediator between workplace stressors and employee retention. The mediation analysis demonstrated that *MD Frequency* does not directly predict turnover intentions but exerts its influence through its impact on job satisfaction. These findings align with broader occupational psychology literature, which highlights the protective role of job satisfaction in mitigating stress-related attrition. For example, Ning et al. (2023) found that job stress increases turnover intention among primary health care workers, while job satisfaction reduces it. Their study demonstrated that both job satisfaction and presenteeism significantly mediate the relationship between job stress and turnover intention, identifying these as key targets for retention efforts. Similarly, Luo et al. (2023) reported that job satisfaction partially mediates the impact of workplace psychological violence on turnover intention, accounting for 44% of the total effect, thereby underscoring the importance of fostering job satisfaction to reduce nurse turnover. In line with these findings, Chen et al. (2023) found that job satisfaction reduces both burnout and turnover intention among primary care workers and partially mediates their relationship, further supporting its role in mitigating workforce attrition.

Future theoretical frameworks should explicitly integrate *MD Frequency* and job satisfaction as critical factors influencing employee retention. By refining occupational health models to account for moral distress, researchers and policymakers may develop more effective strategies for supporting clinician wellbeing and reducing workforce turnover.

Future research should adopt longitudinal methodologies to assess the long-term impact of *MD Frequency* on clinical psychologists' career trajectories. Cross-sectional studies, such as the present research, provide valuable insights into associations between moral distress and workplace outcomes; however, they cannot capture how these relationships evolve over time. Longitudinal studies could help clarify whether repeated exposure to moral distress contributes to burnout, as suggested by the Crescendo model (Epstein and Hamric, 2009). They may also shed light on links to professional disengagement or early career exit, offering a more comprehensive understanding of its lasting effects. Longitudinal studies would be able to further explore the links this research has made with aging and moral distress. Additionally, such studies could explore whether certain workplace interventions effectively mitigate against moral distress over extended periods, providing evidence-based recommendations for organisational policy development. Future research should adopt longitudinal methodologies to assess the long-term impact of *MD Frequency* on clinical psychologists' career trajectories.

Qualitative research offers a valuable mean of exploring the lived experiences of moral distress among clinical psychologists. Although qualitative methodology is relatively dominant across the literature, few studies focus specifically on the experiences of clinical psychologists. While quantitative data can highlight general trends and associations, qualitative methodologies such as in-depth interviews or focus groups can illuminate the

specific contexts in which moral distress arises and how psychologists navigate these challenges. Understanding the narratives and coping strategies of professionals could inform the design of more targeted interventions, ensuring that solutions are grounded in the realities of clinical practice. Moreover, qualitative research could shed light on how different professional and cultural contexts influence the experience of moral distress, addressing gaps in the literature related to diversity and systemic influences on ethical challenges.

Finally, intervention studies are needed to assess the effectiveness of specific workplace strategies aimed at reducing *MD Frequency* and improving job satisfaction. Experimental or quasi-experimental designs could evaluate the impact of such interventions. Imbulana et al, (2021) evaluated twelve studies investigating interventions aimed at mitigating moral distress among nursing and medical clinicians in intensive care settings. Despite identifying various approaches—including moral empowerment programs, end-of-life education, reflective exercises, multidisciplinary debriefings, and moral resiliency training—the overall low methodological quality and high risk of bias limited definitive conclusions on their efficacy. The authors emphasise the need for larger, rigorous randomised trials involving all intensive care clinicians to assess the effectiveness of multifaceted interventions.

Recent research highlights promising interventions to address the impacts of moral distress. Khaghanizadeh et al. (2023) demonstrated that ethical decision-making training significantly enhanced nurses' moral reasoning and sensitivity, with group discussions yielding greater benefits than lectures; both approaches reduced moral distress compared to controls. Hem et al. (2018) found that systematic ethics reflection groups enabled mental health professionals to critically engage with ethical challenges, particularly regarding

coercion, thereby increasing ethical awareness, professional confidence, team trust, and promoting constructive dialogue. Morley and Horsburgh (2021) proposed Moral Distress Reflective Debriefs as an effective intervention, using structured group discussions led by clinical ethicists to foster ethical attunement, perspective-taking, and alleviate emotional constraints such as anger and frustration linked to moral-constraint distress. Severinsson and Kamaker (1999) reported that clinical nursing supervision significantly reduced moral stress and improved job satisfaction by enhancing moral sensitivity, personal development, and self-awareness, essential for managing ethical tensions in nursing.

Given the growing recognition of moral distress as a workplace stressor, developing and testing evidence-based interventions should be a priority for future research. By implementing and rigorously evaluating targeted strategies, healthcare institutions can work towards fostering more ethically supportive environments that enhance both staff wellbeing and patient care quality.

4.7. Self reflexivity

As a white British female trainee Clinical Psychologist with over a decade of experience in mental health services, I acknowledge the ways in which my professional and personal identities have shaped the development and conduct of this research. My prolonged exposure to the healthcare system has sensitised me to the emotional and ethical challenges faced by practitioners, including experiences of moral distress and emotional labour, both witnessed and personally encountered. These experiences likely influenced my initial interest in this topic and shaped my attentional focus during data analysis.

Furthermore, my feminist and social justice-oriented values informed the critical lens through which I approached questions of systemic power, structural constraints, and

practitioner wellbeing. These values, while important motivators, also posed risks of confirmation bias—particularly the tendency to interpret data in ways that validate pre-existing beliefs about injustice in public services. To mitigate this, I engaged in reflexive journaling during the research process and sought regular peer supervision, using these spaces to examine the assumptions I brought to interpretation and decision-making.

I also recognise the potential influence of my status as a trainee—positioned both within and somewhat outside of the systems under study. This dual position may have conferred advantages (e.g, access and empathy) as well as limitations (e.g, interpretive blind spots, role conflict). Acknowledging this, I aimed to maintain a position of epistemic humility, recognising that participants' experiences may diverge from my own, and ensuring the voices of qualified psychologists and diverse perspectives were represented as faithfully as possible.

To preserve objectivity, interpretations were grounded in statistical findings rather than personal assumptions. Additionally, engagement with diverse perspectives, including peer discussions, consultative review, and supervisor feedback, helped mitigate potential biases in the analysis.

4.8. Concluding comments

This thesis provides the first known quantitative examination of moral distress among Clinical Psychologists and trainees within UK mental health services. Through the use of validated measures and statistical modelling, the study makes a significant empirical contribution by identifying the correlational, predictive, and mediating relationships between moral distress, job satisfaction, stress, and intent to leave. These findings offer robust

evidence that moral distress is not only prevalent in this professional group, but meaningfully associated with key indicators of occupational wellbeing and retention.

A particular strength of the research lies in its disaggregation of moral distress into frequency and intensity, demonstrating that the frequency of morally distressing events holds more predictive value for negative workplace outcomes than the subjective level of distress they evoke. The identification of job satisfaction as a mediator between moral distress and turnover intention further clarifies the mechanisms through which ethical tensions affect workforce sustainability, and offers a clear direction for organisational intervention.

While the empirical findings form the central contribution of this thesis, the literature review also introduces a definition of moral distress tailored to mental health professionals, emphasising its relational and systemic dimensions. Moral distress is conceptualised not simply as a reaction to constrained ethical action, but as a response grounded in the clinician's relationship with the patient, shaped by professional values, and constrained by broader institutional, political, and structural forces.

Crucially, this thesis underscores the importance of reframing moral distress not as a personal pathology or deficit, but as a sign of moral sensitivity, a marker of clinicians' commitment to ethical practice in the face of systemic adversity. This reframing shifts the focus away from individualised notions of resilience and towards a broader analysis of organisational and structural conditions. When moral distress is understood in this way, it becomes not merely a problem to be solved at the individual level, but a signal of deeper ethical misalignments within systems of care.

Addressing moral distress therefore requires more than emotional coping strategies; it demands ethical reflection, institutional responsiveness, and systemic change. By evidencing the real impact of moral distress on Clinical Psychologists and trainees, this thesis contributes to a growing call for the development of ethically sustainable working environments, ones that recognise, rather than suppress, the moral sensibilities of those working within them.

5. Dissemination

The dissemination of this study's findings will be pivotal in advancing the understanding of moral distress in Clinical Psychology and healthcare. Several strategies will be employed to ensure the research reaches key audiences and has a meaningful impact.

5.1 Academic Journals and Conferences

Submission for publication in relevant journals will be pursued after the report is finalised.

Appropriate peer-reviewed journals such as the Journal of Clinical Psychology, and Psychological Services will be explored for publication. These journals are well-regarded within the field and will allow the results to reach a broad audience of psychologists and healthcare professionals. Additionally, conferences may provide an opportunity for interaction with experts in the field, facilitating discussion and feedback.

5.2 Stakeholder Engagement and Policy Recommendations

A comprehensive summary report will be prepared and shared with potential key stakeholders, including NHS managers, Moral Harm stakeholders group, clinical training programmes, and professional bodies such as the BPS and NHS Trusts. This report will outline the key findings of the study, particularly the implications for workforce well-being and retention. It will also provide evidence-based recommendations aimed at reducing moral distress, supporting workforce health, and informing future policies on clinical practice and professional development.

5.3 Online Platforms and Social Media

In order to reach a wider audience, key findings will be shared through professional online platforms, including Twitter, LinkedIn, and relevant Facebook groups for Clinical Psychologists and mental health professionals. Short, impactful infographics summarising the key findings and recommendations will be developed and shared to increase accessibility and engagement. This will help to inform both professionals and the general public about the importance of addressing moral distress in healthcare settings.

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Appendix A

Recruitment flyers


HELP IMPROVE THE NHS
PARTICIPANTS NEEDED
MORAL DISTRESS & CLINICAL PSYCHOLOGY
Have you experienced situations that make you feel uneasy ethically?
Were you unable to pursue what you felt was right at work?
Do you work in the Psychology field?
ERAMS Reference number - ETH2223-1215
This research is exploring the experience of moral distress in the clinical psychology profession and would involve answering questions anonymously about your experiences with morality/ethics at work.
Contact
kh22604@essex.ac.uk
University of Essex

Appendix B

MMD-HP

Measure of Moral Distress – Healthcare Professionals (MMD-HP)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of constraints or barriers. This survey lists situations that occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you have experienced each item. Also, rank how distressing these situations are for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how distressed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* and *Level of Distress*.

	Frequency					**Level of Distress**				
	Never				Very frequently	None				Very distressing
	0	1	2	3	4	0	1	2	3	4
1. Witness healthcare providers giving "false hope" to a patient or family.										
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.										
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.										
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.										
5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.										
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.										
7. Be required to care for patients whom I do not feel qualified to care for.										
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.										
9. Watch patient care suffer because of a lack of provider continuity.										
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.										
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.										
12. Participate in care that I do not agree with, but do so because of fears of litigation.										
13. Be required to work with other healthcare team members who are not as competent as patient care requires.										
14. Witness low quality of patient care due to poor team communication.										
15. Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.										

	Frequency					Level of Distress				
	Never				Very frequently	None				Very distressing
	0	1	2	3	4	0	1	2	3	4
16. Be required to care for more patients than I can safely care for.										
17. Experience compromised patient care due to lack of resources/equipment/bed capacity.										
18. Experience lack of administrative action or support for a problem that is compromising patient care.										
19. Have excessive documentation requirements that compromise patient care.										
20. Fear retribution if I speak up.										
21. Feel unsafe/bullied amongst my own colleagues.										
22. Be required to work with abusive patients/family members who are compromising quality of care.										
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.										
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.										
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.										
26. Participate on a team that gives inconsistent messages to a patient/family.										
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.										
If there are other situations in which you have felt moral distress, please write and score them here:										

Have you ever left or considered leaving a clinical position due to moral distress?

- ☐ No, I have never considered leaving or left a position.
- ☐ Yes, I considered leaving but did not leave.
- ☐ Yes, I left a position.

Are you considering leaving your position now due to moral distress?

- ☐ Yes
- ☐ No

Appendix C

Correspondence with Beth Epstein

From: **Hiney-Saunders, Kate R** kh22604@essex.ac.uk
Subject: Re: MDS-R
Date: 5 February 2023 at 17:38
To: Epstein, Beth (meg4u) meg4u@virginia.edu

Hi Beth,

That's really great to hear! I am enjoying my time here very much.

Thank you so much for responding, its been so difficult to get hold of the measure I really appreciate your support. I will likely have questions!

Just having a quick glance at the measure and I'm wondering if it would work for Clinical Psychologists, as they are not usually dealing with physical health. I wondered if any other versions of the measure existed? Or if you have any recommendations to adapt the measure?

Let me know your thoughts

Kind regards
Kate Hiney-Saunders

From: Epstein, Beth (meg4u) <meg4u@virginia.edu>
Date: Saturday, 4 February 2023 at 18:30
To: Hiney-Saunders, Kate R <kh22604@essex.ac.uk>
Subject: Re: MDS-R

Hi Kate,

I've been to the University of Essex! Loved my visit!

We recently updated and revised the MDS-R and the newer instrument is quite a bit more comprehensive. I'm attaching the paper that describes the revision process and the instrument as well. I'd be delighted for you to use it.

Happy to answer questions you might have along the way.

Beth

Beth Epstein
Professor
Associate Dean for Academic Programs
Professor, UVA Center for Health Humanities and Ethics
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Appendix D

Ethics aprroval

01/12/2023

Miss Kate Hiney-Saunders

Health and Social Care

University of Essex

Dear Kate,

Ethics Committee Decision

Application: ETH2223-1215

I am pleased to inform you that the research proposal entitled "Moral Distress within the Clinical Psychology profession " has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Alexandra Kaley

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Appendix E

Qualtrics information sheet

Moral distress within Clinical Psychology

Ethical Approval granted by the University of Essex on 1st December 2023
Invitation to our study
If you are or have been working in the Clinical Psychology field, we would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or you would like more information.
What happens if you agree to participate
You will be asked to complete a series of short self report questionnaires. These questions will be relevant to demographic information, occupational information, moral distress and experiences at work/workplace related factors. This should not take longer than 10 minutes. You may be invited to a follow up interview in which you will be asked to share your experience around ethical issues within your professional role. This part of data collection is entirely your decision and there is no obligation to complete the interview. This interview will cover your views on the role of Clinical Psychologist, how it relates to your own values, you will also be asked about an example where you felt compromised ethically and your broader experience with ethical issues.

Potential risks
Due to the issues raised by the research some of the questions may be emotive, particularly if you take part in interviews. Although interviews aren't therapeutic in nature, I will take a non judgemental and compassionate position to manage these issues. There are risks relating to confidentiality and anonymity, you will be exploring issues related to ethical practice and because of this data will be kept confidential and anonymous. Some names and email addresses may be collected in order to complete interviews, however these will only be known to the researcher and within the report and dissemination each participant will be given a pseudonym. Demographic information will be stored separately and securely from collected data, and all identifying details will be permanently deleted at completion of the research.

Informed consent
Should you agree to take part in this experiment, you will be asked to indicate consent on an online form before the experiment commences.

Withdrawal
Your participation is voluntary and you will be free to withdraw from the project at any time without giving any reason and without penalty. If you wish to withdraw, you simply need to notify the principal investigator (see contact details below). If any data have already been collected, upon withdrawal, your data will be destroyed if possible, unless you inform the principal investigator that you are happy for us to use such data for the scientific purposes of the project. It will not be possible to destroy any data that have already been shared anonymously on data sharing repositories.

Data gathered
We will collect the following data from each participant: demographic information, occupational information, information around moral distress and experiences at work/workplace related factors. You will also be given the option to leave an email address if you are happy to be contacted for an interview.
We are using your data to investigate the prevalence and nature of the phenomena of moral distress within the Clinical Psychology profession. Your data will be gathered by Kate Hiney-Saunders. Personally identifying data will be stored in secure electronic files only accessible to Kate Hiney-Saunders and Paul Hanel (Supervisor). Our legal basis for processing your personally identifying data is that you have consented to it. The data controller is the University of Essex. Essex University's Data Protection Officer can be contacted on dpo@essex.ac.uk. Your data may be anonymised (so that you cannot be identified from them) and published in scientific journal articles, and shared in permanent, publicly accessible archives accessible from any country.

Funding
The research is funded by the Department of Health and Social Care, University of Essex.

Ethical approval This project has been reviewed on behalf of the University of Essex Ethics Sub-committee 2, and had been given approval with the following Application ID: ETH2223-1215

Concerns and complaints
If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the Principal Investigator of the project (see contact details below). If you are still concerned or you think your complaint has not been addressed to your satisfaction, please contact the Director of Research in the Principal Investigator’s department

(see below). If you are still not satisfied, please contact the University's Research Integrity Manager (see below).

Contact details
Principal investigator Kate Hiney-Saunders (kh22604@essex.ac.uk)
Co-investigators Participant Information Sheet Date
Paul Hanel (p.hanel@essex.ac.uk)
Director of Research, Dept of Psychology Prof Sheina Orbell (sorbell@essex.ac.uk)
University of Essex Research Integrity Manager Mantalena Sotiriadou, Research & Enterprise Office, University of Essex, Wivenhoe Park, CO4 3SQ, Colchester. Email: ms21994@essex.ac.uk. Phone: 01206-873561

Appendix F

Qualtrics consent form

Consent.
Please tick the box below to indicate that you have;

Read and understood the information provided above.
Given consent voluntarily and without coercion.
Been given full information about the study and contact details of the researchers.
Understood that your anonymised data will be shared on publicly accessible repositories.
Understood that your participation is voluntary and can be withdrawn at any time, for any reason with no penalty.

☐ I agree to participate in the research project, “Moral Distress and Clinical Psychologists” being carried out by Kate Hiney-Saunders (Trainee Clinical Psychologist)