Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Ethics Under Constraint: Moral Conflict, Institutional Power, and Ethical Self-Negotiation Among Mental Health Workers

Saranya T.S

saranya.t.sathish@gmail.com

Amity University Bengaluru

Sebnam Yucel

Selçuk University

Sandeep Kumar Gupta

Mohan Babu University

Recep Yucel

Kırıkkale University

Research Article

Keywords: Moral distress, institutional ethics, mental health professionals, power, thematic analysis

Posted Date: March 6th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-8751942/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Ethical practice in mental health care is often conceptualised as individual adherence to professional codes and moral principles. However, such frameworks inadequately capture the lived ethical realities of mental health workers operating within institutional systems shaped by bureaucratic control, legal mandates, risk management protocols, and hierarchical power relations. This study examines how mental health professionals experience, interpret, and navigate ethical conflict when professional values collide with institutional constraints. Adopting a qualitative, interpretivist design, in-depth semi-structured interviews were conducted with psychologists, counsellors, psychiatric social workers, and psychiatrists working across public, private, and non-governmental mental health settings. Data were analysed using reflexive thematic analysis to foreground participants' moral reasoning, emotional responses, and adaptive strategies. Four interrelated themes emerged: institutional moral dissonance, hierarchies of power and constrained ethical agency, moral distress and emotional residue, and ethical negotiation as a survival practice. Participants described ethics not as a stable set of principles but as an ongoing process of negotiation shaped by organisational expectations and power asymmetries. Ethical compromise was experienced less as personal failure and more as a structural inevitability, producing enduring emotional consequences such as guilt, exhaustion, and ethical numbing. To sustain professional functioning, participants engaged in pragmatic ethical recalibration—seeking to minimise harm while preserving dignity within constrained systems. The findings challenge individualised models of ethical accountability and argue for a structural understanding of moral distress in mental health care. The study highlights the need for ethics education, supervision, and institutional policies that acknowledge ethical ambivalence, legitimise moral distress, and address the organisational conditions that constrain ethical agency. By centering practitioners' lived experiences, this research reframes ethics as a relational, embodied, and contextually situated practice rather than a purely normative ideal.

Introduction

Ethical practice is widely regarded as the moral cornerstone of mental health care. Professional training and regulatory frameworks emphasise adherence to ethical principles such as beneficence, non-maleficence, autonomy, justice, and respect for persons (American Psychological Association [APA], 2017; Beauchamp & Childress, 2019). Within this normative framing, ethical competence is often conceptualised as an individual practitioner's ability to apply ethical codes, exercise sound judgment, and manage dilemmas through principled decision-making. However, such formulations risk obscuring the institutional conditions under which ethical practice actually unfolds. Mental health professionals do not practise in ethical vacuums; rather, they operate within complex organisational systems shaped by bureaucratic regulation, legal surveillance, economic constraint, and hierarchical power relations. These institutional forces frequently constrain ethical agency, generating moral conflict that cannot be resolved through individual reasoning alone.

In contemporary mental health settings, practitioners are routinely required to balance care with compliance, empathy with risk management, and professional values with organisational mandates.

Decisions related to involuntary treatment, discharge planning, documentation, confidentiality, and resource allocation are often governed by institutional protocols that prioritise efficiency, liability management, or administrative accountability over relational or contextual care (Mol, 2008; Rose, 2019). As a result, clinicians may find themselves compelled to act in ways that contradict their ethical convictions or clinical judgment. This disjuncture between what professionals believe is ethically appropriate and what institutions permit or demand has been conceptualised as *moral distress*—a phenomenon originally identified in nursing but increasingly recognised across health and mental health professions (Jameton, 1984; Epstein & Hamric, 2009).

Moral distress refers not merely to ethical uncertainty but to the psychological and emotional suffering that arises when individuals know the ethically right course of action yet are unable to pursue it due to external constraints. In mental health work, moral distress is intensified by the relational nature of care and the high stakes involved in decisions affecting autonomy, safety, and dignity (Austin et al., 2008). Research has linked moral distress to burnout, compassion fatigue, emotional withdrawal, and attrition from the profession (Rushton et al., 2016). Yet much of this literature remains focused on individual outcomes, often framing moral distress as a problem of resilience, coping, or professional competence. Such approaches risk pathologising practitioners while leaving institutional structures largely unexamined.

Critical scholars argue that ethical conflict in health care must be understood as a *structural* rather than purely individual phenomenon (Tronto, 2013; Banks, 2018). Institutions exercise power not only through explicit rules but through subtle mechanisms of surveillance, performance metrics, and professional hierarchies that shape what can be said, documented, or defended as “ethical” practice (Foucault, 1988; Power, 2004). In mental health systems, these dynamics are particularly pronounced, as practitioners operate at the intersection of medicine, law, and social control (Rose, 1998). Ethical decisions are therefore embedded within regimes of accountability that privilege institutional legitimacy over relational or contextual forms of care. This raises critical questions about where ethical responsibility truly lies—and whose ethics are ultimately being served.

Despite growing recognition of these tensions, there remains a paucity of qualitative research that centres mental health workers’ lived experiences of ethical conflict within institutional contexts. Quantitative studies have measured levels of moral distress or ethical stress, but they offer limited insight into how professionals *interpret*, *emotionally process*, and *negotiate* ethical compromise over time (Morley et al., 2019). What is often missing is an exploration of ethics as it is lived—felt in the body, carried home after work, and woven into practitioners’ sense of professional identity. Similar to how life disruptions such as illness or divorce constitute biographical ruptures (Bury, 1982), persistent ethical conflict can destabilise clinicians’ moral self-understanding, producing feelings of guilt, erosion of meaning, and ethical fatigue.

Qualitative approaches are particularly well suited to capturing these dimensions of ethical life. By attending to practitioners’ narratives and reflections, such methods illuminate how ethical subjectivity is

formed, strained, and recalibrated within specific institutional arrangements (Riessman, 2008). Rather than treating ethics as a fixed set of rules, a qualitative lens allows ethics to be understood as a situated practice—one that is relational, emotionally laden, and continuously negotiated (Mol, 2008). This perspective resonates with feminist and care-ethics traditions, which emphasise attentiveness, responsibility, and responsiveness within unequal power relations, rather than abstract moral reasoning alone (Gilligan, 1982; Tronto, 2013).

This study adopts such a lens to examine how mental health professionals navigate ethical conflict under institutional constraint. Drawing on in-depth interviews with practitioners across public, private, and non-governmental settings, the research explores how participants experience moral dissonance, perceive institutional power, and develop strategies to survive ethically compromised environments. Rather than asking whether practitioners follow ethical codes, the study asks how ethics is *lived*, *strained*, and *reworked* within systems that often make "good" ethical choices impossible. In doing so, it shifts the analytic focus from individual ethical failure to the organisational and structural conditions that produce moral distress.

By foregrounding practitioners' voices, this research contributes to a growing body of critical mental health scholarship that calls for institutional accountability in ethical practice (Banks, 2018; Morley et al., 2019). It argues that ethical integrity in mental health care cannot be sustained through individual moral effort alone, but requires systemic change, reflective spaces, and organisational cultures that recognise ethical ambivalence as an inherent feature of practice. Understanding ethics under constraint is therefore not only an academic concern but an urgent professional and policy issue—one that has direct implications for practitioner well-being, quality of care, and the moral sustainability of mental health systems.

Methodology

Research Design

This study adopts a qualitative research design grounded in an interpretivist paradigm to explore the lived ethical experiences of mental health professionals working within institutional settings. Qualitative inquiry was selected as it enables an in-depth examination of meaning-making processes, moral reasoning, and emotional responses that cannot be adequately captured through quantitative or survey-based approaches. Ethical conflict, moral distress, and professional ambivalence are complex, contextually embedded phenomena that require attention to narrative depth, relational dynamics, and institutional positioning.

The study conceptualises ethics not as a static adherence to professional codes, but as a lived, negotiated practice shaped by power relations, organisational cultures, and structural constraints. In-depth interviews were therefore employed to allow participants to articulate their experiences of ethical tension in their own words, reflect on moral dilemmas over time, and situate their ethical decisions

within institutional contexts. This approach aligns with qualitative traditions that treat lived experience as a legitimate source of ethical knowledge and foreground subjectivity as analytically meaningful rather than as bias to be eliminated.

Data Sources

Primary Data

The primary data source for this study consisted of one-to-one, semi-structured in-depth interviews with mental health professionals. Participants included psychologists, counsellors, psychiatric social workers, and psychiatrists employed across public hospitals, private mental health clinics, and non-governmental organisations. Purposive sampling was used to ensure variation in professional role, institutional setting, and years of clinical experience, thereby capturing a broad range of ethical encounters and institutional constraints.

Participants were recruited through professional networks and peer referrals. Inclusion criteria required that participants had a minimum of two years of clinical experience in institutional settings and had encountered ethical dilemmas related to institutional policies, authority structures, or organisational mandates. The final sample comprised professionals with diverse training backgrounds and employment conditions, enabling comparative insight into how ethical conflict is shaped by positionality within institutional hierarchies.

Each interview lasted between 60 and 90 minutes and was conducted individually, either in person or via secure video conferencing platforms, depending on participant availability and preference. A semi-structured interview guide was used to balance consistency across interviews with flexibility for participants to direct the conversation toward ethically salient experiences. Interview prompts focused on experiences of ethical dilemmas, perceived institutional constraints on ethical practice, emotional responses to ethical compromise, and strategies used to cope with or negotiate moral conflict. Interviews were audio-recorded with informed consent and transcribed verbatim to preserve linguistic nuance, affective tone, and narrative flow.

Data Analysis

Data were analysed using reflexive thematic analysis, a method well suited to identifying patterned meanings across qualitative data while retaining sensitivity to context and subjectivity. Analysis followed a systematic, multi-phase process that prioritised depth, reflexivity, and analytic transparency.

Familiarisation with the data:

All interview transcripts were read repeatedly to gain an overall sense of participants' ethical worlds, institutional contexts, and emotional registers. During this phase, analytic memos were written to

document initial impressions, recurring tensions, and reflexive observations regarding the researcher's interpretive positioning.

Initial (first-cycle) coding:

Transcripts were coded inductively using line-by-line open coding. Codes captured expressions of ethical conflict, references to institutional power, emotional responses to ethical compromise, and coping or negotiation strategies. In-vivo codes were retained where possible to preserve participants' own ethical language and metaphors. This phase generated a large pool of preliminary codes reflecting both explicit ethical dilemmas and latent moral tensions.

Thematic clustering and refinement:

Related codes were then grouped into broader conceptual categories through an iterative process of comparison and refinement. These categories were examined for internal coherence and conceptual distinctiveness, resulting in the development of higher-order themes that captured patterned ethical experiences across participants. Attention was paid to both convergence and divergence across professional roles and institutional contexts.

Reflexive interpretation:

Themes were further refined through reflexive engagement, examining how institutional power, professional hierarchies, and organisational norms shaped ethical meaning-making. Rather than treating themes as objective discoveries, they were understood as interpretive constructions emerging from the interaction between data, theory, and researcher reflexivity. Analytic decisions were documented through memos to ensure transparency and auditability.

To enhance credibility, peer debriefing was conducted with an experienced qualitative researcher who reviewed selected transcripts and thematic structures. Discrepancies were discussed and resolved through analytic dialogue rather than consensus-seeking, consistent with reflexive qualitative standards.

Ethical Considerations

Ethical approval

for the study was obtained from the relevant institutional ethics committee prior to data collection. Given the sensitive nature of discussing ethical conflict and institutional power, particular care was taken to protect participants' confidentiality and professional safety. Participants received detailed information about the study's aims, procedures, and their rights, including the right to withdraw at any stage without consequence.

Written informed consent was obtained from all participants. Pseudonyms were used in transcripts and reporting, and identifying details related to institutions, supervisors, or specific cases were removed or altered to prevent indirect identification. Audio recordings and transcripts were stored securely on password-protected devices accessible only to the researcher.

Recognising that recounting experiences of moral distress may evoke emotional discomfort, interviews were conducted with sensitivity, and participants were reminded that they could pause or decline to answer any question. Where distress was evident, appropriate support resources were shared. The study adhered to ethical principles of respect, beneficence, and non-maleficence throughout the research process.

Results

The thematic analysis of in-depth interviews revealed that ethical conflict in mental health practice is not episodic or exceptional but an enduring feature of institutional work. Participants described ethics as something they constantly *navigate*, *manage*, and *absorb*, rather than something they simply apply. Four interrelated themes were identified: **institutional moral dissonance**, **hierarchies of power and constrained ethical agency**, **moral distress and emotional residue**, and **ethical negotiation as survival practice**. Together, these themes illuminate how ethical subjectivity is shaped, strained, and recalibrated within institutional mental health systems.

Theme 1: Institutional Moral Dissonance

Participants consistently described a pervasive tension between their professional ethical commitments and institutional mandates. This dissonance was most acutely felt in situations involving risk management, discharge decisions, documentation practices, and limits on therapeutic engagement. While participants articulated clear internal ethical frameworks grounded in care, dignity, and relational responsibility, these values frequently clashed with institutional priorities such as efficiency, liability avoidance, and adherence to rigid protocols.

One psychologist working in a public hospital reflected:

Ethically, I want to slow down, understand context, listen. Institutionally, I'm expected to move cases along. That gap never really closes.

This moral dissonance was not experienced as confusion about what was ethically right; rather, participants often expressed clarity about the ethical course of action but felt blocked from pursuing it. Institutional policies were described as creating "ethical ceilings"—points beyond which care could not be ethically extended without professional risk.

Several participants noted that over time, repeated exposure to such dissonance altered their ethical expectations. What initially felt unacceptable gradually became normalised, producing what some

described as a “quiet erosion” of ethical idealism.

Table 1
Forms of Institutional Moral Dissonance

Institutional Constraint	Ethical Value in Conflict	Participant Experience
Risk-management protocols	Client autonomy	Overriding client wishes
High caseloads	Attentive care	Rushed therapeutic encounters
Documentation demands	Relational confidentiality	Defensive note-writing
Discharge pressures	Continuity of care	Premature termination

Table 1 summarises the most frequently reported sites of moral dissonance, illustrating how institutional logics repeatedly collide with ethical commitments central to mental health practice.

Theme 2: Hierarchies of Power and Constrained Ethical Agency

Ethical agency was deeply shaped by participants’ positionality within institutional hierarchies. Junior staff, contractual employees, and professionals working under medical or administrative authority reported significantly reduced capacity to challenge ethically troubling decisions. Participants described institutions as vertical moral spaces, where the ethical voice was unevenly distributed.

A psychiatric social worker noted:

You can raise concerns, but only to a point. After that, it becomes insubordination, not ethics.

For many, ethical decision-making was not a shared deliberative process but a top-down directive. Those in senior positions acknowledged greater ethical latitude but also greater responsibility for enforcing institutional norms, sometimes against their own ethical judgment.

Interestingly, ethical resistance rarely took overt forms. Instead, participants described subtle, everyday acts of negotiation—advocating informally for clients, selectively interpreting guidelines, or quietly extending care beyond institutional expectations.

Theme 3: Moral Distress and Emotional Residue

Ethical conflict did not end with institutional compliance; it left a profound emotional and moral residue. Participants described carrying unresolved ethical tension beyond the workplace, manifesting as guilt, exhaustion, rumination, and emotional numbing. Unlike acute stress, this distress accumulated gradually, producing what several participants described as “ethical fatigue.”

One counsellor explained:

You tell yourself you did what you could. But something stays with you. It shows up at night, in your body.

Participants emphasised that moral distress was not simply about difficult cases but about repeated ethical compromises that went unacknowledged or unprocessed within institutional cultures. Formal supervision often focused on clinical outcomes rather than ethical or emotional impact, leaving practitioners to manage distress privately.

Some participants described a troubling shift from ethical discomfort to ethical desensitisation. While this numbing allowed continued functioning, it was experienced as a loss of moral vitality.

Table 2
Emotional Consequences of Ethical Conflict

Emotional Response	Description	Long-Term Impact
Guilt	Acting against ethical judgment	Persistent rumination
Helplessness	Inability to change outcomes	Reduced agency
Emotional exhaustion	Chronic ethical strain	Burnout risk
Ethical numbing	Emotional detachment	Loss of professional meaning

Table 2 demonstrates that moral distress operates not merely as momentary discomfort but as an accumulative emotional burden shaping long-term professional well-being.

Theme 4: Ethical Negotiation as Survival Practice

Despite sustained ethical constraint, participants did not abandon ethical reflection. Instead, they reconfigured ethics as a pragmatic, negotiated practice aimed at minimising harm rather than achieving moral idealism. Ethics, in this sense, became situational, relational, and deeply embodied.

A senior clinician articulated this shift succinctly:

I stopped asking whether something was perfectly ethical. I started asking whether it was the least harmful option available.

Participants described developing personal ethical thresholds—internal boundaries that allowed them to continue working without complete moral disengagement. These thresholds were not formally articulated but were shaped through experience, peer conversations, and self-reflection.

Ethical negotiation strategies included selective advocacy, reframing institutional mandates to preserve dignity, and prioritising relational ethics even when systemic outcomes were fixed. Importantly, these strategies were described not as resistance but as survival.

Table 3
Strategies of Ethical Negotiation

Strategy	Description	Ethical Function
Micro-advocacy	Informal client support	Harm reduction
Ethical reframing	Reinterpreting mandates	Moral coherence
Compartmentalisation	Separating roles	Emotional survival
Peer validation	Informal ethical dialogue	Shared meaning

Table 3 illustrates how ethics functioned as an adaptive practice rather than a rigid standard.

Cross-Theme Integration: Ethics as Lived, Situated Practice

Across all four themes, ethics emerged as a lived, relational process rather than a codified rule system. Participants' accounts revealed ethics as something negotiated daily within constraints of time, power, and emotional labour. Ethical subjectivity was shaped not only by professional training but by institutional cultures that normalised compromise while rarely acknowledging its moral cost.

Comparative Patterns Across Participants

While all participants reported ethical constraint, variations emerged based on institutional context and professional role. Those in public-sector settings described greater structural rigidity and surveillance, while private-sector professionals reported market-driven ethical pressures such as client retention and financial viability. NGO-based practitioners experienced ethical strain related to funding priorities and donor expectations.

Table 4
Institutional Context and Ethical Experience

Setting	Dominant Constraint	Ethical Impact
Public institutions	Bureaucratic rigidity	Reduced autonomy
Private practice	Market pressures	Ethical commodification
NGOs	Funding mandates	Mission drift

Table 4 highlights how ethical conflict is shaped not only by individual role but by broader institutional logics.

Summary of Results

Taken together, the findings reveal that mental health professionals practise ethics under sustained institutional constraint. Ethical conflict is not an anomaly but a structural condition of practice, producing moral distress that accumulates emotionally and professionally. Participants respond not

through ethical abandonment but through continuous ethical negotiation aimed at survival, harm reduction, and preservation of moral selfhood.

By foregrounding practitioners' lived experiences, these results challenge individualised understandings of ethical failure and redirect attention toward institutional accountability. Ethics, as revealed here, is not simply about choosing the right action but about enduring moral complexity within systems that rarely make ethical clarity possible.

Discussion

This study examined how mental health professionals experience and navigate ethical conflict within institutional settings characterised by bureaucratic regulation, hierarchical authority, and risk-oriented governance. The findings demonstrate that ethical conflict is not an episodic challenge resolved through individual moral reasoning but a sustained and structurally embedded condition of professional practice. Ethics, as lived by participants, emerged as a negotiated, relational, and emotionally embodied practice—continually recalibrated in response to institutional constraint.

A key contribution of this study is its articulation of moral distress as a structurally produced phenomenon rather than an individual ethical failure. Participants consistently reported clarity about what constituted ethically appropriate care, yet experienced repeated obstruction by institutional policies, administrative mandates, and hierarchical decision-making. This aligns with Jameton's (1984) original conceptualisation of moral distress as the experience of knowing the ethically right action but being unable to enact it due to external constraints. However, the present findings extend this framework by demonstrating how moral distress is embedded within organisational systems that normalise ethical compromise while continuing to demand individual accountability.

The findings resonate strongly with critical perspectives that locate ethics within regimes of power rather than solely within individual agency (Foucault, 1988; Power, 2004). Institutional protocols, documentation requirements, and risk-management procedures functioned as moral technologies that shaped what could be defended as legitimate ethical action. Participants' descriptions of "ethical ceilings" illustrate how institutions delimit the boundaries of ethical possibility, often privileging organisational safety and legal defensibility over relational care. This supports Mol's (2008) argument that ethical practice in care settings cannot be reduced to abstract principles but must be understood as situated, materially constrained, and organisationally mediated.

The uneven distribution of ethical agency across institutional hierarchies further underscores the structural nature of ethical constraint. Junior professionals and contractual staff reported limited capacity to voice ethical concerns without fear of reprisal, while senior professionals described a different form of ethical burden—namely, the responsibility of enforcing institutional decisions they did not always ethically endorse. These findings align with previous research indicating that moral distress disproportionately affects professionals with less decision-making power (Austin et al., 2008; Morley et al., 2019). Ethical voice, therefore, emerges not as a function of ethical competence or professional

values but of institutional positioning. This challenges dominant ethical frameworks that assume equal moral agency among practitioners and highlights the need to explicitly theorise power within professional ethics.

The emotional consequences of sustained ethical conflict formed a central dimension of participants' experiences. Moral distress was described not as acute or episodic but as cumulative, producing what participants referred to as ethical exhaustion, guilt, and emotional numbing. These findings are consistent with literature linking moral distress to burnout and compassion fatigue (Rushton et al., 2016), yet they also deepen this understanding by foregrounding the moral nature of such exhaustion. Participants were not merely fatigued by workload; they were worn down by repeated ethical compromise. This distinction is critical, as it suggests that interventions focused solely on workload management or individual resilience may fail to address the ethical roots of professional distress.

Ethical numbing emerged as a particularly significant and troubling outcome. While emotional detachment enabled practitioners to continue functioning within constrained systems, it was experienced as a loss of moral vitality and professional meaning. This finding echoes Cvetkovich's (2012) analysis of how prolonged exposure to systemic strain produces quiet forms of affective depletion rather than dramatic breakdowns. Ethical numbing, in this context, should not be read as ethical indifference but as a protective adaptation to morally injurious environments. At the same time, such adaptation raises serious concerns about the long-term sustainability of ethical practice in mental health systems that lack institutional spaces for ethical reflection and repair.

One of the most important conceptual contributions of this study is the identification of *ethical negotiation as a survival practice*. Rather than abandoning ethical commitments, participants recalibrated them pragmatically, shifting from ideals of moral purity toward strategies of harm minimisation, dignity preservation, and relational care. Ethics, as practised by participants, occupied a grey zone between compliance and resistance. These findings complicate simplistic binaries that frame ethical action as either principled adherence or ethical failure. Instead, ethical practice appears as a form of everyday moral labour conducted under constraint.

This negotiated ethics aligns closely with feminist ethics of care, which foreground relational responsibility, contextual judgment, and responsiveness over rule-based decision-making (Gilligan, 1982; Tronto, 2013). Participants' ethical strategies—such as micro-advocacy, selective interpretation of guidelines, and informal relational support—reflect care-oriented practices aimed at sustaining human dignity within restrictive systems. At the same time, these strategies reveal the limits of care ethics when institutional structures consistently undermine relational work.

The findings can also be interpreted through Foucault's (1988) concept of ethical self-cultivation, wherein individuals actively shape their moral selves within existing power relations rather than outside them. Participants' accounts suggest that ethical agency did not disappear under constraint but was reconfigured—expressed through subtle, contingent, and often invisible practices. This understanding of agency aligns with Butler's (2004) argument that agency is not a sovereign capacity exercised outside

power but a situated practice enacted within normative limits. Ethical agency, in this sense, was partial, fragile, and deeply contextual.

However, the reliance on individual ethical negotiation also exposes a critical institutional failure. When ethical survival becomes an individual responsibility, institutions effectively displace accountability for the moral injuries they produce. Scholars of moral injury caution against this individualisation, arguing that moral suffering arising from systemic injustice requires collective and organisational response rather than personal coping alone (Litz et al., 2009; Dean et al., 2019). The present findings support this position, highlighting how the absence of formal ethical dialogue, shared decision-making, and organisational acknowledgment of moral distress leaves practitioners isolated in their ethical struggles.

Methodologically, this study demonstrates the value of in-depth qualitative interviews in ethics research. While quantitative measures capture the prevalence of moral distress, they often obscure how ethical conflict is interpreted, embodied, and carried over time. Participants' narratives revealed not only what ethical dilemmas occurred, but how they reshaped professional identity, emotional life, and ethical self-understanding. In doing so, the study aligns with Riessman's (2008) assertion that qualitative methods are uniquely suited to capturing moral experience as lived, ambivalent, and often unresolved.

In practical terms, the findings underscore the need for a reorientation of ethics education, supervision, and organisational policy in mental health care. Ethics training must move beyond abstract principles to include critical engagement with institutional power, ethical ambivalence, and moral distress (Banks, 2018). Supervisory practices should create structured spaces for ethical reflection that legitimise discomfort and uncertainty rather than framing them as individual weakness. At the organisational level, moral distress should be recognised as an indicator of ethical dysfunction within systems, not as a deficit in practitioner resilience.

In sum, this study reframes ethical conflict in mental health practice as a structural and relational phenomenon shaped by institutional power. Ethics emerges not as a stable code but as a continuous, negotiated practice marked by moral distress, emotional labour, and ethical adaptation. By centering practitioners' lived experiences, the study challenges individualised models of ethical failure and calls attention to the urgent need for ethical accountability at the institutional level. Ethical practice, as revealed here, is not merely about doing the right thing, but about sustaining moral integrity within systems that routinely make ethical clarity difficult—if not impossible.

Conclusion

This study set out to explore how mental health professionals experience and navigate ethical conflict within institutional environments shaped by bureaucratic regulation, hierarchical authority, and risk-oriented governance. The findings demonstrate that ethical conflict is not an occasional dilemma resolved through individual moral reasoning, but a persistent and structurally embedded feature of mental health practice. Ethics, as lived by practitioners, emerges not as a fixed adherence to professional

codes, but as a continuous process of negotiation shaped by institutional constraints, power relations, and emotional labour.

By centering practitioners' lived experiences, the study reframes moral distress as a systemic condition rather than an individual ethical failure. Participants consistently articulated clear ethical commitments grounded in care, dignity, and relational responsibility, yet encountered repeated barriers to acting upon these values. Such constraints generated enduring moral distress, emotional residue, and ethical fatigue—experiences that accumulated over time and reshaped professional identity. These findings challenge dominant ethics frameworks that individualise ethical responsibility while under-theorising the organisational conditions that produce ethical compromise.

Importantly, the study reveals that practitioners do not abandon ethics under constraint; rather, they adapt it. Ethical practice was reconfigured as a pragmatic, situational endeavour aimed at minimising harm, preserving dignity, and sustaining moral selfhood within imperfect systems. This negotiated ethics reflects both resilience and vulnerability: while it enables professional survival, it also exposes the limits of individual adaptation in the absence of institutional accountability. When ethical survival becomes a personal burden, institutions risk normalising moral injury while remaining ethically unexamined.

The implications of these findings extend beyond individual practice to ethics education, supervision, and policy. Ethics training must move beyond principle-based instruction to address power, constraint, and moral distress as central features of professional life. Supervisory and organisational cultures must create spaces where ethical ambivalence and discomfort are acknowledged as legitimate and meaningful, rather than as signs of incompetence or weakness. Without such structural support, ethical negotiation remains a fragile and exhausting achievement.

In conclusion, ethics in mental health care cannot be sustained through individual moral effort alone. Addressing ethical conflict requires ethical institutions—systems that recognise moral distress as a signal of organisational dysfunction and commit to shared ethical responsibility. By illuminating the lived realities of ethics under constraint, this study calls for a shift from individualised ethical accountability toward collective, institutional, and relational approaches to ethical practice in mental health care.

Implications

The findings of this study carry significant implications for mental health practice, ethics education, institutional governance, and policy, particularly in contexts where professionals work under sustained bureaucratic and hierarchical constraint. By demonstrating that ethical conflict is structurally produced rather than individually caused, the study calls for a fundamental shift in how ethical responsibility is conceptualised and addressed within mental health systems.

Implications for Clinical Practice

At the level of everyday practice, the findings highlight the need to legitimise ethical ambivalence and moral distress as ordinary aspects of mental health work rather than as indicators of professional inadequacy. Practitioners require safe, non-punitive spaces to articulate ethical discomfort, reflect on moral compromise, and share responsibility for ethically complex decisions. Clinical supervision should therefore move beyond a narrow focus on case outcomes or technical competence to include structured ethical reflection that acknowledges power, constraint, and emotional residue. Normalising ethical dialogue can reduce isolation, mitigate ethical numbing, and support practitioners in sustaining moral integrity over time.

Implications for Ethics Education and Training

The study underscores the limitations of principle-based ethics education that emphasises abstract decision-making while neglecting institutional realities. Ethics training must be reoriented to include critical engagement with **institutional power, organisational ethics, and moral distress**. Trainees should be prepared not only to recognise ethical principles but also to navigate ethical compromise, hierarchical authority, and conflicting accountabilities. Incorporating case-based discussions drawn from real institutional contexts, along with reflective and narrative methods, can better equip professionals to manage ethical complexity without internalising moral failure.

Implications for Organisations and Institutional Culture

At the organisational level, the findings suggest that moral distress should be treated as an ethical indicator of systemic dysfunction, not as an individual resilience deficit. Institutions have an ethical obligation to examine how policies, workloads, surveillance mechanisms, and risk-management practices constrain ethical agency. Establishing ethics committees, reflective practice forums, and shared decision-making structures can redistribute ethical responsibility and reduce the burden placed on individual practitioners. Importantly, institutions must recognise that ethical sustainability is inseparable from staff well-being and quality of care.

Implications for Policy and Governance

Finally, the study has implications for mental health policy and governance. Regulatory frameworks often emphasise accountability, documentation, and risk containment, inadvertently intensifying ethical constraint. Policymakers must balance these imperatives with provisions that protect professional judgment, relational care, and ethical discretion. Policies that mandate ethical reflection, protect whistleblowing, and acknowledge moral distress as an occupational hazard can contribute to more ethically responsive mental health systems.

In sum, the implications of this study point toward the necessity of ethical institutions, not merely ethical individuals. Addressing ethics under constraint requires collective responsibility, organisational reflexivity, and policy-level commitment to creating conditions in which ethical practice is not only expected, but genuinely possible.

Limitations and Future Directions

While this study offers in-depth insight into the lived ethical experiences of mental health professionals, certain limitations must be acknowledged. The qualitative design and purposive sampling, though appropriate for exploring depth and meaning, limit the generalisability of findings across diverse institutional and cultural contexts. The reliance on self-reported interview data may also reflect retrospective interpretation and selective recall. Additionally, the study did not systematically compare ethical experiences across specific professions or institutional types, which may have yielded further nuance. Future research could address these limitations by incorporating larger and more diverse samples, comparative designs across mental health systems, and longitudinal approaches to examine how ethical subjectivity and moral distress evolve over time. Mixed-methods studies integrating qualitative insight with organisational data may also help translate lived ethical experiences into actionable institutional and policy reforms.

Limitations and Future Directions

While this study offers in-depth insight into the lived ethical experiences of mental health professionals, certain limitations must be acknowledged. The qualitative design and purposive sampling, though appropriate for exploring depth and meaning, limit the generalisability of findings across diverse institutional and cultural contexts. The reliance on self-reported interview data may also reflect retrospective interpretation and selective recall. Additionally, the study did not systematically compare ethical experiences across specific professions or institutional types, which may have yielded further nuance. Future research could address these limitations by incorporating larger and more diverse samples, comparative designs across mental health systems, and longitudinal approaches to examine how ethical subjectivity and moral distress evolve over time. Mixed-methods studies integrating qualitative insight with organisational data may also help translate lived ethical experiences into actionable institutional and policy reforms.

Declarations

Ethical approval

The study was reviewed and approved by the Institutional Ethics Committee of Amity Institute of Behavioural Health and Allied Sciences, Amity University Bengaluru (Ref: 07/01/2025) All methods were performed in accordance with the relevant guidelines and regulations of the Institutional Ethics Committee. The research protocol was approved in accordance with the ethical guidelines for research involving human participants issued by the committee.

Consent to participate

Informed written consent was obtained from all adult participants prior to participation. For student participants, informed consent was obtained from parents or legal guardians, along with assent from the

students themselves.

Consent to publish

Not applicable. The study does not include any identifiable images or personal data of participants.

Competing Interest

Authors declare no competing interest in this research.

Funding

Declaration

There is no funding received for this research.

Author Contribution

S.T.S supervised the study and S.Y validated the study. S.K collected data and R.Y conducted data analysis. All the authors contributed to develop the manuscript and proofread the same.

Data Availability

The datasets generated and/or analysed during the current study are not publicly available due to ethical restrictions related to participant confidentiality but are available from the corresponding author on reasonable request.

References

1. Austin W, Lemermeyer G, Goldberg L, Bergum V, Johnson MS. Moral distress in healthcare practice: The situation of nurses. HEC Forum. 2008;20(1):33–48.
2. Banks S. Ethics in professional life: Virtues for health and social care. Ethics Social Welf. 2018;12(1):3–16.
3. Beauchamp TL, Childress JF. Principles of biomedical ethics. J Med Ethics. 2019;45(11):709–14.
4. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Res Psychol. 2006;3(2):77–101.
5. Bury M. Chronic illness as biographical disruption. Sociol Health Illn. 1982;4(2):167–82. https://doi.org/10.1111/1467-9566.ep11339939.

6. Butler J. Undoing gender. Signs: J Women Cult Soc. 2004;30(1):33–53. https://doi.org/10.1086/421361.
7. Cvetkovich A. Depression is ordinary: Public feelings and cultural politics. J Lesbian Stud. 2012;16(4):377–86.
8. Dean W, Talbot S, Dean A. Reframing clinician distress: Moral injury not burnout. Fed Practitioner. 2019;36(9):400–2.
9. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330–42.
10. Gilligan C. Moral development and the ethics of care. Ethics. 1982;93(2):237–54.
11. Jameton A. Nursing practice: The ethical issues. J Med Ethics. 1984;10(4):203–4.
12. Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, Maguen S. Moral injury and moral repair in war veterans. Clin Psychol Rev. 2009;29(8):695–706.
13. Mol A. The logic of care: Health and the problem of patient choice. Theory Cult Soc. 2008;25(1):1–22.
14. Morley G, Ives J, Bradbury-Jones C, Irvine F. Moral distress and austerity: An avoidable ethical challenge in healthcare. Health Care Anal. 2019;27(3):201–13.
15. Power M. The risk management of everything. J Risk Res. 2004;7(1):1–19.
16. Riessman CK. Narrative methods for the human sciences. Qualitative Res Psychol. 2008;5(4):336–8.
17. Rushton CH, Batcheller J, Schroeder K, Donohue P. Burnout and resilience among nurses practicing in high-intensity settings. Am J Crit Care. 2016;25(5):412–20. https://doi.org/10.4037/ajcc2015291.
18. Tronto JC. Caring democracy and the problem of moral boundaries. Political Theory. 2013;41(5):679–706.