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Beyond individual resilience: The need for transforming the ethical environment in mental health settings: A scoping review

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Abstract

Nurses working in psychiatric and mental health settings face a complex set of ethical challenges that often lead to moral distress, impaired clinical decision-making, and adverse individual and organizational consequences. The ethical environment of clinical units is a key determinant of the severity and experience of these challenges; however, existing evidence is fragmented, and a comprehensive understanding of this phenomenon remains lacking.

This Scoping review was conducted to elucidate the ethical challenges faced by nurses in mental health settings and examine the role of the ethical environment in the process of clinical decision-making.

A comprehensive search was conducted in PubMed, Scopus, Web of Science, CINAHL, SID, and IranMedex databases. Relevant articles were identified without time limitations and screened using a stepwise screening approach. Eligible studies were analyzed based on conceptual themes, and findings were synthesized in a critical narrative manner.

Evidence demonstrated that the most significant ethical challenges include the use of coercive measures, shortage of human and organizational resources, conflict between professional principles and safety requirements, role ambiguity, and insufficient managerial support. The ethical environment, particularly the quality of interprofessional communication, organizational ethical support, the presence of ethical reflection mechanisms, and leadership style, plays a fundamental role in how nurses perceive and manage these challenges, and can increase or decrease the severity of moral distress and the effectiveness of clinical decision-making.

The results indicate that ethical challenges in psychiatric nursing have multidimensional and structural characteristics, and individual-focused interventions alone cannot address this complexity. Strengthening the ethical environment, establishing formal structures for ethical support, and developing combined individual and organizational approaches to promote ethical resilience and improve clinical decision-making are essential. Presenting structured models of ethical support and case-based reflection can help reduce moral distress and improve the quality of care in mental health settings.

Keywords: Psychiatric nursing, Moral distress, Ethical challenges, Ethical environment.

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Introduction

The concept of moral distress was introduced into nursing literature and subsequently into healthcare ethics vocabulary in 1984 by the American philosopher and bioethicist Andrew Jameton (1). Moral distress is a recognized occupational hazard for nurses, particularly those caring for vulnerable populations in acute psychiatric settings (2). This phenomenon occurs when nurses know the ethically appropriate action to take but are prevented from doing so by internal or external constraints (3). Research indicates that moral distress is not only a personal issue but also an organizational one, experienced at the individual level (4). This phenomenon is prevalent among nurses working in acute mental health units and is associated with adverse outcomes for nurses, patients, and healthcare organizations (5). Studies show that the use of physical restraints, patient isolation, and other coercive measures are among the strongest triggers of moral distress in psychiatric nursing (3, 6, 7). Although these measures are sometimes considered necessary to ensure the safety of patients and staff, they conflict ethically with patient rights and principles of person-centered care, eliciting emotions such as shame, guilt, and moral discomfort in nurses (3).

Staff shortages and limited resources required for adequate care have been identified in both international and Iranian studies as another key factor contributing to moral distress (2, 4, 5, 8, and 9). Nurses report that insufficient time to establish therapeutic relationships, engage effectively with patients, and conduct thorough clinical assessments results in patients receiving inadequate attention and care (5). These conditions not only reduce the quality of care but also increase nurses' feelings of moral helplessness and professional frustration (10). In the Iranian context, findings from studies conducted in mental health and ICU units indicate that factors such as severe staffing shortages, economic pressures to reduce hospital costs, and ambiguity in professional roles and responsibilities are among the most significant structural contributors to moral distress (9, 11, 12).

Another factor influencing nurses' moral distress is the quality of the ethical climate in clinical units, which plays a fundamental role in shaping their experience of moral distress (2, 13). Results from another study in Iran indicate that a supportive ethical climate and professional nursing values play a critical mediating role in reinforcing nurses' professional identity and can reduce the intensity of moral distress (14). This includes support from colleagues, ethical leadership, and nurses' ability to participate in ethical decision-making (15). If moral distress remains unresolved, it may evolve into what is termed moral residue (16), a significant contributor to nurse burnout (17) and potentially negatively affecting the quality and safety of patient care (12). One possible consequence of moral residue is moral numbness, where nurses lose sensitivity to ethical situations (18).

In high-stress mental health environments, nurses employ decision-making patterns when faced with complex ethical dilemmas that combine cognitive-rational and intuitive-experiential elements (19). In this context, unwritten unit norms, the responses of physicians and managers to nurses' suggestions, and prevailing leadership styles critically influence how ethical principles are translated into daily decisions (20). For instance, nurse managers' strategies when facing ethical issues can lead to varying outcomes for nurses, patients, and even the entire healthcare system (20). Accordingly, nurses' ethical decision-making is highly influenced by environmental and structural factors (19).

Research indicates that interventions aimed at strengthening moral courage can be effective in reducing moral distress (21). For example, an Iranian study in 2023 showed that a supportive ethical climate and reduced overtime hours significantly influenced the enhancement of nurses' moral courage (22). Effective interventions may include ethics education programs, case reflection sessions, ethical consultation, and leadership support (23–25).

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These interventions can be implemented at both individual levels (e.g., ethical resilience training, mindfulness, peer support) and organizational levels (e.g., ethics briefings, unit ethics committees, transformational leadership) (24). To assess and manage moral distress, tools such as the Moral Distress Scale possess adequate validity and reliability and can assist in early detection and monitoring of intervention effectiveness.

Despite the growing body of research on moral distress, current knowledge regarding nurses' experiences in psychiatric units remains fragmented and insufficient. These environments, due to the use of coercive measures, resource limitations, conflicts between patient rights and safety requirements, and structural pressures, constitute some of the most complex settings for ethical decision-making. Therefore, it is necessary to conduct a comprehensive narrative review to collate and analyze existing evidence on nurses' ethical challenges in mental health units and the role of the ethical climate in clinical decision-making, thereby laying the groundwork for designing effective interventions, improving policy, and enhancing the quality of care.

Methodology

This study was conducted as a scoping review to map and synthesize the available evidence on ethical challenges faced by nurses in mental health settings and the role of the ethical environment in clinical decision-making. Scoping review methodology was chosen due to the complex and multifaceted nature of the topic, allowing identification of key concepts, gaps in the literature, and areas for future research (Arksey & O'Malley, 2005; Peters et al., 2020).

Search Strategy

A systematic search was performed in the electronic databases PubMed, CINAHL, Scopus, Web of Science, and Google Scholar. Keywords included: moral distress, ethical climate, moral sensitivity, psychiatric nursing, mental health nursing, ethical decision-making, clinical decision-making, physical restraint, coercive measures. Boolean operators (AND, OR) were used to combine search terms. The search timeframe was 2005–2025 to capture both foundational and recent studies.

Inclusion and Exclusion Criteria

Inclusion criteria:

- Studies addressing moral distress or ethical dilemmas among nurses (clinical, administrative, or supervisory) in psychiatric and mental health settings, including qualitative, quantitative, mixed-methods, and review studies.
- Studies examining ethical challenges related to restraining measures, such as the use of physical restraints or isolation.
- Studies with interpretable findings published in English.

Exclusion criteria:

- Conference abstracts without accessible full texts.
- Studies lacking methodological rigor or relevance to the research question.

Study selection

The screening process followed a stepwise approach inspired by PRISMA. A total of 989 records were initially retrieved. After removal of duplicates, titles were screened for relevance. Articles that clearly did not address the key concepts were excluded. Abstracts of remaining articles were then reviewed to identify studies meeting the inclusion criteria. Finally, full texts of eligible articles were assessed for relevance, conceptual quality, and alignment with the review objectives. Following this process, 16 key studies were purposefully selected to ensure comprehensive coverage of the topic (Table 1).

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The selection of articles was guided by their relevance to ethical challenges, contribution to understanding the moral environment, and conceptual richness rather than statistical representativeness. A descriptive PRISMA flow diagram was created to illustrate the selection process (Figure 1).

Quality Appraisal

The methodological quality of included studies was assessed using the JBI Critical Appraisal Tools appropriate for each study design. Studies were evaluated for clarity of research objectives, methodological rigor, data analysis transparency, and relevance to the review question.

Data Extraction and Analysis

Key data were extracted regarding study aims, design, setting, population, main findings, and implications for ethical practice. Both qualitative and quantitative data were analyzed using inductive thematic analysis, guided by Braun and Clarke's six-step framework (26), to identify patterns, themes, and conceptual clusters. The synthesis was performed conceptually, organizing evidence into themes to identify relationships and gaps in the literature. This approach ensured a comprehensive and structured understanding of ethical challenges in mental health nursing and the role of the ethical environment in supporting ethical decision-making.

Ethical Considerations

This scoping review was conducted in accordance with scientific research guidelines and ethical principles. All perspectives and findings from the included studies were treated with respect. Since this study did not involve primary data collection from human participants, no institutional ethics approval was required.

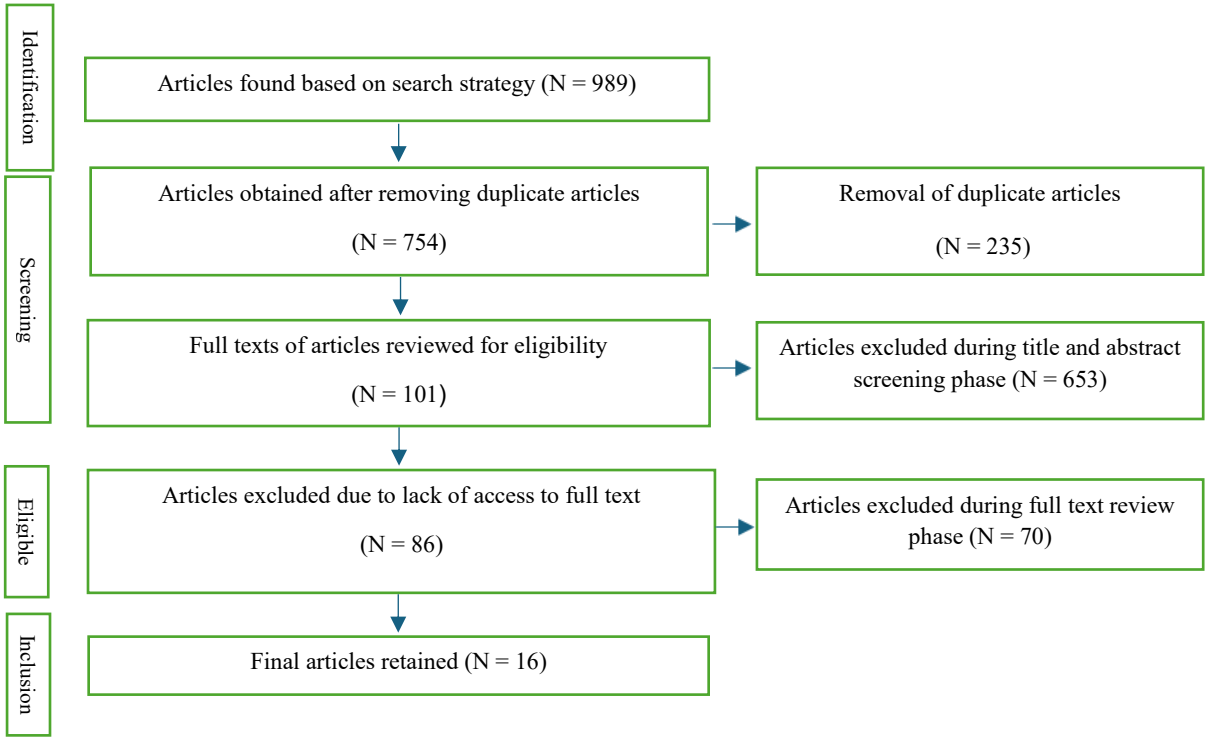

Figure 1. flow diagram of the study selection process

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Table 1. Characteristics of included studies

Row	Article Title	Author Names	Year Conducted	Study Location	Study Type	Study Participants	Methodology	Findings
1	Coping with moral distress on acute psychiatric wards: a qualitative study	Trine-Lise Jansen, Marit Helene Hem, Ingrid Hanssen	2021	Norway	Qualitative	30 nurses working in acute psychiatric wards	30 nurses working in acute psychiatric wards were selected through purposeful sampling and maximum variation. Data were collected through semi-structured interviews lasting 30-60 minutes on average. Data analysis was conducted using thematic analysis based on the steps proposed by Braun and Clarke.	Nurses use various coping strategies, with colleagues and the work environment playing important roles in selecting coping strategies. Nurses' strategies can impact both clinical performance and their private lives
2	Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands Trine-Lise Jansen, Marit Helene Hem, Ingrid Hanssen	Trine-Lise Jansen, Marit Helene Hem, Ingrid Hanssen	2020	Norway	Qualitative	16 nurses working in psychiatric wards	Data were collected through in-depth and structured interviews with 16 nurses working in psychiatric wards, and data analysis was conducted using thematic analysis based on the steps proposed by Braun and Clarke.	A broad spectrum of moral distress was introduced in this study. Stressful ethical situations included forced medication prescription, coercion that may be avoidable, and resistance to the use of coercion.
3	Moral distress, moral sensitivity and ethical climate of nurses working in psychiatric wards	Dabok Noh, Sunah Kim, Sanghee Kim	2013	Korea	Descriptive and cross-sectional	108 nurses working in psychiatric wards	Data were collected using self-report questionnaires (for 108 nurses) and focused interviews (for 8 nurses). The tools used included the Moral Distress Questionnaire, Moral Sensitivity Questionnaire, and Ethical Climate Scale.	Findings indicated that the mean score for moral distress was 3.74 and for moral sensitivity was 4.67. Factors that significantly affected moral distress included: clinical experience in psychiatric settings, ethical sensitivity, personal interests, and friendship. Results suggest that in developing interventions to reduce moral

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								distress in nurses working in psychiatric settings, the factors affecting moral distress and the content of moral distress should be considered.
4	Impact of moral sensitivity on moral distress among psychiatric nurses	Kayoko Ohnishi, Kazuyo Kitaoka, Jun Nakahara	2019	Japan and Finland	Cross-sectional	997 nurses working in 12 psychiatric hospitals in Japan and 974 nurses working in 10 psychiatric hospitals in Finland	Convenience sampling was conducted. Samples completed questionnaires, including moral distress, ethical sensitivity, and ethical climate.	Findings showed that the relationship between ethical sensitivity and moral distress in both countries is positive and similar, although the structure of ethical sensitivity and moral distress factors in Japan and Finland differs to some extent.
5	Psychiatric nurses' experience of moral distress: its relationship with empowerment and coping	Michiko Tomura	2023	Japan	Descriptive and cross-sectional	180 nurses are working in psychiatric wards	Data from this study were collected through questionnaires on moral distress, conditions of structural and psychological effectiveness in the second version, and a brief questionnaire on coping styles.	In this study, participating nurses reported moderate levels of both structural and psychological empowerment.
6	Moral distress among acute mental health nurses: a systematic review	Sara Lamoureux, Amy E Mitchell, Elizabeth M Forster	2024		Systematic review	10 studies	This study is a systematic review. Four quantitative studies examined moral distress in acute mental health nurses, and six qualitative studies examined the phenomenon of moral distress as experienced by nurses in these settings.	Moral distress is common among nurses working in acute mental health settings. Quantitative studies identified relationships between moral distress and emotional exhaustion, depersonalization, cynicism, lower job satisfaction, lower sense of coherence, weaker ethical climate, and less experienced ethical support. Qualitative studies revealed factors associated with moral distress, including inaction,

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								inappropriate colleague behavior, time pressures, professional consequences, policy and legal consequences, patient aggression, and safety.
7	Ethical Problems and Application of Ethical Decision-Making Models in Nursing Practice: A Scoping Review	De Silva Kaushalya, Asurakkoby	2024	Sri Lanka	Review	24 studies	24 articles with topics of ethical problems in nursing practice, elements and strategies of ethical decision-making in nurses, and application of ethical decision-making models in healthcare were included in the study	Three main categories of ethical problems in nursing practice were identified: Problems related to healthcare team members, including team interaction, conflict between nurses and physicians, and other professions. Problems related to patients: conflict over treatment decisions, violations of privacy, etc. Problems related to caring behavior and professional performance, such as inadequacy in care, negligence, inattention, etc.
8	Ethical dilemmas and decision-making in emergency and critical care nursing in Western Amhara region, Northwest Ethiopia: a multi-method qualitative study	Abebe Dilie Afenigus, Mastewal Ayehu Sinshaw	2025	Ethiopia	Qualitative multi-method	28 nurses, including 10 nurses for individual in-depth interviews and 18 nurses in three focus groups, participated in the study.	Data collection involved semi-structured interviews and focus group discussions. All interviews were recorded with informed consent, then transcribed, translated into English, and entered into MAXQDA software for analysis. An inductive thematic analysis was performed to identify themes and subthemes from the qualitative data.	Nurses reported multiple instances of ethical dilemmas, including End-of-life decisions and the choice between continuing treatment or palliative care. Allocation of limited resources in critical situations forces nurses to prioritize and make difficult decisions. Pain management in end-of-life patients and the conflict between reducing pain and avoiding harm. Conflict between patient autonomy and the healthcare team's duty of care regarding refusal of ventilation when the

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								team believes in resuscitation.
9	Factors influencing ethical decision-making in nursing: A mixed-methods systematic review	Ming Sun, Xianghua Jin, Zhuyin Wang	2025	China	Mixed-methods systematic review	13 quantitative and 4 qualitative studies	Studies that directly examined factors affecting ethical decision-making in nurses, including both quantitative and qualitative studies in both Chinese and English, were included. Qualitative data were categorized into themes and subthemes. Quantitative data were integrated by reviewing statistical results and the effects of various factors.	Factors affecting ethical decision-making were categorized into 4 main groups: Factors related to nurses: professional identity, feeling, experience, ethical knowledge, and ethical sensitivity. Factors related to patients/hospital: patients' clinical conditions and their changes. Team/colleague dynamics: interprofessional communication, peer and manager support. Context/decision-making conditions: work intensity, time pressure, and organizational structure.
10	Strategies of Iranian Psychiatric Nurses to Deal with Moral Distress	Nahid Tavakol, Zahra Molazem, Mahnaz Rakhshan, Omid Asemani	2023	Iran	Qualitative content analysis	12 nurses working in psychiatric wards	12 nurses working in psychiatric wards were selected using purposeful sampling with maximum variation considered, and data were collected through semi-structured interviews with participants. Each interview lasted 40-60 minutes and continued until data saturation was achieved.	Coping strategies with moral distress in psychiatric nurses fall into 4 main categories: 1. Confrontational coping strategies: reporting, strict enforcement, and punishing colleagues who do not perform their duties. 2. Establishing therapeutic and professional relationships: team participation, therapeutic communication. 3. Management support for nurses. 4. Commitment to religious beliefs.

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11	Contextual influence on nurses' decision making in cases of physical restraint.	Bernadette Dierckx de Casterlé, Sabine Goethals, Chris Gastmans	2015	Belgium	Qualitative descriptive	21 nurses working in acute elderly care wards	21 nurses were selected through purposeful sampling, and individual in-depth interviews were conducted. Qualitative analysis was conducted using content analysis and inductive analysis.	Contextual factors influencing nurses' decision-making included: Interpersonal domains such as relationships with colleagues and family. Policies, institutional regulations, and legal issues, such as the presence or absence of guidelines and legal frameworks. Physical structure of the ward, such as ward design and available facilities, that affect the feasibility of alternatives to physical restraint. Access to resources and alternatives, such as the presence or absence of alternative methods and tools. Practical care certainty, such as workload and clinical conditions that may influence nurses' decisions.
12	Exploration of the Association between Nurses' Moral Distress and Secondary Traumatic Stress Syndrome: Implications for Patient Safety in Mental Health Services	Maria Christodoulou-Fella, Nicos Middleton, Elizabeth D. E. Papathanassoglou , Maria N. K. Karanikola	2017	Cyprus	Cross-sectional	206 nurses from mental health care units	206 nurses were selected through purposeful sampling, and data were collected using the Moral Distress Scale in Clinical Settings, a scale for measuring symptoms of secondary traumatic stress resulting from exposure to psychological injuries of patients, and a scale for measuring general psychological distress.	Mental health nurses reported high levels of moral distress and secondary traumatic stress. There is a positive and significant relationship between moral distress and secondary traumatic stress; the higher the moral distress, the more severe the symptoms of secondary traumatic stress. General psychological distress plays a partial mediating role between moral distress and secondary traumatic

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								stress. Three main factors predicting secondary traumatic stress: moral distress, general psychological distress, and emotional exhaustion. These findings suggest that moral distress and secondary traumatic stress can affect nurses' mental health and patient safety.
13	Moral Injury in Mental Health Nursing--A Qualitative Descriptive Study in Switzerland.	Célina Heitzmann, Veronika Waldboth, Mirjam Mezger	2025	Switzerland	Qualitative descriptive	19 nurses working in psychiatric wards	Data were collected through focused interviews addressing ethical problems and analysis of structured content with the extraction of categories and subcategories from interview text using an inductive method.	Nurses Experienced severe moral distress when facing organizational limitations and challenging ethical situations. Main factors causing moral injury include workforce and resource shortages, high work pressure, organizational hierarchy, and disregard. for nurses' opinions, coercive or freedom-restricting measures against patients. Consequences of moral injury: feelings of guilt, shame, helplessness, anxiety, and spiritual exhaustion. Some nurses left their jobs or changed work areas, protective and coping factors: group discussions with colleagues and managers, personal reflection and critical thinking, organizational support, and teaching of crisis management skills.
14	Moral distress in Iranian psychiatric	Nahid Tavakol, Zahra Molazem, Mahnaz	2023	Iran	Qualitative and content analysis	12 nurses working in psychiatric wards	12 nurses were selected through purposeful sampling, and	7 main categories were identified as contextual/causal factors for moral

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	nurses: a content analysis.	Rakhshan, Omid Asemani					semi-structured interviews were conducted with each participant, lasting 40-60 minutes. Audio files were transcribed, and initially primary codes were extracted, then these codes were continuously transformed through processes of integration into subcategories, and finally 7 main categories and 20 subcategories were identified.	distress, including: lack of professional competence (shortage of knowledge, skills, etc.). Organizational culture (structure, values, organizational norms). Individual factors (personality characteristics of nurses, such as beliefs and ethical sensitivity, and decision-making ability). Environmental and organizational factors (such as resources, work pressure, and human resource shortage). Managerial factors (managerial decisions, policies, managers' support, etc.). Weakness in professional communication (problems in communication between the care team, patient, and manager). Witnessing ethical problems (when a nurse witnesses an action or situation that contradicts their ethical values and principles).
15	Coercive measures in psychiatry: a review of ethical arguments.	Maria Chieze, Christine Clavien, Stefan Kaiser, Samia Hurst	2021		Narrative review	99 articles	In this study, articles directly examined ethical issues of coercive freedom-restricting measures in adult inpatient psychiatric settings. All arguments and ethical statements were extracted, and then the arguments were decomposed into basic ethical elements such as values, rights,	Most authors in ethical literature, considering ethical balance, believe that the use of coercion may be justified in exceptional circumstances, if other less invasive options are not feasible, and to protect more important values (such as patient safety or others, or maintaining patients' long-term identity and

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							beliefs, feelings, scientific considerations, and risks.	autonomy). However, given the ethical complexity and variability of conditions (law, culture, clinical conditions), the decision about coercion should be made on a case-by-case basis. It is important that in research and clinical practice, less invasive alternatives (such as crisis reduction methods, relational care, psychological intervention, safe environment, dialogue) be examined and strengthened to reduce the need for coercion.
16	Exploring the relationship between compassion fatigue, stigma, and moral distress among psychiatric nurses: a structural equation modeling study	Hanaa M. Abo Shereda, Samirh Said Alqhtani, Abdullah Hamoud ALYami, Hani Mohammed ALGhamdi, Mohammed Ibrahim Osman Ahmed, Norah Abdulrahman ALSalah	2025	Saudi Arabia	Cross-sectional	Psychiatric nurses working in psychiatric units	Data were collected using scales measuring compassion fatigue, clinical social stigma of patients, and moral distress for healthcare professionals.	Findings confirmed the important and central role of compassion fatigue as a strong mediator in the relationship between social stigma and moral distress in nurses. The study recommends interventions such as peer support groups, resilience training, and organizational measures to reduce stigma and compassion fatigue in mental health environments.

Findings

Moral distress is a common and pervasive challenge for nurses in acute psychiatric settings (2, 5). This phenomenon occurs when nurses know the correct course of action but organizational constraints prevent them from executing it (10). Psychiatric nurses report high levels of moral distress, with a mean moral distress score of 3.74 among them (27). One of the situations inducing moral distress involves coercive measures or restrictions on patient freedom (28, 29). Nurses experience intense moral distress when confronted with

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organizational constraints and difficult ethical situations (30).

Theme 1: Nature and Sources of Moral Distress in Psychiatric Nursing

Multiple factors contribute to the occurrence of moral distress and ethical dilemmas in psychiatric nursing, which can be categorized as follows:

Patient-related factors: In psychiatric care, especially when coercive measures become necessary, a prominent ethical tension arises between the principle of patient autonomy (the patient's right to make decisions about their care) and the principles of beneficence (acting for the patient's good) and non-maleficence (preventing harm) (29). This tension occurs when limiting patient autonomy, for instance through forced medication or physical restraint, is deemed necessary to maintain the safety of the patient or others (28, 30). In these situations, nurses feel caught between their professional ideals (upholding dignity, autonomy, and the therapeutic relationship) and organizational or safety demands (2, 5, 31). Factors such as patient aggression and safety concerns (2, 32), conflicts over treatment decisions and violations of patient privacy (30), rapid discharge of patients without adequate preparation, feelings of inadequacy in providing optimal care (33), and witnessing ethical dilemmas that conflict with nurses' values are among other contributors to nurses' moral distress (29, 31).

Organizational and systemic factors: Elements such as unwritten unit norms, leadership style, and patient census influence how ethical principles (e.g., respect for autonomy) are interpreted and applied (30, 34). Chronic staffing shortages and pressure to manage high-risk behaviors in minimal time, alongside disregarding nurses' opinions, push them toward moral distress (2, 10, 35). Low staffing levels during night shifts often result in high-risk patients being supervised by less experienced personnel (34). Furthermore, time constraints hinder the development of constructive relationships with patients, engagement in therapeutic conversations, monitoring of patients under supervision, and conducting clinical assessments, preventing nurses from knowing their patients beyond diagnosis and medication (7).

Interpersonal and team-related factors: Conflicts between nurses, physicians, and other professionals, being compelled to carry out treatment measures and physician orders without informed patient consent, inappropriate colleague behaviors (which may include disrespect, neglect, or any action that creates a negative work environment), poor professional communication within the treatment team, and pressure for unjustified invasive treatments contribute to nurses' moral distress (2, 7, 31, 32).

Nurse-related factors: Lack of professional competence (insufficient knowledge and skills), personal interests, and clinical experience in psychiatric settings influence nurses' experience of moral distress (10, 27). Nurses with higher educational levels (e.g., master's degrees) report greater moral distress, which may be related to greater responsibility, higher expectations, and encountering more complex ethical conflicts (33).

In different cultural contexts in Iran, sources such as conflicts with physicians or other team members, lack of administrative and organizational support, and experiences of patient restriction have been identified as key causes of this phenomenon, emphasizing the importance of examining structural and contextual factors alongside clinical ones (31). It should be noted that higher levels of moral distress are associated with reduced empowerment and increased use of avoidant coping strategies (36). Continued exposure to such situations without supportive mechanisms and ethical reflection may lead to emotional exhaustion, burnout, and intentions to leave the profession. Collectively, these findings depict moral distress as a phenomenon shaped not only by case-specific conflicts but also by the

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recurrent pattern of facing structural barriers to ethical judgment (2).

Theme 2: Role of Ethical Climate and Moral Sensitivity in the Intensity and Experience of Moral Distress

Moral distress in psychiatric nursing is significantly influenced by the quality of the unit's ethical climate and individual characteristics such as moral sensitivity. Nurses' perception of a supportive ethical environment, characterized by open ethical dialogue, managerial support, and mutual respect, is significantly associated with lower levels of moral distress (29). In contrast, units where decisions are made hierarchically without nurse participation exacerbate the conflict between individual ethical judgment and organizational policy, resulting in persistent moral distress (27, 34, 35).

Studies indicate that without changes to the organizational culture, nurses' moral sensitivity has limited opportunity to translate ethical concerns into dialogue and action, resulting in moral helplessness. Nurses working in environments where the use of restrictive measures is considered routine and unquestionable, even with high moral sensitivity, have limited opportunities to convert their ethical concerns into dialogue or practical change, leading to feelings of ethical powerlessness and helplessness. Overall, these findings suggest that moral sensitivity without a supportive ethical climate can increase moral distress, whereas in a supportive ethical environment, the same sensitivity can enhance the quality of care and professional growth (28, 30, 34). Moreover, a toxic ethical climate combined with moral distress and secondary stress reduces nurses' ethical decision-making capacity, empathy, and clinical accuracy, forming a vicious cycle that jeopardizes patient safety (7).

Theme 3: Coping Strategies and Ethical Decision-Making Patterns in Clinical Practice

Studies show that nurses employ a range of coping strategies to manage moral distress, some adaptive and others maladaptive. Adaptive strategies include reflection and philosophical reasoning, communication, and pursuing interests outside the workplace, while maladaptive strategies include passive acceptance, taking leave, and alcohol consumption (23).

Psychiatric nurses typically use three coping methods: internalization and silence (enduring without expressing concerns), forced compliance with norms and orders, and seeking dialogue and collective reflection. Continuous reliance on silence and denial strategies, although potentially preventing open conflict with colleagues or managers in the short term, is associated with long-term emotional exhaustion and professional alienation. Conversely, formal or informal spaces for ethical case discussions, such as case reflection sessions, peer groups, or ethics committees, enable nurses to transform moral distress into a source of learning and professional improvement (5, 36). Colleagues and workplace culture are crucial in shaping coping strategies; in units where decisions are made hierarchically and nurses' ethical concerns are ignored, nurses are more likely to adopt maladaptive strategies such as silence (37).

Studies indicate that discussing experiences with colleagues is considered the most effective coping method. Regular ethical discussion sessions allow nurses to process and manage their experiences more effectively (36). Iranian psychiatric nurses employ strategies including reporting issues, enforcing accountability among non-compliant colleagues, team participation, therapeutic communication, managerial support, and adherence to religious beliefs (22).

The most critical consequence of failing to cope effectively with moral distress is the emergence of moral injury. Hitsman and colleagues describe moral injury in psychiatric nursing as a psychospiritual harm resulting from action or inaction that violates an individual's deepest ethical beliefs. This condition extends beyond burnout and is accompanied by symptoms resembling post-traumatic stress

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disorder, severe guilt, shame, and reduced trust in the system and colleagues. These findings emphasize that silence and internalization in the face of structural barriers can transform moral distress into a traumatic experience (30).

Regarding ethical decision-making in clinical practice, studies indicate that nurses often use a combination of intuitive and stepwise models when confronting ethical dilemmas. The three main pillars of nurses' ethical decision-making are ethical knowledge (familiarity with autonomy, beneficence, non-maleficence, and justice), clinical experience, and support from the ethical environment. However, many decisions in practice are based on rapid situational assessment and implicit evaluation of consequences rather than explicit adherence to formal models. Silva and colleagues demonstrated that structured models, such as integrated six-step frameworks, are only effectively applied in practice when deliberately integrated into in-service training and team discussions; otherwise, ethical decision-making remains largely individual and reactive (32, 35).

Studies emphasize that for fair and unbiased evaluation in clinical situations, all elements relevant to the scenario must be identified, properly weighted, and balanced, enabling ethically acceptable choices regarding coercive interventions and reducing the likelihood of hasty, emotion-driven decisions (29). Aftigus et al. (37), in the context of emergency and critical care (non-psychiatric), showed similar dimensions of decision-making under high-pressure conditions. Participating nurses explained that in the absence of clear guidelines and real-time support from physicians and managers, they must make difficult decisions about patient prioritization, initiating or stopping invasive interventions, and managing family conflicts alone, based on personal judgment. This pattern aligns with the findings of Jensen et al. (28), in which psychiatric nurses also perceive themselves at the intersection of the patient, treatment team, and organizational structure—a situation that, without supportive structures and clear decision-making models, reinforces ethical loneliness and increases moral distress. It should be noted that inability to make decisions alone is insufficient for applying coercion, as this may lead to paternalism and power misuse (29).

Theme 4: Individual and Organizational Outcomes and the Need for Systemic Interventions

At the individual level, moral distress among psychiatric nurses has consequences beyond momentary discomfort, posing a direct threat to workforce sustainability and care quality. Recurrent moral distress is associated with burnout, reduced job satisfaction and resignation, emotional exhaustion, depersonalization, reduced quality of care and professional confidence, guilt, shame, helplessness, anxiety, incompetence, and spiritual fatigue (7, 29, 30, 33). Nurses working with psychiatric patients may also face prejudice and social stigma, which exacerbate moral distress and negatively impact professional identity and self-esteem (33). Continuous exposure to patient suffering combined with work pressures leads to compassion fatigue, reducing emotional energy, fatigue, and empathic capacity (33).

Understanding the psychological dimensions of these outcomes is deepened by two key findings:

- **Secondary traumatic stress:** Persistent exposure to unresolved ethical dilemmas, particularly involving patient harm, can lead to indirect traumatic symptoms in nurses, posing a serious threat to patient safety as affected nurses are prone to emotional exhaustion and avoidant behaviors in clinical interactions (7).
- **Reduced empowerment:** Higher levels of moral distress are associated with reduced feelings of empowerment, creating a vicious cycle: distressed nurses participate less in decision-making processes, which in turn

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intensifies their sense of ethical helplessness (36).

At the organizational level, studies indicate that poor ethical environments are not only associated with higher moral distress but also with outcomes such as a culture of silence, reduced interprofessional trust, and normalization of problematic practices. In units where nurses' ethical concerns are ignored or labeled as resistance to organizational policy, the likelihood of documentation or reporting of issues decreases, potentially compromising patient safety. Conversely, Lamarius' review and analyses by Sun and Silva emphasize that supportive structures, such as clinical ethics committees, regular reflection sessions, and scenario-based ethics training programs, can play a protective role against the negative outcomes of moral distress (35, 2, 32, 27, 34).

These findings highlight that moral distress among psychiatric nurses should be addressed as an organizational and systemic issue rather than merely an individual coping deficit (7). This perspective aligns with Jensen et al. (28), who argue that without changes in decision-making structures, improved nurse-to-patient ratios, and strengthened ethical climates, any individual-focused interventions (e.g., coping skills training) cannot sustainably reduce the intensity and consequences of moral distress. Solutions should therefore focus on organizational empowerment of nurses, including fostering a culture of ethical dialogue, improving staffing ratios, strengthening support systems, and training in ethical resilience and decision-making. These measures not only protect nurses' mental health but also enhance patient safety by reducing errors and improving care quality (7).

Discussion

Nurses working in psychiatric units continuously face unique ethical and emotional challenges. This narrative review emphasizes the importance of understanding these challenges and the critical role of the ethical environment in supporting nurses' clinical decision-making.

One of the most prominent ethical challenges faced by psychiatric nurses is moral distress (3, 10, 31), often intertwined with compassion fatigue and social stigma (33). Moral distress is associated with low self-esteem, burnout, depression, hopelessness, reduced job satisfaction, intention to leave, higher nurse turnover, decreased moral sensitivity, and impaired ethical reasoning and clinical decision-making (25, 29, 30, 34, 38). This disturbance may result from nurses' inability to perform ethically appropriate actions due to organizational constraints or conflicts with colleagues (3).

Burnout, emotional fatigue, pessimism, and reduced job satisfaction, although consequences of moral distress, may themselves exacerbate moral distress (2). Conversely, spirituality and individual spiritual sensitivity may influence moral distress, with positive spiritual factors potentially mitigating it (22).

One of the most common causes of moral distress is the use of restraints and coercive behaviors in psychiatric units. Studies indicate that some coercive measures are permissible only under exceptional circumstances, justified through a fair balance of reasons considering laws, official recommendations, and all ethical elements related to the situation. Others advocate for absolute prohibition, emphasizing non-negotiable fundamental human rights, such as respecting autonomy under all conditions. Most authors acknowledge that even fundamental rights like autonomy may be overridden in exceptional clinical situations, but only after all more respectful alternatives have failed and coercion serves the greater good (e.g., imminent risk to the patient or others) (7, 29, 34). Furthermore, patients also perceive these situations and experiencing coercive interventions alongside inadequate nurse–patient communication can negatively affect recovery,

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sense of safety, and trust in the healthcare system (39).

Findings of this narrative review indicate that moral distress in psychiatric nursing is a multilayered phenomenon arising from the complex interaction of individual, environmental, and organizational factors (2, 28). Individual factors such as age, gender, education level, work experience, and personality traits influence the experience of moral distress (27, 31). For example, less experienced and younger nurses report higher moral distress (7, 33).

Regarding gender, findings are mixed: some studies report that female nurses experience higher levels of moral distress (27), while others find no significant association between gender and moral distress (31).

Environmental factors, particularly moral sensitivity and ethical climate, are key components of the moral distress puzzle, acting as either protective or exacerbating influences. Nurses with higher moral sensitivity recognize ethical situations more deeply, but in environments lacking supportive structures, this sensitivity increases moral distress rather than enhancing care. In contrast, in units with a supportive ethical climate, the same high moral sensitivity strengthens ethical reasoning, improves care quality, and promotes constructive coping strategies (27). Additionally, organizational factors such as unwritten norms, leadership style, and interprofessional communication patterns play a significant role in how ethical principles are applied in nurses' daily clinical decisions (10, 27, 34). Conflicts in professional judgment or clinical decision-making within multidisciplinary teams may lead to moral distress, particularly when nurses' concerns are ignored by those in power (10).

One notable finding is the consistency of the fundamental relationship between moral sensitivity and moral distress across cultures. Onishi's study in Japan and Finland, involving participants with differing perspectives and work conditions, reported an identical correlation (β = 0.21) for both countries, indicating that the overall pattern transcends cultural boundaries and may be considered a universal principle in understanding nurses' moral distress. However, significant differences in factor structures between the two countries (particularly in the relationships of moral sensitivity with moral authority and moral distress with staff shortages) suggest that intervention strategies must be adapted to local and organizational contexts (10).

To improve the situation, attention to moral distress among psychiatric nurses is essential. Enhancing their clinical decision-making abilities through educational programs and workshops can support the provision of optimal nursing care. Increasing nurses' knowledge, especially among novice nurses, regarding moral distress and strengthening their professional competence in decision-making are among the recommended strategies.

Study Limitations

Despite their value, the existing studies have notable limitations:

1. None of the reviewed studies reported evidence-based interventions for reducing moral distress, representing a significant gap; future research should focus on developing and testing effective interventions.
2. Although several studies used the Moral Distress Scale for Psychiatric Nurses (MDS-P), others employed different tools, complicating within- and between-study comparisons.
3. Most studies were conducted in welfare countries (Japan, Norway, Canada), limiting knowledge about moral distress in resource-constrained settings.

Recommendations for the Iranian Context (Psychiatric Units)

In Iran, evidence indicates that nurses in mental health and other high-stress units face high levels of moral distress, with structural factors such as

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staff shortages, economic pressure, and role ambiguity playing a decisive role. Additionally, Iranian studies on psychiatric nurses have shown that dimensions such as acceptance of patient rights violations, unethical team behavior, and staff shortages appear as primary factors in the factor structure of the moral distress scale in Iran, consistent with international findings in psychiatric nursing. Based on this overlap, the following recommendations can be proposed for psychiatric units in Iran (8, 9).

1. Structural Strengthening of the Ethical Environment:

Clear definition and explanation of policies and protocols related to restraining measures (restraints, isolation, forced medication), along with emphasis on patient rights and minimum use criteria.

Formation or activation of clinical ethics committees in hospitals with psychiatric departments, with the ability to promptly refer challenging cases by nurses.

Improvement of nurse-to-patient ratios and reduction of crowded shifts, which have been reported in Iranian and international studies as one of the strongest drivers of moral distress.

2. Creating Safe Spaces for Ethical Reflection:

Regular ethical case review sessions in mental health settings with the presence of frontline nurses, psychiatrists, and unit managers to discuss recent difficult situations.

Use of peer support groups to reduce feelings of moral isolation and facilitate sharing of moral distress experiences in a non-punitive environment.

3. Targeted Education in Ethical Distress and Decision-Making:

Designing short-term courses based on Sun and Silva's studies in which simple and practical ethical decision-making models (e.g., step-by-step models) are practiced with examples from Iranian psychiatric settings.

Integration of concepts such as moral distress, ethical resilience, and a culture of reporting into psychiatric nurse refresher programs, using adapted tools such as the Iranian Moral Distress Scale.

4. Supportive Individual and Organizational Interventions:

Using evidence of educational interventions in Iran (such as professional ethics workshops that have shown a reduction in moral distress severity) to design regular programs, not episodic ones.

Strengthening psychological support and counseling services for mental health setting nurses, given the overlap of moral distress with depression, anxiety, and burnout in domestic studies.

Overall, combining international evidence in psychiatric nursing and Iranian data shows that in psychiatric settings in the country, focusing on improving the ethical environment, enhancing organizational justice, structured teaching in the field of ethical decision-making, and creating safe spaces for reflection and dialogue can be a more strategic approach than purely individual-focused interventions in reducing moral distress and improving quality of care.

Conclusion

This narrative review highlights that moral distress among nurses in psychiatric and mental health settings is not merely an individual psychological response, but a multidimensional phenomenon rooted in ethical, organizational, and structural conditions. The findings demonstrate that ethical challenges such as the use of coercive measures, resource limitations, role ambiguity, and weak interprofessional communication are deeply intertwined with the ethical environment in which nurses' practice.

Importantly, the review shows that the quality of the ethical environment plays a decisive role in shaping nurses' experiences of moral distress and their capacity for ethical and clinical decision-making. Supportive leadership, opportunities for

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ethical dialogue, ethical reflection mechanisms, and organizational support structures can mitigate moral distress, whereas hierarchical decision-making and cultures of silence intensify ethical pressure and moral injury.

Overall, the evidence suggests that interventions focused solely on individual coping or resilience are insufficient. Sustainable reduction of moral distress in psychiatric nursing requires systemic and organizational approaches that strengthen the ethical environment while simultaneously supporting individual ethical competence and moral resilience. Future research should prioritize the development and evaluation of context-sensitive, organization-level interventions and structured ethical support models to enhance nurses' well-being, ethical decision-making, and the quality of care in mental health settings.

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