BMC Nursing

RESEARCH

Open Access

Moral distress effects on spirituality determinants in nurses

Nahid Tavakol[1], Majid Tavakol[2*] and Shima Daman[1]

Abstract

Background Moral distress in nurses is a widespread issue with lasting consequences. Understanding the relationship between spiritual factors, like spiritual sensitivity, workplace spirituality, and moral distress, is important due to the significant role of spirituality in nursing ethics. This study explores the connections between these three phenomena, focusing on the psychological, spiritual, and ethical dimensions of nursing.

Methods This cross-sectional study involved 120 nurses from hospitals affiliated with Jahrom University of Medical Sciences, selected randomly using a number table. Inclusion criteria were having at least a bachelor's degree in nursing, at least 6 months of work experience, and no history of mental health issues or medication use. Participants completed questionnaires on moral distress (Hamrick et al.), workplace spirituality, and spiritual sensitivity. Descriptive tests were used to determine the frequency distribution of demographic variables. Analysis of variance (ANOVA) and independent t-tests were used to compare the mean scores of variables across different groups of nurses based on demographic factors. Pearson's correlation coefficient and linear regression were used to determine relationships between the variables. Data were analyzed using SPSS version 23, with a significance level set at 0.05.

Results In determining the relationship between moral distress and the study variables, demographic and occupational variables (i.e., gender, age, and type of department and moral distress) were significantly related. Similarly, it shows that gender, level of education, and the organization's type of department significantly impact spiritual sensitivity. Conversely, there is a significant relationship between age, the organization's department type, and workplace spirituality. Workplace spirituality and spiritual sensitivity displayed substantial negative correlations with moral distress.

Conclusion According to this study, positive environmental and individual spiritual factors significantly influenced and reduced moral distress in nurses. The findings highlight the significance of spiritual education for nurses to strengthen spiritual awareness and environmental strategies to promote a spiritual environment in healthcare settings. More studies are suggested in this field.

Clinical trial number Not applicable.

Keywords Ethics, Nursing, Spirituality, Morals, Distress

*Correspondence:
Majid Tavakol
mtavakol.313@gmail.com
[1]Department of Nursing, School of Nursing, Jahrom University of Medical Sciences, Jahrom, Iran
[2]Medical Ethics Research Center, Jahrom University of Medical Sciences, Motahari Street, Jahrom, Fars 7414846919, Iran

Background

Of the important professions in healthcare, nursing is confronted with multiple ethical and spiritual dilemmas [1]. Moral distress is also one of the most familiar concepts in nursing, described when a nurse identifies the appropriate ethical action but is hindered by organizational or environmental matters from proceeding with the execution of that action [2]. Surveys have shown that some extent of moral distress has afflicted at one time or another about 80% of nurses [3, 4]. The results of moral distress might be increased burnout, less job satisfaction, and a higher intention to leave the profession [5, 6]. Most of Iranian nurses reported moderate to severe moral distress [7]. Some factors that contribute to moral distress are inadequate staffing, financial and equipment limitations, high workload associated with insufficient ethical knowledge, and institutional policies [8–10].

Spirituality forms the basis of ethical practice. According to Taylor et al. (2020), spirituality is the values framework that defines ethical behavior [11]. Spiritual sensitivity refers to being able to identify a patient's spiritual needs and respond to them accordingly [12]. Spiritual sensitivity is defined as spiritual health, which determines the efficacy of nurses while providing spiritual care [13]. The concept is fundamental in a healthcare setting whereby critical patients need spiritual support more than any other form of care [14]. The higher the spiritual sensitivity of a nurse, the more he or she can identify and respond to patients' spiritual needs, communicate efficiently with them and their relatives, and perform critical and terminal care [15]. Higher spiritual sensitivity, however, has been linked with better quality and more patient satisfaction in some studies [16].

Workplace spirituality is defined as experiences of interconnectedness among a transcendent dimension, others, and oneself within the work setting [14]. Workplace spirituality in nursing often has been found to relate to significant resources when trying to cope with job stress or ethical problems [17]. Correspondingly, researches indicate that higher spirituality is associated with increased job satisfaction and lower rates of burnout. In this context, nurses show an enhanced feeling of resilience against occupational stressors [18, 19]. It is also related to workplace spirituality, better relations with colleagues, and higher organizational commitment [20].

With spirituality going to the core of nurses' ethical conduct, studying the relationship of spiritual factors of spiritual sensitivity and workplace spirituality to moral distress needs to be considered from the standpoint of nursing along psychological, and spiritual determinants to ethical dimensions. While some previous studies have explored mainly these variables separately, no study to date has examined the relationships among all three above variables. Most of the research conducted in Western countries may not apply to anything other than the cultural context of Iran. The focus of the current study is examining the relationship between moral distress and spiritual sensitivity with workplace spirituality among nurses in hospitals affiliated with Jahrom University of Medical Sciences.

Methods

Study design

In our study, we used a questionnaire and implemented it cross-sectionally.

Study time

This survey was carried out during the period from March 2024 to May 2024.

Setting

The current study was conducted in three hospitals affiliated with Jahrom University of Medical Sciences, Fars Province, southern Iran.

Sample size and participants

According to the results of the study by Akbari et al. (2023) [21], the statistical consultant determined the required sample size as 120 nurses, considering the lowest correlation coefficient of the studied variables (0.3) and $\alpha = 0.05$ and $\beta = 90\%$ for the two-sided test. The population for nursing in these three hospitals was about 700 nurses, out of which 120 nurses were selected for this research.

Recruitment

After getting the Ethics Committee approval of Jahrom University of Medical Sciences, the nurses working in the university hospitals were selected based on the inclusion criteria. The invitation letter was forwarded to the nurses, then the participants were selected based on a random number table according to simple random sampling. The inclusion criteria were to hold at least a bachelor's degree in nursing, to have experience of 6 months of work, and not to have any mental illness or medications. First, the goals of this study were explained for the participants, and the informed consent in writing was taken from the participants. It was guaranteed for them that their information would be kept confidential in the research. The questionnaires were distributed among the nurses who were asked to fill in within a week. Finally, the questionnaires completed were collected by the research team.

Survey tools

Moral distress questionnaire

For this study, the Moral Distress Questionnaire as developed by Hamric et al. [22] in the year 2012-a revision of

the Corley Moral Distress Scale-was utilized. Hamric has measured the internal consistency of this tool in the nursing community through the Cronbach's alpha to be 0.98. Soleimani et al. [23] psychometrically tested this revised version of the Moral Distress Questionnaire in Iran in the year 2019. Reliability based on the internal consistency was reported at 0.70. This instrument contains 21 items, using a 5-point Likert scale about the intensity and frequency of moral distress. The frequency of moral distress is scored on a Likert scale from 0 to 4, and the intensity of moral distress is measured on a Likert scale ranging from 0 to 4. For each item, then, the score is determined by the product of its frequency and intensity, therefore ranging between 0 and 16. All 21 items, hence, range between 0 and 336, where the highest score denotes a high level of moral distress. The total score is the sum of the subscales for frequency and intensity.

Workplace spirituality questionnaire

The Workplace Spirituality Questionnaire developed by Milliman et al. [24] back in 2003 after using a three-dimensional adaptive scale consists of 20 items for measurement. Estimation with respect to measurement of spirituality at workplace was drawn up by a 5-point Likert-scale. The reliability value for the same questionnaire came out being 88.2% ($\alpha = 0.882$). Three dimensions appeared from the result of factors analysis, naming as 'meaningful work', another one is 'sense of community' alignment to explaining the organizational values variance shared up to 76 percentages. The scores are rated on the 5-point Likert scale, ranging from strongly disagree to 5 strongly agree; thus, the range of possible scores ranges between a minimum of 20 to a maximum of 100. Its reliability has been confirmed in Iran with Cronbach's alpha coefficient 0.882 [25]. In Farmahini's research [18], the reliability of the questionnaire for each subscale For the meaningful work, sense of community, and alignment to organizational values scales, the Cronbach's alpha coefficient obtained was, respectively, 0.824, 0.784, and 0.862. Cronbach's alpha coefficients > 0.7 have shown that the reliability of the workplace spirituality scale has been confirmed.

Spiritual sensitivity questionnaire

The Spiritual Sensitivity Questionnaire was designed and validated by Akbari et al. (2023) [21]. This study was conducted among Iranian nurses from March 2011 to October 2012. The scale consists of 20 items; professional spiritual sensitivity of nurses and inner spiritual sensitivity. It explains 57.62% of the total variance. Convergent validity was proven by a strong correlation between the spiritual sensitivity scale and the spiritual intelligence scale by King, in $r = 0.66$. The reliability was excellent: Cronbach's alpha of 0.927, an omega coefficient of 0.923, and ICC of 0.937. The response scale includes never (0), rarely (1), sometimes (2), often (3), and always (4).

The total score can range from 0 to 100, with scores categorized as follows: 0–20 representing very low spiritual sensitivity, 21–40 representing low, 41–60 representing moderate, 61–80 representing high, and 81–100 representing very high.

Statistical tests

In the present study, descriptive tests were used to determine the frequency distribution of demographic variables. ANOVA and independent samples t-tests were used to compare the mean score of variables in various groups of nurses in terms of demographic variables. Pearson correlation coefficients and linear regression were used to determine the relationships between the studied variables.

Ethics

The study was approved before initiating the research itself by the Ethics Committee of Jahrom University of Medical Sciences (Ethic Code: IR.JUMS. REC.1402.123) and by first explaining the objectives of the research by ensuring participants' privacy before consent and permission by the research participants for consent to publication.

Results

In all, 120 nurses participated in this study. Of the participants, 38 (31.7%) were male and 82 (68.3%) were female. The mean age of the nurses was 46.00 ± 30.70 years. The demographic data analysis results are shown in Tables 1 and 2. In the independent T-test results regarding the variables of gender and education level, significant relations of moral distress (pP = 0.022) and spiritual sensitivity ($p = 0.010$) to gender were observed. It was also observed that moral distress was higher in males, while spiritual sensitivity was higher in females. However, no significant relationship was found between workplace spirituality and gender, as shown by $p = 0.333$.

There was also a statistically significant relationship between spiritual sensitivity ($p = 0.013$) and the level of education such that spiritual sensitivity was higher for those participants with a master's degree. No statistically significant association prevailed between moral distress ($p = 0.551$) and workplace spirituality ($p = 0.464$) with education level. The Marital status did not significantly change the study variables, so Table 1 represents additional information.

According to the One-Way ANOVA, there was a significant relationship between moral distress ($P = 0.019$) and workplace spirituality ($p = 0.003$) with the age of nurses, but no significant relationship between spiritual sensitivity and age was observed (Table 2).

Table 1 Frequency distribution of demographic variables and comparison of average moral distress and spiritual sensitivity according to demographic characteristics based on an independent T-test

		Number (%)	Moral Distress				Workplace Spirituality				Spiritual Sensitivity (SS)			
			Mean ± SD	Df	F	*p*-Value	Mean ± SD	Df	F	*p*-Value	Mean ± SD	Df	F	*p*-Value
Gender	Male	38 (31.7)	102.868 ± 49.84	118	0.193	0.022	65.947 ± 19.24	118	0.258	0.333	58.815 ± 23.58	118	1.274	0.010
	Female	82 (68.3)	81.219 ± 46.62				62.512 ± 17.39				69.451 ± 19.23			
Education level	Bachelor's degree	115 (95.8)	87.521 ± 49.23	118	2.784	0.551	63.347 ± 18.06	118	0.001	0.464	65.087 ± 20.92	118	1.407	0.013
	Master's degree	5 (4.2)	100.800 ± 27.09				69.400 ± 16.97				89.000 ± 14.61			
Marriage status	Single	51 (42.5)	87.725 ± 44.71	118	0.785	0.946	64.741 ± 20.84	118	4.853	0.551	65.833 ± 20.27	118	0.738	0.912
	Married	69 (57.5)	88.333 ± 51.47				62.753 ± 15.66				66.268 ± 22.00			

LSD test showed that moral distress was higher in the age group of 20–29 years, and workplace spirituality varied between the age group of 40–49 years and other age groups. Similarly, spiritual sensitivity differed between the age group of 30–39 years and the rest of the age groups significantly (Table 3). Additionally, moral distress was found to be related to the type of ward the nurses worked in, workplace spirituality, and spiritual sensitivity ($p < 0.001$). LSD test showed that there were significant differences in moral distress of internal medicine and emergency wards with other wards, workplace spirituality of surgery ward with other wards, and spiritual sensitivity of the intensive care unit with other wards. There is no meaningful relationship between the status of moral distress and workplace spirituality, spiritual sensitivity and employment status of nurses. Furthermore, no significant relation was found between moral distress, workplace spirituality, and spiritual sensitivity in the nurses' work experience (Table 2).

The mean score related to moral distress was 88.07 ± 48.52; the mean frequency of moral distress was 36.44 ± 14.34, while the mean intensity was 40.94 ± 14.52. The mean score on workplace spirituality for nurses was 63.60 ± 17.99, made up of the following domain scores: Meaningful Work, 19.68 ± 5.94; Sense of Community, 22.34 ± 6.52; and Alignment with Organizational Values, 6.40 ± 18.77 (Table 4).

The spiritual sensitivity revealed a mean of 16.96 ± 52.86, pointing to the presence of a moderate level of spiritual sensitivity among the nurses; Professional Spiritual Sensitivity was 10.60 ± 31.47 and Internal Spiritual Sensitivity was 7.38 ± 21.39, respectively (Table 4).

Pearson's product correlation coefficient was conducted to examine the links between moral distress with workplace spirituality and spiritual sensitivity. Statistically moderate negative correlations are visible via the relationship between moral distress versus, workplace spirituality [r=-0.398, P = 0.000] and second Moral Distress with that of Spiritual Sensitivity, [$r = -0.240$, P = 0.008] (Table 4).

Multivariate linear regression was used to investigate the relationship between the variables of spirituality in the workplace and spiritual sensitivity with moral distress. The results showed that 19.7% of the changes in moral distress are predicted by changes in the predictor variables (spirituality in the workplace and spiritual sensitivity). Also, the value of the relationship between the linear combination of independent.

variables and the dependent variable was $R = 0.443$. Given that the Fisher statistic (F) was significant at the 95% confidence level (significance level less than 0.05), therefore the model had a good fit. According to Table 5, the significance level for the predictor variables is less than 0.05, therefore, with 95% confidence, the presence

Table 2 Frequency distribution of demographic variables and comparison of average moral distress, workplace spirituality and spiritual sensitivity according to demographic characteristics based on one way ANOVA test

		Number (%)	Mean ± SD	Moral Distress		Workplace Spirituality		Spiritual Sensitivity (SS)	
				F	*p*-value	F	*p*-value	F	*p*-value
Age			46.00 ± 30.70	4.074	0.019	6.004	0.003	0.193	0.825
	20 to 29 years old	37 (30.8)							
	30 to 39 years old	61 (50.8)							
	40 to 49 years old	22 (18.3)							
Ward				8.911	0.000	6.284	0.001	6.723	0.000
	Medical ward	31 (25.8)							
	Surgical ward	33 (27.5)							
	Critical ward	20 (16.7)							
	Emergency ward	36 (30)							
Employment status				1.560	0.214	0.135	0.874	0.063	0.939
	Compulsory training course	44 (36.7)							
	Permanent employee	74 (61.7)							
	Temporary employee	2 (1.7)							
Work experience years			5.85 ± 4.52	0.504	0.605	1.083	0.342	0.101	0.904
	1 to 4 years	54 (45)							
	5 to 9 years	46 (38.3)							
	> 10 years	20 (16.7)							

of the variables of spirituality in the workplace and spiritual sensitivity is significant for predicting moral distress. ($\beta \neq 0$)

Discussion

This study analyzed the correlation between nurses' moral distress, workplace spirituality, and spiritual sensitivity. The results showed that gender, age, and ward type correlated with moral distress. Also, there was an effect of gender; an evaluation concerning spiritual sensitivity was conducted by education and type of ward in this study. The age, ward type, and workplace spirituality of the nurses correlated significantly. A negative correlation was found between moral distress, workplace spirituality, and spiritual sensitivity.

Gender, age, and ward type statistically significantly predicted moral distress among the nurses. In any case, such findings are compatible with other works that point to demographic factors as the most powerful predictors of moral distress in nursing. The younger the age, of a nurse working in a specific type of stream, say emergency departments or ICUs, the higher the level of moral distress [26, 27]. Gender differences also play a role in the level of moral distress, and Singh et al., [28] stated that is probably due to conflict resolution training and styles of coping, male nurses may have another level of moral distress than female nurses. Thus, these findings outline the need to give more attention to moral distress prevention and educational and supportive programs for employees at greater risk in the nursing field.

The current study further highlighted that gender, educational background, and type of ward made significant difference to spiritual sensitivity. This result agrees with McGee et al. [29] as the female nurses usually show a higher spiritual sensitivity score than the male nurses. Such may partly be because of the differential influence brought by the socialization process. Indeed, in various cultural contexts, gender, educational level, and ward type have been considered influencing factors to spiritual sensitivity. These determinants influence patients' spiritual conceptions and experiences and facilitate the expression of their needs for care and spirituality. During socialization, females have more focus on nurturing attributes; thus, female nurses express spiritual sensitivity more often than males. Research suggests that gender influences the perception of the patient's spiritual needs and females are more apt to initiate spiritual conversations. The greater the educational experience the greater awareness of principles of spiritual care [30, 31].

Regarding the relationship between education level and spiritual sensitivity, no study was found that was consistent with this result. This finding suggests that higher educational levels are associated with increased awareness and understanding of the principles of spiritual care. Shahraki 's [32] study has shown that spiritual care training, educating nurses in spiritual principles and values, helps them have a deeper understanding of patients' problems, and this helps increase their empathy and professional commitment. Nurses with more education are more likely to participate in educational programs that increase cultural and spiritual sensitivity, which leads to improved patient care outcomes [33]. The present study therefore postulates that the level of educational level influences nurses' perceptions and involvement in

Table 3 Multiple comparisons of mean difference according LSD test

			Moral Distress		Workplace Spirituality		Spiritual Sensitivity (SS)	
			Mean difference	*p*-value	mean difference	*p*-value	mean difference	*p*-value
Ward	Medical ward	Surgical ward	43.42326*	0.000	-18.26002*	0.000	1.73412	0.663
		Critical ward	36.38387*	0.005	-7.54032	0.123	-15.58710*	0.001
		Emergency ward	-1.98835	0.855	-8.70699*	0.038	2.89068	0.458
	Surgical ward	Medical ward	-43.42326*	0.000	18.26002*	0.000	-1.73412	0.663
		Critical ward	-7.03939	0.576	10.71970*	0.027	-17.32121*	0.000
		Emergency ward	-45.41162*	0.000	9.55303*	0.021	1.15657	0.763
	Critical ward	Medical ward	-36.38387*	0.005	7.54032	0.123	15.58710*	0.001
		Surgical ward	7.03939	0.576	-10.71970*	0.027	17.32121*	0.000
		Emergency ward	-38.37222*	0.002	-1.16667	0.805	18.47778*	0.000
	Emergency ward	Medical ward	1.98835	0.855	8.70699*	0.038	-2.89068	0.458
		Surgical ward	45.41162*	0.000	-9.55303*	0.021	-1.15657	0.763
		Critical ward	38.37222*	0.002	1.16667	0.805	-18.47778*	0.000
Employment status	Compulsory training course	Permanent employee	-15.81634	0.088	1.76781	0.609	−0.99816	0.760
		Temporary employee	3.88636	0.912	2.22727	0.865	-2.79545	0.821
	Permanent employee	Compulsory training course	15.81634	0.088	-1.76781	0.609	0.99816	0.760
		Temporary employee	19.70270	0.570	0.45946	0.972	-1.79730	0.884
	Temporary employee	Compulsory training course	-3.88636	0.912	-2.22727	0.865	2.79545	0.821
		Permanent employee	-19.70270	0.570	−0.45946	0.972	1.79730	0.884
Work experience years	1 to 4 years	5 to 9 years	11.14887	0.260	-2.91006	0.421	-2.17590	0.542
		> 10 years	36.19656*	0.005	-15.54791*	0.001	−0.90541	0.844
	5 to 9 years	1 to 4 years	-11.14887	0.260	2.91006	0.421	2.17590	0.542
		> 10 years	25.04769*	0.035	-12.63785*	0.004	1.27049	0.765
	> 10 years	1 to 4 years	-36.19656*	0.005	15.54791*	0.001	0.90541	0.844
		5 to 9 years	-25.04769*	0.035	12.63785*	0.004	-1.27049	0.765

*The mean difference is significant at the 0.05 level

Table 4 Correlation among moral distress, workplace spirituality and spiritual sensitivity (SS) ($n = 120$)

			Moral distress		Workplace Spirituality		Spiritual Sensitivity (SS)	
		Mean ± SD	r	P	r	P	r	P
Moral Distress (MD)	Total Score	88.07 ± 48.52	1		-0.398	0.000	-0.240	0.008
	MD Frequency	36.44 ± 14.34	0.927	0.000	-0.365	0.000	-0.315	0.001
	Intensity MD	40.94 ± 14.52	0.800	0.000	-0.333	0.000	-0.182	0.049
Workplace Spirituality	Total Score	63.60 ± 17.99	-0.398	0.000	1		0.118	0.200
	Meaningful work	19.68 ± 5.94	-0.412	0.000	0.900	0.000	0.202	0.027
	Sense of community	22.34 ± 6.52	-0.335	0.000	0.953	0.000	0.153	0.095
	Alignment with organizational values	18.77 ± 6.40	-0.152	0.097	0.128	0.162	0.907	0.000
Spiritual Sensitivity (SS)	Total Score	52.86 ± 16.96	-0.240	0.008	0.118	0.200	1	
	Professional SS	31.47 ± 10.60	-0.280	0.002	0.097	0.290	0.961	0.000
	Internal SS	21.39 ± 7.38	-0.149	0.103	0.131	0.155	0.917	0.000

Table 5 The results of multivariate linear regression analysis to predict the moral distress

Predictors variables	B	SE	Beta	T	P
Constant	182.090	18.375		9.910	0.000
Workplace Spirituality	−1.012	0.225	−0.375	−4.498	0.000
Spiritual sensitivity	−0.561	0.239	−0.196	−2.348	0.021

ADJ.R^2 = 0.183, R^2 = 0.197, R = 0.443

Dependent variable: Moral Distress, independent variables: Workplace Spirituality, Spiritual sensitivity

spiritual care in specialized wards and calls for suitable targeted educational interventions to be offered in these settings for enhancement of spiritual sensitivity.

The significant relationship between age and ward type with workplace spirituality among nurses also reflects the findings of Cruz [34], which suggest that older nurses, especially those in supportive environments, tend to exhibit more spirituality in the workplace.

Yet, an opposing view by Miller [35] supports that the workplace spirituality element is more organization culture-driven rather than driven by the demographic factor, proving that the environment plays a better role than ever. Workplace spirituality increased through supportive management practices improves job satisfaction and performance among nurses; education about spirituality in nursing is necessary continuously to meet diverse patients' needs and improve quality care [36, 37].

The research showed that moral distress was inversely associated with workplace spirituality and spiritual sensitivity. There was no study in relate to our findings but studies reported that higher levels of spiritual well-being [38] and workplace spirituality enhances job commitment, satisfaction, and performance, leading to better patient care [39] may reduce experiences of moral distress. However, some authors like Gibbons [40], in a critical look at this situation, point to the fact that even as spirituality can give one relief from moral distress, it cannot dispel the ethical challenges a nurse has to face. It added that for such an impact, structural changes in health care environments would also be needed.

Koonce & Hyrkas [39] stated that high levels of workplace spirituality might decrease moral distress in nurses, above all, when the origin of moral distress is related to ethical conflict and lack of support. Workplace spirituality is also associated with a decrease in burnout; thus, a spiritually supportive work environment may contribute to less stress and moral distress [41].

Studies have confirmed the finding that increased spiritual well-being decreases the levels of moral distress [38]. For example, nurses who self-reported higher levels of spirituality had lower levels of moral distress, which again suggests that spirituality might play a role in coping with difficult ethical situations [39]. Najafi et al. [42] have also reported that spiritual health is closely related to mental health and that patients with higher spiritual health suffer from less stress, anxiety, and depression.

Therefore, the interaction between the spiritual dimensions of nurses and moral distress may suggest that an environment that fosters spiritual values lessens ethical dilemmas and enhances resilience among nursing staff during periods of high tension.

Besides, the structural impediments within healthcare settings concerning the inadequacy of staff and heavy workloads also must be addressed. These are basic changes without which the most supportive spiritual environment alone cannot contribute towards reduction of moral distress [43].

Therefore, spiritual support and systemic reforms are needed in a holistic approach to make nursing practice sustainable and ethically healthy.

Limitations

The limitations of this study are that the sample size is not large, and self-measured biases may occur in the measurement. Besides, the cross-sectional design could further limit the casual relationships between the variables under investigation. Longitudinal or intervention design with larger sample sizes shall be used in further studies to better understand these variables over time.

Conclusion

The present study also found that nurses experience moral distress, which relates to workplace spirituality and spiritual sensitivity. Spiritual aspects of a person and of their environment can enrich and mitigate moral distress. It means that spiritual support within both personal and work contexts enhances the quality of care as well as patients' satisfaction and, therefore, is supposed to become a core part of a nurse's job. Demographic variables also support implications for the design of particular programs. Such findings might inspire educational interventions to enhance spiritual awareness among nurses develop policies, and establish a spiritual work climate. The study also lays the foundation for further research in terms of moral distress in Iranian cultural contexts and local development of strategies related to spirituality in the workplace.

Abbreviations

MD Moral Distress
SS Spiritual Sensitivity

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12912-025-03003-1.

Supplementary Material 1

Acknowledgements
We want to acknowledge and honor the significant contributions of all nurses that participate in this study.

Author contributions
Majid Tavakol, Nahid Tavakol and Shima Daman were involved in the manuscript's conception, design, drafting, data collection, and revising.

Funding
There was no funding for this research.

Data availability
All data generated or analyzed during this study are included in this published article.

Declarations

Ethics approval and consent to participate
The study adhered to the Helsinki Declaration. It was approved by the Ethics Committee of Jahrom University of Medical Sciences (IR.JUMS.REC.1402.123). Participants were reassured about objectives, methods, anonymity, the recording of the interviews, the confidentiality of data and their right to withdraw from the study at any time. The facilitator's contact information was provided for the participants.

Consent for publication
Written informed consent was obtained from the participants.

Competing interests
The authors declare no competing interests.

Received: 12 January 2025 / Accepted: 19 March 2025
Published online: 31 March 2025

References

1. Heng TJT, Shorey S. Experiences of moral distress in nursing students–A qualitative systematic review. Nurse Educ Today. 2023;129:105912.
2. Semler LR. Moral distress to moral success: strategies to decrease moral distress. Nurs Ethics. 2023;30(1):58–70.
3. Miljeteig I, Forthun I, Hufthammer KO, Engelund IE, Schanche E, Schaufel M, et al. Priority-setting dilemmas, moral distress and support experienced by nurses and physicians in the early phase of the COVID-19 pandemic in Norway. Nurs Ethics. 2021;28(1):66–81.
4. Peng M, Saito S, Guan H, Ma X. Moral distress, moral courage, and career identity among nurses: A cross-sectional study. Nurs Ethics. 2023;30(3):358–69.
5. Kovanci MS, ATLI ÖZBAŞ A. Moral resilience and intention to leave: mediating effect of moral distress. Nurs Ethics. 2024:09697330241272882.
6. Kasım D, Oflaz F. Attitudes towards futile treatments, moral distress and intention to leave job in nurses. Eur Psychiatry. 2023;66(S1):S163–4.
7. Salari N, Shohaimi S, Khaledi-Paveh B, Kazeminia M, Bazrafshan M-R, Mohammadi M. The severity of moral distress in nurses: a systematic review and meta-analysis. Philos Ethics Humanit Med. 2022;17(1):13.
8. Morley G, Field R, Horsburgh CC, Burchill C. Interventions to mitigate moral distress: A systematic review of the literature. Int J Nurs Stud. 2021;121:103984.
9. Corradi-Perini C, Beltrão JR, Ribeiro URVCO. Circumstances related to moral distress in palliative care: an integrative review. Am J Hospice Palliat Medicine®. 2021;38(11):1391–7.
10. Tavakol N, Molazem Z, Rakhshan M, Asemani O. Moral distress in Iranian psychiatric nurses: a content analysis. Iran J Psychiatry Behav Sci. 2022;16(3).
11. Neathery M, Taylor EJ, He Z. Perceived barriers to providing spiritual care among psychiatric mental health nurses. Arch Psychiatr Nurs. 2020;34(6):572–9.
12. Spekkink A, Jacobs G. The development of moral sensitivity of nursing students: A scoping review. Nurs Ethics. 2021;28(5):791–808.
13. Heidari A, Afzoon Z, Heidari M. The correlation between spiritual care competence and spiritual health among Iranian nurses. BMC Nurs. 2022;21(1):277.
14. Bahramnezhad F, Asgari P. Spiritual care for COVID-19 patients: A neglected necessity. Infect Dis Clin Pract. 2021;29(1):e63.
15. Connolly M, Timmins F. Experiences related to patients and families' expression of spiritual needs or spiritual support within healthcare settings during the COVID-19 pandemic: A scoping review. J Relig Health. 2022;61(3):2141–67.
16. Kazemi SY, Jafari A, Rabiei L, Nikfarjam M, Omidi M, Masoudi R. Exploring the concept of spiritual sensitivity from the perspectives of healthcare providers in Iran. J Relig Health. 2022;61(5):3806–21.
17. Saadatyar FS, Poursalimi M, Al-Tabbaa O, Iannotta M. Workplace spirituality as a source for competitive advantage: an empirical study. Int J Organizational Anal. 2020;28(3):655–76.
18. Farmahini Farahani M, Jaberi K, Purfarzad Z, Workplace, Spirituality. Compassion satisfaction, burnout, and secondary traumatic stress: A Cross-Sectional study in Iranian nurses. Perspect Psychiatr Care. 2023;2023(1):7685791.
19. Tomaszewska K, Kowalczuk K, Majchrowicz B. Relationships between job satisfaction, occupational burnout and rationing of care among intensive care unit nurses. Front Public Health. 2024;12:1400169.
20. Chiang Y-C, Lee H-C, Chu T-L, Wu C-L, Hsiao Y-C. The relationship between spiritual health, health-promoting behaviors, depression and resilience: A longitudinal study of new nurses. Nurse Educ Pract. 2021;56:103219.
21. Akbari O, Dehghan M, Tirgari B. Development and validation of the nurses' spiritual sensitivity scale in southeastern Iran. J Relig Health. 2023;62(5):3529–45.
22. Hamric AB, Borchers CT, Epstein EG. Development and testing of an instrument to measure moral distress in healthcare professionals. AJOB Prim Res. 2012;3(2):1–9.
23. Soleimani MA, Sharif SP, Yaghoobzadeh A, Panarello B. Psychometric evaluation of the moral distress scale–revised among Iranian nurses. Nurs Ethics. 2019;26(4):1226–42.
24. Milliman J, Czaplewski AJ, Ferguson J. Workplace spirituality and employee work attitudes: an exploratory empirical assessment. J Organizational Change Manage. 2003;16(4):426–47.
25. Alizadeh S. Relationship between spirituality in workplace as an ethical factor and team working. 2018.
26. Fattori A, Comotti A, Brambilla P, Bonzini M. Moral distress as a persistent risk factor for impaired mental health among healthcare workforce. J Affect Disorders Rep. 2024;17:100817.
27. Sedaghati A, Assarroudi A, Akrami R, Rad M. Moral distress and its influential factors in the nurses of the nursing homes in Khorasan provinces in 2019: A descriptive-correlational study. Iran J Nurs Midwifery Res. 2020;25(4):319–24.
28. Singh D, Shunthwal J, Gowane G, Khanna S. Gender differences in moral distress and ethical conflict: A survey of Indian veterinary practitioners. Agricultural Sci Digest. 2024;44(3):571–9.
29. McGhee P. Cultivating ethicality in organizations through spirituality, practical wisdom, and indigeneity. Journal of Management, Spirituality & Religion; 2024.
30. Akbari O, Dehghan M, Tirgari B. Muslim Nurse's spiritual sensitivity as a higher perception and reflection toward spiritual care: a qualitative study in Southeast Iran. Bmc Nurs. 2022;21(1):270.
31. Safri S, Nurachmah E, Setianto B, Umar J, Yona S. Phenomenology study: the nurse perception of experience in providing spiritual nursing care in the cardiovascular unit. Healthcare in Low-resource Settings. 2024.
32. Shahraki SK. The effect of spiritual care education on nurses' empathy and professional commitment. J Military Med. 2023;25(1):1730–8.
33. Chang H-Y, Yang Y-M, Kuo Y-L. Cultural sensitivity and related factors among community health nurses. J Nurs Res. 2013;21(1):67–73.
34. Cruz JP, Alquwez N, Balay-odao E. Work engagement of nurses and the influence of spiritual climate of hospitals: A cross-sectional study. J Nurs Adm Manag. 2022;30(1):279–87.
35. Miller M, Addicott K, Rosa WE. Spiritual care as a core component of palliative nursing. AJN Am J Nurs. 2023;123(2):54–9.
36. Ribeiro M, Caldeira S, Nunes E, Vieira M. A commentary on spiritual leadership and workplace spirituality in nursing management. J Nurs Adm Manag. 2021;29(3):602–5.
37. Noh GM, Yoo MS. Effects of workplace spirituality and organizational citizenship behavior on nursing performance. J Korean Acad Nurs Adm. 2016;22(3):251–9.
38. Soleimani MA, Sharif SP, Yaghoobzadeh A, Sheikhi MR, Panarello B, Win MTM. Spiritual well-being and moral distress among Iranian nurses. Nurs Ethics. 2019;26(4):1101–13.
39. Koonce M, Hyrkas K. Moral distress and spiritual/religious orientation: moral agency, norms and resilience. Nurs Ethics. 2023;30(2):288–301.

40. Stevens AM. The role of spiritual fitness on burnout and organizational commitment in High-Stress environments. Liberty University. 2023.
41. Humaira Y, Aprilia ED, Mirza M, Khatijatusshalihah K. Workplace Spirituality to Reduce Burnout in Members of The Regional Police Mobile Brigade. Seurune: Jurnal Psikologi Unsyiah. 2024;7(1).
42. Najafi K, Khoshab H, Rahimi N, Jahanara A. Relationship between spiritual health with stress, anxiety and depression in patients with chronic diseases. Int J Afr Nurs Sci. 2022;17:100463.
43. Alazmani-Noodeh F, Abdi K, Ranjbar H. The moderating effect of spiritual beliefs on job dissatisfaction related to the futile care. BMC Nurs. 2021;20:1–9.

Publisher's note