

RESEARCH ARTICLE

Moral Suffering in Frontline Social Care Workers: A Study of Moral Injury and Moral Distress

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Introduction: Moral suffering (MS) is psycho-emotional harm derived from a conflict between one's circumstances and one's deeply held moral values. It includes the constructs of moral distress (MD) and moral injury (MI) and is characterized by constraints or mandates preventing the perceived morally correct event. Evidence has demonstrated the application of MS in helping professions, and research has linked MS to a deterioration of mental health, self-identity, worldview, and job-performance.

Aims: In this study, we examined the relationship between MD, MI, burnout, and external/internal constraints in Frontline Social Care Workers (FSCWs) in the UK.

Methods: We employed a quantitative, cross-sectional correlational design, recruiting 119 FSCWs (female = 91.6%, tenure 1–2 years = 27.4%) using convenience sampling. Participants completed an online survey including the Moral Injury Events Scale and the Copenhagen Burnout Inventory. Measures for MD, external constraints (stress, time, and resources), and internal constraints (psychological safety and preparedness) were informed by previous research.

Results: Participants reported a significant prevalence of moderate-to-high MD (25.4%), MI (33.3%), and burnout (64.9%), and we found significant relationships between the constructs and dimensions. Constraints were significant predictors of MS (explaining 35.3% of MD variance and 30.1% of MI variance), with stress, time, and psychological safety making the strongest contributions.

Conclusions: FSCWs can be examined as a unitary population experiencing morally challenging circumstances that may result in MS and burnout. Improved MS measures, increased awareness, and policy shifts are necessary to redefine the paradigm of work-related distress, taking systemic constraints and the potential for moral harm into account.

Keywords: moral suffering, moral injury, moral distress, social care, frontline workers

Introduction

Frontline social care work (FSCW) includes a wide range of non-medical professions operating daily in direct contact with individuals in vulnerable populations (NHS, 2024), advocating for them and supporting them psychologically, emotionally, and practically (UKHSA, 2023). As with other caring sectors, a high level of exposure to others' suffering and vulnerability uniquely defines FSCW, as does a one-way caring relationship with clients (Skovholt, 2005), where it is a job requirement to provide care, empathy, and understanding without expecting it in return (Skillsforcare, 2013), and professionals are educated in a culture of self-sacrifice (Posluns & Gall, 2020).

It is not surprising then, that these professions are at high risk of mental health issues related to caring for others, such as compassion fatigue, work stress, burnout, and vicarious PTSD (Ondrejková & Halamová, 2022), with one study on UK social workers showing emotional exhaustion prevalence at 73.0% and depersonalization at 26.0% (McFadden, 2015). Social care (SC) rates of work-stress and stress- and mental health-related sickness absences also stand among the highest compared to all other sectors in the UK (Ravalier et al., 2023). This type of work-related mental ill-health carries a very high cost to the individual, with serious physical, psychosocial, and financial ramifications (Lederman et al., 2019), as well as to professional organizations and society, with a UK report estimating the yearly cost of employees' mental health issues at £35 billion, including sick-leave, presenteeism, and staff-turnover (Parsonage & Saini, 2017).

Among the issues faced by professionals in the SC sector, is Moral Suffering (MS), a form of severe moral dissonance which has only recently been given increasing attention (Papazoglou & Chopko, 2017) and that can be defined as “the anguish in response to moral adversity, harms, wrongs, or failures, or unrelieved moral stress” (Rushton, 2018, p. 10). Two dimensions of MS are Moral Distress (MD) and Moral Injury (MI), and both can have a serious impact on professionals' wellbeing (Sugrue, 2019). A consensus on their definitions and interaction has yet to be reached; however, both are a) related to witnessing, committing, or failing to prevent “morally challenging situations and their potential psychological and spiritual consequences for the individual self-integrity” b) due to institutional constraints or mandates, c) in a critical situation (Grimell & Nilsson, 2020, p. 2). The moral infraction shakes the individual's moral core and negatively affects their feelings and beliefs, resulting in MS.

Constraints to the perceived morally correct action can be internal (e.g., lack of psychological safety or preparedness), and/or external (e.g., systemic/institutional issues, such as lack of funding, resources and time, heavy caseloads, inappropriate policies, conflicting interests) (Deschenes et al., 2020; Fourie, 2017). This feature calls into question burnout as the main paradigm of occupational distress (Dean et al., 2019). “A syndrome conceptualized as resulting from chronic workplace stress that has not successfully been managed” (World Health Organization, 2019, para. 3), burnout finds its causes in a failure of the individual to cope with trying circumstances, and its solution in the individual's responsibility to care for themselves (i.e., self-care). MS shifts perspective from an individual failing to a failing of the system, since, while self-care strategies offer important support for individual mental health, they are far from addressing constraints as the potential systemic roots of occupational distress (Dean et al., 2019).

While sparsely examined, MS remains a very prevalent issue and has been linked to the development of mental health disorders (Hall et al., 2021; Hanna, 2004). Recently, a BMA survey of over 1900 UK doctors revealed that more than 48.0% of the respondents had not heard of MI, and more than 43.0% had not heard of MD, whereas 78.4% responded that MD resonated with their work-experience, and 51.0% said the same of MI (BMA, 2021). A recent meta-analysis found that potentially morally injurious experiences (PMIEs) accounted for a significant variance: 9.4% of PTSD, 5.2% of depression, and 2.0% of suicidality (Williamson et al., 2018). PMIEs were also associated with higher levels of anxiety and behavioral issues (i.e., hostility and aggression). MS has also been associated with other caring-related issues such as compassion fatigue, vicarious PTSD and burnout (Pehlivan & Güner, 2018) and has been consistently linked to occupation, with health and social care, and military and police sectors being at especially high risk (Braxton et al., 2021).

Given the direct link between MS and the (in)ability to provide high ethical standards of care, it has been proposed that the COVID-19- and post-pandemic contexts had a strong impact on the prevalence and severity of these issues (Williamson et al., 2020), and generally on the mental health of helping professionals (Muller et al., 2020; Pfefferbaum & North, 2020). For example, the same 2021 BMA survey showed that 96.4% of respondents thought that COVID-19 had significantly increased their risk of MD. Moreover, these factors have aggravated the existing crisis in the SC sector, with a report showing staff turnover rates at 34.4%, 8.2% job vacancies, and average worker absences having almost doubled since 2020 (SkillsforCare, 2022/23). The pandemic also highlighted and exacerbated the scarcity of resources and systemic issues that may place professionals in morally conflicting circumstances (Godshall, 2021). PPE shortages, increased workloads, clients' increasingly complex needs, and lack of resources, constituted some of the obstacles faced by SCW (Ashcroft et al., 2022). Moreover, SC sectors such as Violence Against Women and Girls (VAWG) and Social Work are exposed daily to immoral acts and acts of interpersonal violence; issues such as intimate-partner violence, domestic violence, and domestic homicides also saw a steep rise (ONS, 2020), whereas resources for clients (refuges, advocacy, child protection, etc.) decreased (Romanou & Belton, 2020), pointing to an increase in the external constraints and moral challenges known to contribute to MS (Ashcroft et al., 2022). On the other hand, the post-pandemic and post-Brexit context and transitions have not been without unique and acute moral challenges due to factors including the cost-

of-living crisis, staff and resource shortages, industrial strikes, and the severe strain on services (Waitzman, 2022).

These factors implicate MS as a topical, prevalent, costly, and understudied issue, related to a host of mental health conditions. This study aimed to examine MD and MI in relation to external/internal constraints and burn-out within the population of frontline social care workers (FSCWs), to gain a clearer picture of the prevalence of MS, its roots, and related factors. FSCWs include, but are not limited to, social workers, care home workers, VAWG workers, support workers, and care workers. MS has rarely been examined in the context of this population (Greason, 2020), and while the challenges faced by individual professions within this population, such as social workers (Kinman & Grant, 2010) and care home workers (Kabir et al., 2020), have been looked at, FSCW as a whole, and other SC professions (such as VAWG workers), have rarely been examined. This constitutes a notable gap in knowledge, given that FSCWs are highly likely to be exposed to the moral conflicts and circumstances associated with MS (Webber et al., 2021). This study aimed to help understand MS as experienced by an often overlooked population (Lev & Ayalon, 2016), and shed light on the systemic roots of mental health issues in caring professions.

Situating Frontline Social Care Workers

The Social Care Sector in the UK employs over 1.55 million professionals (Foster, 2024; Kulakiewicz et al., 2022) in a wide range of professions supporting vulnerable individuals from a non-clinical standpoint (NHS, 2017). Vulnerability is defined as requiring additional care, assistance, or safeguarding due to characteristics including age, disability, gender, and background (OHID, 2022). Therefore, vulnerable populations supported by SCWs may include children, elderly, disabled, refugees, disadvantaged, and survivors of violence. Here, the “frontline” designation describes those SCWs who – as opposed to, for example, management and administration – have a caseload responsibility and work in direct contact with service users (NHS, 2024). Day-to-day tasks for FSCWs may include supporting service users with protection, housing, financial, and legal needs, risk- and needs-assessing and safety planning, liaising and advocating with other professionals on service users’ behalf, as well as providing for their basic care needs. Necessary values across SC include empathy, reliability, openness, and understanding (Professional Standards of Social Work England, 2019), selflessness and compassion (NIA, 2020), as well as warmth, a commitment to quality care, the ability to stay calm in a crisis, and to recognize and manage one’s own stress (Skillsforcare, 2022).

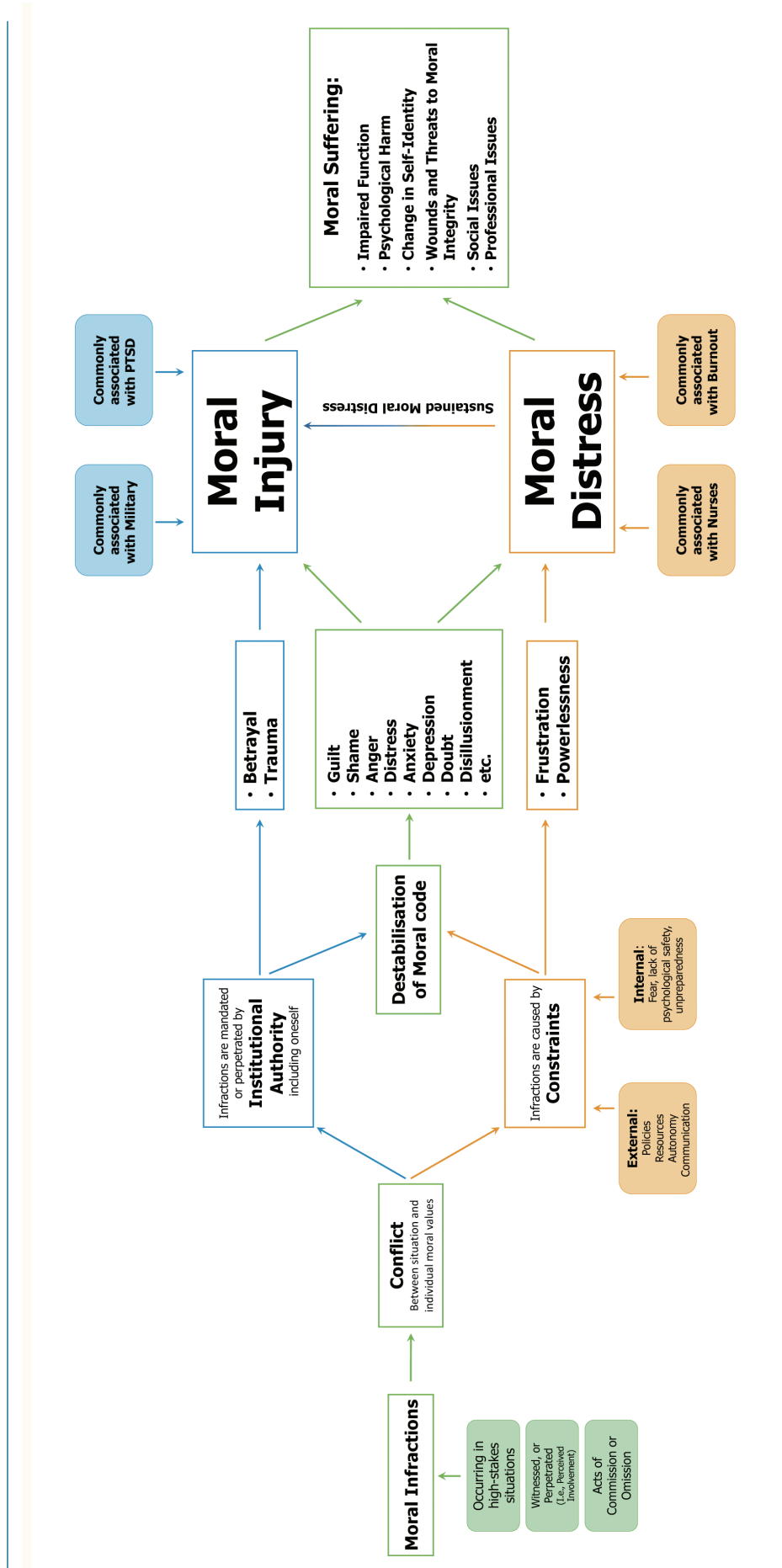
While backgrounds and tasks may vary across the population, for the purposes of this paper, we examined FSCWs as a unitary population characterized by the features noted above, while individual professions and service user groups did not factor in the analysis.

Background on Moral Suffering

While originating from distinct theories in different sectors, MD and MI have since been included in the general construct of moral suffering (Braxton et al., 2021; Mänttari-van der Kuip, 2020). MS indicates the experience of psycho-emotional, social, and existential harm arising from a conflict between circumstances and deeply ingrained moral values (Sugrue, 2019). Several different definitions have been given for MD and MI, distinguishing between 1) job-specifics (e.g., military, nursing, or unrelated to occupation), 2) presence or absence of constraints, 3) role of the affected individual (witnessing or perpetrating), 4) occurrence of moral conflict by accident or by choice, and 5) emotional reaction to such conflicts (e.g., frustration and betrayal). However, a more recent broadening of the MI and MD definitions (Campbell et al., 2016; Litz et al., 2009), proposed integrating these concepts into the construct of MS. [Figure 1](#) shows a conceptual model featuring the two MS constructs of MI and MD for the purposes of this paper.

While MS and burnout can contribute to each other, share several symptoms (e.g., depression, anxiety, etc.), and are both generally linked to occupation, they are distinct constructs with different causes and loci (Dean et al., 2019; Fumis et al., 2017; Rushton, Nelson, et al., 2022). Burnout can occur as a reaction to chronic stressors at work and the individual’s depleted internal resources (Maslach et al., 2001), whereas MS arises when circumstances create dissonance with the individual’s moral values, destabilizing their self-identity and worldview (Gabel, 2013; Wong, 2020). Similarly, where general- and work-stress relate to psychophysiological responses to overwhelming circumstances overtaking one’s ability to cope and threatening one’s wellbeing (Hutmacher, 2021), MS results from a threat to profoundly engrained moral values, such as fairness, compassion, respect, and ethical practice (Čartolovni et al., 2021).

Figure 1. Conceptual Model of the Moral Suffering constructs Moral Distress and Moral Injury



Note: Created for the purposes of this paper, based on models by BMA (2021), Mänttari-van der Kuip (2019), and Sugrue (2019). Shared Moral Suffering characteristics are in green, Moral Injury characteristics in blue, and Moral Distress characteristics in yellow.

Moral Distress

Originally theorized based on the nursing sector (Jameton, 1984), MD is the emotional and psychological distress that occurs when a professional can identify an ethically correct action, especially toward someone in their care, but is unable to take it, usually due to institutional constraints (BMA, 2021). In other words, MD is the discomfort that arises in a professional, when a mandated behavior contravenes their moral principles. This can be initial (the immediate reaction to moral conflict), or reactive (persistent and lingering distress after the event) (Jameton, 1993). MD can be due to systemic issues such as lack of funding, resources, training, staff, or time, as well as to related organizational policies or conflicting interests, that make it impossible for the professional to provide the care that meets their moral standards. This construct has been associated with inward- (i.e., mental health and self-identity), as well as outward harm (i.e., avoiding interactions with patients, quitting one's job, and abandoning one's moral values) (Hamric, 2012; Sugrue, 2019). The COVID-19 pandemic has been linked to an intensification of MD prevalence and symptoms (Lake et al., 2021; Silverman et al., 2021). MD has been commonly linked with burnout and the two have been found to be strongly associated (Fumis et al., 2017). MD has been proposed as a root cause of burnout (Dzeng & Wachter, 2019), or as having complex interplay with certain risk factors of burnout, such as home-work imbalance (Kok et al., 2021), but a full scope of the relationship is still unclear.

Several nurse studies sought to identify patterns and causes of MD. Some relevant themes are ambivalence toward the appropriateness and prioritization of care, distress derived from others' ethical insensitivity, limited autonomy, and conflicts with physicians and policies (Atli Özbaşı et al., 2021; Choe et al., 2015). Potential sources of MD include the loss of individual decision-making power, the lack of explicit ethical framework in guidelines, and lack of organization-wide forums to discuss ethical concerns (Prompahakul et al., 2021; Thomas et al., 2022). Bullying, lack of communication and collaboration, as well as concerns over quality, quantity, and consistency of care provided, were identified as factors of MD (Henrich et al., 2016; Vincent et al., 2020), whereas frustration was identified as the most common emotion associated with MD (Henrich et al., 2017; Rodney, 2017). Anger, guilt, and powerlessness were also associated with the construct, as well as a perception of negative impact on patient care, and frequent thoughts about quitting (De Brasi et al., 2021; Wiegand & Funk, 2012). MD's protective factors include longer tenure, collaborative and supportive working environments, cooperation between colleagues and organizations, as well as being based in community rather than hospital settings (Hancock et al., 2020; Webber et al., 2021).

Few studies examined MD outside of medical and nursing professions, and fewer still with quantitative methods. This gap accounts for the absence of a validated measure of MD relevant or adaptable to SC professions (Mänttari-van der Kuip, 2015). For example, the Moral Distress Scale (MDS), MDS-Revised (Epstein et al., 2019), and the Moral Distress Appraisal Scale (Baele & Fontaine, 2021) are specific to the healthcare population both in items and validation, whereas the Questionnaire of Moral Distress Among Long-Term Care Social Workers (Lev & Ayalon, 2016) is specific to care-home workers. One study of social welfare workers in Finland assessed MD through reported experiences of impaired mental wellbeing at work and of two independent question-items, which were not part of a formal scale; this study found that 11.0% of participants were experiencing MD based on all three criteria and 30.2% of the variance was accounted for by the external constraint "perceived insufficient resources" (Mänttari-van der Kuip, 2015, p. 92). Another quantitative study on MD in child welfare caseworkers in the US measured MD using two items of the role conflict subscale from the 60-item, 15-dimension CRISO Psychological Climate Questionnaire (Gagnon et al., 2009) as well as internal constraints (i.e., psychological safety and preparedness), external constraints (i.e., time pressure and job stress), and burnout (He et al., 2021). Over 60% of participants reported experiencing one or both MD conditions. Both studies' findings support the hypothesis that a) SCWs experience MD, b) external constraints account for much of the distress, and c) there is a need for validated measures of MD in SCWs.

Moral Injury

MI can be defined as the functional and psychological impairment arising from experiences of moral dissonance (Shay, 1995), as well as resulting from sustained MD (BMA, 2021). As a form of trauma, MI can arise when a) moral violations are perpetrated (commission or omission), b) by figures of authority (including oneself) c) in high stakes situations; e.g., combat resulting in civilian casualties, being involved in shootings, or killing enemy combatants (Shay, 1995). Such instances of commission, omission, or witnessing, are known as PMIEs. MI can manifest itself through feelings of shame, guilt, anger, disgust, and betrayal (i.e., feeling betrayed by authority figures, institutions, colleagues, etc.), destabilizing an individual's mental health and moral compass (Shay, 2014).

MI was originally coined in reference to military veterans when it became clear that the PTSD diagnosis could not account for the moral components of veterans' distress, which was also resistant to any type of PTSD treatment (Williamson et al., 2021). MI has often been proposed as a predictor of PTSD (Jordan et al., 2017), and both have been consistently found to coexist in individuals who simultaneously struggle with trauma/mortality and with reconciling their moral core with lived experiences (Ferrajão & Oliveira, 2014; Litz et al., 2009; Spence et al., 2014). Most empirical studies focus on veterans, where PMIEs have been linked to current psychopathology and suicidality, with high prevalence in the dimensions of betrayal and witnessed transgressions (Wisco et al., 2017). Transgressions by the self are significantly less reported and have been especially associated with mental disorders and suicidal ideation, whereas the dimension of betrayal has been associated with suicide attempts.

On the other hand, MI can occur independently of traumatic experiences and has been associated with occupations outside of the military (Williamson et al., 2018); for example, researchers found a high prevalence of MI in health care workers after the COVID-19 pandemic, and particularly in nurses (Rushton, Nelson, et al., 2022; Rushton, Thomas, et al. 2022). MI has also been specifically associated with the SC sector (Dombo et al., 2013). FSCWs operate in morally complex settings (e.g., child protection, jails, hospitals, etc.) where they are likely to be exposed to or commit PMIEs and, if unaddressed, such experiences may lead to reduced effectiveness and burnout (Haight et al., 2016). While MI, like MD, has rarely been examined in this population, one study of child protective services professionals found participants to have comparable MI prevalence to that of military populations (Haight et al., 2017). Here, PMIEs were rooted in some of the same external constraints associated with MD: insufficient resources, unfair policies, an adversarial system, and poor service quality. On one hand, this suggests that for FSCWs, both MD and MI find some of their roots in external constraints to caring for service users and being exposed to morally complex situations; on the other, it supports the view of MI as a form of sustained MD (BMA, 2021), and of MI and MD as dimensions of the same construct (MS) (Mänttari-van der Kuip, 2020).

In this study, we focused on gaining a better understanding of 1) the prevalence of MI and MD among FSCWs, 2) whether a correlation exists between MI and MD, and with burnout, and 3) whether MI and MD can be accounted for by internal/external constraints. The results reported in this study may help shed light on issues faced by FSCWs in the UK and factors underlining psycho-emotional distress in this population. To the best of the authors' knowledge, this is the first investigation examining both MD and MI in FSCWs in the UK.

Methods

The study used a quantitative approach via online survey with a cross-sectional correlational design and was approved by the University's Research Ethics Committee (Ethics Approval Number: 2003940_220127).

Participants and Data-Collection

One hundred and nineteen healthy, UK-based FSCWs completed the survey. Participants were predominantly female (91.6%), with the average age at 37.8 ($SD = 11.54$), from various SC professions, and with a wide range of tenure (years in the field). Due to convenience, much of the recruitment was done in Violence Against Women and Girls (VAWG) organizations, supporting survivors of gender-based violence and abuse. A summary of descriptive statistics can be found in Table 1. Inclusion criteria included

Table 1. Frequency Distribution for Gender, Title, and Tenure

Sample Characteristics	<i>n</i>	%
Gender		
Female	109	91.6
Male	5	4.2
Non-Binary	5	4.2
Job Title		
Advocate	13	10.9
Social Worker	14	11.8
IDVA	19	15.9
ISVA	4	3.4
DAPA	4	3.4
Refuge Worker	7	5.9
Youth Worker	3	2.5
Case Worker	12	10.1
Other Frontline worker	43	36.1
Tenure		
1–2 years	32	27.4
3–5 years	21	17.9
6–10 years	27	23.1
11–19 years	19	16.3
20+ years	18	15.3

Note. Demographic questions were formulated based on ONS, 2016.

IDVA (Independent Domestic Violence Advocate), ISVA (Independent Sexual Violence Advocate), DAPA (Domestic Abuse Prevention Advocate) are professions in the Violence Against Women and Girls (VAWG) sector.

being employed in SC, for at least one year within the last six months, with frontline status (i.e., interacting with service users daily as part of their job). While backgrounds and tasks may vary across the population, for the purposes of this paper, we examined FSCWs as a unitary population characterized by the features described above, while individual professions and service user groups did not factor in the analysis.

We used convenience sampling, and recruited participants through professional networks, as well as through SCWs networks on social media. Sample size parameters were calculated through a priori G*Power analysis. With a medium effect size of .15, α at .05, and .80 power, the minimum sample size was 103 participants (Gatsonis & Sampson, 1989).

Participants completed a one-time 10–15-minute online survey, following institutional and BPS ethical guidelines (Oates et al., 2021).

Measures

Due to the absence of relevant validated measures of MD at the time of this study, measures for MD as well as all internal and external constraints were drawn from two founding studies examining SCWs with a quantitative design: Mänttari-van der Kuip (2015) and He et al. (2021).

Moral Distress

As per He et al.'s (2021) methods, two items were adopted from the four-item role conflict subscale found in the Psychological Climate Questionnaire, a validated and reliable measure of organizational psychological climate (Gagnon et al., 2009). The items chosen related to two dimensions of MD; i.e., “I have to do things in my job that are against my better judgment” (MD better judgment) and “Too many rules and regulations interfere with how well I am able to do my job” (MD rules). The Cronbach's α for the role conflict subscale (four items) came to .74 (Gagnon et al., 2009). Here, the Cronbach's α coefficient for the two items was .73 and we found the inter-item correlation at 0.58, indicating good reliability (Briggs & Cheek, 1986). Two items were taken from Mänttari-van der Kuip's (2015) methods, measuring two dimensions of MD: “I often have to work in a way that conflicts with my professional values” (MD values) and “I often feel that I am unable to do my job as well as I want to” (MD unable to perform). All four items were paired with a five-point Likert scale (5 = strongly agree, 1 = strongly disagree).

As the four items are not part of a formal scale, we conducted principal component analysis (PCA). With an excellent Kaiser-Meyer-Olkin value of .74 (Kaiser, 1974), which verified sample size adequacy, and statistical significance for Bartlett's Test of Sphericity (Bartlett, 1954), one component was extracted with an eigenvalue exceeding 1, explaining 60.2% of the variance. All items loaded strongly onto one component suggesting that they fall under the same theoretical construct and could be examined together (Pallant, 2010). We also conducted reliability analysis for a total MD score of all four items, showing good internal reliability: $\alpha = .78$, and inter-item correlation at .47 (Briggs & Cheek, 1986; Pallant, 2010). Thus, the items were examined both separately and together as measuring different dimensions of MD.

Moral Injury

The Moral Injury Events Scale (MIES) (Nash et al., 2013) is a nine-item tool paired with a six-point Likert scale (6 = strongly agree, 1 = strongly disagree) measuring two dimensions of MI: perceived transgressions (witnessed and committed) and perceived betrayals in the professional context. An example item is: “I am troubled because I violated my morals by failing to do something that I felt I should have done.” The MIES has been found to have good internal, discriminant, and concurrent validity (Nash et al., 2013). While originally intended for military personnel, it has been used in studies on SCWs (Haight et al., 2017) with small tweaks in language (i.e., “fellow service members” to “colleagues” and “U.S. Military” to “organization”). Both in Nash et al. (2013) and in the current study $\alpha = .90$ (.90 for the transgression dimension and .85 for betrayal), indicating excellent internal consistency.

Internal Constraints: Preparedness

Preparedness for work was assessed through a three-item subscale of the 14-item Professional Development and Preparation for Work Scale, capturing perceived worker preparation (Butler Institute for Families, 2009; He et

al., 2021; Leake et al., 2021). The scale is paired with a four-point Likert scale (4 = strongly agree, 1 = strongly disagree). An example item is “When I was hired, I received training that prepared me for this job.” In the Butler Institute for Families (2009), the Cronbach’s α for the whole 14-item scale was .90, whereas for this study the three-item subscale had $\alpha = .62$ and inter-item correlation at .36, indicating fair internal reliability.

Internal Constraints: Psychological Safety

Based on He et al. (2021), a modified three-item version of the Psychological Safety Scale (Edmondson, 1999) was used measuring dimensions of psychological safety in the working environment. Items are paired with a four-point scale (1 = very inaccurate to 4 = very accurate). An example item is “It is easy for me to ask colleagues for help.” Considering the small number of items, the scale exhibited good internal consistency with $\alpha = .67$ and inter-item correlation at .41 (Briggs & Cheek, 1986; Pallant, 2010).

External Constraints: Time Pressure

Based on He et al. (2021), we measured time pressure at work using a three-item subscale from the Instrument for stress-related job analysis (ISTA) (Version 6.0) (Malik, 2015; Semmer et al., 1998). The scale is paired with a 5-point Likert response scale (5 = almost always, 1 = almost never). An example item is “How often must you finish work later because of having too much to do?” The time pressure subscale is reported with good internal validity based on standardized items at $\alpha = .70$. Here, $\alpha = .87$, indicating excellent internal consistency.

External Constraints: Resources

Based on Mänttari-van der Kuip (2015), the lack of resources and funding was measured with three items concerning budget constraints and insufficient resources, paired with a five-point Likert scale (5 = strongly agree, 1 = strongly disagree). An example item is: “Budget constraints affect my work.” For this study $\alpha = .82$.

External Constraints: Job Stress

As per He et al. (2021), the stress subscale, measuring dimensions of organizational stress in the workplace, was used from the CJ Organizational Readiness for Change Program Staff Version (TCU CJ ORC-S) (Institute of Behavioral Research, 2004). The scale was paired with a four-point scale (1 = strongly disagree, 4 = strongly agree). An example item is “The heavy workload reduces my effectiveness.” For this study $\alpha = .83$.

Burnout

We assessed burnout through the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005). The inventory covers three dimensions of burnout: personal (six items), work-related (seven items), and client-related (six items). Each item is paired with a five-point scale (5 = always or to a very high degree, 1 = never/almost never or to a very low degree). An example item is “Are you exhausted in the morning at the thought of another day at work?” According to Kristensen et al. (2005), Cronbach’s α coefficients stand high across the scale and its subscales (.85 – .87). Here, overall $\alpha = .94$ (personal $\alpha = .93$, work-related $\alpha = .86$, and client-related $\alpha = .87$), indicating excellent internal consistency.

Statistical Analysis

The present study aimed to examine the relationships among MI, MD, and burnout, as well as the contribution of external and internal constraints to MD and MI. To this end, we conducted prevalence, correlations, and standard multiple regression analyses (SMLR), which are reported here. Across all analyses, preliminary tests were carried out to ensure that parametric assumptions for correlation and SMLR analyses were not being violated, with no major concerns detected (Pallant, 2010); therefore, we performed parametric tests that we report below.

Results

Prevalence of MI, MD, and Burnout in FSCW

On the four items measuring MD in the context of work experiences, 72.3% of participants reported often feeling unable to do their job as well as they would want to (MD unable to perform), 61.8% of participants reported that too many rules and regulations interfere with their ability to do their job (MD rules), 52.1% reported having to do things against their better judgment (MD better judgment), and 37.0% reported having to work in a way that conflicted with their professional values (MD values). Overall, 25.4% of respondents moderately-to-strongly agreed with all four items and, when looking at total MD scores (all four items), 33.9% of participants reported moderate-to-high levels of MD.

In terms of the MIES, 33.3% of participants reported moderate-to-high levels of MI. Specifically, 56.4% of participants had moderate-to-high scores in the betrayal dimension, and 48.6% produced moderate-to-high scores in the transgression dimension, with witnessed transgressions at 60.5% and committed transgressions at 25.7%. Burnout scores (Creedy et al., 2017) are reported in Table 2.

Table 2. Severe and Moderate Burnout Distributions in Percentages

Burnout	<i>n</i>	%
Overall Burnout		
High	29	25.4
Moderate	45	39.5
Personal Burnout		
High	55	46.2
Moderate	40	33.6
Work Burnout		
High	41	34.7
Moderate	51	43.3
Client Burnout		
High	11	9.6
Moderate	28	24.3

Examination of Interrelationships Between Variables

As the constructs of MI and MD have rarely been examined together and within this population, we examined several relationships using Pearson product-moment correlation coefficient. MI, MD, and burnout correlations, including subscales, are reported in Table 3. While not all examined relationships were strong, all were positive and significant.

The Impact of Internal and External Constraints on Moral Distress

To understand how internal and external constraints predicted MD, a SMLR was conducted (Uyanık & Güler, 2013). Total MD was used as a dependent variable. The model was found to explain 35.3% of the variance (using adjusted R square due to the sample size as per Pallant, 2010) and constraints were significant predictors of MD with $F(5, 103) = 12.77, p < .001$. We report summary statistics in Table 4. Once burnout was added as a predictor, the model explained 37.1% of the MD variance $F(6, 101) = 11.50, p < .001$. Here, time ($\beta = .26, p = .013$), burnout ($\beta = .23, p = .050$), and preparedness ($\beta = -.19, p = .049$), were all significant predictors.

The Impact of Internal and External Constraints on Moral Injury

To understand whether and how internal and external constraints predicted MI scores, a SMLR was conducted. Results of the regression indicated that the model explained 30.1% of the variance (again, using adjusted R square) and that the model also explained a significant amount of MI variance, $F(5, 90) = 9.43, p < .001$. We report summary statistics in Table 5. Once we added burnout to the model as a predictor, the model explained 35.0% of the variance, and served as a significant predictor of MI scores, $F(6, 89) = 9.53, p < .001$. Here, only burnout ($\beta = .32, p = .010$) and preparedness ($\beta = -.22, p = .036$) made significant contributions to the model.

Table 3. Interrelationships Between MD, MI, and Burnout

Variables	<i>M</i>	<i>SD</i>	Minimum	Maximum	1	2	3	4	5	6	7	8	9	10	11	12	13
1. MD (total)	13.24	3.97	4	20													
2. MD (better judgement)	3.29	1.23	1	5	.79**												
3. MD (rules)	3.47	1.31	1	5	.80**	.58**											
4. MD (values)	2.76	1.32	1	5	.74**	.45**	.36**										
5. MD (unable)	3.74	1.25	1	5	.78**	.44**	.53**	.45**									
6. MI (total)	28.44	11.97	9	54	.68**	.54**	.43**	.55**	.59**								
7. MI (transgressions)	17.93	8.24	6	36	.62**	.49**	.37**	.53**	.49**	.93**							
8. MI (betrayal)	10.54	5.15	3	18	.59**	.44**	.40**	.44**	.55**	.82**	.55**						
9. MI (transgressions witnessed)	7.92	3.34	2	12	.44**	.32**	.29**	.43**	.31**	.79**	.78**	.54**					
10. MI (transgressions committed)	10.00	5.99	4	24	.57**	.45**	.33**	.47**	.48**	.84**	.93**	.46**	.50**				
11. Burnout (total)	57.80	19.20	14	96	.52**	.36**	.39**	.41**	.46**	.56**	.46**	.54**	.36**	.44**			
12. Burnout (personal)	69.68	23.05	13	100	.54**	.38**	.43**	.41**	.47**	.48**	.36**	.50**	.25**	.34**	.90**		
13. Burnout (work)	65.25	20.87	17	100	.53**	.35**	.42**	.42**	.46**	.47**	.36**	.49**	.27**	.34**	.93**	.89**	
14. Burnout (client)	40.90	21.51	4	93	.34**	.27**	.21*	.28**	.30**	.52**	.48**	.43**	.38**	.46**	.81**	.51**	.58**

Table 4. Model Summary for MD (total) and Constraints

Model	β	t	p
1. Preparedness	-.22	-2.24	.027
2. Psychological Safety	-.02	-.16	.871
3. Time	.26	2.54	.013
4. Resources	-.08	-.98	.332
5. Stress	.32	2.92	.004

Table 5. Model Summary for MI and Constraints

Model	β	t	p
1. Preparedness	-.26	-2.41	.018
2. Psychological Safety	-.19	-1.88	.063
3. Time	.02	.21	.832
4. Resources	.04	.42	.673
5. Stress	.26	2.18	.032

Discussion

This study aimed to examine the prevalence and interrelationships between MS constructs of MD and MI, their relationships with burnout in FSCWs, as well as the role of internal and external constraints in predicting MS. A secondary aim was to increase the awareness of MS as affecting both workers' wellbeing and service provision (Epstein & Hamric, 2009; Williams et al., 2020), and of FSCWs as a unitary population liable to experience the same MH issues as other helping professions (Gray-Stanley & Muramatsu, 2011), as well as to challenge burnout as the main paradigm of work-related distress in such sectors (Dean et al., 2019).

Results showed concerning amounts of worker distress with over 1/3 of the sample reporting moderate-to-high levels of MD and MI, and 64.9% of participants reporting moderate-to-high levels of overall burnout. The three constructs of MD, MI and burnout had significant medium-to-strong positive relationships. Interrelationships between construct domains ranged from weak to strong and were all positive and significant. Stress, lack of preparedness and burnout were significant predictors of both MD and MI, and time constraint also served as a significant predictor of MD. In general, constraints and burnout explained 37.1% of the variance in MD and 35.0% in MI, supporting this study's hypothesis.

In this study, prevalence of MD stands significantly higher than the 11.0% found by Mänttari-van der Kuip (2015). However, part of this difference may be accounted for by the fact that a) this study was conducted with somewhat different measures, b) the previous study was conducted in Finland, and system specifics are inherently connected to MS's mandates and constraints, and c) COVID-19 occurred between the two studies, likely causing a significant increase in MS (BMA, 2021). The MD dimensions of inability to perform, too many rules, and having to work against one's better judgment were present in over half the sample, whereas over a third reported sometimes having to work against professional values.

MI prevalence was comparable with an examination of child protection workers (Haight et al., 2017), as well as with results in military populations (Bryan et al., 2016), implicating MI as an equally relevant issue to FSCWs. Here, the dimensions of betrayal and witnessed transgressions were especially frequent. On the other hand, committed transgressions were less reported (25.7%), which also remains consistent with previous results (Haight et al., 2017). This may be due to SCWs being more likely to be exposed to others' transgressions (e.g., child/ elder/ intimate partner abuse), and/or to a resistance to recognizing one's own transgressions. This warrants further exploration, as MS may come with its own dissonance-resolution strategies to reduce internal moral conflict. Understanding what these are and whether they act as a protective or exacerbating factor may provide key insights into MS's features and treatments.

Overall burnout appeared more prevalent than in comparable studies (Gómez-García et al., 2019), although, here too, the occurrence of COVID-19 and the post-pandemic context are likely to have had a significant effect. While over half of participants reported personal and work-related burnout, client-related burnout was reported by less than a third. This is an interesting result, as the defining feature of FSCW is direct contact with clients, so one might have expected this domain to be a more significant source of burnout. This factor may support MS as a crucial concern in FSCWs, where client-work and consequent exposure to others' suffering may cause less distress than the practicalities and institutional constraints of the profession (Parry, 2021). Client burnout exhibited a weak relationship with MD but a moderate one with MI, specifically the betrayal domain, which contributes to the previous explanation as it may imply that workers who feel more betrayed by organizations and leaders have a harder time working with clients. This is also in line with findings linking higher feelings of betrayal with increases in mental distress and PTSD symptoms (Park et al., 2023).

The relationships between these constructs should be further examined when aiming to understand the nature of work-related distress in helping professions. What appears clear is that, as previous articles have argued,

burnout alone is not sufficient to explain mental health challenges in these populations (Dean et al., 2019; Parry, 2021). On the other hand, treating MI and MD as fully distinct constructs and relating them to specific professions seems to offer restricted information regarding the conceptualization and experience of MS. In fact, the strong positive correlation between MI and MD is an important finding, which, combined with both constructs being significantly predicted by external and internal constraints, supports the view of MS as a unitary model of work-related distress (Mänttari-van der Kuip, 2020; Sugrue, 2019).

The main predictors of MS we found to be external constraint stress (i.e., heavy workload, pressure, and frustration), internal constraint preparedness (i.e., feeling that one did not receive enough information and training), burnout, and time constraints. While 66.0% of the sample reported medium-to-high levels of insufficient resources ($M(SD) = 13.08(2.43)$), contrary to previous findings (Mänttari-van der Kuip, 2015) and this study's hypothesis, this was not a significant predictor of either MD or MI. So, while lack of resources remained an important concern for most of the sample, it did not seem to make a significant contribution to MS. This unexpected outcome could possibly be due to the use of general questions, rather than ones discussing resources in the context of FSCW; for example, whether workers feel that the lack of resources affects their ability to provide high standards of support to clients.

In general, these results support the theory of MS as a multidimensional construct of worker distress (Mänttari-van der Kuip, 2020), with constraints and burnout making a significant contribution. Moreover, this study identified FSCWs as a discrete population, facing unique moral challenges, and reporting comparable levels of MS to those seen in health or military professionals. However, from a theoretical viewpoint, the lack of consensus on how MS is defined, and it being viewed as job-specific, limits research rigor and the ability to generalize results from other sectors. A great deal more research is necessary to understand this construct, including further dimensions of MS, comorbidities, constraints and/or mandates, and interactions among these, as well as protective factors and treatment (Sugrue, 2019). Along the same lines, a more in-depth examination of constraints is needed, including the "external" and "internal" characterization, as, for example, preparedness and psychological safety, currently defined as internal constraints (He et al., 2021), are still somewhat anchored to external causes; e.g., an organization's responsibility to adequately train and prepare staff, or to create a safe climate for employees to seek help and guidance. In terms of protective factors and interventions, the recent theorization of the concept of moral resilience (MR) as "the capacity of an individual to preserve or restore integrity in response to moral adversity", was found to be a valuable protective factor for MS and led to the development of interventions focusing on building MR (Rushton, 2023; Spilg et al., 2022). Further research into MR, MR-based interventions, and its applications, including in SC, may lead to important results.

Strengths and Limitations

Quantitative examinations of MS and examinations of FSCWs are sparse, and virtually nonexistent in the UK, which, combined with the paper's results, make this a novel contribution to the study of work- and caring-related mental health concerns.

Limitations of this study included the sample size, sampling method, insider research, and the lack of a validated measure of MD, which warrant caution in interpreting results. While a larger sample would have allowed for a closer approximation of the population, this sample was amply within a priori G*Power analysis and no major concerns arose in analysis assumptions. While convenience sampling presents generalizability issues and this should be considered when examining results (Jager et al., 2017), practical constraints, the wide scope of recruitment, the specificity of inclusion criteria, and SC being a sparsely examined population justify the sampling method and speak to the value of the results. Along the same lines, sample size and risks of power biases prevented sample homogenization by gender. However, the analysis did not yield any major outliers and, while gender differences have been found in moral domains, the evidence of significant gender differences in MS, particularly in the SC context, still remains lacking (Maguen et al., 2020; O'Connell, 2014). The issue of insider research was mitigated by employing an anonymous online survey, reducing researcher/participant interaction and biases, and avoiding the collection of any identifiable data (Evans & Mathur, 2005). Finally, while there are no validated MD tools appropriate for FSCWs and no unitary MS tools, the measures for MD used here were based on previous research and had good internal reliability. The MIES had previously been used with SCWs and possessed excellent internal reliability (Haight et al., 2017; He et al., 2021; Mänttari-van der Kuip, 2020).

Conclusions, Implications and Future Directions

Given the relationship between MS, burnout (Thibodeau et al., 2023), and mental health disorders (Williamson et al., 2018), as well as the very high rate of work-related mental health concerns in the SC sector (Ondrejková & Halamová, 2022), further research is required to fully understand the weight of the moral dimension on mental health. Considering the preceding, however, the concept of self-care (the collection of practices to promote one's biopsychosocial wellbeing), which has seen a steep rise in popularity since the start of COVID-19 (Miller & Reddin Cassar, 2021), may seem acutely insufficient to fully address the roots and ramifications of work-related distress in helping professions (Dean et al., 2019). While self-care has proven to be a beneficial practice, maintaining healthy sleep, dietary, exercise, and socialization habits, while also cultivating mindfulness and professional growth (Posluns & Gall, 2020), is not only made exceedingly difficult by the same stress, overwork and time constraints that contribute to MS, but also burdens the individual, rather than institutions, with the responsibility of caring for themselves in the face of problems that may be more systemic than personal.

Future research should also focus on what individual characteristics increase the probability of MS. For example, examining the impact of socio-demographic factors, including gender and background, and work-related factors, including title and tenure, across different populations at risk of MS, would contribute to a unitary characterization of the construct. Moreover, there may be a relationship between MS and public service motivation (PSM); i.e., the attribute of many helping professionals that explains the inclination to serve the public and seek intrinsic (e.g., work-satisfaction) rather than extrinsic (e.g., monetary) rewards (Ritz et al., 2016). As individuals with the PSM attribute are likely to choose service/helping professions (Belrhiti et al., 2019), they may also be more likely to struggle with the moral dissonance derived from being unable to provide high standards of care.

From a methodological standpoint, future research should focus on a validated and reliable measure of MD, adaptable to assess different populations, and a complete measure of MS, integrating the construct's dimensions (Mänttari-van der Kuip, 2020). Along the same lines, coupled with or independently of these measures, a need exists for a unitary tool assessing the presence of internal and external constraints, including, but not limited to, those examined here. Qualitative research on populations at risk of MS could provide insight into field-specific mandates and constraints, which would allow for more reliable results and for researchers not having to dissect scales and subscales to identify MS predictors and problem areas in the workplace. Moreover, mixed methods and longitudinal studies would help provide insights into the realities of MS across fields and the factors that may be influencing it over time (Parry, 2021). This is especially important in the wake of COVID-19 and in the post-pandemic context, when the increased pressures on FSCWs, decreased resources, and overwhelmed institutions may foster the surge of each MS domain discussed here, including feeling betrayed by leaders and organizations, witnessing (and committing) infractions of care standards, feeling unprepared in the face of unprecedented challenges, and unable to work, or obligated to work in a way that conflicts with one's better judgment and values. The conceptualization of MS and this study's results suggest the need for a systemic shift in the way governing bodies, organizations, and individual teams view and support helping professionals. Burnout and MS were shown to be significantly prevalent and linked to a wide range of mental health issues that are costly to individuals, organizations, and society (Hanna, 2004; Parsonage & Saini, 2017; Pehlivan & Güner, 2018). Appropriately funding and remunerating the SC sector could help reduce turnover, workload, and the pressure on individual workers, and could significantly improve access and service provision, thereby also reducing the occurrence of PMIEs (Idriss et al., 2021).

In general, reducing the high expectations and culture of self-sacrifice placed on helping professionals and focusing on fixing systemic problems (i.e., constraints) could address much of the roots of work-related distress. Acknowledging the PMIEs inherent to specific fields and providing appropriate resources and organization-wide forums for workers to address these collectively (Thomas et al., 2022), may also help FSCWs feel empowered, come to terms with moral challenges, and foster collaborative environments which may help build moral resilience (Webber et al., 2021). Taking measures to reduce constraints on a systemic level by increasing funding and changing policies, while also providing spaces to address moral challenges and fostering moral resilience in workers through forums and training, could go a long way toward addressing MS.

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Author contribution

Sara HARPER: conceptualization, design, methodology, investigation, project administration, data management, formal analysis, interpretation, writing original draft.

Anatoli KARYPIDOU: design, methodology, project administration, formal analysis, supervision, writing review and editing.

Declaration of interest statement

Sara Harper is an employee of a London-based VAWG organization. Any potential risks attached to insider research were addressed during Ethical Approval and at all stages of research. The authors have no conflicts of interest to declare. All co-authors have seen and agree with the contents of the manuscript and there is no financial interest to report. We certify that the submission is original work and is not under review at any other publication.

Ethical statement

This manuscript is the authors' original work.

All participants engaged in the research voluntarily and anonymously.

Their data are stored in coded materials and databases without personal data.

The studies involving human participants were reviewed and approved by the Research Ethics Committee of Birmingham Newman University on January 27th 2022, with Ethics Approval Number: 2003940_220127.

Data Availability Statement

Datasets presented in this article are available from the corresponding author upon reasonable request.

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