Journal of Family Violence
https://doi.org/10.1007/s10896-023-00567-x

ORIGINAL ARTICLE

Experiencing Moral Distress Within the Intimate Partner Violence & Sexual Assault Workforce

Rachel J. Voth Schrag[1] · Sophia Fantus[1] · Sarah Leat[2] · Saltanat Childress[1] · Leila Wood[3]

Accepted: 20 April 2023

Abstract

Purpose Moral distress (MD) refers to the psychological disequilibrium that emerges when institutional policies and/or practices conflict with an individual's professional values and ethics. MD has been interrogated frequently in health care and ancillary medical settings, and has been identified as a critical barrier to enhanced organizational climate and patient care. However, little work has investigated experiences of MD among members of the intimate partner violence (IPV) and sexual violence (SV) workforce.

Methods This study investigates MD in a sample of IPV and SV service providers via secondary analysis of 33 qualitative interviews conducted with service providers in the summer and fall of 2020 as the COVID-19 pandemic response was unfolding.

Results Qualitative content analysis revealed multiple overlapping vectors of MD experienced by IPV and SV service providers related to institutional resource constraints, providers working beyond their capacity and/or competency, shifting responsibilities within service agencies creating burdens among staff; and breakdowns in communication. Impacts of these experiences at individual, organizational, and client levels were identified by participants.

Conculsions The study uncovers the need for further investigation of MD as a framework within the IPV/SV field, as well as potential lessons from similar service settings which could support IPV and SV agencies in addressing staff experiences of MD.

Keywords Moral Distress · Occupational stress · Intimate partner violence · Sexual violence · Workforce issues

The Centers for Disease Control and Prevention consider intimate partner violence (IPV) and sexual violence (SV) significant threats to public health that present lifelong challenges to the well-being of individuals across all ages, races, and gender identities (CDC, 2021). In the US, The National Intimate Partner Violence Survey found that one in four women and one in 10 men experienced physical, sexual, or psychological violence from an intimate partner in their lifetime (Smith et al., 2018). Similarly, one in three women and one in four men experienced sexual violence involving sexual contact in their lifetimes (Smith et al., 2018). Black, Latinx, and Native American/Indigenous women are at higher risk for IPV when compared to white women due to structural oppression, economic inequality, racism in service access, gender-based beliefs and stigma (O'Connor et al., 2022; Scheer et al., 2022). The coronavirus pandemic heightened the risk for severity of violence for many individuals across the US. IPV prevalence increased during the coronavirus pandemic with some major cities in the US reporting increases in police responses to DV calls ranging from 10 to 27% (Boserup et al., 2020). Measures to prevent the spread of COVID-19 (e.g. lockdowns and stay at home orders) potentially led to increases in IPV due to new economic challenges within the family, lack of access to informal support networks and formal support services due to social distancing, and stay at home orders (McClay, 2022; Sharma & Borah 2022; Voth Schrag, Leat, & Wood, 2022; Wood et al., 2021). Furthermore, advocates working

✉ Rachel J. Voth Schrag
rachel.vothschrag@uta.edu

[1] The University of Texas at Arlington School of Social Work, 211 S. Cooper, Arlington, TX 76019, USA

[2] The University of Memphis, Memphis, USA

[3] The University of Texas Medical Branch at Galveston, Galveston, USA

Published online: 27 April 2023

in IPV and SV service agencies faced significant challenges providing support to survivors.

While there were frequent discussions about the impact of COVID-19 and accompanying lockdowns on first responders, IPV and SV advocates faced the challenge of providing services to survivors who experienced abuse in their own homes during stay-at-home orders (Bradbury-Jones & Isham, 2020; Wood et al., 2021). Moral distress (MD), the psychological disequilibrium that emerges when agency policies and/or practices conflict with an individual's professional values and ethics, is a critical issue to address to enhance effective human services. However, little work has investigated experiences of MD within the IPV and SV workforce. This study investigates MD in a sample of 33 service providers, via analysis of qualitative interviews conducted in the summer and fall of 2020 as the COVID-19 pandemic response was unfolding.

IPV and SV Services Impact

Across the United States, there are over 2,000 community-based agencies that see an average of 70,032 IPV survivors a day (NNEDV, 2022). Agencies that support survivors of IPV and SV provide a wide range of direct services, including advocacy, safety planning, counseling and social support, food, housing and economic support, and prevention education (Kulkarni et al., 2012; Macy et al., 2009; Edmond, Voth Schrag, & Bender, 2019). There is growing evidence that empowerment focused, survivor-centered services provided in community-based IPV and SV service agencies are effective at reducing violence and improving survivors' well-being, including enhancing emotional, social, and physical well-being, as well as improving access to economic resources and informal support (Rivas, Vigura, Cameron, & Yeo, 2019, 2016; Sullivan, Goodma, Virde, Strom, & Ramirez, 2018; Wood et al., 2022). Programs address the immediate losses experienced after violence through building a structure of informal and/or formal support around a survivor. This can include the collaborative work of advocates and survivors in building tailored, supportive plans to address specific risks and needs of each survivor (Sullivan et al., 2018).

IPV and SV service agencies support survivors in addressing lost resources by facilitating connection, providing direct material support, and enhanced emotional support and safety planning (Davies & Lyon, 2014; Sullivan & Goodman, 2019). These services center survivors' rights and facilitate access to support based on individualized needs in order to enhance resources and improve survivor, family, and community well-being (Davies & Lyon, 2014; Sullivan & Goodman, 2019; Wood et al., 2020). There is strong evidence that a portion of this impact comes though the power of connection with IPV and SA program staff (Wood et al., 2022). Empathic, voluntary, and low barrier services which are delivered in formats focused on addressing the impact of trauma and marginalization are linked with improved survivor autonomy and empowerment as well as improved mental and physical health and survivor well-being (Nnawulezi et al., 2018).

IPV & SV Service Provision & Workforce Challenges

Professionals who work in IPV and SV service agencies have occupational roles with titles including advocate, counselor, case manager, prevention educator, program director, and executive director (Wood et al., 2017). Workers in IPV and SV support agencies face a wide range of stressors, including lack of funding and organizational capacity, risks of physical and mental danger to themselves and their clients navigating violence, constant exposure to traumatic and distressing material, and exposure to structural oppression and microaggressions (Wood et al., 2017; Voth Schrag et al., 2022). Staff have reported longer term negative mental health and well-being impacts from witnessing the aftermath of violence, feeling unable to provide protection to survivors, and risks to their own safety and stability (Ellis & Knight, 2021; Kulkarni et al., 2013). A notable feature of the IPV and SV workforce is their sustained high levels of attachment and commitment to the mission of ending violence and supporting survivors (Bemiller & Williams, 2011; Wood, 2017). Importantly, data highlight that negative well-being outcomes, including burnout, compassion fatigue, and vicarious trauma, may be heightened when staff feel that program goals or activities that they are expected to preform are not well aligned with the needs of survivors in their community (Goodmark, 2011; Wachter et al., 2020; Voth Schrag et al., 2022).

Moral Distress: Theory & Impact

The challenges encountered by the IPV and SV workforce, including limited funding and an inability to provide protection, may not only contribute to experiences of burnout, compassion fatigue, and vicarious trauma but may also lead to MD. The concept of moral distress has been operationalized predominantly in healthcare settings to explain specific psychological and emotional stress responses of nurses and physicians in the aftermath of ethical conflict (Whitehead et al., 2015). Moral distress is defined as a circumstance 'when one knows the right thing to do, but institutional

constraints make it nearly impossible to pursue the right course of action' (Jameton, 1984). Moral distress refers to the psychological disequilibrium that emerges when institutional policies and/or practices conflict with an individual's professional values and ethics. Triggers of moral distress among healthcare workers may include inadequate end-of-life care or pain management, staff shortages and increased caseloads, poor interdisciplinary collaboration, managerial conflict, and a lack of organizational support (Epstein et al., 2019; Henrich et al., 2017).

Encounters of moral distress are different from experiences of burnout or compassion fatigue. Whereas moral distress results from value conflict, burnout and compassion fatigue are based on general occupational demands rather than as a response to ethical conflict (Lloyd, King, & Chenoweth, 2022). Moral distress may be a leading cause of burnout and result in reduced client care, poor retention, and negative psychological and emotional sequalae (Denne et al., 2019; Fumis et al., 2017). Although extensive empirical work has been conducted in healthcare, to our knowledge there has been no prior conceptualization of moral distress among the IPV and SV workforce. It is imperative to understand the triggers of IPV and SV workers' moral distress to inform future research directions, to consider novel approaches to ameliorate moral distress and heighten moral resilience, and learn behaviors to navigate ethical dilemmas and nurture professional efficacy (Rushton, 2017). Attention to MD in the IPV and SV field could point to additional modifiable factors to support workers and enhance well-being.

As an individual is coerced to assume duties that violate their personal and/or professional moral judgment, encounters of moral distress may lead to short-term physical, psychological, and emotional stress responses (Epstein et al., 2019; Hamric, 2014). In turn, repeated and unresolved moral distress, more commonly referred to as moral residue, is associated with longer-term sequalae, including job dissatisfaction, workplace attrition and turnover, detachment from colleagues and peers, and reduced investment in patient care (Cacchione, 2020; Lamiani, 2016). In recent years, the concept of moral distress has broadened into the field of public social welfare and child protection services (Stahlschmidt et al., 2021). Triggers of moral distress among child protective workers may derive from performing tasks against the social work code of ethics and adhering to rules and regulations that negatively impact job performance (He et al., 2021). Other factors that may contribute to moral distress among child welfare workers include a sense of complicity in working within institutions that have failed to prevent abuse (Brend, 2020), systemic shortcomings of the child welfare system, and limited resources available within the system to focus on the promotion of child welfare (Brend, 2020). International research mirrors these findings, as studies from Finland (Mänttäri-van der Kuip, 2016), Norway (Østertun Geirdal et al., 2022), Israel (Lev & Ayalon, 2018), and Canada (Greason, 2020; Webber et al., 2021) demonstrate that insufficient resources, budget constraints, underfunded systems, overburdened caseloads, and poor interdisciplinary collaboration lead to moral distress.

Research has identified a range of impacts on providers facing moral distress in their workplace (Fantus et al., 2022), including physical indicators (e.g., headaches, nausea, and panic attacks) and emotional indicators (e.g., anger, frustration, fatigue, and guilt) (Hamric et al., 2006; Henrich et al., 2017). Moral distress has also been implicated in poorer job satisfaction, greater workplace attrition, and worse patient care outcomes (Hamric & Blackhall, 2007; Hamric, 2014; Whitehead et al., 2015).

The Current Study

Previous research has established that the IPV and SV workforce provide lifesaving support to survivors in often challenging occupational environments, and that protective factors to improve the work environment can have cascading beneficial impacts on both service providers and the survivors they serve. However, indicators of moral distress have not previously been examined in the context of IPV and SV service providers. As such, the current study asks the following questions: How do members of the IPV and SV workforce experience moral distress? What are the consequences of moral distress for individuals in the IPV and SV workforce?

Methods

Data for this project are drawn from a mixed methods study of survivor and staff experiences in IPV and SV service agencies during the first year of the COVID-19 pandemic in the United States. The parent study included an initial web-based survey for service providers and survivors fielded in the spring and summer of 2020 (total provider $n = 352$), followed by qualitative interviews with staff and survivors ($n = 58$) to gain deeper insights into the impact of the pandemic on survivor safety, service experiences, and workforce challenges (see Voth Schrag et al., 2021; Wood et al., 2021 for details). Because the current study is focused on the occupational experiences of IPV and SV staff, data analyses were focused on the semi-structured qualitative interviews conducted with IPV and SV service providers ($n = 33$).

Participants

Participants for staff interviews were recruited from among the 352 respondents to the staff pathway of the initial web-based survey disseminated in April to June 2020. As such, all participants were working in IPV and SV service agencies at the outset and initial ramp up of COVID related programming shifts. Folks were invited to participate in an interview if they had provided their consent to be recontacted in the initial quantitative survey and had indicated that they were at least 18 years of age and working in a staff role in an interpersonal violence service agency at the time of the preliminary survey. The team reached out to 50 staff initially, and in total, 33 service providers from agencies focused on interpersonal violence were interviewed. Participants predominantly identified as female (n = 30), with others identifying as male or non-binary. The majority (n = 20) identified as White, with six identifying as Hispanic/Latina, and others identifying as Black and Asian. They ranged in age from 28 to 65, and came from 10 states across the United States. Their roles within their agencies included direct service (60%), including survivor advocate, legal advocate, counselor, etc., administrative roles (19%), including executive director and program leadership, and hybrid positions encompassing both leadership and direct service roles (21%).

Procedures

All interviews lasted between 35 and 90 min, and were conducted via ZOOM or over the phone based on the preference of the participant. Interviews were audio recorded and transcribed verbatim for analysis. Participants provided verbal informed consent for participation and audio recording before the beginning of the interview, and two members of the study team conducted all the interviews. Both interviewers are PhD level social workers with extensive experience in qualitative interviewing, and came from 'insider' perspectives as former interpersonal violence service providers themselves. A process of memo-ing (notes taken by the interview team independently during the interview process and then reviewed by the team) was used to enhance trustworthiness and highlight emerging findings as interviews unfolded (Birks, Chapman, & Francis, 2008; Patton 1999). Most notably for this study, emerging findings related to staff conflict and communication breakdown emerged through this process and became part of the interview guide as interviews continued. Participants received a $25 gift card as a thank you for their time.

The semi-structured interview protocol was reviewed with an additional study team member, as well as representatives from survivor service organizations, prior to the beginning of interviews. The interview protocol included a structured demographic questionnaire as well as open-ended questions and prompts focused on personal and client experiences with the pandemic and safety, job task adaptations, their agency's approach to social distancing, challenges in their workplace, and experiences of occupational stress. Sample questions from which data for this secondary analyses were drawn included: "What are your top work stressors at the moment," "How has your job shifted in the wake of the coronavirus pandemic" and "what could be done to better support you in your work?" The study procedures were approved by the institutional review board of the sponsoring university prior to the beginning of data collection.

Data Analysis

Qualitative content analysis guided the process of organizing, describing, and analyzing the qualitative data, with a deductive approach to considering the research questions related to MD (Sandelowski, 2010). Professional transcriptions of each interview were combined with the memos created by the interviewers to comprise the data for analysis. Data were broken into high level codes reflecting general categories of data (e.g., data related to job tasks and responsibilities, data related to provider health and well-being, data related to organizational conflict or challenges, data related to survivor needs & safety). These initial categories were developed by the first author after an initial review of the transcripts, with input and review by the third and fifth authors. From this review, a secondary analysis was undertaken of data that had been initially categorized as related to occupational experiences, workplace barriers, and provider outcomes. A deductive lens was used to identify indicators of moral distress within the data, with those data then inductively breaking into examples of MD and consequences of MD. The data naturally fell into these two categories. Two additional researchers conducted the secondary MD focused analysis. One of these researchers has extensive expertise in moral distress and health/social care ethics outside of the IPV/SA service field, and one has extensive experience in IPV and SV service provision but is not a moral distress expert. Memos (notes documenting coder thought process) and consultation (ZOOM meetings between the coding team) were used to define and name the developed code categories from within the data. Data analysis credibility steps employed include the use of multiple coders from different positionalities (IPV experts and non-expert, MD expert and non-experts), and thick description in data presentation (providing context and additional insight into quotations) (Elo et al., 2014; Tracy, 2010).

Results

These interviews demonstrate that IPV and SV service providers overwhelmingly share a sense of connection to and investment in the mission of their agencies, and a deep sense of duty to and care for the survivors they work with and on behalf of, regardless of their role within their workplace. They were also clear that service providers are facing new occupational challenges in the wake of COVID-19. Conversations highlighted how shifts due to the pandemic underscored existing problems and further entrenched disparities that jeopardized the effective functioning of agencies and teams. Across interviews, themes were identified in response to two research questions focusing on (1) experiences of moral distress among members of the IPV and SA workforce; (2) the personal and agency/team consequences of experiencing moral distress.

Moral Distress Experiences of the IPV & SV Workforce

These interviews demonstrate that IPV and SA service providers have experienced varied forms of moral distress as they seek to meet the needs of survivors. Staff frequently encountered ethical conflict wherein they were able to identify an ethically correct path in relationship to their work, colleagues, and survivors, but faced institutional and situational barriers to enacting that path. Themes identified in this area highlight causes of moral distress including (1) institutional and situational resource constraints leading to providers being unable to meet their own professional expectations and ethics; (2) providers working beyond their capacity and/or competency to make up for systemic gaps in resources or capacity; (3) shifting responsibilities within service agencies that created uneven shouldering of systemic burdens among staff; and (4) breakdowns in team support and communication.

The most prevalent descriptions of moral distress within these interviews connect to the role of **institutional and situational resource constraints** in impacting the ability of service providers to serve survivors to the level that they would wish and would view as ethically appropriate. Advocates highlighted feelings of desperation trying to link survivors with lifesaving shelter, protective order support, or cash, which were highlighted when the barrier to finding those resources was organizational problems, capacity caps, or other resource constraints. Across the board, providers spoke to the limits of their agencies' capacity to meet the needs of survivors in terms of housing, economic hardship, and mental health support. They then frequently linked these gaps with having to make intervention decisions that were in violation of their professional and personal ethics and against best practices for survivors and their communities. One service provider highlighted how the pandemic has led to a *new* inability to meet survivor needs, and the stress this has caused her and others in her agency, sharing:

> I think it's really hard for me on a level of looking at my shelter…We had never had to deny service for shelter to anybody prior. In the prior years I think it had always been zero, and it might have been one to three people in an entire year. I mean, the number of people we have to deny services to is extremely disturbing‖I think that's the way the emotional stress comes in of wanting to serve every person that walks through your door. It's not possible during a pandemic, it's like you're cutting that in half of what's possible, so I think there's just a lot of stress on that. (P9, Hybrid Direct Service/Admin Role)

Another staff member shared about the distress she experienced conducting sexual violence intake assessments over ineffective video-conferencing technology, purchased because the agency could not afford ZOOM, causing survivors to have to re-explain and ultimately re-expereince their sexual trauma multiple times. This provider shared:

> Initially, because we're nonprofit and Zoom was unaffordable at the time, and we're rural, we had to go with video conferencing that was more affordable, and it would drop calls‖. People would be in the middle of doing intakes and talking about their sexual trauma, and we would get cut off, and I would be, "Oh my gosh." Everything that is part of being a therapist and having compassion and empathy, and then you took it on as you did something to them (P23, Direct Service Role)

This inability to provide the level of care that service providers are accustomed to, or that they desire to provide to survivors, was highlighted both in terms of internal agency capacity and the way that the whole service response system contracted in the wake of the pandemic at just the time that many survivors needed greater levels of support. Rather than being able to provide excellent and timely care, service providers shared cascading frustrations and increasing moral conflict as their referral sources dried up, their wait-lists lengthened, the avenues for service shrunk, and the scope of survivor need seems to expand all at once. In particular, participants felt complicit, feeling compelled to enact processes in a system unable to provide care to the level they saw as needed and appropriate. This is exemplified by one supervisor who shared about keeping folks in

their services even as they had a need for a higher level of care because there were no services available:

> There's a dramatic decrease in open availability, and so it's now weeks before we can get people in to see external counselors, or external psychiatrists. So the other challenge is that, even when they're not appropriate for us because they're too sick, getting them additional care is actually more complicated. So we're holding folks that are more sick than we normally would, because there's no place to send them for a high level of care. (P 27, Hybrid Role)

Staff also shared how restrictions in place due to the pandemic specifically elicited a sense of being unable to preform their jobs to their own highest standards of care and concern. This was often centered around challenges with telework or technology. An example of this was shared by one staff member who reflected on the limitations that remote work placed on their ability to provide safe services in the preferred modality and approach of some clients, which is a hallmark of high quality IPV intervention services. They said "*for a while there I was remote and so I could only offer online services, which not everybody's comfortable with and not everybody is safe to do."* (P29, Direct Service).

This gap in providers' capacity to meet the needs of survivors, both that which is seemingly baked into our survivor response system (e.g., long waiting lists for mental health services, gaps between housing requests and housing availability, and lack of flexible funding to meet unique survivor needs) and that which was exacerbated by the restrictions of the COVID-19 pandemic (e.g., reliance on telehealth where this creates barriers to care, shelter capacity caps), emerges in these interviews as a major driver of another aspect of moral distress. Service providers spoke frequently and openly about **working beyond both their own competency and their sustainable capacity** to make up for, or at least ameliorate in some small way, the systemic capacity gaps of the IPV and SA service sector. As one advocate shared, a major source of internal conflict was the volume of work they face on a daily basis, and their inability to provide the focus, skill, and empathic connection in each survivor-interaction and work task they wish for their work. In some cases, prevention educators or shelter support staff talked about stepping into frontline advocacy roles that they were not trained for or prepared to undertake in order to meet the needs they were faced with, particularly in hybrid working environments where some staff members (such as shelter support workers) were in person and others were working remotely. As one prevention educator shared, *"Still, there are days when we get turned into advocates because we were in the building and every other advocate that we've got over there is not available because they're with a client."* (P6, Direct Service Role) In other cases, participants talked about assuming responsibilities beyond their emotional and physical capacity in order to bridge the gaps they were seeing around them and to meet their own expectations of the level of support survivors deserve. As one advocate shared:

> I do see that my case work hours increased because they need more right now. They are so much more in crisis than I've seen them in the last two years that I've been there. Their crisis is, their anxiety levels are much higher. They can't manage as much on their own. So that part has changed. There's additional case work hours one-on-one. (P12, Direct Service Role)

In these instances, moral distress arose from feeling coerced or required to take on roles that were beyond their professional competencies and from increased caseloads and demands that meant less time with survivors and their families. An example of this is provided by a participant who provides services in several languages. She shared about feeling like she was being forced to work less competently by the situation she faced, as providing virtual services prevented her from using many of the resources or strategies she would otherwise use to effectively communicate with clients. She shared.

> For me, the most stressful part is, again, we serve clients who have so many needs. There's language barriers… Let's say somebody calls from the attorney general's office to her, and the next thing I know is she calls me with a panic, "I called this." So I have to figure out what happened. Honestly, when I met with them face to face, it was a lot of the mixture of body language, signs, very basic English, even breaking the English into different things. This is how I operate with my clients…So for people who have very limited English, that has been very difficult. Very difficult talking on the phone. Somehow that's the most frustrating part. (P27, Direct Service) Providers also shared that moral distress was brought on **by shifting responsibilities and power within agencies**, as some job roles (often those held by folks with more institutional and societal power) were able to move to remote work in the wake of the pandemic, while others stayed in person. The daily tasks of running an in-person agency, particularly agencies that include an on-site housing component such as an emergency shelter or transitional housing program, began to fall to smaller and smaller groups of staff, who were thus expected (or felt internal pressure of behalf of survivors) to work longer, harder, and further beyond their capacities. As one advocate shared, *"[everything became] more difficult for everyone because usually we will have like three or four people doing*

one job and now you only have one person or two." (P11, Direct Service). Another advocate shared:

> Our agency is letting people work from home if they choose too. There are people that are still choosing to work from home, which makes the rest of us who are coming to the office have to do twice the work because if you're not physically there in the office you can't help answer the phone, or respond to a client at the door, or accept a donation that arrives. You can do your phone calls, or your support group, or provide client services over the phone or something but when it has to do with the day to day, checking the mail or logging stuff online, and taking hotline calls and stuff like that, there's much more work like that for those of us who are willing to come to the office to do. I think there's frustration probably on several staff members and that like, "Look, those of us who are coming and working eight hour days during this tough time. It's not fair that we're having to work harder during those eight hours, and the ones who are still working from home, they're doing their laundry during their work hours. …Especially since we've been so overwhelmed. The hotline calls and people needing protective orders. (P1, Direct Service)

Not only does this contribute to advocate moral distress as staff feel incapable of providing the care they would wish to provide, it also has the potential to negatively impact the safety of the community as rates of IPV increase and survivors, families, and bystanders are further exposed. Providers highlighted how this both impacted the quality of the work, and power dynamics within agencies. As one case manager shared:

> And the fact that at least case managers have been relying a lot more on advocates to get things done in the office with clients. So for example, when we're working from home and a client needs something printed, or they need a letter, or they need a list of some sort, then we have to rely on them. And I feel like we're also putting in additional work on them when they usually wouldn't have to, because when we're in the office we can get it done ourselves, but since we're not, then we're relying on them. (P11, Direct Service)

Across the board, service providers shared that **agency communication-** which is often cited as a challenge in the pre-pandemic IPV and SA workforce literature- became more difficult, and that this contributed to challenges in being able to do the work of advocacy to the level and capacity they would wish, particularly in a fast evolving crisis environment. Working remotely disrupted normal patterns of communication, accountability, and accessibility, resulting in increased frustration and in some cases suspicion. For example, staff talked about wondering what their colleagues were doing at any given moment, and if a lack of an instantaneous response or phone pick-up indicated less work happening. Participants also highlighted how reduced communication also had cascading impacts on team cohesion, as well as reducing the team's ability to support ethical decision making at a team level. One advocate shared:

> I think communication has suffered as a team, and even maybe some accessibility to my team. For instance, I need to staff a case with my supervisor today, and sent him a text message earlier, and I haven't heard back, so I'm like, okay, do I wait until next week? Where normally I could just make like several passes past his office. Catch him while he's got a minute or whatever, or grab him as he walks past mine. So, that's I stated to say, communication, accessibility, and honestly, probably some social stuff too. (P7, Hybrid Role)

Another advocate highlighted the way that written communication, particularly when it is produced in an atmosphere of tension and frayed trust, can hurt rather than help build cohesion and community. She shared:

> And then quite frankly, people, as you can imagine, as everyone has been, everyone has a really short fuse right now. And also all of this correspondence that we're doing through email has led to a lot of really reactive responses from the people that we work with. So much of the nuance of face-to-face contact has been lost. And that's been a huge issue because it's led to some huge blow ups that didn't really need to happen, so causes a lot of stress as well. (P31, Direct Service)

These challenges with team communication, isolation, and trust were occurring in the middle of multiple worldwide traumas, and in the case of the IPV and SA service sector, in the middle of the daily vicarious trauma experienced by direct service staff as they accompany survivors on their journeys. Repeatedly in these interviews, providers shared the difficulty of doing trauma work in the midst of trauma. This was powerfully put by one therapist, who highlighted the values conflict between professional/personal boundaries and the need to meet clients in trauma when they were facing similar traumas, sharing:

> I think one thing that we did talk about that I think is probably relevant here is, it's very unusual for us

> clinicians who do this kind of trauma work, to be working with somebody who has a particular trauma that we, as clinicians, are also experiencing. So if we think of COVID as being a traumatic experience, except for natural disasters it doesn't often happen that your having a co-process with client in-person, giving the service, going through the same trauma at the same time. And so I think that's a challenge for my staff and for me, because things like burnout and COVID fatigue, and fear about our loved ones being sick, all of that is true not just for our clients but also for us. And so it's changed the emotional load that then we carry, because we're working with students and telling them, "Oh it's good to have a routine. It's good to do self-care." And then telling ourselves the same thing because we're going through the exact same process. (P27, Direct Service)

For IPV and SV service providers, the depth of their commitment to survivors and ending violence frequently comes into conflict with the extent of institutional resources, internal capacities, and personal competencies. This can elicit moral distress as the promise of IPV and SV services go unmet in some cases, or as service providers work beyond either their competency or their physical or emotional capacity in an attempt to personally overcome the constraints of their situation on behalf of survivors. These situations have been heightened in the recent past by additional constraints put in place due to COVID, both cutting off access to resources, introducing additional stressors into the lives of staff and thus impacting their capacity for their emotional work, and creating an unequal distribution of risk and work among staff working remotely compared to staff working in-person.

Consequences of Experiencing Moral Distress for IPV & SV Service Providers

Many of the consequences of moral distress that have been explicated in other occupational settings are evident among these IPV and SV service providers. Service providers talked about **difficulties disconnecting** from work and feeling challenged by the constant inability to meet the needs of survivors to the level they are used to or would wish. As one participated shared in response to being asked what has been hard about her work recently, *"Being limited by choices and having many things taken away as a result, that's not serving me well. So it's a lot more of having to be flexible over and over again."* (P23, Direct Service) Many service providers also highlighted specific ways that their own **mental health or well-being** had been impacted by the difficulties meeting survivor needs during the pandemic response. Encounters of moral distress had deleterious consequences on their emotional and psychological health, demonstrating a lack of empathy and motivation, sadness and frustration, and feelings of isolation, avoidance, and detachment. One shared that she was dealing with "a *lack of motivation, a lack of want to leave the house or do physical activity."* (P29, Direct Service). While another talked about trying to cope with the challenges of the pandemic and her work in the short term, knowing that the avoidance strategies she was using are unsustainable and unhealthy long term. She shared:

> I find that my feelings are just below the surface. If I dig into it with anyone I immediately am crying so it feels like it's right there but it also feels like I don't have the capacity to deal with it. I find that I've been avoiding a lot more than I typically do. Some of that is so that I can still show up for my clients or for my friends but then, "I'm fine, I'm fine, I'm fine," and then I'm not, right?‖Then I kind of crawl back up and then, "I'm fine, I'm fine, I'm fine," and then I'm not. So I know that long term it's not healthy but it feels like the most effective solution in the short term so that's what I've been doing, whether conscious or not. (P4, Direct Service)

Several service providers talked about the way that the combination of their inability to address the needs of survivors and the increased social isolation created specific **occupational challenges**, including the risk of crossing professional boundaries. One participant highlighted that *"[I] think my feeling of isolation and disconnectedness from my support system and seeing that echoed in my clients and my needing to be mindful of healthy and professional boundaries and things like that with them."* (P12, Direct Service) Ultimately, these interviews highlight the deep connection of service providers to the mission and aims of the service sector, with participants repeatedly sharing the ways that their inability to live up to their own high standards was impacting their well-being and sense of professional efficacy. This is well summarized by a participant:

> [I have been] feeling really sad I think, some lack of motivation, and I'm grateful to be able to keep doing the work that I'm doing, but I think that has always been an impact too. In this field, you always feel like you're not doing enough. There's been more barriers too. I'm someone who really thrives off the purpose of what I'm doing and I feel really personally impacted if I'm not feeling successful professionally. (P29, Direct Service)

Participants reported unique approaches to reduce encounters of moral distress. Service providers shared acts of moral resilience, like in the way they learned to advocate for boundaries even in the context of agencies with limited resources. The foresight to communicate with managers and supervisors was a method used to anticipate moral distress and to prevent moral residue. A service provider reported telling her supervisor *"I've got to take a break. This is too much for me to take," that's when you just kind of step back and go, "Oh, it's not just me. I'm not the only one having clients that there's a cluster of this."* (P13, Direct Service) The need for this self-advocacy was highlighted frequently by participants who shared about the many negative experiences they had witnessed their colleagues face. A supervisor shared that:

> "We have seen more serious illness of staff in the pandemic than any time before, and I've worked with most of these people for four years…It's a lot of hospitalizations, none of it's been COVID, but once again, I think it's part of that stress and the detachment and trying to find a space that's just yours and for yourself." (P9, Hybrid Role)

For IPV and SV staff, the negative impacts of working in a resource constrained environment and in the middle of shifting expectations and personal capacity manifested in personal mental and physical health impacts, as well as a reduced sense of connection to support systems. The strategies used to ameliorate moral distress and its negative sequalae emerged from identifying the triggers of moral distress and addressing these with supervisors and managers.

Discussion

The pandemic response and new constraints on organizational resources, physical proximity, and modes of interaction appear to have exacerbated experiences of moral distress within the IPV and SV workforce. However many of the examples of moral distress identified in these interviews have been long standing challenges within the IPV and SV service sector (Wood et al., 2017; Kulkarni et al., 2013). Things like the way that institutional constraints prevent a provider from taking the most ethically desirable action (e.g., lack of shelter space causing a provider to have to turn away a survivor in need), and ineffective team communication leading to challenges with team-based ethical decision making are not novel challenges. However, new challenges also emerged, including challenges providing high quality services via technology, leading to potentially re-traumatizing survivors or reducing the efficacy of advocacy services. While concepts including compassion fatigue, burnout, and vicarious trauma are frequently considered in the IPV/SV work force literature, this examination of workforce challenges through the lens of moral distress contributes a new perspective which highlights the ethical and moral dilemmas faced by advocates, counselors, and agency leadership.

As a field built on the strong alignment of its workforce with its core mission, and with a workforce that is uniquely exposed to human suffering and trauma on a daily basis, systemically addressing the conditions and dynamics that led to experiences of moral distress takes on an urgency. This is doubly true at a time when new practices are being entrenched and new systems are being established to meet the demands of a post-pandemic field. IPV and SV service providers are deeply committed to survivors and ending violence, and this commitment provides a primary motivation to work in an underpaid, low status, dangerous, and frequently traumatic field. This dedication heightens the risk for experiencing moral distress when factors like institutional, situational, and personal capacity interrupt a staff person's ability to provide optimal support to survivors and their families. The impacts of moral distress on IPV and SV staff are clear in these interviews, including reduced connection to the agency and social support systems, and negative mental and physical health outcomes, all of which can lead to worse survivor and staff outcomes.

These results echo prior findings in both healthcare and social welfare that demonstrate that moral distress is a universal concern among frontline workers. However, given that IPV and SV service agencies are organized and operated differently than many other health systems or social welfare organizations, it is critical to understand the ways in which IPV and SV agencies can support providers' health and mental health and work towards alleviating the deleterious emotional, psychological, and occupational responses of moral distress. This lens could be seen as uniquely appropriate to a field which places a great deal of weight on ethical, equitable, and justice centered work, with staff often citing this alignment of values and ethics as a primary motivator. Future research could consider using moral distress as a framework for examining root causes of provider stress and building interventions to support moral resilience in the IPV/SV workforce. Future work should also investigate other staff wellness issues that arose in these interviews, including the shared trauma of experiencing a global pandemic, racial justice reckoning, and surging interpersonal violence, challenges with communication and team cohesion, and tensions between work-from-home and work-from-the-office/shelter staff roles. As moral distress has been extensively studied across healthcare sectors, interventions and practices already developed to ameliorate moral distress may be potential avenues for workforce support in

the IPV/SV sector as well, including the integration of ethics committees and educational workshops and seminars on the topic.

Recommendations for Practice

The literature demonstrates that community and agency support, as well as connection to mission, are key protective factors against a host of negative occupational outcomes for IPV and SV service providers, including secondary traumatic stress and burnout (Wood et al., 2017; Wachter et al., 2020; Voth Schrag et al., 2021). Given the clear presence of moral distress in the IPV/SV workforce that these data indicate, and the close tie between moral/ethical decision making and connection to this type of work for many service providers, it is imperative for organizational leaders to consider strategies for identifying and addressing moral distress as part of their overall approach to building healthy and safe work environments for staff.

Agency and service sector leaders can monitor organizational climate and trends across agencies to identify frequent sources of moral distress, including identifying ethical concerns, resources gaps, and how agencies respond to staff when they raise ethical issues. Data from complimentary helping systems show that proactively addressing sources of ethical conflict can reduce the impact of moral distress and enhance overall workplace climate (Wilson et al., 2022). One strategy which has been demonstrated in the literature to address moral distress in the workplace, which could be considered in IPV/SV settings, is the implementation of peer support programs, in which a designated team of staff respond to assist employees dealing with especially challenging situations (Helmers et al., 2020). Teams help consult on allocation of resources and ethical challenges, and support staff in implementing their own preferred strategies for well-being (Helmers et al., 2020). Along with peer led support, agencies may sometimes benefit from expert led facilitation and consultation around particularly ethically challenging situations. The field of IPV and SV services could benefit from examining interventions such as Moral Distress Reflective Debriefing, which is a promising approach led by a clinical ethicist as a facilitator for addressing moral distress in health care (Morley & Horsburgh, 2021).

In a study of staff in a pediatric intensive care unit, a 'resiliency bundle' technique was tested (Davis & Batcheller, 2020). A suite of small moral distress focused interventions was provided for staff to select in an a-la carte manner. These interventions included the implementation of an ethical issue resolution process, mindfulness reminders provided via a cell phone application, case conference discussion, structured debriefings with pastoral care staff, case conference discussions, leadership engagement, and social events all aimed at supporting staff managing moral distress. Overall, the intervention led to an increase in moral resilience among staff and an improvement in awareness of moral distress, resources, and support. The a-la carte approach of this intervention, in which each staff member could chose to engage with the components that best addressed their needs and preferences, mirrors much of how IPV/SV services are modeled, which could make it a uniquely appropriate.

Across both the moral distress literature in other fields of practice as well as within related literature in the area of IPV/SV, the importance of implementing effective, frequent, and responsive supervision practices that include an understanding of trauma and ethical decision-making is clear (Nuttgens & Chang, 2013; Voyles et al., 2020). In particular, there is a call to train supervisors to be proactively aware of issues related to ethical decision making and moral distress. This can include ensuring that supervisors are knowledgeable about triggers of moral distress, aware of ways to heighten moral resilience, and able to use resources to reduce points of dissonance between ethical expectations and services-as-provided.

The IPV and SV field could learn from work occurring in healthcare settings related to organization driven strategies for addressing moral distress. In these settings, there is work being done to create institutional mechanisms to promote mental health awareness by integrating mental health provision into the aims and mission of organizations (Vig, 2022). Further, organizations are providing financial support to promote moral distress debriefs (such as moral distress consultation services led by clinical ethics consultants) and external counseling when there are ethically complex cases, and having leadership shadow providers and see what they do on a daily basis to create better organizational policies and practices that are aligned with providers' ethics and values (Anke, Anneke, Alise Struijs, & Willems, 2013). The local focus and grassroots nature of many IPV/SV service agencies means agency leadership may sometimes also be on the front lines of service and may not need to shadow staff to understand their job intimately. However, thinking about the alignment of practices and policies with staff ethics and values could be a useful step for agencies to take in building a climate of moral resiliency. This may mean bringing more service providers to the table to make diverse and inclusive leadership decisions and ensure transparent and frequent communication. This approach may also help to break down power differentials and foster opportunities for open dialogue and to reduce providers' fears of disclosing encounters of moral distress. Leadership may consider how to explicitly promote staff mental health and wellbeing as it relates to ethical conflict and moral distress. Research

has demonstrated that experiences of psychological safety in the workplace, including agency and supervisory support, help to reduce the negative stress responses associated with moral distress and increase moral resilience (Miner, Berkman, de Jesus, & Grady, 2022).

Along with monitoring and addressing ethical conflicts, working to reduce the substantial gaps between survivor needs and agencies capacities to meet those needs is also a crucial component of addressing moral distress in the IPV/SV service sector. Social change and policy emphasis are necessary to increase funding for IPV and SV services across the board, with special attention to being able to quickly meet survivor's basic needs including access to safe housing, economic supports, flexible funding, child care, and food. Being able to increase the total amount of economic resources available to survivors and agencies is a crucial step in addressing MD and ending interpersonal violence. When asked about their major work stressors and things that would make them better at their job, respondents overwhelmingly spoke of the need for increased resources for agencies and survivors. Legislative and policy steps to address gaps in institutional capacity would reduce staffs' experiences of having to constantly turn survivors down for life saving services. Further, it would allows agencies to pay staff salaries that are commensurate with their skills, experience, and the realities of working in a high trauma and sometimes dangerous job. Agencies should also consider the need to sometimes reallocate resources where there are (or are likely to become) substantial need-capacity gaps. Having an awareness of likely moments of high volume (e.g., summer or winter for shelter depending on the program) or high severity (e.g., the outset of a global pandemic), and being able to shift resources quickly to address changing service needs can prevent experiences of MD and improve service provision overall. This might include moving financial resources as well as having an on-going program of cross training staff to promote the internal flexibility to shift to understaffed roles e.g. hotline, crisis intervention or housing, depending on the current need.

Macro-level approaches to reduce moral distress are essential. Encounters of moral distress are not simply a result of individual agency policies but are connected to unjust social practices. Being able to pay advocates a solid living wage which gives them to capacity to make choices for themselves free from economic coercion is also a component of this task for agencies and the field as a whole. Having the financial stability to set effective boundaries around how much work to take on (e.g., extra clients, extra hotline shifts, more time at the shelter, holiday shifts) is an important part of staff being able to maintain their own internal capacity and work to the level at which they would wish to preform. For a field which dramatically under pays its front line workers even compared to other helping professions, addressing pay equity is a pressing ethical issue (Wood et al., 2017).

Limitations

This study has several limitations to consider. The interviews occurred with a group of 33 service providers during a unique historical timepoint- the beginning of the COIVD-19 pandemic. Specific ethical and occupational issues, such as social distancing and public health considerations, were uniquely at play in workplaces across the world that may influence the relative emphasis of certain themes or ideas among the service providers who were interviewed. While participants were recruited from across the United States, the plurality came from one southern state (blinded), so the practice and policy landscape of that context likely shapes these data. Additionally, these questions were not initially conceptualized as part of the investigation, but the lens of moral distress was applied after data were collected, so nuances may have been missed that a different data collection and analysis approach could have captured. Going forward, researchers are encouraged to use frameworks and lessons from moral distress theories and interventions from the outset of research endeavors to further capture the extent and impact in this sector. For example, prior scholarship has conceptualized moral distress across four distinct factors: (1) clinical considerations, (2) working conditions, (3) structural conditions, and (4) internal moral sources (Fantus et al., 2022). Research using these factors to deductively guide question development could shed greater light on this issue in the IPV and SV workforce.

Conclusion

IPV and SV advocates and agencies are a critical thread in the web of safety supports for survivors of interpersonal violence. Challenges in the work environment impact both service providers and survivors. This is the first known study to investigate indicators of moral distress in this work context. Interviews clearly identified situations in which staff face institutional and situational barriers to enacting their preferred ethical path with survivors. Staff identified ways that these experiences impacted their individual and agency climate, and ultimately survivors. As such, it is imperative for IPV/SV services to begin to incorporate an understanding of

moral distress and moral distress ameliorating interventions into organizational practice.

Declarations

Conflict of Interest The authors declare that they have no conflict of interest.

References

Anke, J. E., Anneke, L., Alies, S., & Willems, D. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies*, *50*(1), https://doi.org/10.1016/j.ijnurstu.2012.08.017.

Bemiller, M., & Williams, L. S. (2011). The role of adaptation in advocate burnout: A case of good soldiering. *Violence Against Women*, *17*(10), https://doi.org/10.1177/1077801210393923.

Birks, M., Chapman, Y., & Fracis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), https://doi.org/10.1177/174498710254.

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *American Journal of Emergency Medicine*, *38*, 2753–2755.

Bradbury, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. *Journal of Clinical Nursing*, *29*(13–14), 2047–2049.

Brend, D. M. (2020). Residential childcare workers in child welfare and moral distress. *Children and Youth Services Review*, *119*, 105621.

Cacchione, P. (2020). Moral distress in the midst of the COVID-19 pandemic. *Clinical Nursing Research*, *29*(4), 215–216.

Davies, J. M., & Lyon, E. (2014). *Domestic violence advocacy: Complex lives/difficult choices* (2nd ed.). SAGE Publications.

Davis, M., & Batcheller, J. (2020). Managing Moral Distress in the Workplace:: Creating a Resiliency Bundle. *Nurse Leadership*, *18*(6), 604–608. https://doi.org/10.1016/j.mnl.2020.06.007.

Denne, E., Stevenson, M., & Petty, T. (2019). Understanding how social worker compassion fatigue and years of experience shape custodial decisions. *Child Abuse and Neglect*, *95*, 104036. https://doi.org/10.1016/j.chiabu.2019.104036.

Edmond, T., Schrag, V., R., & Bender, A. (2019). Opening the black box: Identifying common practice approaches in urban and rural rape crisis centers. *Violence Against Women*, *26*(3–4), https://doi.org/10.1177/1077801219832803.

Ellis, C., & Knight, K. (2021). Advancing a Model of Secondary Trauma: Consequences for Victim Service Providers.Journal of Interpersonal Violence, *36*(7–8), 3557 3583.

Elo, S., Kaarianinen, M., Kanste, O., Polkki, R., Utriainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustworthiness. *Sage Open*, *4*, 1–10.

Epstein, E., Whitehead, P., Prompahakul, C., Thacker, L., & Hamric, A. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics*, *10*(2), 113–124.

Fantus, S., Cole, R., & Hawkins, L. (2022). The hierarchy is your constraint:' a qualitative investigation of social workers' moral distress across a U.S. health system. *Social Work in Health Care*. https://doi.org/10.1080/00981389.2022.2128156. online first.

Fumis, R. R. L., Amarante, J., de Fátima Nascimento, G. A., A., & Vieira Junior, J. M. (2017). Moral distress and its contribution to the development of burnout syndrome among critical care providers. *Annals of Intensive Care*, *7*(1), 71–71.

Greason, M. (2020). Ethical reasoning and moral distress in social care among long-term care staff. *Journal of Bioethical Inquiry*, *17*, 283–295.

Hamric, A. B. (2014). A case study of moral distress. *Journal of Hospice and Palliative Nursing*, *16*(8), 457–463. https://doi.org/10.1097/NJH.00000000000104.

Hamric, A. B., & Blackhall, L. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, *35*(2), 422–429. https://doi.org/10.1097/01.CCM.0000254722.50608.2D.

He, A. S., Lizano, E. L., & Stahlschmidt, M. J. (2021). When doing the right thing feels wrong: Moral distress among child welfare caseworkers. *Children and Youth Services Review*, *122*, 105914.

Helmers, A., Palmer, K. D., & Greenberg, R. A. (2020). Moral distress: Developing strategies from experience. *Nursing Ethics*, *27*(4), 1147–1156. https://doi.org/10.1177/0969733020906593.

Henrich, N. J., Dodek, P. M., Gladstone, E., Alden, L., Keenan, S. P., Reynolds, S., & Rodney, P. (2017). Consequences of moral distress in the intensive care unit: A qualitative study. *American Journal of Critical Care*, *26*(4), https://doi.org/10.4037/ajcc2017786.

Jameton, A. (1984). *Nursing practice: The ethical issues* (p. 6). Englewood Cliffs, NJ: Prentice-Hall.

Kulkarni, S., Bell, H., Hartman, J., & Herman-Smith, R. (2013). Exploring individual and organizational actors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research*, *4*(2), 114–130.

Lev, S., & Ayalon, L. (2018). Development and content validation of a questionnaire to assess moral distress among social workers in long-term care facilities. *Social Work in Health Care*, *57*(3), 190–205.

Loyd, C., King, R., & Chenoweth, L. (2002). Social work, stress, and burnout: A review. *Journal of Mental Health*, *11*(3), https://doi.org/10.1080/09638230020023642.

Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the black box. *Aggression and Violent Behavior*, 14, 359–373. https://doi.org/10. 1016/j. avb. 2009. 06. 002

Mänttäri-van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International Journal of Social Welfare*, *25*, 86–97.

Miner, S. A., Berkman, B. E., Altiery de Jesus, V., Jamal, L., & Grady, C. (2022). Navigating pandemic Moral Distress at Home and at work: Frontline Workers' Experiences. *AJOB Empirical Bioethics*, *13*(4), 215–225. https://doi.org/10.1080/23294515.2022.2064000.

Morley, G., & Horsburgh, C. C. (2021). Reflective Debriefs as a Response to Moral Distress: Two *Case Study Examples. HEC Forum*. https://doi.org/10.1007/s10730-021-09441-z.

National Network to End Domestic Violence (2022). Domestic Violence Counts Annual Summary. Retrieved from www.nnedv.org

Nnawulezi, N., Godsay, S., Sullivan, C. M., Marcus, S., & Hacskaylo, M. (2018). The influence of low-barrier and voluntary service policies on survivor empowerment in a domestic violence housing organization. *American Journal of Orthopsychiatry*, *88*(6), 670–680.

Nuttgens, S., & Chang, J. (2013). Moral distress within the supervisory relationship: Implications for practice and research. *Counselor Education and Supervision*, *52*(4), 284–296.

O'Connor, J., Nikolova, K., Cardenas, I., & Snyder, S. (2022). The mediating effect of traditional gender beliefs on the relationships between gender disparities and intimate partner violence prevention. *Journal of Aggression, Maltreatment, and Trauma*, advanced publication online, 1–15. https://doi.org/10.1080/10926771.2022.2088322

Østertun Geirdal, A., Nerdrum, P., Høglend, P. A., & Bonsaksen, T. (2022). Changes in psychological distress in five groups of welfare state service workers over a nine-year period. *Healthcare (Basel)*, *10*(4), 592.

Patton, M. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, *34*(5), 1189–1208.

Rivas, C., Vigurs, C., Cameron, J., & Yeo, L. (2019). A realist review of which advocacy interventions work for which abused women under what circumstances. *Cochrane Database of Systematic Review*, *6*, 1–169.

Rushton, C. H. (2017). Cultivating moral resilience. *American Journal of Nursing*, *117*(2), S11–S15. https://doi.org/10.1097/01.NAJ.00000512205.93596.00.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362.

Scheer, J. R., Pachankis, J. E., & Branstrom, R. (2022). Gender-based structural stigma and intimate partner violence across 28 countries: A population-based study of women across sexual orientation, immigration status, and socioeconomic status. *Journal of Interpersonal Violence*, *37*(11/12), https://doi.org/10.1177/0886260520976212.

Sharma, A., & Borah, S. B. (2022). Covid-19 and domestic violence: An indirect path to social and economic crisis. *Journal of Family Violence*, *37*, 759–765.

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2018). The National Intimate Partner Violence Survey (NICSVS): 2015 data brief – updated release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Stahlschmidt, M. J., He, A. S., & Lizano, E. L. (2021). A dynamic theory of moral distress in child welfare workers. *The British Journal of Social Work*, bcab247. https://doi.org/10.1093/bjsw/bcab247.

Sullivan, C. M., & Goodman, L. A. (2019). Advocacy with survivors of intimate partner violence: What it is, what it isn't, and why it's critically important. *Violence Against Women*, *25*(16), 2007–2023.

Sullivan, C. M., Goodman, L. A., Virden, T., Strom, J., & Ramirez, R. (2018). Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents. *American Journal of Orthopsychiatry*, *88*, 563–570. https://doi.org/10.1037/ort0000286.

The Centers for Disease and Prevention (2021). Violence prevention. https://www.cdc.gov/violenceprevention/index.html

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*, 837–851. https://doi.org/10.1177/1077800410383121.

Vig, E. (2022). As the pandemic recedes, will Moral Distress continue to surge? *American Journal of Hospice and Palliative Medicine*, *39*(4), 401–405. https://doi.org/10.1177/10499091211030456.

Voth Schrag, R., Leat, S., & Wood, L. (2021). Everyone is living in the same storm, but our boats are all different:" Safety and safety planning for survivors of intimate partner and sexual violence during the COVID-19 pandemic. *Journal of Interpersonal Violence*. https://doi.org/10.1177/08862605211062998. online first publication.

Voth Schrag, R. J., Wood, L. G., Wachter, K., & Kulkarni, S. (2022). Compassion fatigue among the intimate Partner violence and sexual assault workforce: Enhancing Organizational Practice. *Violence Against Women*, *28*(1), 277–297. https://doi.org/10.1177/1077801220988351.

Wachter, K., Voth Schrag, R., & Wood, L. (2020). Coping Behaviors Mediate Associations between occupational factors and Compassion satisfaction among the intimate Partner violence and sexual assault workforce. *Journal of Family Violence*, *35*, 143–154.

Webber, J., Trothen, T., Finlayson, M., & Norman, K. (2021). Moral distress experienced by community service providers of home health and social care in Ontario, Canada. *Health and Social Care in the Community*. https://doi.org/10.1111/hsc.13592. Advance Online Publication.

Whitehead, P., Herbertson, R., Hamric, A., Epstein, E., & Fisher, J. (2015). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship*, *47*(2), 117–125.

Wilson, C. A., Metwally, H., Heavner, S., Kennedy, A. B., & Britt, T. W. (2022). Chronicling moral distress among healthcare providers during the COVID-19 pandemic: A longitudinal analysis of mental health strain, burnout, and maladaptive coping behaviors. *International Journal of Mental Heath Nursing*, *31*(1), 111–127. https://doi.org/10.1111/inm.12942.

Wood, L., Wachter, K., Wang, A., Kammer-Kerwick, M., & Busch-Armendariz, N. (2017). *VOICE: Victim services occupation, information, and compensation experiences survey*. Austin: Institute on Domestic Violence & Sexual Assault.

Wood, L., Baumler, E., Voth Schrag, R., Temple, J. R., Guillot-Wright, S., & Torres, E. (2021). Don't know where to go for help": Safety and economic needs among violence survivors during the COVID-19 pandemic. *Journal of Family Violence*, *37*, 959–967.

Wood, L., Backes, B., Baumler, E., & McGiffert, M. (2022). Examining the impact of duration, connection, and dosage of domestic violence services on survivor well-being. *Journal of Family Violence, advance online publication*, https://doi.org/10.1007/s10896-021-00298-x