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Understanding Moral Distress in Long-Term Care: Influencing Factors and Coping Mechanisms

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Abstract

This study set out to review the current scientific literature on moral distress among healthcare professionals in long-term care environments, specifically highlighting key contributing factors and the various methods used to manage it. This scoping review was conducted according to the methodological steps outlined by Arksey and O'Malley (2005) and follows the PRISMA-ScR reporting standards. The research questions were first reframed using the PICO model (population, intervention, comparison, and outcome). The Population included all healthcare professionals involved in daily care delivery within long-term care organizations, such as care workers, nurses, and youth workers. Eight articles met the inclusion criteria for this review. Moral distress can seriously undermine the wellbeing of healthcare professionals. The primary factors contributing to moral distress were identified as insufficient resources, inadequate communication, and misalignment with colleagues. Coping strategies involved openly discussing ethical dilemmas with others, drawing on support from colleagues and supervisors, and seeking external help beyond the immediate team or organization. On a personal level, healthcare professionals relied on their individual traits and sense of professional identity, turning to techniques such as rationalizing the circumstances, creating emotional distance, or simply accepting the reality of the situation to manage their moral distress. The experience of moral distress among healthcare professionals in long-term care does not seem markedly different from that observed in other areas of healthcare. While this overlap allows for valuable cross-learning between settings, it simultaneously raises concerns about whether the definition of moral distress has become overly expansive.

Keywords: Moral distress, Healthcare professionals, Long-term care, Scoping review

Introduction

Healthcare professionals regularly face ethically challenging scenarios that can trigger deep value conflicts or moral uncertainty. These issues often emerge when institutional policies favor cost-saving measures and operational efficiency at the expense of care quality, when staff feel their skills and input are not properly appreciated, when teamwork suffers from weak communication, or when staffing levels and other resources fall short. Such conditions often lead to moral distress in the workforce [1-9].

The term moral distress was originally introduced by philosopher Andrew Jameton in 1984. He defined it as the painful awareness of the ethically correct action while being constrained in a setting where carrying it out is extremely difficult [10-16]. In the decades since, the idea has sparked considerable discussion in academic publications, with scholars examining its precise boundaries, connections to similar notions, and its relevance to real-world healthcare delivery [17-21]. Even though moral distress lacks a universally agreed-upon definition and is occasionally labeled an "umbrella term" [12], most experts concur that it constitutes a major challenge in healthcare. It is widely acknowledged that

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moral distress exerts a strong negative influence on professionals, leading to frustration, job dissatisfaction, insomnia, physical illness, and burnout [12, 15, 22-33]. Moreover, it is frequently cited as a reason why healthcare workers ultimately resign, thereby intensifying the persistent worldwide shortage of personnel [17, 34, 35].

Dealing with moral distress in long-term care has become increasingly critical, given that these environments face escalating workforce shortages and tighter budgets [6, 11]. These constraints are likely to generate even more ethically demanding situations for staff.

Numerous literature reviews have already explored moral distress within short-term or acute care contexts, such as general clinical wards [13, 23], intensive care units [3], critical care departments [2, 19], and cancer care services [8]. However, to the best of our knowledge, no prior review has concentrated on the specific context of moral distress among healthcare professionals delivering daily care in long-term care settings.

Long-term care refers to assistance provided over an extended period, focused on meeting a patient's everyday personal needs. Care can take place in dedicated facilities offering continuous 24-hour support or through home-based services. Recipients of long-term care commonly depend on ongoing help due to persistent physical or cognitive health issues, limitations in daily functioning, or a mix of both [25]. Typical long-term care environments encompass services for older adults, mental health support, care for individuals with intellectual disabilities, and youth care programs. What distinguishes long-term care is the enduring and intimate nature of the caregiver-patient relationship [6]. Consequently, both the conceptualization and the lived experience of moral distress in these settings may diverge from those observed in environments oriented toward short-term medical treatment and recovery.

This study aims to map the available scientific literature on moral distress among healthcare staff in long-term care settings, highlighting key contributing factors and practical approaches to address it.

The research questions guiding this review are as follows:

1) How is moral distress understood and defined in long-term care contexts?

2) What are the consequences of moral distress for healthcare professionals working in long-term care settings?

3) Which coping strategies and interventions have been designed to assist healthcare professionals in long-term care settings with managing moral distress?

Materials and Methods

Design

This scoping review was conducted according to the methodological steps outlined by Arksey and O'Malley [1] and follows the PRISMA-ScR reporting standards [30].

PICO

The research questions were first reframed using the PICO model (Population, Intervention, Comparison, Outcome). The Population included all healthcare professionals involved in daily care delivery within long-term care organizations, such as care workers, nurses, and youth workers. The review focused on four specific long-term care areas: elderly care, mental health care, intellectual disability care, and youth care. Moral distress served as the Intervention. No particular Comparison was applied. The Outcome covered both the impact of moral distress on staff and the support strategies found to be beneficial.

Search strategy

Relevant publications were identified using a systematic search approach grounded in the PICO elements. The search combined official MeSH terms (Morals, Nurses, Long-term care, Residential facilities, Mental health services, Psychiatric nursing, Intellectual disability, Child welfare, Child protective services, Nursing homes, and Health services for the aged) with natural language terms (covering moral and ethical distress/stress, dilemmas, challenges, care workers, caregivers, nursing staff, youth or child protection workers, group homes, care homes, assisted living facilities, mental healthcare, intellectual disability care, youth or child care, and elderly care). Boolean operators (AND/OR) were used to connect the terms. The query was initially constructed in PubMed and then modified for use in Embase, CINAHL, and PsycINFO.

Search outcome

Database searches were conducted in PubMed, Embase, CINAHL, and PsycInfo in October 2023, with no time restrictions. This yielded 3141 records. After duplicate

removal, 2245 unique articles remained. Titles and abstracts were uploaded to Rayyan and screened by the two authors independently, under blind conditions, in accordance with the eligibility criteria. Conflicts were settled through joint discussion until full agreement was reached, narrowing the pool to 40 articles for full-text evaluation. No qualifying studies were identified in the field of intellectual disability care.

All 40 articles, plus the manually added article, underwent full-text review and detailed assessment by both authors to determine whether they addressed at least one research question. Following discussion and resolution of differences, 8 articles were ultimately included.

The full selection procedure is displayed in the PRISMA flow diagram in **Figure 1.**

projects.

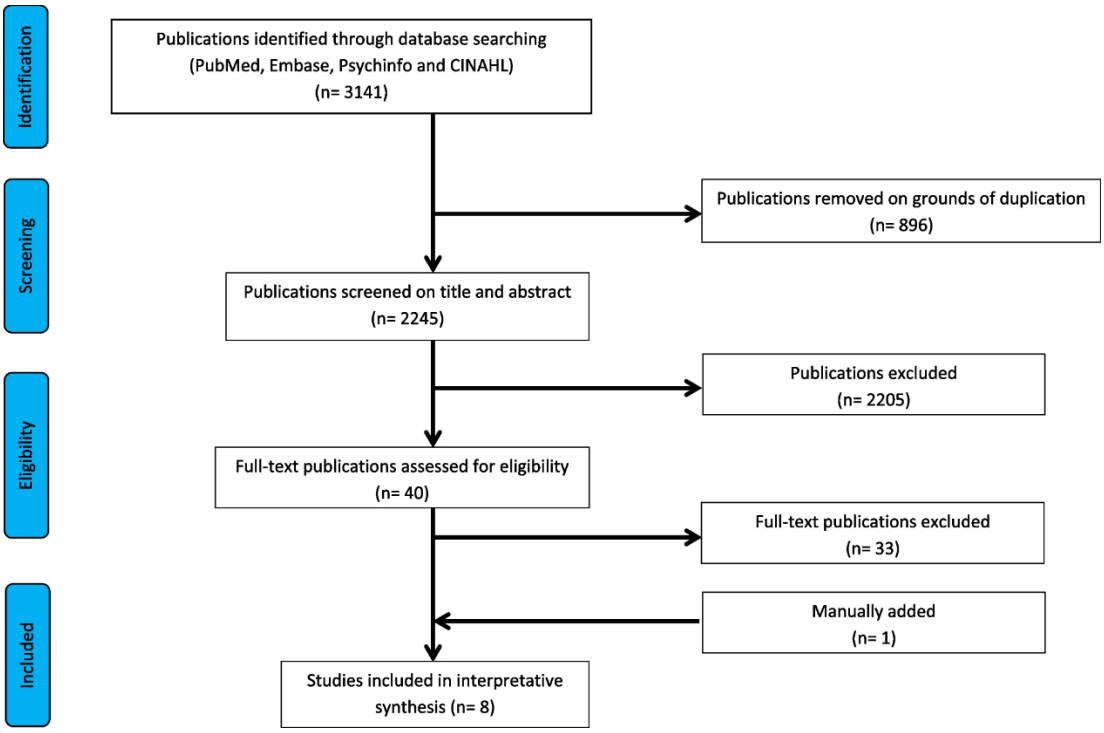

Figure. 1 Flow diagram of the study search and selection process. From: Moral distress among healthcare professionals in long-term care settings: a scoping review

Inclusion and exclusion criteria

Articles were eligible if they fulfilled these requirements:

• Published in English or Dutch

• Targeted healthcare professionals as the main study group

• Took place in long-term care environments, specifically elderly care, mental healthcare, intellectual disability care, or youth care

• Focused on moral distress

• Reported original empirical findings

Studies conducted in non-long-term care settings (e.g., hospitals), as well as reviews, doctoral theses, editorials, and theoretical/conceptual papers, were excluded.

Quality appraisal

No quality evaluation of the selected articles was carried out because the purpose of this scoping review was purely exploratory.

Data abstraction

Relevant sections from the 8 included articles—covering authors, study objectives, definitions of moral distress, influencing factors, observed effects, and support strategies—were extracted and organized in a summary table. The authors repeatedly discussed and refined the extracted content together.

Synthesis

Using thematic analysis [5], the first author clustered and condensed the information under each main topic

(definition of moral distress, influencing factors, effects, and helping strategies). These summaries were then cross-checked and fine-tuned in collaboration with the second author to ensure alignment with the review's objectives.

Results and Discussion

Of the 3141 articles initially located, seven met the inclusion criteria, and one additional article was included by hand, bringing the final count to eight studies in this review. The selected articles were published between 2013 and 2023 and originated from several countries spanning Europe, North America, and the Middle East, namely Finland, Italy, the United Kingdom, Canada, and Iran. None of the included research took place in intellectual disability care. The largest share of studies was carried out in elderly care [9, 31, 36] or mental healthcare [22, 27, 28]. One article examined female healthcare professionals broadly [26], and another focused on youth care and social welfare [18]. Nearly all investigations relied on qualitative methods, especially semi-structured interviews. A single study adopted a quantitative approach that collected data via an online survey [18].

The bulk of the research examined the causes of moral distress, its consequences for healthcare staff, and how professionals responded to it. Some studies also examined practical approaches that staff reported as effective in easing moral distress [9, 22, 26, 31, 36]. One study focused entirely on the coping methods used by healthcare professionals [28]. An overall summary of the findings on these aspects appears in **Table 1**.

Table 1. Overview of included articles. From: Moral distress among healthcare professionals in long-term care settings: a scoping review

Study	Study aim	Conceptualization of moral distress	Determinants/influencing factors of moral distress	Impact of moral distress on healthcare professionals	Coping/supportive strategies
Edwards *et al.* [9]	To describe how registered nurses in long-term care respond to early experiences of moral distress, including perceived supports and barriers	Initial moral distress [15]: situations where treatments requested by families or teams conflict with residents' wishes or best interests; compromised care due to limited resources; and diminished resident dignity, shaped by contextual factors	Feeling socially and professionally isolated due to value misalignment with colleagues; lack of managerial or leadership support leading to frustration, isolation, and despair	Not reported as a distinct outcome category	Opportunities for discussion with colleagues and managers; being heard and supported in decision-making processes; access to external resources such as education, literature, and objective consultation
Musto *et al.* [22]	To explore how acute mental health care professionals manage ethically difficult situations, exercise moral agency, and	Based on Jameton [14]: inability to act with respect, dignity, and compassion toward individuals with mental health conditions; limited time and space resources	Not explicitly categorized	Not examined	Collegial and leadership support; psychologically safe teams; structured ethical discussions; external consultation; cognitive strategies such as rationalization, emotional distancing, acceptance, and

	reduce moral distress				maintaining professional identity
Smith *et al.* [26]	To identify forms of moral distress among female healthcare workers during COVID-19 and explore feminist political economy perspectives	Based on Morley *et al*. [21], moral distress arises from both paid clinical work and unpaid caregiving responsibilities	Workforce shortages are limiting care quality and patient interaction; inconsistent or poor communication, and conflicting information	Mental health deterioration, burnout, and physical health effects (including cardiovascular events)	Psychotherapy or counseling; reliance on professional identity and pride; recognition of compounded ("double burden") moral distress across paid and unpaid roles
Tavakol *et al.* [27]	To identify causes of moral distress among psychiatric nurses	Based on Jameton [14]	Lack of professional competence; organizational culture issues; individual-level contributors; environmental constraints, including high workload, staffing shortages, and inadequate physical space; weak communication; observation of ethical conflicts	Not studied	Not studied
Tavakol *et al.* [28]	To explore coping strategies used by psychiatric nurses when facing moral distress	Based on Jameton [14]	Working alongside underperforming colleagues; witnessing colleagues' mistakes; use of force in managing aggressive patients; poor communication among staff, and with patients	Emotional harm, including guilt, regret, reduced motivation, and physical symptoms	Reporting concerns to supervisors; disciplinary action toward underperforming staff; correcting colleagues' errors; adjusting work allocation; anger management training; religious coping; improving patient communication through empathy and listening; strengthening peer communication; managerial recognition and support
Villa *et al.* [31]	To explore moral distress among healthcare professionals providing	Based on Jameton [14]	Limited staffing and resources; inability to allocate adequate time to elderly patients; communication difficulties with families or caregivers	Emotional reactions during events (helplessness, fear); post-event reactions	Team-based reflection and shared moral reasoning; reliance on personal traits such as optimism and

	care for older adults in both hospital and community settings			(satisfaction if actions were justified, or regret and rumination); physical effects (fatigue, hypertension); psychological effects (isolation, distraction)	calmness; professional experience; leadership trust and support; psychological support services; relational competence; organizational improvements such as increased staffing and clearer role allocation
Young *et al.* [36]	To explore nursing home staff experiences of moral distress in end-of-life care	Based on Peter and Liaschenko [24]	Communication breakdowns; strained relationships; conflicting value systems among stakeholders; fear of making incorrect decisions	Not studied	Open communication among all stakeholders; recognition of differing values; collaborative decision-making; mutual respect for input from all parties
Mänttäri-van der Kuip [18]	To examine reactive moral distress among social workers and the role of limited resources in public welfare settings	Reactive moral distress [15]	Resource scarcity, including increasing budget constraints and workload pressures	Reduced enthusiasm, motivation, pride, and energy; lower job retention intention; higher sickness absence; fewer positive job experiences compared to unaffected colleagues	Not specified

The presentation begins by explaining the definitions of moral distress applied in the studies and the elements identified as shaping it. Next comes a description of the ways moral distress impacts healthcare professionals. The final part outlines the strategies described as helpful for dealing with moral distress.

How moral distress is defined

Except for two studies [26, 36], all others built their work on Jameton's original definition of moral distress. Back in 1984, Jameton portrayed moral distress as the painful state in which a healthcare professional clearly knows the ethically correct action but cannot carry it out due to barriers created by the institution [14]. Jameton later broadened this idea in 1993 by distinguishing between initial and reactive moral distress. Initial moral distress involves immediate emotions such as frustration, anger, and anxiety triggered by institutional hurdles or clashes in personal values. Reactive moral distress refers to the lasting discomfort that follows when a person fails to follow through on their initial response [15]. One study specifically looked at reactions to initial moral distress [9], while another examined reactive moral distress,

calling it "a lingering state that impairs wellbeing over a longer term" [18].

The two studies that moved away from Jameton's definition took different paths. Young *et al*. [36] followed the updated view from Peter and Liaschenko [24], defining moral distress as "a challenge that arises when one has an ethical or moral judgment about care that differs from that of others in charge" [24, 36]. The other study drew on Morley *et al*. [20], describing moral distress as the combination of (1) facing a moral situation, (2) feeling psychological distress, and (3) a clear causal connection between the first two [20, 26]. Even though the exact wording varies, every definition across the studies centers on healthcare professionals being prevented from acting in accordance with their moral principles.

Influencing factors of moral distress

Findings across the studies reveal that moral distress stems from a wide range of triggers. Edwards *et al*. [9] highlighted that the distress often arises not only from the core conflict but also from surrounding circumstances, such as prior relationships with the people involved, limited response time, the professional's level of certainty about the right choice, and whether others were open to discussing the matter [9]. Smith *et al*. [26] discovered that female healthcare workers faced moral distress linked to both their paid jobs and unpaid caregiving duties, indicating that hidden gender expectations play a role [26]. Young *et al*. [36] found that clashing values with team members left professionals feeling powerless to influence care choices, thereby intensifying moral distress. Fear of committing errors or reaching poor decisions was also noted as a contributing element [36].

Resource shortages were a frequent driver of moral distress across most studies [9, 18, 22, 26, 27, 31]. This issue mainly involved having too few staff members, which made it difficult to deliver proper care [9, 26] or spend enough time with residents [26, 27, 31]. Some research found that insufficient professional skills were a risk factor for mistakes and subsequent moral distress [27]. One study highlighted the physical layout and size of facilities, noting that cramped spaces and overcrowded wards added to the strain [27]. Another study focused on financial constraints and heavy workloads as direct sources of moral distress [18].

Inadequate communication appeared repeatedly as a significant factor [26, 27, 28, 31, 36]. Problems included weak information flow inside the organization [26, 36], disagreements with family members about care plans [31, 36], and harsh or unempathetic interactions with patients [27, 28]. Friction and disputes among team members due to poor collaboration were also common [27, 28]. Communication gaps between nursing homes, hospitals, and general practitioners were also noted [36].

Colleagues' conduct was another notable trigger. Examples included colleagues showing little engagement [28], displaying poor skills, or discriminating against patients [27], as well as errors or violent behavior toward residents [27, 28]. Moral distress also emerged when team members supported treatment decisions that went against a resident's wishes or best interests [9]. Threats to a resident's dignity were likewise reported as important causes [9, 22].

How moral distress affects healthcare professionals

Five articles examined the impact of moral distress on healthcare professionals [9, 18, 26, 28, 31].

First, moral distress influences the emotional state of healthcare staff. Mänttäri-van der Kuip [18] described reduced levels of enthusiasm, inspiration, pride, and energy following experiences of moral distress [18]. Tavakol *et al*. [28] noted feelings of remorse, guilt, and decreased motivation [28]. Villa *et al*. [31] highlighted immediate emotions such as helplessness and fear of repercussions during morally challenging situations, as well as later emotions ranging from satisfaction when the correct action was taken to a sense of failure when it was not [31].

Second, moral distress can lead to physical and psychological consequences. These include increased sick leave [18], hypertension, fatigue [31], heart problems, burnout [26], mental health difficulties [26], fewer positive experiences at work [18], difficulty concentrating [31], and feelings of isolation stemming from differing values with colleagues [9, 31]. When professionals lack support from managers or leaders, they often feel isolated, frustrated, and hopeless [9].

Third, moral distress can also influence the wider care organization. Mänttäri-van der Kuip [18] reported that 42.4% of healthcare professionals experiencing reactive moral distress were unwilling to remain in their current position [18].

Strategies and interventions to handle moral distress

Several studies have shown that healthcare professionals develop personal coping strategies to reduce moral

distress. Villa *et al*. [31] indicated that individual traits such as calmness, optimism, faith, along with professional experience and strong relational abilities, affect how effectively moral distress is managed [31]. Many studies highlighted the value of discussing moral distress with team members or managers [9, 28]. Within teams, professionals can clarify ethical responsibilities and boundaries. On a personal level, staff may justify their choices, emotionally detach from patients [22], accept the situation to protect their own wellbeing [22], or rely on their sense of professional identity, pride, and satisfaction [22, 26]. External support beyond the team or organization also proved helpful [9, 22], as did seeking counseling or psychological assistance [26, 31].

Tavakol *et al*. [28] found that nurses addressed moral distress by attempting to remove its root causes — for instance, correcting colleagues' mistakes, enforcing stricter accountability, adjusting work schedules, strengthening anger management, enhancing patient communication, or turning to religious beliefs [28].

Certain conditions were identified as essential for effectively managing moral distress. Strong managerial support is crucial for creating a positive ethical climate where professionals feel safe to voice concerns. Those who received backing from colleagues or leaders and felt their moral agency was respected reported greater capacity to manage moral distress [9, 22, 28, 31, 36]. Professionals need to feel heard and for their views to be valued [9, 22, 28, 36]. When teams maintain a safe, professional, and emotionally supportive space, staff are more willing to consult one another and develop solutions [22]. Good teamwork can lower moral distress [36] and is strengthened by improved professional communication [28]. Making collective moral decisions as a team can also prevent moral distress [31]. Even when discussions do not fully resolve issues, they remain valuable because they allow concerns to be acknowledged [9]. Young *et al*. [36] added that developing a mutual understanding of differing values and maintaining open dialogue on ethical matters can reduce moral distress [36]. Villa *et al*. [31] further noted that organizations should establish clear responsibility structures and increase staffing levels to help alleviate moral distress [31].

This review sought to clarify how moral distress is conceptualized in long-term care research, its effects on healthcare professionals, and the strategies that support coping with it. Although definitions of moral distress vary, they consistently center on situations in which professionals are unable to act in accordance with their ethical beliefs. Contributing factors included resource shortages (such as limited staff, heavy workloads, and inadequate competencies), poor communication within and across organizations, and difficulties between colleagues, patients, and families. These issues are not unique to long-term care; similar causes appear in other healthcare environments. For example, nursing shortages and working with underqualified staff were reported as triggers in surgical care [7], intensive care [3], and general clinical settings [13, 23]. Reviews by Arnold *et al*. [2] and McAndrew *et al*. [19] in critical care also identified colleague behavior — such as crossing professional boundaries or observing malpractice — as important sources of moral distress [2, 19]. Communication breakdowns during end-of-life decisions among nurses, patients, families, and physicians were also frequently noted [19].

The review identified multiple effects of moral distress on healthcare professionals, including impacts on emotional wellbeing (e.g., lowered enthusiasm, fear, insecurity, and frustration), physical and psychological consequences (e.g., frequent sick leave and burnout), and effects on team and organizational climate. Comparable outcomes have been reported in short-term care settings, including frustration, anger, and fatigue [2, 13, 23], as well as staff turnover [7, 13, 19] among nurses in surgical, critical, and clinical environments.

Strategies for reducing moral distress stress the value of open discussion with colleagues, counseling, and organizational support. Reviews in other healthcare fields similarly recommend addressing moral distress at an organizational level [13], empowering nurses to raise ethical concerns [7], and call for more intervention studies to evaluate the effectiveness of different coping approaches [2, 19, 23].

Strengths and limitations

While several reviews of moral distress in healthcare already exist, this study is the first to focus specifically on empirical research on moral distress in long-term care settings. Because long-term care covers a wide variety of practices and is hard to define clearly, we narrowed the search to specific long-term care environments where professionals provide daily support to individuals who depend on them. This decision to focus the scope may be

viewed as a limitation, since daily caregiving also occurs in various short-term care contexts.

Although the literature search generated a large number of results, most articles failed to satisfy the inclusion criteria. Furthermore, the final selection did not show an even spread across the different long-term care fields. This imbalance may stem from the fact that fewer studies on moral distress among healthcare professionals have been conducted in youth care and intellectual disability care. As this is a scoping review, it aimed for breadth rather than depth, so it may not offer an exhaustive picture of the existing literature on the subject.

An additional limitation is that the research questions in this scoping review treat moral distress as an inherently negative experience, a view also reflected in the included studies. However, some research indicates that moral distress can carry a positive meaning, suggesting that professionals are morally sensitive and engaged [10, 29]. This positive dimension was deliberately excluded to keep the review focused.

Conclusion

This scoping review indicates that moral distress among healthcare professionals in long-term care settings is defined and experienced in ways largely similar to those in other healthcare environments (such as short-term care settings). On one hand, this is an encouraging finding because it suggests that different healthcare sectors can learn from one another. Strategies developed to reduce moral distress in one area, for instance, could be adapted and shared across sectors. A clear example is the importance of creating moral space and empowering nurses to voice their ethical concerns. Establishing an ethical climate in teams and organizations — where professionals feel safe to raise moral issues — depends heavily on strong support from management.

On the other hand, these findings raise important questions about the concept of moral distress itself. Could the current definition be too broad if it fails to highlight meaningful differences between long-term and short-term care settings? When morality is viewed as a social practice, it becomes clear that moral understandings are shaped by social and cultural contexts [4, 32]. This suggests that moral distress may vary across specific social and cultural environments. Future research should examine whether characteristics unique to long-term care influence how moral distress is experienced and whether specialized strategies are required to reduce it in these settings.

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