



Article

“I Was Everything What I Never Wanted to Be” — Exploring Moral Injury Within Forensic Healthcare Settings

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Abstract

Moral injury has been gaining increasing prominence as a means of understanding psychological suffering in response to moral transgressions. Despite repeated evidence of exposure to moral transgressions among those detained in forensic services, moral injury as a construct within this population has not been widely explored. This research aimed to explore the lived experience of moral injury in service users detained in a forensic healthcare setting. Interviews with six service users and eight practitioners were conducted. Three themes were identified using multi-perspective interpretive phenomenological analysis: *the mutuality of moral injury, pathways to harm, and a road to healing*. Findings identified a complex trajectory towards moral injury, which significantly affected service users' cognitive and emotional processes. Results also highlighted the impact of moral injury on risk to self and others. Implications for practice and policy are considered. These include: the need for wider recognition of moral injury and its effects within formulations and assessments, collective responsibility to reduce feelings of shame, and greater opportunities to seek forgiveness and generate a sense of purpose.

Keywords: moral injury; forensic mental health; moral distress; trauma; shame; prison; identity; rehabilitation; PMIEs

1. Introduction

The construct of moral injury has gained increasing prominence as a means of understanding psychological suffering that arises not from threat to life, but from violations of deeply held moral beliefs and expectations (Litz et al. 2009; Shay 2014). The most common understanding of the development of moral injury derives from concepts related to evolutionary psychology, cognitive psychology, and attachment theory. The need for social cohesion is imperative within human survival leading to the development of shared moral expectations (Morris et al. 2015). Such expectations are modelled by primary attachment figures resulting in an internalization process during infancy and childhood. Consequently, early experiences and social interactions shape one's mental representations of the self, others, and the world known as internal working models (Bowlby 1969). Whilst internal working models are largely stable, new experiences are integrated, resulting in subtle changes over the course of the life span. However, moral injury is argued to develop when exposure to events fails to be integrated into existing internal working models. This creates cognitive dissonance and disrupts internal working models, trigger-

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ing intrapsychic crises that undermine self-perception, moral reasoning, social belonging, and one's sense of meaning and purpose in life (Litz et al. 2022; Litz and Walker 2025).

The concept of moral injury was initially developed in relation to military combat experiences (Shay 1994). Whilst the body of work exploring moral injury has substantially expanded conceptualizations of trauma beyond fear-based models, research on moral injury has remained largely concentrated to military populations (Williamson et al. 2021) and those in critical occupations (Miller 2022). By contrast, moral injury has received comparatively little attention in forensic psychology despite individuals frequently encountering situations involving coercion, violence, betrayal, and moral compromise both prior to and during imprisonment.

Forensic populations occupy a unique moral terrain. Individuals within forensic settings are often positioned simultaneously as both perpetrators and victims of harm. The prevalence of adverse childhood experience is high (Webb et al. 2025). Furthermore, acts that lead to criminal convictions may involve direct violations of personal moral codes, actions taken under perceived necessity or threat, or behaviors retrospectively appraised with profound guilt and shame (Mottershead 2023). At the same time, imprisonment itself can expose individuals to further morally injurious experiences, while offering little control over one's group or social identity, thus leading to situations in which survival may require actions that conflict with one's moral values (Jewkes 2012). Emerging qualitative work with incarcerated individuals has begun to highlight themes consistent with moral injury, including pervasive guilt, shame, spiritual and existential distress (Atkey et al. 2025; Bont 2020; Maddocks 2021; Roth et al. 2022). Furthermore, quantitative research has found high prevalence rates of moral injury in forensic samples (DeCaro et al. 2024; Steen et al. 2024). However, the experience of moral injury is not captured by existing diagnostic frameworks or risk assessments and may remain unaddressed within standard psychological interventions.

Dominant psychological frameworks applied to forensic populations have, understandably, tended to emphasize risk, pathology, and behavioral management to support rehabilitation and risk management (Goodley and Pearson 2023). While trauma-informed approaches have been increasingly incorporated into forensic services, these frameworks have largely been shaped by fear-based conceptualizations of trauma, most notably post-traumatic stress disorder (PTSD). Whilst research has documented that moral injury can co-occur with PTSD, noted differences have emerged (Barnes et al. 2019). PTSD is primarily characterized by dysregulation of threat and survival systems following exposure to life-threatening events, with core symptoms including hyperarousal, avoidance, and intrusive re-experiencing. In contrast, moral injury centers on violations of moral expectations and is dominated by emotions such as guilt and shame. Such differences have been further supported by studies which have found that those with PTSD tend to have higher metabolism within the amygdala which is associated with processing fearful and threatening stimuli. In comparison, those whose trauma did not compromise their physical safety, and were therefore categorized as having experienced 'non-danger-based' trauma, had higher metabolism in the precuneus which is responsible for self-referential processing (Barnes et al. 2019; Ramage et al. 2016).

Given the overlap in symptomology between PTSD and moral injury, attempts have been made to consider functional differences between overlapping symptoms. Within this, Farnsworth et al. (2017) highlighted how avoidance is present in those experiencing both PTSD and moral injury. However, whilst avoidance in PTSD was determined to function as a means of achieving feelings of safety, in the case of moral injury, avoidance is related to managing feelings of shame and the perception of being undeserving of social connection (Farnsworth et al. 2017). Such work has since been expanded by Litz and Walker (2025) who developed a Social-Functional model of Moral Injury. Within this, clinicians are en-

couraged to consider not only the disruptions which can occur in response to morally injurious events, but how such disruptions lead to functional impairments in appraisals of the self and others, moral thinking, social behaviour, and spiritual connection.

Whilst cognitive, evolutionary, and attachment-based theories of moral injury have arguably dominated the literature, there has been an absence of research exploring the different trajectories of events with regard to their impact on individuals. Consequently, the dual process model proposes that while moral injury and PTSD can arise from the same event, their pathways are independent (Barr et al. 2022). Whereas PTSD progresses through cognitive, emotional, and physiological symptoms, moral injury results from disturbances in virtues, character, and identity, provoking a crisis of character and existence (Atuel et al. 2021; Barr et al. 2022). This crisis results in a destabilized identity that is maintained through maladaptive behavioural changes used to cope with such destabilization (Atuel et al. 2021).

Whilst a destabilization in identity has been found to occur within those experiencing moral injury, the dual process model acknowledges differing effects depending on the individual's role within the event (Atuel et al. 2021). As such, Atuel et al. (2021) proposed that whilst shame is central to moral injury and is experienced whether an individual was a victim, witness, or perpetrator of the event, other emotions experienced are role dependent (Atuel et al. 2021; Griffin et al. 2019; Litz et al. 2022). With regard to the role of a perpetrator, Atuel et al. (2021) proposed that regret and guilt are commonly experienced with associated rumination regarding behaviour and its subsequent consequences, leading to possible feelings of grief and sorrow. On the other hand, victims of morally injurious events often experience righteous anger, contempt, disgust, and inaction regret (Atuel et al. 2021; Litz et al. 2022). Meanwhile, witnesses experience the combined affective states of both victim and perpetrator (Litz et al. 2022). Whilst the model requires further empirical testing and support, research has assessed differing effects of moral injury depending on one's role within the event. Consequently, research has indicated the most detrimental effects occur for those who have been victims of morally injurious events as opposed to those who have perpetrated or witnessed morally injurious events (Litz and Kerig 2019). Nevertheless, perpetration-based events have been associated with increased guilt, self-blame, and higher suicidal ideation after adjusting for PTSD, depression, and substance use (Bryan et al. 2018; Litz 2023; Maguen et al. 2012).

Taking this together, this research conceptualizes moral injury as a form of existential trauma arising from experiences that fundamentally challenge an individual's moral framework, sense of self, and understanding of meaning and purpose. While moral injury shares important features with fear-related traumatic processes, distinctions have been drawn between guilt associated with perceived moral transgressions or failures to uphold one's values (moral guilt) and guilt stemming from traumatic events, such as being unable to prevent harm (traumatic guilt). Similarly, shame may emerge from the perpetration of harm or from experiences of victimization and social exclusion. Although these forms of guilt and shame are conceptually distinct, they frequently overlap with cognitions involving responsibility, self-worth, trust, and meaning-making, highlighting the complex interplay between moral injury and broader post-traumatic responses.

Nevertheless, given that trauma-informed care is largely centered on fear-based models, operationalized changes typically prioritize psychological safety, emotional regulation, and the mitigation of perceived threat. Although these approaches represent an important shift away from punitive paradigms, they may be insufficient for addressing forms of distress rooted not in fear, but in moral conflict leading to identity disruption.

The limited application of moral injury frameworks within forensic research may reflect broader discomfort with acknowledging moral suffering among individuals who have committed offences. There is an implicit risk that recognizing moral injury in those

detained may be misconstrued as excusing harmful behavior or diminishing accountability. However, moral injury does not negate responsibility; rather, it provides a framework for understanding how moral transgressions and betrayal can fracture an individual's moral identity and impede processes of rehabilitation and desistance, thus supporting both wellbeing and risk management.

The experience of moral injury within those detained in forensic settings warrants further exploration. This paper contributes through addressing the following research questions:

1. How do service users detained in forensic healthcare settings in the UK experience moral injury?
2. What are the key elements of moral injury experienced by service users in UK forensic healthcare settings?
3. How does moral injury impact service users' identity, wellbeing, and risk?
4. How do service users cope with and recover from moral injury?

2. Materials and Methods

2.1. Ethics

A favorable ethical opinion was obtained from all relevant organisations, including the university establishment (1896054) and the National Health Service (24/SC/0257) prior to commencing the research.

2.2. Research Design

This research was situated within an interpretivist paradigm to explore how individuals detained within a UK forensic mental health service made sense of their experiences associated with moral injury. Grounded in a subjectivist epistemology and a relativist ontology, this approach assumes that moral injury is shaped by individuals' personal interpretations of potentially morally injurious events rather than representing objective or diagnostically discrete phenomena. Consistent with this approach, participants self-identified with the concept of moral injury and recognised aspects of their experiences within a moral injury framework. Consequently, the study was not designed to differentiate empirically between moral injury, PTSD, or broader forms of psychopathology. The findings should therefore be understood as participants' subjective accounts interpreted through a moral injury framework rather than evidence that moral injury can be clearly distinguished from PTSD or other forms of trauma-related distress within this sample.

To investigate these subjective meaning-making processes, multi-perspective interpretive phenomenological analysis (MP-IPA) was used (Blagden et al. 2024; Larkin et al. 2019). This enabled an exploration of how service users' accounts intersected with the perspectives of practitioners involved in their care, recognising that experiences of moral injury are shaped not only by individual cognition but also by interpersonal dynamics, institutional structures, and the constraints of detention which cannot be fully understood from a single viewpoint.

The first authors' position as a practitioner-researcher offered valuable insider understanding that supported rapport and contextual sensitivity, while also necessitating ongoing reflexive attention to how their professional role, assumptions, and moral frameworks influenced both data collection and interpretation.

2.3. Participants

A sample of six service users and eight practitioners was recruited through purposive sampling. The sample size was considered appropriate for maintaining the study's idiographic and in-depth focus on lived experience (Smith and Fieldsend 2021). Sample ade-

quacy was therefore determined by the richness and depth of the data rather than numerical size. In line with IPA principles, participants were recruited for their ability to provide detailed experiential accounts relevant to the research aims. Consistent with IPA methodology, data saturation was not used as a primary criterion for determining when to stop data collection or recruitment; instead, emphasis was placed on developing nuanced and coherent interpretative themes aligned with the study's exploratory and epistemological commitments.

With regard to service user recruitment, those who lacked capacity to consent, as determined by their Responsible Clinician, were not included to protect their wellbeing. Service users currently engaged in therapy with the researcher were also excluded to avoid dual-role conflicts that could compromise the therapeutic relationship, the quality of therapy, or the research findings. To recruit service users, an email outlining the research aims was sent to inpatient clinical teams within forensic healthcare settings, and professionals were asked to identify potential participants who had experienced potentially morally injurious events. Identified service users were approached by a member of their clinical team, rather than the researcher, to minimise any perceived pressure with all being informed that participation was entirely voluntary and had no impact upon their clinical care or pathway. Seven service users were approached, six of whom expressed interest in participating (Table 1). All service users who agreed to take part were male and were detained under the Mental Health Act 1983, which provides the legal framework for assessing, detaining, and treating individuals with mental illness in England and Wales. All service users were detained in a forensic healthcare setting following conviction for a violent offence. At the time of interview, none reported experiencing active psychotic symptoms that would have impaired their capacity to engage in the interview process or reflect on their experiences.

Table 1. Service user demographics.

Pseudonym	Age (Years)	Ethnicity	Diagnosis	Section	Index Offence
Rob	54	White British	Paranoid Schizophrenia	47/49	Attempted murder
Dan	56	White British	Psychotic Depression	45A	Manslaughter by reason of diminished responsibility
Lewis	22	Black (African Caribbean) British	Drug-Induced Psychosis	37/41	Wounding with intent
Luke	58	White British	Depression, Obsessive–Compulsive Disorder and Post-Traumatic Stress Disorder	47/49	Murder
Michael	42	White British	Paranoid Schizophrenia	37/41	Manslaughter by reason of diminished responsibility
Terry	31	Asian British	Schizoaffective Disorder	37/41	Possession of an offensive weapon with intent to cause fear of violence

Practitioners were eligible to take part if they worked directly with service users in a clinical capacity; those without direct contact were excluded due to not having the relevant experience required for the aims of the research. The recruitment of practitioners involved a global email sent to staff working within inpatient forensic healthcare settings, accompanied by an information sheet outlining the research. Interested practitioners contacted the researcher directly. Eight practitioners expressed an interest in participating. Practitioners worked across a range of clinical roles including nursing, psychiatry, psychology, social work, and occupational therapy (Table 2). This diversity reflects the multi-disciplinary nature of UK forensic mental healthcare, where multi-disciplinary profes-

sionals work collaboratively to provide assessment, treatment, and risk management (Haines et al. 2018).

Table 2. Practitioner demographics.

Pseudonym	Age (Years)	Ethnicity	Gender	Job Role	Length of Service
Amanda	60	White British	Female	Technical Instructor	20 years
Lucy	53	White British	Female	Social Worker	5 years
James	30	White British	Male	Nurse	9 years
Sarah	25	White British	Female	Nursing Associate	3 years 6 months
Paul	38	Black African	Male	Healthcare Worker	1 year 1 month
Sam	27	White British	Female	Assistant Psychologist	3 years
Jordan	51	Indian	Male	Psychiatrist	12 years
Stephen	28	White British	Male	Psychiatrist	9 months

The researcher met individually with all prospective participants in a confidential room to discuss the study in more depth, provide an information sheet and consent form, and explain confidentiality and its limits. All participants gave written consent and were informed of their right to withdraw up to two weeks after data collection, with the researcher's contact details provided. Interviews were arranged at times convenient for participants, and no participants chose to withdraw.

2.4. Data Collection

Individual semi-structured interviews were used to collect data. This approach was selected because it balances structure with flexibility, enabling participants to articulate their experiences in depth while allowing researchers to probe emerging meanings and clarify complex or sensitive issues. Separate interview schedules were created for the practitioner group and the service user group. Each interview schedule was designed around the research questions to explore associated cognitions, emotions, coping, and recovery in response to morally injurious events and how such experiences impact upon identity and risk. Both interview schedules began with broad, general questions before progressing to more focused questions about moral injury. This structure reflected an awareness of the sensitivity of the topic and aimed to foster participant comfort and trust before exploring potentially distressing experiences in greater depth. For the practitioner group, the questions were adapted to focus explicitly on their observations and interpretations of service users' experiences of moral injury. This involved reframing prompts that would typically ask participants to describe their own direct experiences so that they instead invited practitioners to reflect on service users' experiences.

All interviews took place in a confidential therapy room within the hospital and were recorded using an Olympus DS9000 digital voice recorder fitted with a 256-bit AES encryption and device pin-lock (OM Digital Solutions, Tokyo, Japan). At the beginning of each interview the information sheet and consent form were reviewed to provide a further opportunity for any questions. Throughout the interviews, prompts were included to elicit the expansion of answers and follow up questions were used to enhance the depth of the data collected. For the practitioner group, interviews lasted between 41 min and 1 h 15 min (Mean: 59 min). For the service user group, interviews lasted between 40 min and 1 h and 40 min (Mean: 1 h and 5 min). All interviews were conducted in a single sitting and concluded when participants indicated that they had discussed all issues they considered pertinent.

2.5. Data Analysis

All interviews were transcribed verbatim by the first author, with pauses, intonations, and other paralinguistic features retained in the transcripts. Following transcription, each interview recording was reviewed in full and systematically compared against the corresponding transcript to ensure accuracy and completeness. Data were analyzed in accordance with the guidelines of Smith and Fieldsend (2021). Service users' and practitioners' accounts were analyzed separately to preserve the distinctiveness of each perspective and prevent epistemic weighting in line with the inherent power imbalances that are present in forensic settings. Each transcript was first analyzed ideographically through repeated reading, detailed noting, and the development of experiential statements, which are concise phrases capturing the participant's experience. Personal experiential themes were then developed to capture broader meaning within the data, integrating participants' accounts with the researcher's interpretation of participants' meaning, thereby employing the double hermeneutic central to IPA (Smith 2017). Once personal experiential themes had been developed for all participants within the group, group experiential themes were developed through analyzing patterns of convergence and divergences across cases. Names for group experiential themes were then generated, representing the authenticity of experience and capturing the essence of the findings (Nigbur and Chatfield 2025). Following the independent development of group experiential themes for service users and practitioners, convergent and divergent experiences between the two groups were further analyzed. As part of this process, researchers interpreted similarities, differences, and relational dynamics across the dataset. Multi-perspective group experiential themes were then devised and cross-referenced with each participant's personal experiential themes and the wider group experiential themes to ensure they were firmly grounded in participants' experiences.

Commitment and rigor were demonstrated through the depth of the analysis, supported by a clear audit trail that enhanced transparency around the interpretative process and was further reinforced through the inclusion of participant quotations (Darawshah 2014). Reflexivity was maintained throughout the study via a reflexive journal to promote critical self-awareness of any biases that may have impacted the analysis, and to maintain a reflective stance throughout the research. Although the research was not preregistered, which is a common limitation in qualitative research, the study's credibility was upheld through systematic documentation of analytic processes, adherence to ethical protocols, and the use of established methodological frameworks.

3. Results

Three themes were developed from the data analysis: 'The Mutuality of Moral Injury,' 'Pathways to Harm,' and 'A Road to Healing.' Figure 1 represents the themes as part of a dynamic process, highlighting their sequential and interdependent nature. The results are organized to reflect both shared and contrasting perspectives, highlighting how moral injury is simultaneously experienced at an individual level and shaped by institutional contexts.

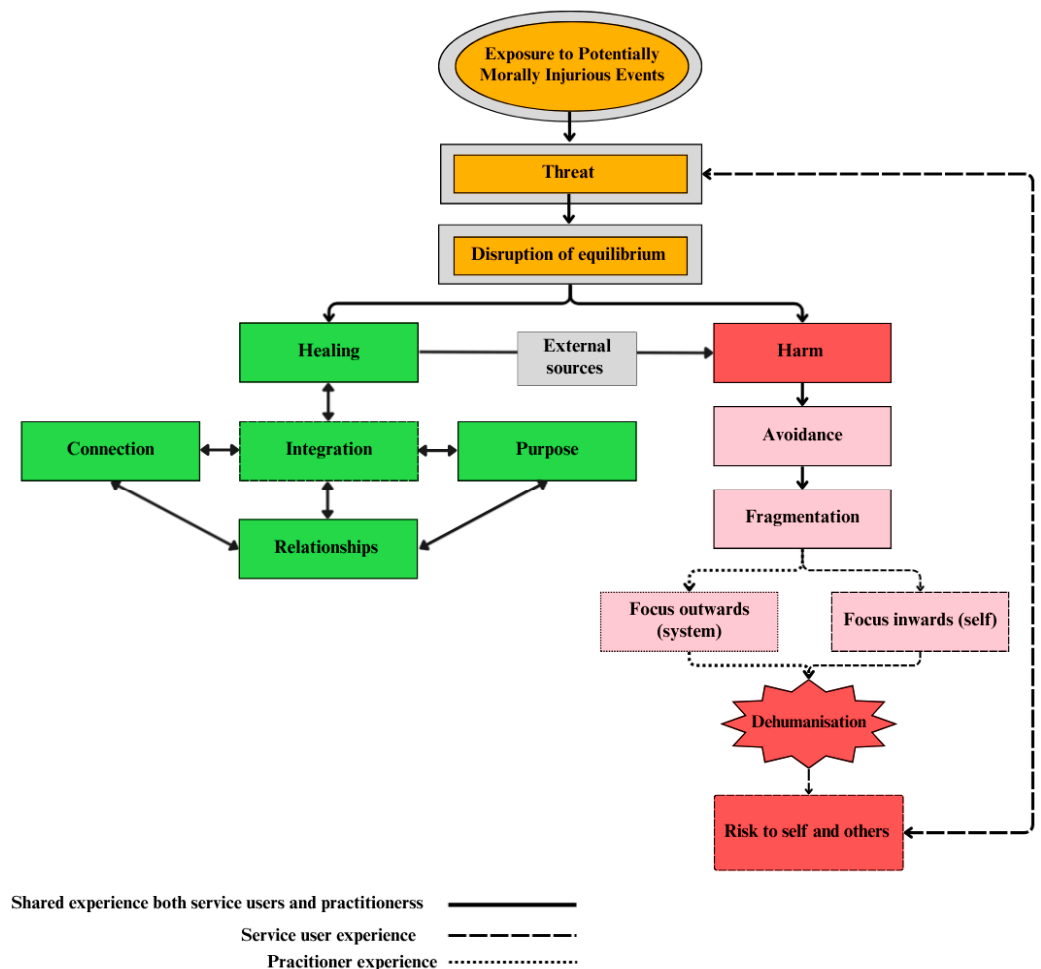


Figure 1. MP-IPA Analysis of Service User and Practitioner Perspectives on the Lived Experience of Moral Injury. Orange = Group Experiential Theme 1: The Mutuality of Moral Injury; Red = Group Experiential Theme 2: Pathways to Harm; Green = Group Experiential Theme 3: A Road to Healing

3.1. Group Experiential Theme 1: The Mutuality of Moral Injury

Within the research, there was a shared recognition of the wide range of incidents that service users are exposed to prior to entering forensic settings, many of which embodied both fear-based and moral dimensions of trauma. Both service users and practitioners acknowledged exposure to abuse, violence, and systemic injustice within family and community contexts, often from an early age. While these experiences involved threats to safety characteristic of fear-based trauma, they also constituted profound violations of trust and moral expectations, disrupting individuals' sense of self, relationships, and meaning in ways consistent with moral injury as an existential form of trauma.

Well a lot of trauma, we put up with a lot of people with trauma in the community and here [erm] you know. [Lucy—practitioner]

Lucy's observation that "we put up with" people with trauma reveals an ambivalent emotional position. On the one hand, there was an implicit recognition of the pervasive trauma that service users endure with trauma being routine and even expected. However, on the other hand, this realization appeared to evoke frustration possibly signifying a sense of moral injustice, not only in what service users are subjected to, but also in how widespread suffering seems to go unchallenged. Lucy seemingly struggled to assimilate such opposing experiences. Difficulties in assimilating such events was present throughout participants' experiences. This appeared to reflect an existential disruption that led

individuals to lose their sense of meaning, shown through participants' repeated use of phrases such as 'I don't know' and their tendency to leave sentences unfinished.

It changed the way I perceived people, it changed me, the way I look at life, how I look at people, and I just ended up growing up I don't know just [pause]. [Rob—service user]

He had so much insight and like I don't know, I don't know because I've worked with like many people that have killed others and there's...I've never had the same response from them as I did him. [Sarah—practitioner]

Despite exposure to a range of morally injurious events and the noted challenges in assimilation, there was convergence between both groups regarding the belief that morality was largely innate.

There hasn't been a patient that I've worked with regardless of where they come from, their experiences, or their views of me particularly, I've still witnessed and observed them to display their values in one way or another. [James—practitioner]

Participants' strong commitment to the idea that morality is innate appeared to serve an important stabilizing function within their accounts. Holding onto this belief seemed to help both groups create a sense of order when faced with experiences that fundamentally challenged their understanding of themselves and others. For some, this belief offered a temporary sense of clarity. Yet, despite drawing on this assumption to maintain a sense of internal balance, repeated encounters with morally injurious events continued to unsettle service users. Over time, these experiences prompted deeper questioning about their own meaning, purpose, and identity, revealing the limits of this belief as a sustaining resource.

You're not good enough, you won't make it, like you won't make your dreams happen, [erm] no one cares like this is gunna happen, this is gunna happen, almost like tryna predict the worst outcomes. [Lewis—service user]

Such existential threats disrupted individuals' sense of equilibrium, affecting both cognitive and emotional functioning. This disruption was reflected in experiences of guilt and shame, which appeared to arise from both traumatic and moral appraisals of events. For some, shame was linked to experiences of victimization whereas for others it was associated with perpetration of harm and failures to act in accordance with personal values. Similarly, guilt encompassed both trauma-related concerns regarding responsibility for adverse events and moral guilt related to perceived transgressions. These experiences were accompanied by negative self-appraisals, alongside broader disruptions in meaning, trust, and identity, highlighting the overlap between trauma-related cognitions and moral injury processes. However, whilst both practitioners and service users acknowledged the impact of morally injurious experiences on cognitive and emotional functioning, there was divergence in how these impacts were understood. Practitioners' accounts often reflected a perceived dichotomy in service users' interpretations of these experiences, with some viewed as primarily positioning themselves as victims.

I think about someone who [sigh] if they've experienced [err] violence or sexual abuse and then they do what they perceive is a lesser crime or lesser less severe crime to another person they might not deem that as wrong because for them they've experienced worse if that makes sense so yeah it allows them to kind of say well I've experienced worse that's not that big of a deal, that's not as bad. [Sam—practitioner]

This was described as a coping mechanism, with such alignment seeking to manage complex emotions by providing a clear position in relation to their identity. However, this was not evident within service users' accounts who identified joint cognitive changes in their beliefs about others and themselves, acknowledging both having harmed and having been harmed.

I went from being bullied to hanging about with the bullies. [Michael—service user]

The practitioners' accounts therefore suggested that morally injurious experiences were often understood in relation to victimization rather than perpetration. In contrast, service users' accounts introduced a contradictory picture of how such events were interpreted with them holding both the position of victim and perpetrator. This divergence appeared to reflect the protective position adopted by some practitioners, who seemed to rely on reframing the identity of service users.

When I first came, I was a bit 'oh will I be able to see a person or will I see a crime'. [erm] a...I'd always kinda not particularly looked at peoples offence so that I could make my own opinion of somebody before I kinda had a [sigh] had a false opinion of them really [erm] and when I came and saw some of the LD lads I thought you can't really fasten your own shoe laces so I don't...I can't see the crime because I can see a poorly person that needs some help. [Amanda—practitioner]

Most of them erm the way I see it is that most of them would have not offended if it was not for their mental illness. [Jordan—practitioner]

The phrase "if it was not for the mental illness, they would not have offended" [Jordan—practitioner] presented in various ways throughout Jordan's transcript. This also mirrored other professionals' accounts whereby they described offending as "it was more of an out-of-body experience for them" [Paul—practitioner] and appeared to separate those in hospital from those in prison.

There then comes this element of bad versus mad I would call it...in hospital you have got a lot of people who were mentally unwell who are coming to terms with that and would not have offended if it was not for the mental illness as we said but in prison you've got a lot of people who have offended without mental illness [er] then they develop mental illness so there's that disparity between he's a bad man who's now become mad to put it you know crossly, whereas in a hospital you have mad people who have done bad things. [Jordan—practitioner]

By assigning virtue to those receiving care and blame to those being punished, practitioners seemed to create a clearer moral order in a world where boundaries between right and wrong, and illness and criminality, are often blurred (Darby and Weinstock 2018). Consequently, practitioners discussed moral injury emerging from "shock" [Lucy] at having deviated from one's moral code through the commission of offences. Subsequently, bigger discrepancies between one's moral code and one's actions, alongside the severity of one's actions, were believed to intensify moral injury.

From their perception they've seen themselves as very successful, of being a contributing member of society, of [erm], being how they you know [erm] perceive of having a good moral basis that took them to that place and then found themselves in a situation that they never believed they would be. [Lucy—practitioner]

In contrast, Stephen was the only participant to discuss a more unsettling possibility of moral injury arising from enjoyment at having harmed others, thereby leading to concerns regarding one's identity.

I think the shocking thing for a lot of people is not oh my god I've just shot this person and I've seen it and its traumatic, it's a, it's a oh that was easy actually, or I enjoyed it, or something there is seen within yourself and that changes a bit of, oh I'm not necessarily who I thought I was. [Stephen—practitioner]

Whilst reframing appeared to offer professionals more comfort, with many practitioners giving "leniency" [Paul] to those who had committed offences in the context of mental illness, service users experienced the opposite.

Relapsing mentally and from drugs and stuff and just [err] stress, getting unwell again, the thought of it terrifies me so...I don't know what could happen, I would have never dreamed of what happened in my index offence happening so I don't want to get that bad again. [Michael—service user]

These findings suggest that morally injurious events may be experienced as a form of existential trauma, wherein actual or perceived violations of moral expectations disrupt core assumptions regarding trust, justice, personal identity, and meaning, alongside the broader psychological impacts commonly associated with fear-based traumatic exposure. The results highlight the diverse ways in which moral injury can manifest, with such experiences also present for practitioners. Dichotomous ways of thinking to make sense of moral complexity appeared throughout practitioners' experiences. As such, polarized appraisals of self and others were reinforced, with individuals often struggling to reconcile experiences of victimization and perpetration.

3.2. Group Experiential Theme 2: Pathways to Harm

The mutual experience of disequilibrium resulting from moral injury contributed to avoidance. However, rather than reflecting avoidance of perceived threat or danger, these behaviours appeared to function as a means of avoiding morally painful internal experiences. Overt avoidance strategies were acknowledged by service users including the use of illicit substances and social withdrawal.

I started smoking cannabis at the age of fifteen sixteen due to the reason of [er] trying to [er] trying to forget all these bad stuff that happened to me in life, everything, every day, I used to smoke it. I used to forget everything. [Terry—service user]

However, practitioners identified more subtle mechanisms such as compartmentalization, externalization, denial of distress, and relational detachment.

Some people are quite defensive about it, they would rather not sit and share and just give you as little engagement, they feel the more they keep within them, the less you know. [Paul—practitioner]

Paul's experience captures the recognition of emotional containment and the challenges this poses for therapeutic relationships. On the surface, Paul appeared to be reflecting on the challenges of working with service users who do not want to engage. However, by using the phrase "keep within," there is a subtle recognition that this containment is not simply about silence, but about protective concealment. Interestingly, avoidance was not solely employed by service users but was also evident in practitioners with there being a notable reluctance to engage deeply with the felt, embodied aspects of moral injury that service users experience.

They don't all open up, not necessarily to the therapy team because we're not as close to them as nurses that's there 24/7. [Erm] they've normally come to us to do something that they want to do really. Yes, you get chatting and things but [erm] you don't always get the deep conversation. [Amanda—practitioner]

The tendency for practitioners to engage in a cognitive understanding of experience, rather than engaging with the emotional impact of moral injury, created a dynamic of mutual avoidance. This appeared to exacerbate moral injury by impeding reflective processing and preventing reconciliation thereby compromising the development of an integrated and coherent identity. As part of this, avoidance appeared to divide the groups, creating distinct differences in how the sustaining factors of moral injury were understood. This not only compromised coherence, but stilted recognition of the cumulative sources of moral injury that arise from intersecting personal actions and systemic failings. Surprisingly, practitioners appeared to externalize, focusing on systemic factors.

I think that also filters in with trying to get service users into other services because they'll read reports and they'll read histories and it sticks and it clearly influences decisions but that's not who the person is at this current time. [James—practitioner]

In comparison, offences became the dominant focus for service users.

I mean you question everything, am I a killer? That was one thing what I struggled with quite a lot at the beginning, I thought I've killed somebody now, you know I've killed somebody so does that mean I'm a killer, is that in me, am I that sort of a person or what?.

[Dan—service user]

The shock regarding the extremity of action and the aftermath of recognizing the permanence of the offence marked a turning point for Dan in how he saw himself. The impossibility of reversal led to a growing self-concept that now included the capacity to cause severe harm. Consequently, despite many service users having questioned their goodness throughout life in response to others transgressions, the act of taking a life became all-consuming and disrupted their moral self-concept, resulting in the self becoming “a murderer” [Luke—service user], “a killer” [Dan—service user] and ultimately “everything what I never wanted to be” [Dan—service user].

Although the perspectives of perpetuating factors contrasted between internal and systemic sources, they were tethered by a common thread of dehumanization. The experience of dehumanization ultimately distanced service users from a sense of compassion leading to convergence between the groups in the identification of moral disconnection and alienation.

If you feel pushed away, and unwanted, and scorned by society or, or, or...or the the sort of quote-unquote normal systems. I think there can often be a sense of well if you don't...if you don't love me why should I love you? You know you've never given me kindness, so why should I give you kindness [erm] and I'm not saying that means that most patients go in with that consciously. [Stephen—practitioner]

This disconnection and loss of humanity posed a significant risk not only to the self through increasing the risk of suicide, but also to others, influencing risk behaviors, relationships, and ethical decision-making.

I wanted to end everything. I was a waste of space, there were no going back from what had happened, I was embarrassed...I was everything what I never wanted to be...so I just thought everyone is better off without me. That's all I could think...I just wanted to end it...I just thought when I got hold of her, I thought you're not right. [Dan—service user]

I couldn't take anymore and I snapped and when I snapped, I went too far...I was brought up to have morals. I was brought up to help your fellow man. [Rob—service user]

However, reflections on the link between moral injury and risk were absent from practitioners' accounts, possibly reflecting the novelty of moral injury and lack of consideration as to how moral injury may influence risk.

3.3. Group Experiential Theme 3: A Road to Healing

Whilst many accounts centered on experiences of harm, both service users and practitioners also identified a parallel pathway to healing. Integration, which is defined within this research as the ability to make sense of experience and generate a coherent, stable sense of self which acknowledges the impact of harm whilst balancing strengths, was deemed fundamental to healing. For service users, therapy provided a platform for understanding.

I'm not keeping it all to myself. I find, I feel, I feel kind of better in myself that I've been able to talk things through about what happened and to help me come to terms with the fact that it's really happened, and it's not a bad dream. [Luke—service user]

However, practitioners rarely identified therapy as relevant in healing from moral injury. Despite the differences in views regarding therapy aiding recovery, there was striking alignment regarding the importance of relationships.

Family gives that emotional support we need. They might not necessarily get the emotional support they need from the staff or the doctors or...but when you have a family member, a loved one telling you you're going to make it, that positive reinforcement goes a long way. [Paul—practitioner]

Just having people that were compassionate and kind towards me when I first got in there was really good...I...I...I thought all the staff would hate me and [err] I thought like [err] like I wouldn't get any sort of positivity from anyone so so that that was really helpful. [Michael—service user]

Healing was therefore viewed as hinging on a range of relationships including peers, family, professionals, or communities. These relationships acted as restorative platforms, grounding service users and enabling them to rebuild purpose, generate a sense of belonging, and rebalance identities. In considering this, collective responsibility may play a role in both preventing offending behavior and healing moral injury in those detained in forensic settings, by shifting the burden of blame solely from the individual to the broader social context in which harm occurred.

4. Discussion

Moral injury is the term used to refer to suffering arising from exposure to events which transgress one's moral beliefs, values, and expectations. Past research has explored moral injury across populations. However, it remains under-explored as a concept relevant to those detained in forensic settings, despite research highlighting possible prevalence rates (Steen et al. 2024). Consequently, this research aimed to explore the lived experience of moral injury in service users detained within a medium secure unit through combining perspectives of service users and the practitioners working with them.

The present findings highlight the complexity and fluidity of temporal relationships between experience and moral injury. Participants' accounts suggested that moral injury was not confined to a single point in time but was instead experienced as a dynamic and evolving process. The findings suggest that moral injury within forensic populations may be best understood as an interactional process rather than a linear sequence. Victimization, perpetration, and institutional experiences each contribute to, amplify, and reshape moral meanings over time leading to identity disruptions. However, given the retrospective and cross-sectional nature of the data, the temporal ordering of these processes cannot be established with certainty, and the pathways described reflect participants' reconstructed meaning-making experience rather than objective causal sequences.

Despite the prominence of harm-focused narratives that position individuals in forensic settings as morally deficient, both practitioners and service users appeared to retain a belief that morality is, to some extent, innate. This shared assumption resonates with perspectives in evolutionary psychology and nativist theories, which propose that humans possess pre-existing moral capacities (e.g., Hauser 2006; Graham et al. 2013). While the present study cannot confirm such theoretical claims, participants' accounts suggest that viewing morality as inherent may function as a psychological buffer. In particular, this belief seemed to offer both groups a degree of protection against the existential uncertainty associated with moral injury, which threatens one's sense of goodness. By anchoring themselves in the idea of an underlying moral core, participants appeared able to

restore a sense of coherence and internal harmony in the face of morally injurious experiences.

Despite such attempts to restore harmony, repetitive exposure to morally injurious events contributed to an existential threat leading service users to question their sense of meaning and wider identity. Such findings align with past research which has documented difficulties with shame, guilt, and distorted self-appraisals in those experiencing moral injury (Litz et al. 2022). However, whilst both practitioners and service users acknowledged the impact of morally injurious events on cognitive and emotional processes, there was clear divergence in how they conceptualized the cognitive impact. The accounts of practitioners revealed a perceived dichotomy in how service users made sense of morally injurious events, framing themselves as victims. However, this was not evident in service users' accounts, with them representing a more balanced appraisal of both having harmed and having been harmed. The divergent findings may be explained through differences between conscious and unconscious processes (Norman 2010). When applied to this research, conscious moral injury involves active awareness of the moral conflict or harm caused and experienced. In contrast, unconscious moral injury may manifest in more defended ways including detachment, denial, and externalizing behaviors, with service users being unaware of the moral dimensions to their distress. In this research, all service users had engaged in therapy. Consequently, it is possible that such experiences enabled service users to develop greater self-awareness and an understanding of their experiences, thereby allowing them to articulate them. In comparison, other service users, particularly those earlier in their therapeutic journey or those presenting with stronger defensive structures, may experience moral injury at a more unconscious level.

Another explanation, however, may point to the operationalization of a parallel process whereby practitioners use the same defenses as service users themselves, thus leading them to focus more upon the victimized part of service users than the parts which have perpetrated harm. The idea that practitioners may develop vicarious moral injury is not something which has been attended to within the literature. Past research has considered the development of moral injury within professionals emerging because of systemic constraints, failures, or ethically troubling practices (Webb et al. 2024). However, this research highlights how empathic engagement with morally injured service users and the conflict that emerges through engaging with individuals who have violated shared moral foundations, may lead to a secondary disruption of practitioners' own moral identity.

The second theme within the findings emphasized the pathway to harm which can occur in response to moral injury. Interestingly, within this, the finding that service users focused more upon their offending behavior as both a source and perpetuating factor of moral injury is contradictory to research which has documented greater focus being placed on others' transgressions as opposed to self-transgressions within forensic samples (Steen et al. 2024). Several explanations may account for the opposing finding within this research. Firstly, increased self-awareness may enable service users to speak more openly about their experiences without relying on psychological defenses, allowing for greater focus on their own transgressions which led to their detention. Secondly, deeply internalized feelings of worthlessness may limit their recognition of broader systemic harms, narrowing their focus on personal failings. Finally, there may be an underlying fear that acknowledging systemic or institutional harms in detail could be interpreted as minimization or denial which is a particularly sensitive issue in the criminal justice system, where such interpretations are closely linked to assessments of risk (Freeman et al. 2010).

Furthermore, the finding of moral injury perpetuating risk to both self and others was again only represented within service users' experiences. Despite practitioners typically holding accountability for judgements regarding risk, it is possible that the novelty of moral injury within forensic settings has contributed to a lack of consideration about

the links between moral injury and risk, despite past research highlighting the connection between moral injury and anger (Jinkerson 2016; Wojciechowski 2021). As such, moral injury, particularly when associated with guilt and remorse, may be viewed as protective against future harm, leading to less empirical focus on the interlinks between moral injury and risk.

In considering recovery, there was an acknowledgement from both groups regarding the importance of supportive and restorative relationships. Such findings are consistent with recent literature exploring treatments for moral injury in which acceptance and forgiveness from others are noted to have promising effects (Morgan et al. 2024). These findings challenge traditional therapeutic models which place emphasis on individual pathology and internal processes and instead highlight the healing power of communities (LeBel et al. 2015). The trauma literature has consistently emphasized the importance of relationships, highlighting how safe and attuned connections can foster recovery and resilience (Hübl 2023). Attunement in the form of emotional presence and responsivity creates the foundation for co-regulation, where individuals can manage overwhelming emotions through supportive relational dynamics (Ostlund et al. 2017). The experience of being understood and emotionally supported is important for re-establishing a sense of safety and rebuilding a sense of belonging (Fonagy and Campbell 2023). This is particularly relevant in the context of moral injury, where individuals struggle with trust and identity following moral transgressions (Litz et al. 2009).

Taking such findings into account, healing from moral injury may require relational repair. The use of relational repair in the context of moral injury links to the concept of collective responsibility. Collective responsibility refers to the shared accountability of a group for actions or outcomes regardless of direct involvement (Giubilini and Levy 2018). In many cultures, individual responsibility is deeply ingrained and often prioritized (Darwish and Huber 2003). However, considering moral injury and its impact on crime as a collective issue may build shared accountability through acknowledging systemic failings. This shared acknowledgement may allow reintegration into a community which may serve to reduce risk and enhance wellbeing.

4.1. Strength and Limitations

This research offers detailed insights into how moral injury is experienced and understood by service users detained in forensic healthcare settings, informed by the perspectives of both practitioners and service users. A key strength of this research lies in the alignment between the research design and the research questions. By capturing the interplay between individual accounts and broader institutional and interpersonal dynamics, this research was able to offer a more holistic understanding of how moral injury is conceptualized and experienced in forensic settings.

That said, this research is not without limitations. Firstly, all service users who participated were male, and there was limited certainty regarding whether the sample demographics reflected the wider population within forensic healthcare settings. Although males are disproportionately represented in such environments compared to females (NHS Digital 2024), the absence of gender diversity limits the breadth of experiential variation captured within this study. As such, a more nuanced understanding would come from research conducted with further diverse groups.

Another notable limitation is the homogeneity of offence type. Whilst IPA is enhanced by homogeneity, all participants were convicted of violent offences. This again was not a deliberate inclusion criterion. However, this does not account for how moral injury may manifest in relation to other offence types, such as sexual offending, fire setting, or extremism. Exploring these different offences may reveal alternative experiences not captured in this research.

Similarly, the clinical characteristics of the sample warrant careful consideration when interpreting the findings. Most service user participants had psychotic-spectrum diagnoses, raising the possibility that experiences of guilt, shame, self-condemnation, and identity disruption which participants characterized as effects of morally injurious events may overlap with phenomena associated with severe mental illness. Although none of the service user participants reported experiencing active psychotic symptoms at the time of data collection, it is not possible to determine definitively the extent to which their accounts reflect moral injury specifically, broader psychopathological processes, or interactions between these experiences. As such, the potential overlap between moral injury, fear-related trauma, and psychosis-related experiences should be considered when interpreting the findings, and future research involving larger and diagnostically more diverse forensic samples is needed to further clarify these relationships.

4.2. Implications for Forensic Practice and Policy

The findings of this research offer insights for improving forensic practice across individual, organizational, and societal levels. However, it is acknowledged that given the small sample size such implications should be considered tentative pending further empirical research.

At an individual level, this research highlights the importance of increasing awareness of moral injury among both practitioners and service users. Whilst participants were able to articulate the moral dimensions of their experiences, this language and conceptual understanding are not yet widely embedded within forensic services. Introducing accessible, reflective psychoeducation around moral injury could help to further validate these experiences, reduce internalized shame, and provide pathways for meaning making.

Therapeutically, approaches that support moral reintegration need to be further explored. Within the research, service users spoke of identity disruption highlighting how moral injury can fracture a person's sense of self which may complicate recovery. Therapy that allows for the integration of moral pain and not only focuses on skill development, but also considers wider issues including identity and moral distress, may help to promote a more compassionate and coherent self-understanding. There is also a need to consider the intersections between moral injury and risk. Moral distress, when unacknowledged or unresolved, may contribute to hopelessness, disconnection, and aggression (Frankfurt and Frazier 2016). Considering the links between moral injury and risk to self and others within formulations may enhance understanding of behavior and inform intervention strategies aimed at enhancing wellbeing.

Organizationally, the research highlights systemic factors that may compound moral injury, particularly the erosion of community and relational safety. Opportunities to foster prosocial relationships and operationalize moral values may strengthen relational safety, thus improving outcomes for both service users and professionals. Furthermore, moral injury should be considered a core component of trauma-informed care. Expanding the scope of trauma-informed care to incorporate moral injury recognizes the importance of ensuring existential threats in response to events that transgress moral beliefs are not overlooked and are equally considered within efforts to enhance wellbeing.

At a societal level, there is need to consider ways of promoting compassion and understanding in how we think about people who have offended. Public narratives often rely on punitive framings that obscure the moral complexity of human behavior and prevent meaningful reintegration, thus possibly deepening shame. As such, creating opportunities that recognize individual change, support social reintegration, and offer pathways for people to make meaningful contributions to society in the future may allow for a reparative process which could support wellbeing.

4.3. Implications for Future Research

The present findings are exploratory and suggest several directions for future research. First, there is a need to further disentangle moral injury from overlapping psychopathological processes—particularly the intersections between moral-injury-related guilt and shame, moral injury-specific cognitions, trauma-related cognitions associated with PTSD, and psychosis-related phenomena such as self-referential distortions. Mixed-methods or longitudinal designs, alongside the use of validated measures, may help clarify the extent to which these experiences represent distinct or interacting constructs.

Secondly, there is a need to develop and evaluate interventions that address moral injury within forensic settings. Such approaches should attend to the complex emotional, relational, and ethical dimensions of moral distress, and their relevance to identity, recovery, and rehabilitation.

Thirdly, while the present study focused on service users, it also highlighted experiences of moral and ethical struggle among practitioners. Further research exploring moral injury in forensic staff is warranted, particularly in relation to its impact on wellbeing, professional functioning, and therapeutic relationships.

Finally, future research should further explore the relationship between moral injury and risk. Understanding whether, and in what ways, unresolved moral distress influences risk behaviours could support more holistic approaches to risk assessment and management, and guide the development of interventions that work to reduce moral distress.

5. Conclusions

The findings of this research highlight the complexities of moral injury in a forensic sample. Cognitive and emotional changes were experienced, leading to disruptions in identity which impacted wellbeing and risk. Despite moral injury being particularly painful, the research highlighted pathways to healing that were fostered by relational attunement and opportunities to make sense of the impact of morally injurious events. This research highlights important implications for practice. These include the need to increase awareness of moral injury and embed this understanding within trauma-informed care practices, whilst enhancing opportunities for relational repair.

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Abbreviations

The following abbreviations are used in this manuscript:

PMIE	Potentially morally injurious experience
MP-IPA	Multi-perspective Interpretive Phenomenological Analysis

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