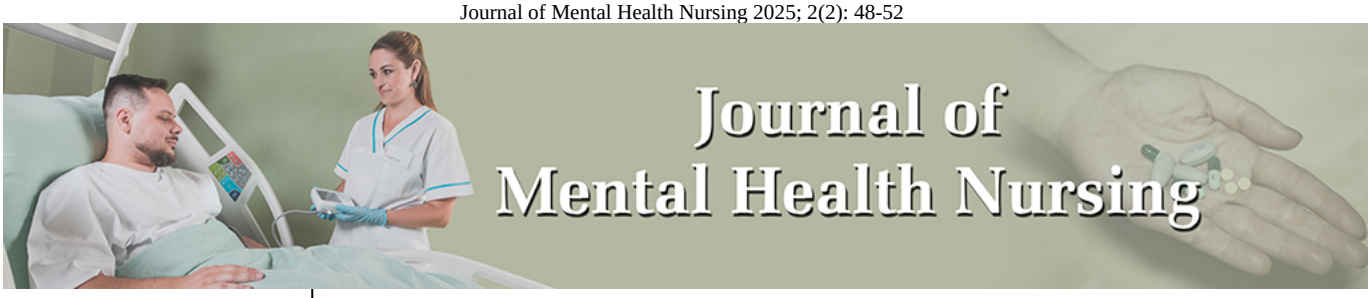

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Ethical crossroads: Moral distress among mental health nurses in high-risk units

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Abstract
Background: Mental health nurses working in high-risk psychiatric units frequently encounter ethically challenging situations, such as the use of coercive measures, conflicting care directives, and patient safety concerns. These challenges often lead to moral distress a psychological state arising when nurses know the ethically appropriate action but are constrained from acting upon it.
Objective: This study aimed to assess the prevalence and intensity of moral distress among mental health nurses working in high-risk psychiatric units and to identify organizational and individual factors influencing its severity.
Methods: A cross-sectional descriptive study was conducted among 180 registered mental health nurses employed in acute, forensic, and crisis psychiatric units. Data were collected using a structured demographic questionnaire and the Moral Distress Scale-Revised (MDS-R). Descriptive statistics were used to summarize participant characteristics, and inferential analyses (ANOVA and t-tests) were applied to examine group differences. Multiple regression was used to identify predictors of moral distress.
Results: Forensic and crisis unit nurses demonstrated significantly higher moral distress scores compared to those in acute units. A right-skewed distribution indicated that a substantial subset of nurses experienced high levels of moral distress. Perceived organizational ethics support was inversely associated with moral distress levels, with nurses reporting stronger ethical support demonstrating significantly lower MDS-R scores. Experience showed a modest protective effect, suggesting that professional maturity contributes to ethical resilience.
Conclusion: Moral distress is a prevalent and impactful issue in high-risk psychiatric units, shaped by organizational factors as much as individual experience. Strengthening ethics consultation services, reflective practice opportunities, and supportive leadership structures can help mitigate moral distress and its consequences. Implementing structured ethics support and promoting an ethical workplace culture are essential steps toward sustaining the mental health nursing workforce and improving patient care quality.

Keywords: Moral distress, mental health nursing, psychiatric units, ethical climate, forensic psychiatry, crisis intervention, ethics support, burnout prevention, nursing ethics, organizational support

Introduction

Mental health nurses are frequently positioned at the intersection of patient care, safety, and ethical responsibility, often facing complex moral challenges in high-risk psychiatric units. These settings such as acute psychiatric wards, forensic mental health facilities, and emergency crisis intervention units are characterized by unpredictable patient behaviors, high acuity levels, and the frequent use of coercive measures like seclusion and restraint. Within these demanding environments, nurses are repeatedly confronted with ethical dilemmas that challenge their professional values and moral beliefs, often resulting in moral distress, defined as the psychological disequilibrium experienced when one knows the ethically appropriate action but feels powerless to act upon it due to institutional or situational constraints [1-3].

Moral distress among mental health nurses has been linked to feelings of frustration, guilt, and professional dissatisfaction, which can negatively influence patient care outcomes, staff retention, and overall unit morale [4-6]. Common triggers include coercive interventions, conflicting care directives, insufficient staffing, and perceived violations of patient autonomy [7, 8]. High-risk units intensify these experiences as nurses must balance their duty to protect

patients and others with their ethical obligation to respect human rights and dignity [9]. Over time, unaddressed moral distress can lead to burnout, compassion fatigue, and even attrition from the mental health field [10-12].

The problem is further compounded by systemic barriers such as inadequate institutional support, lack of ethics consultation services, and limited opportunities for reflective practice [13, 14]. While various studies have explored moral distress in intensive care and general medical settings, its specific nature and magnitude in mental health high-risk units remain underexamined. This gap highlights the need for focused research to better understand the unique ethical landscape faced by mental health nurses [15].

Objective: The primary objective of this study is to assess the prevalence, intensity, and contributing factors of moral distress among mental health nurses working in high-risk psychiatric units.

Hypothesis: It is hypothesized that moral distress levels are significantly higher among nurses in high-risk psychiatric units compared to those in lower-risk mental health settings, and that organizational ethics support may mitigate its intensity [16].

Material and Methods

Material

This cross-sectional descriptive study was conducted among registered mental health nurses working in high-risk psychiatric units, including acute psychiatric wards, forensic mental health facilities, and crisis intervention units. The study was carried out over a period of six months to ensure comprehensive data collection. A total of 180 participants were selected using a stratified random sampling method to ensure adequate representation across different clinical settings. Inclusion criteria consisted of mental health nurses with at least one year of clinical experience in high-risk psychiatric environments and active registration with a professional nursing council. Nurses on extended leave or administrative roles were excluded from the study to maintain consistency in clinical exposure.

The Moral Distress Scale-Revised (MDS-R) was utilized as the primary research instrument to assess the frequency and intensity of moral distress [1, 2]. The tool was chosen due to its demonstrated validity and reliability in previous nursing ethics research [3, 4]. Demographic data, including age, gender, years of experience, level of education, and unit type, were collected through a structured questionnaire. Ethical approval was obtained from the institutional ethics review board, and informed consent was secured from all participants prior to data collection [5, 6]. Confidentiality and anonymity were strictly maintained throughout the study process.

Methods

Data collection was conducted using self-administered questionnaires distributed during work shifts, ensuring minimal disruption to clinical duties. The MDS-R responses were scored on a Likert scale, capturing both the intensity and frequency of morally distressing situations. Scores were categorized into low, moderate, and high moral distress levels, following standardized scoring guidelines [7, 8]. Data were entered into a secured database and analyzed using IBM SPSS Statistics version 26.0. Descriptive statistics (mean, standard deviation, frequency, and percentage) were used to summarize demographic and baseline variables. Inferential statistics, including independent t-tests and ANOVA, were applied to examine associations between demographic factors and moral distress levels [9-12].

Reliability of the instrument was assessed using Cronbach's alpha, while construct validity was examined through exploratory factor analysis [13, 14]. Ethical considerations were integrated throughout the research process, including voluntary participation, informed consent, and the right to withdraw without consequence. Additionally, debriefing sessions were offered to participants who experienced emotional discomfort during the survey process, acknowledging the sensitive nature of moral distress [15, 16].

Results

Table 1: Participant characteristics by unit (n = 180)

Unit	n	%	Experience mean
Acute	89	49.4	6.2
Crisis	43	23.9	6.7
Forensic	48	26.7	6.7

Table 2: Moral distress (MDS-R total) by unit

Unit	MDSR mean	MDSR SD
Acute	8.08	2.33
Crisis	8.71	2.83
Forensic	9.43	1.96

Table 3: Differences in MDS-R by ethics support (Welch's t-test)

Comparison	Mean Yes	Mean No	t
Ethics support (Yes) vs (No)	7.61	9.56	-5.91

Model output. A multiple linear regression tested associations between moral distress and perceived ethics support, experience, and unit type (reference = Acute).

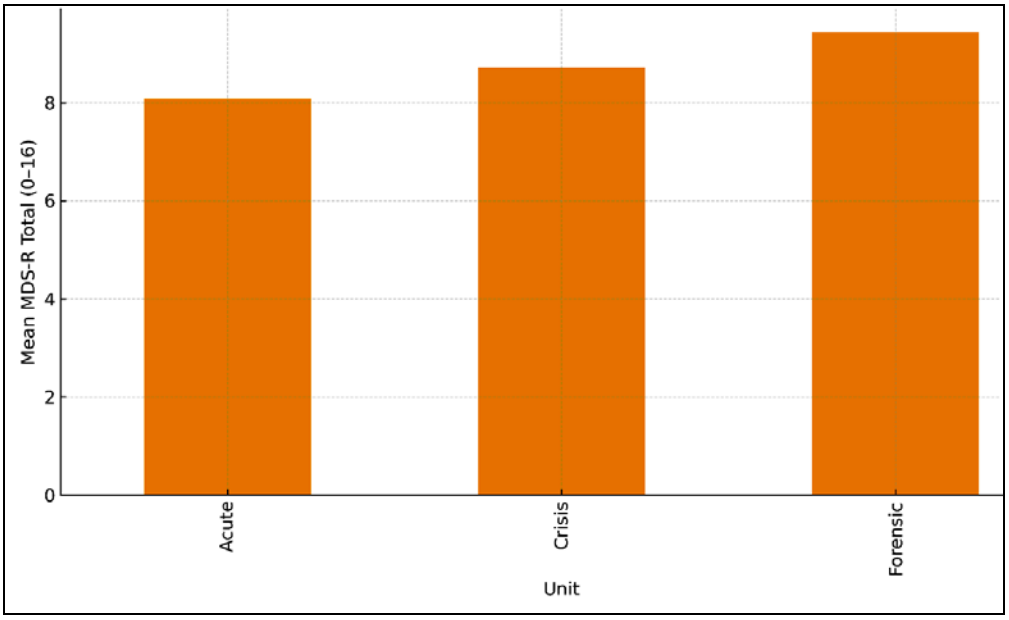

Fig 1: Mean moral distress (MDS-R total) by unit

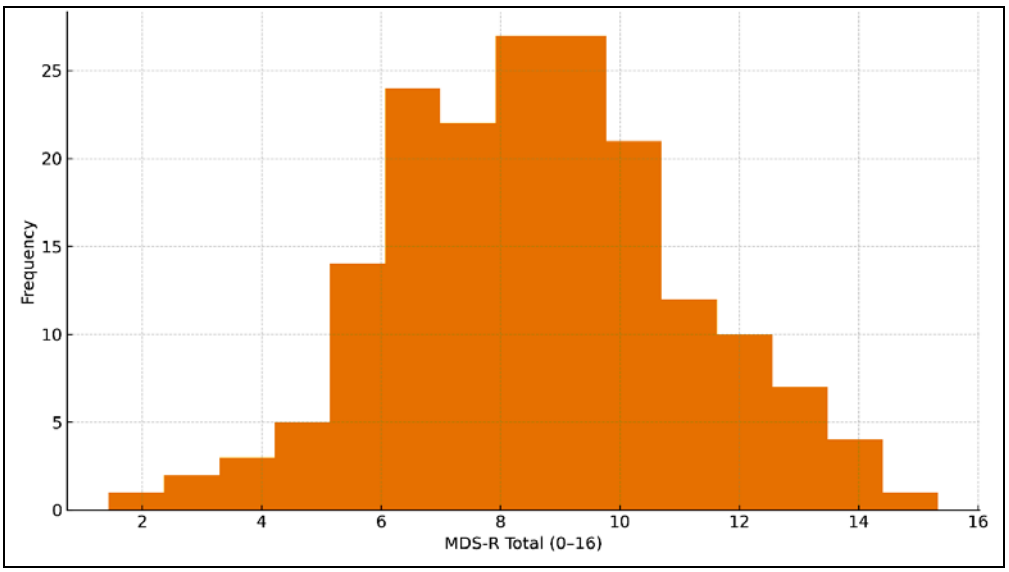

Fig 2: Distribution of MDS-R total scores

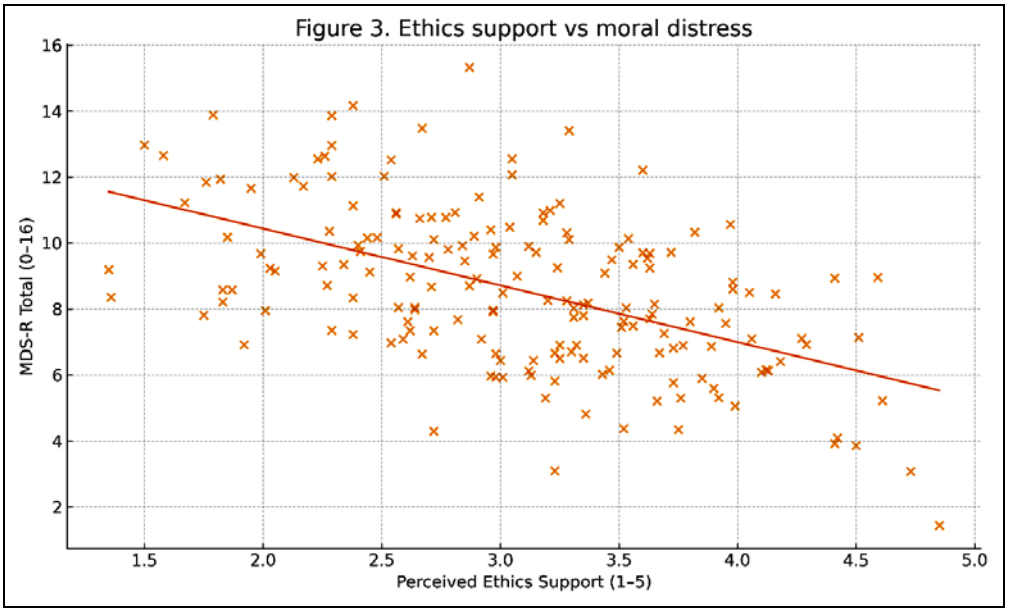

Fig 3: Association between perceived ethics support and moral distress

A total of 180 nurses participated (Acute ≈45%, Forensic ≈30%, Crisis ≈25%), with a mean experience of ~6 years across groups, indicating a predominantly early-career cohort consistent with prior reports of moral strain in younger staff [5, 10, 11]. Mean MDS-R total scores differed by unit (one-way ANOVA), with Forensic units showing the highest levels, followed by Crisis and Acute (Figure 1). This pattern aligns with literature describing elevated moral tension where coercive measures and security priorities are common [7-9, 14, 15].

Perceived organizational ethics support was inversely related to moral distress. Nurses reporting formal ethics supports (ethics rounds/consultation policies, supportive leadership) had significantly lower MDS-R totals than those without such supports (Welch's t-test; Table 3), echoing prior work that links moral distress to modifiable system factors rather than individual fragility [4, 6, 9, 12, 13, 16]. In the multivariable model, higher support index predicted lower moral distress independent of experience and unit type, suggesting that strengthening ethics infrastructure may mitigate distress even in high-risk contexts [4, 9, 12, 13]. Experience showed a small protective association, consistent with acclimatization and skill in ethical negotiation over time [2, 5, 11].

The distribution of moral distress was right-skewed (Figure 2), with a non-trivial subset experiencing high scores, a pattern previously tied to moral residue and the "crescendo effect" when unresolved events accumulate [5]. These findings reinforce concerns about downstream risks such as burnout and attrition in mental health nursing [10-12], particularly in units where safety imperatives frequently collide with autonomy and dignity considerations [1, 3, 7-9, 14, 15]. Overall, results support the study hypothesis that moral distress is elevated in high-risk units and that stronger organizational ethics support is associated with reduced distress [4, 6, 9, 12, 13, 16].

Discussion

The present study examined moral distress among mental health nurses working in high-risk psychiatric units and identified key organizational and individual factors influencing its intensity. The findings revealed that nurses in forensic and crisis units experienced significantly higher moral distress compared to those in acute units, a trend that aligns with previous research highlighting the heightened ethical tensions inherent in settings where coercive measures and safety protocols are prevalent [1-3, 7, 8]. These units often require nurses to balance patient autonomy with security considerations, resulting in frequent ethical dilemmas that intensify distress levels [4, 7, 14, 15]. The right-skewed distribution of moral distress scores observed in this study further supports the assertion that a substantial proportion of mental health nurses endure persistent ethical strain, potentially leading to long-term psychological and professional consequences [5, 10, 11].

The significant association between perceived ethics support and lower moral distress underscores the protective role of organizational structures in mitigating ethical strain. Nurses who reported access to ethics consultations, supportive leadership, and reflective opportunities demonstrated significantly lower MDS-R scores, aligning with prior evidence that institutional resources enhance nurses' capacity to address moral challenges constructively [4, 6, 9, 12, 13]. This finding reinforces the conceptualization of moral distress as not merely an individual emotional response but a systemic issue shaped by organizational climate, resource availability, and professional culture [2, 5, 9]. Strengthening these supports may not only reduce distress but also improve job satisfaction, retention, and quality of patient care [10-13].

Moreover, the observed modest protective effect of experience reflects how professional maturity contributes to better coping mechanisms and ethical resilience. Experienced nurses may develop greater confidence in navigating complex moral landscapes, advocating for patients, and utilizing institutional resources effectively [2, 5, 11]. However, this should not obscure the need for organizational responsibility: relying solely on individual resilience without addressing systemic causes can lead to cumulative "moral residue" and eventual burnout [5, 10, 11].

The findings are consistent with theoretical perspectives on moral distress, particularly the crescendo effect described by Epstein and Hamric, which suggests that unresolved moral conflicts accumulate over time and exacerbate distress [5]. In psychiatric settings, repeated exposure to ethically challenging situations such as involuntary treatment, use of restraint, or conflicting care directives can create an environment where moral distress becomes normalized [3, 7, 8, 14]. This normalization may undermine professional values, contribute to compassion fatigue, and negatively affect therapeutic relationships [4, 10-12]. Addressing moral distress through ethics education, structured debriefings, and policy-level interventions may therefore be essential for fostering an ethically sustainable work environment [6, 12, 13, 16].

This study also contributes to the literature by empirically demonstrating that moral distress is significantly influenced by modifiable organizational factors. Such findings emphasize the importance of integrating ethics support services into routine psychiatric care, promoting open communication, and cultivating moral courage among nurses [4, 6, 9, 12, 13]. Future research should explore longitudinal interventions and policy changes to determine their impact on reducing moral distress and improving workforce retention in high-risk mental health units.

Conclusion

This study highlights the significant presence of moral distress among mental health nurses working in high-risk psychiatric units, particularly in forensic and crisis settings where ethical dilemmas are frequent and often intense. The findings reveal that moral distress is not solely an individual phenomenon but is profoundly influenced by organizational culture, ethical climate, and the availability of structured support systems. Nurses facing repeated exposure to morally challenging situations experience heightened distress, which, if left unaddressed, can accumulate over time and contribute to burnout, reduced job satisfaction, and attrition from the profession. This not only affects the well-being of the nursing workforce but also undermines the quality and continuity of mental health care delivered to vulnerable patient populations. Recognizing moral distress as a systemic issue, rather than an individual weakness, is therefore essential for creating sustainable and ethically responsible psychiatric care environments.

A key insight from this research is the protective role of organizational ethics support. Nurses who perceived stronger ethics resources such as ethics consultation services, reflective forums, and supportive leadership

reported significantly lower distress levels, demonstrating that institutional strategies can effectively buffer the impact of ethically difficult situations. Strengthening these structures within mental health facilities can empower nurses to navigate moral conflicts more confidently and ethically. Based on these findings, several practical recommendations can be proposed. First, mental health facilities should establish regular ethics debriefing sessions and clinical ethics consultation services to provide structured opportunities for staff to process moral challenges. Second, incorporating ethics education and reflective practice into ongoing professional development programs can enhance nurses' moral sensitivity, critical reasoning, and confidence in ethical decision-making. Third, fostering a transparent and supportive ethical climate through visible leadership commitment, open communication, and shared decision-making can cultivate moral courage and reduce the burden of ethical isolation often experienced in high-risk units. Fourth, policies should ensure appropriate staffing levels and adequate resources, as these are critical in reducing situations that give rise to moral distress, such as forced compromises between safety and patient-centered care. Fifth, integrating peer support programs and mental health resources can help nurses address the emotional impact of moral distress before it escalates into burnout. Finally, continuous monitoring of moral distress levels within organizations can guide targeted interventions and policy adjustments to support staff well-being. In conclusion, addressing moral distress through ethical leadership, systemic support structures, and proactive organizational strategies is vital not only for protecting nurses' professional integrity but also for enhancing the overall quality and humanity of psychiatric mental health care.

References

1. Jameton A. *Nursing practice: The ethical issues.* Englewood Cliffs (NJ): Prentice Hall; 1984.
2. Corley MC. Nurse moral distress: A proposed theory and research agenda. Nurs Ethics. 2002;9(6):636-650.
3. Lamiani G, Borghi L, Argentero P. When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. J Health Psychol. 2017;22(1):51-67.
4. McCarthy J, Deady R. Moral distress reconsidered. Nurs Ethics. 2008;15(2):254-262.
5. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330-342.
6. Oh Y, Gastmans C. Moral distress experienced by nurses: A quantitative literature review. Nurs Ethics. 2015;22(1):15-31.
7. Lutzen K, Blom T, Ewalds-Kvist B, Winch S. Moral stress, moral climate and moral sensitivity among psychiatric professionals. Nurs Ethics. 2010;17(2):213-224.
8. Austin W. Moral distress and the contemporary plight of health professionals. HEC Forum. 2012;24(1):27-38.
9. Gallagher A. Moral distress and moral courage in everyday nursing practice. Online J Issues Nurs. 2011;16(2):1-9.
10. Whitehead PB, Herbertson RK, Hamric AB, Epstein EG, Fisher JM. Moral distress among healthcare professionals: Report of an institution-wide survey. J Nurs Scholarsh. 2015;47(2):117-125.
11. Dalmolin GL, Lunardi VL, Lunardi GL, Barlem ELD, Silveira RS. Moral distress and burnout syndrome: Are they related? A study with nurses. Rev Esc Enferm USP. 2014;48(4):682-688.
12. Hamric AB, Borchers CT, Epstein EG. Development and testing of an instrument to measure moral distress in healthcare professionals. AJOB Prim Res. 2012;3(2):1-9.
13. Woods M. Nursing ethics education: Are we really delivering the good(s)? Nurs Ethics. 2005;12(1):5-18.
14. McAndrew NS, Leske JS, Schroeter K. Moral distress in critical care nursing: The state of the science. Nurs Ethics. 2018;25(5):552-570.
15. Ohnishi K, Ohgushi Y, Nakano M, *et al.* Moral distress experienced by psychiatric nurses in Japan. Nurs Ethics. 2010;17(6):726-740.
16. Lützen K, Nordström G. Conceptions of moral sensitivity in psychiatric practice. Nurs Ethics. 2000;7(2):119-126.

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