

RESEARCH ARTICLE

Mediating role of self-compassion in the relationship between morally injurious events and general mental health among South Korean Youth

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Abstract

Background: South Korean youth's strong emphasis on fairness and meritocracy, intensified during COVID-19, may have heightened exposure to morally injurious experiences arising from conflicts between personal values and societal constraints.

Objective: This study investigated the longitudinal associations between morally injurious events (MIEs) and mental health, and examined the mediating roles of self-compassion components among South Korean youth.

Methods: At Time 1, a total of 1,567 young adults aged 20–29 completed the Korean versions of the Moral Injury Events Scale, the Self-Compassion Scale, and the General Mental Health Questionnaire, along with demographic information. After nine months, 726 participants completed a follow-up online survey. Parallel mediation models with 10,000 bootstrap resamples were conducted to test whether six self-compassion subscales mediated the relationships between two types of MIEs—perceived transgressions and perceived betrayals—and general mental health at Time 2.

Results: Both perceived transgressions and perceived betrayals were significantly associated with all six self-compassion components, including positive (e.g., self-kindness, mindfulness, and common humanity) and negative (e.g., self-judgment, isolation, and over-identification) factors. Among these, self-judgment and isolation accounted for significant indirect associations between MIEs and poorer mental health, whereas the positive components did not show significant indirect effects.

Conclusion: Moral injury is associated with enduring adverse mental health outcomes among youth. The findings highlight that negative self-compassion components—particularly self-judgment and isolation—appear to represent key psychological pathways associated with moral distress and mental health outcomes. Interventions that cultivate self-compassion while reducing self-criticism and feelings of isolation may help mitigate the long-term psychological impact of moral injury among young people.

Keywords: Moral injurious event; Self-compassion; Mental health; Youth

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1. Introduction

Recently, South Korean society has been challenged by the distinct ways in which young people in their 20s respond to social events. Compared with earlier generations, they place greater emphasis on the value of “fairness” and tend to endorse highly competitive social norms, often perceiving policies that consider minority groups as unfair.¹ South Korean youths are deeply immersed in such meritocratic beliefs. During the COVID-19 pandemic, restrictions on personal freedoms further accentuated the tension between individual moral expectations and collective social responsibilities.

One factor that may help explain how South Korean youths respond to such social circumstances is the experience of morally injurious events (MIEs). The concept of moral injury originally emerged from research on soldiers who had participated in combat. In these contexts, individuals may commit or witness acts that violate their deeply held moral beliefs or standards (e.g., “Human beings should respect the lives of others”). Litz *et al.*^{2(p.697)} defined MIEs as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.” Importantly, moral injury does not arise solely from exposure to violence or harm but occurs when such experiences conflict with one’s moral values and expectations. Subsequent research has identified potential MIEs—such as committing, witnessing, or failing to prevent perceived moral transgressions, or experiencing betrayal by trusted leaders or institutions—as the core antecedents of moral injury. Building on extensive work with military veterans, Nash *et al.*³ categorized omissions and commissions under the broader construct of perceived transgressions, referring to immoral behaviors observed or perceived in oneself or others, while perceived betrayals denote experiences of betrayal by trusted others.

Moral injury also encompasses the enduring psychological, emotional, and spiritual distress that arises when one’s moral framework is violated. Such distress often manifests as guilt, shame, loss of trust, and difficulty maintaining a coherent sense of self and meaning. Although MIEs do not directly cause mental illness, they undermine individuals’ fundamental beliefs about themselves, others, and the world, thereby heightening vulnerability to a range of negative psychological outcomes. Previous studies have shown significant associations between MIEs and post-traumatic stress disorder symptoms,⁴ and suicidal ideation has been found to increase when moral injury co-occurs with post-traumatic stress disorder.⁵ Recent systematic reviews^{6–8} have further identified links between moral injury or morally injurious events and a wide range of adverse outcomes, including pain, sleep disturbance,

burnout, and other psychiatric symptoms. However, as Hall *et al.*⁷ noted, most of the reviewed studies were cross-sectional and focused primarily on military populations.

Griffin *et al.*⁶ proposed that the concept of moral injury should be extended beyond the military to general populations. A subsequent systematic review⁹ suggested that moral injury can lead to mental health problems across diverse occupational groups and age cohorts. Williamson *et al.*¹⁰ reported that during the COVID-19 pandemic, health professionals in various fields experienced moral injury while coping with ethical and systemic challenges in their workplaces. Importantly, recent validation studies have further demonstrated that moral injury can be reliably assessed in civilian populations, providing empirical support for extending moral injury research beyond military contexts.¹¹

Similarly, the pandemic likely influenced the moral injury experiences of South Korean youth, regardless of occupation. As this generation strongly adheres to particular moral values, the violation of those values during the pandemic was likely perceived more frequently as MIEs. Consequently, the extent of exposure to such experiences may contribute to adverse psychological outcomes. This study therefore aims to examine the longitudinal relationship between MIEs and mental health among non-clinical South Korean youth and to identify psychological factors that may buffer or exacerbate these effects. In a prior study with non-clinical adults in South Korea, experiences of moral injury were significantly correlated with general mental health and depression.¹²

Given these negative consequences, recent research has focused on identifying protective factors that may alleviate the psychological impact of MIEs. Among these, self-compassion has emerged as a key construct that mitigates the detrimental effects of stress and trauma on mental health. Neff¹³ conceptualized self-compassion as comprising three positive components (self-kindness, mindfulness, and common humanity) and three negative components (self-judgment, over-identification, and isolation), each representing opposite poles of a continuum. Building on this foundational framework, a recent comprehensive review has synthesized over two decades of research, highlighting self-compassion as a robust psychological resource that promotes emotional resilience, adaptive coping, and mental health across diverse populations and contexts.¹⁴

Importantly, the six components of self-compassion are not interchangeable indicators of a single trait but represent qualitatively distinct ways of relating to oneself in the face of suffering. Accumulating evidence suggests that negative components, such as self-judgment and

isolation, are more strongly and consistently associated with psychological distress than positive components.¹⁵ Furthermore, improvements in mental health appear to be more closely related to reductions in self-critical and isolating tendencies than to increases in self-kindness alone.^{16,17} In the context of MIEs—often marked by guilt, shame, and moral self-condemnation—specific self-compassion components may serve as proximal psychological mechanisms linking moral distress to later mental health outcomes. Accordingly, examining all six subscales as parallel mediators enables a more fine-grained identification of the self-relational processes most relevant to moral injury-related adjustment, enhancing both conceptual clarity and clinical applicability.

Studies of non-clinical populations have demonstrated multiple beneficial functions of self-compassion: it reduces negative self-evaluation,¹⁵ facilitates coping with acute and chronic stress,¹⁸ and promotes well-being both cross-sectionally¹⁹ and longitudinally.²⁰ Notably, self-compassion enhances emotional stability and overall mental health,²¹ reducing depression and anxiety over time.¹⁶ Among its components, mindfulness has been found to decrease depression and anxiety even over a two-year period.^{22,23}

The role of self-compassion has also been documented among veterans exposed to MIEs. Specifically, empirical research with military personnel has shown that self-compassion moderates the impact of MIEs on depressive symptoms.²⁴ Considering these findings, self-compassion may also alleviate the suffering caused by MIEs in broader non-clinical populations. While earlier studies often regarded self-compassion as a moderator,²⁵ subsequent studies have supported its mediating role, particularly among non-clinical groups such as college students. Self-compassion has been found to mediate the associations between psychosocial stress and behavioral responses,²⁶ childhood maltreatment and emotional regulation difficulties in adulthood,²⁷ and attachment and both depression and quality of life.¹⁶ Notably, studies examining individual subcomponents of self-compassion have revealed differential mediating effects across components.

Based on South Korean youths' sensitivity to fairness and their potential exposure to moral injury arising from social inequalities or systemic constraints during the COVID-19 pandemic, this study sought to clarify the consequences of MIEs as perceived by South Korean youth and to identify mediating psychological mechanisms. The specific aim was to determine whether MIEs exert negative longitudinal effects on mental health and to elucidate the distinct mediating roles of each self-compassion component.

2. Methods

2.1. Participant recruitment and data collection procedure

The first online survey was conducted in December 2020, and the second in September 2021. An online link to participate was distributed to young adults in South Korea aged 20–29 years. At Time 1, participants were informed that a follow-up survey (Time 2) would be conducted several months later and that participation was voluntary. At Time 1, the Korean versions of the Moral Injury Events Scale, the Self-Compassion Scale, and the General Mental Health Questionnaire (K-GMHQ, also referred to as KGHQ-20) were administered to participants who provided informed consent. Participants also reported their gender, age, and education level. Approximately nine months later, the K-GMHQ was re-administered to those who agreed to participate at Time 2. Data were collected from 1,567 participants at Time 1 and 726 participants at Time 2. Participants' personal contact information was not collected; information related to consent, item responses, and survey completion time was retained.

2.2. Ethical considerations

All procedures were approved by the Institutional Review Board of Honam University prior to data collection. Ethical approval for the initial data collection was obtained on July 26, 2019 (IRB No. 1041223-201907-HR-08), and additional ethical approval for subsequent data collection was obtained on August 13, 2021 (IRB No. 1041223-202108-HR-12). All procedures were conducted in accordance with the 1964 Helsinki Declaration and its later amendments. Because the study was conducted using an online survey, informed consent was obtained electronically from all participants prior to participation. All responses were collected anonymously, and no personally identifiable information was obtained. Anonymity and confidentiality were fully maintained throughout the study.

2.3. Measures

2.3.1. The moral injury events scale

Exposure to MIE experiences was measured using the Korean version of the Moral Injury Events Scale, standardized by Jang.¹² Participants answered nine items on a six-point Likert scale (1 = “strongly disagree” to 6 = “strongly agree”). The scale comprises two subscales, and its composition and content were consistent with those of the original scale. Cronbach's α values for the six items of perceived transgressions (e.g., “I saw things that were morally wrong”) and the three items of perceived betrayals (e.g., “I feel betrayed by leaders who I once trusted”) were 0.89 and 0.87, respectively.

2.3.2. The self-compassion scale

Self-compassion was measured using the Korean version of the Self-Compassion Scale, standardized by Kim *et al.*²⁸ Participants answered 26 items on a five-point Likert scale (1 = “almost never” to 5 = “almost always”). The scale comprises six subscales, and its composition and content were consistent with those of the original scale. Cronbach’s α values for self-kindness (e.g., “I try to be loving toward myself when I am feeling emotional pain”); common humanity (e.g., “When things are going badly for me, I see the difficulties as part of life that everyone goes through”); mindfulness (e.g., “When something upsets me I try to keep my emotions in balance”); self-judgment (e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”); isolation (e.g., “When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world”); and over-identification (e.g., “When I am feeling down I tend to obsess and fixate on everything that is wrong”) were 0.82, 0.81, 0.81, 0.86, 0.86, and 0.86, respectively. Mean scores were computed for the six subscales, with higher scores reflecting greater positive or negative self-compassion depending on subscale valence.

2.3.3. The general mental health questionnaire

Mental health was measured using the KGHQ-20, standardized and simplified by Shin.²⁹ This scale comprises 20 items (e.g., “In the last two or three weeks, were you able to concentrate on what you were doing?”), scored on a four-point Likert scale (0 = “strongly disagree” to 3 = “strongly agree”). The total score of the items was calculated and used for analysis, and Cronbach’s α values were 0.90 at Time 1 and 0.90 at Time 2.

2.4. Analyses

Data analysis was conducted using SPSS software (version 24.0, IBM Corp., USA). Hayes’ PROCESS macro (version 4.3) for SPSS was used to conduct mediation (Model 4) and moderation (Model 1) analyses with 10,000 bootstrap resamples to generate 95% bias-corrected confidence intervals for indirect effects. All variables were mean-centered prior to analysis, and gender and baseline general mental health (Time 1) were included as covariates because they were significantly associated with the primary predictors and the outcome. Multicollinearity was examined using variance inflation factors and tolerance values; all variance inflation factors were below 5, and tolerance values exceeded 0.20, indicating that multicollinearity was not a significant concern in the present analyses. Parallel multiple-mediation models were tested to include the six self-compassion subscales at Time 1 as potential mediators. Two models examined the hypothesized indirect effects of

perceived transgressions and perceived betrayals (Time 1) on general mental health (Time 2) through the six self-compassion subscales. Additionally, the moderating effects of the six self-compassion subscales at Time 1 on general mental health at Time 2 were tested.

3. Results

3.1. Participant characteristics

Table 1 presents participants’ demographic characteristics. Mean K-GMHQ scores were similar at Times 1 and 2. The means of the six self-compassion components ranged from 2.51 to 2.75 (out of 5) at Time 1. Participants who did not complete Time 2 ($n = 841$) were younger, included a higher proportion of men, and showed higher levels of mindfulness and common humanity than those who completed Time 2 ($n = 726$).

3.2. Correlations between variables

Table 2 shows the correlations among all variables. At Time 1, both perceived transgressions and perceived betrayals were negatively correlated with general mental health. The three positive components of self-compassion were positively correlated with general mental health, although one correlation did not reach statistical significance. In contrast, the three negative components of self-compassion were negatively correlated with general mental health. The six self-compassion components were significantly and positively correlated with both MIE components. Regarding covariates, only gender was included because it showed a small but significant correlation with the primary variables.

3.3. Mediation of self-compassion between morally injurious events and general mental health

When perceived transgressions were included in the mediational model, the significant total effect ($\beta = -0.17$, $t = 5.69$, $p < 0.001$) remained significant. It had a significant direct effect on the six types of self-compassion cross-sectionally ($\beta = -0.10$, $t = 3.21$, $p < 0.01$). Perceived transgressions had significant indirect effects via self-judgment and isolation. Additionally, general mental health at Time 1 was a significant covariate.

Regarding perceived betrayals by others, the significant total effect ($\beta = -0.17$, $t = 5.59$, $p < 0.001$) remained significant (direct effect: $\beta = -0.11$, $t = 3.40$, $p < 0.01$). Other analyses followed procedures similar to those conducted with perceived transgressions as the independent variable (Figure 1 and Table 3). Accordingly, complete path coefficients and explained variance (R^2) for all mediation and moderation models are reported in Tables 4 and 5 to ensure analytical transparency and facilitate comparison

Table 1. Sample characteristics ($n = 726$)

Sample characteristic	Mean (SD), range	n (%)
Age (years) (T1)	25.70 (2.55), 20–29	-
Gender		
Female	-	411 (56.6)
Male	-	315 (43.4)
Education level (T1)		
<University	-	196 (27.0)
Four or more years of university	-	530 (73.0)
General mental health (T1)	31.72 (9.09), 3.00–60.00	-
General mental health (T2)	31.79 (12.44), 1.00–60.00	-
Perceived transgressions (T1)	2.15 (1.04), 1.00–6.00	-
Perceived betrayals (T1)	2.11 (1.21), 1.00–6.00	-
Self-kindness (T1)	2.51 (0.82), 1.00–5.00	-
Mindfulness (T1)	2.70 (0.87), 1.00–5.00	-
Common humanity (T1)	2.67 (0.86), 1.00–5.00	-
Self-judgment (T1)	2.52 (0.92), 1.00–5.00	-
Isolation (T1)	2.52 (1.01), 1.00–5.00	-
Over-identification (T1)	2.75 (0.95), 1.00–5.00	-

Note: T1 indicates Time 1, whereas T2 indicates Time 2.
Abbreviation: SD: Standard deviation.

across models.

3.4. Test of moderation of self-compassion

Moderation models were tested, and all interaction terms predicting mental health were non-significant. Thus, no evidence was found for self-compassion as a moderator.

4. Discussion

4.1. Morally injurious events and their longitudinal consequences

South Korean youth, known for their heightened sensitivity to fairness, often reacted sharply to perceived injustices

during the COVID-19 pandemic. Based on this tendency, the present study hypothesized that MIEs would negatively affect their mental health—a prediction supported by the findings.

Compared with the Western sample of Nash *et al.*³ (MIE means of 2.13 for perceived transgressions and 1.92 for perceived betrayals), the present study reported slightly higher values (2.15 and 2.11, respectively). This difference suggests that social inequalities and institutional disappointments during the pandemic may have heightened feelings of betrayal among South Korean youth who felt let down by the systems they trusted.

Table 2. Zero-order correlations between variables ($n = 726$)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1 General mental health (T2)	1.00	-	-	-	-	-	-	-	-	-	-	-	-
2 General mental health (T1)	0.62***	1.00	-	-	-	-	-	-	-	-	-	-	-
3 Perceived transgressions (T1)	-0.20***	-0.28***	1.00	-	-	-	-	-	-	-	-	-	-
4 Perceived betrayals (T1)	-0.17***	-0.27***	0.66***	1.00	-	-	-	-	-	-	-	-	-
5 Self-kindness (T1)	0.12**	0.29***	0.24***	0.25***	1.00	-	-	-	-	-	-	-	-
6 Mindfulness (T1)	0.14***	0.32***	0.16***	0.19***	0.73***	1.00	-	-	-	-	-	-	-
7 Common humanity (T1)	0.09*	0.13***	0.17***	0.24***	0.65***	0.68***	1.00	-	-	-	-	-	-
8 Self-judgment (T1)	-0.50***	-0.49***	0.35***	0.32***	0.02	0.08*	0.17***	1.00	-	-	-	-	-
9 Isolation (T1)	-0.54***	-0.57***	0.35***	0.33***	0.05	-0.02	0.10**	0.75***	1.00	-	-	-	-
10 Over-identification (T1)	-0.46***	-0.52***	0.29***	0.28***	0.00	-0.05	0.13***	0.79***	0.79***	1.00	-	-	-
11 Gender	-0.09*	-0.10***	-0.17***	-0.18***	-0.15***	-0.19***	-0.10**	0.03	0.06	0.15**	1.00	-	-
12 Age (T1)	-0.04	-0.04	0.05	0.14***	0.05	0.03	0.05	0.02	0.06	0.02	-0.05	1.00	-
13 Education	0.05	0.04	0.02	0.04	0.06	0.05	0.09	-0.01	0.03	0.01	0.06	0.51***	1.00

Notes: "T1" indicates Time 1, whereas "T2" indicates Time 2. * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$ indicate statistical significance.

Both perceived transgressions and perceived betrayals were linked to poorer mental health cross-sectionally and longitudinally, consistent with prior research showing that exposure to morally injurious experiences predicts depression, anxiety, and post-traumatic stress.^{2,5} These findings are further supported by recent evidence syntheses indicating that moral injury-related outcomes are robustly associated with depression, post-traumatic stress, and other adverse mental health indicators across diverse studies and measurement approaches.⁸ Moral injury appears to erode moral integrity and coherence, leading to guilt, shame, and diminished resilience. The sustained decline in mental health observed nine months later suggests that moral injury may function as a chronic, rather than transient, stressor.

In collectivist cultures such as South Korea, where moral

expectations emphasize harmony and duty, experiences of betrayal or moral failure may intensify self-blame and internal conflict. This cultural context may help explain why morally injurious events are associated with sustained poorer mental health among South Korean youth.

4.2. Mediating role of self-compassion

This study examined whether self-compassion functioned as a mediator or moderator between MIEs and mental health. No significant moderating effects were found; however, several components demonstrated meaningful mediating roles, supporting previous findings²¹⁻²³ and the current hypotheses.

Among the six subcomponents, self-judgment and isolation—the negative dimensions of self-compassion—significantly mediated the longitudinal relationship

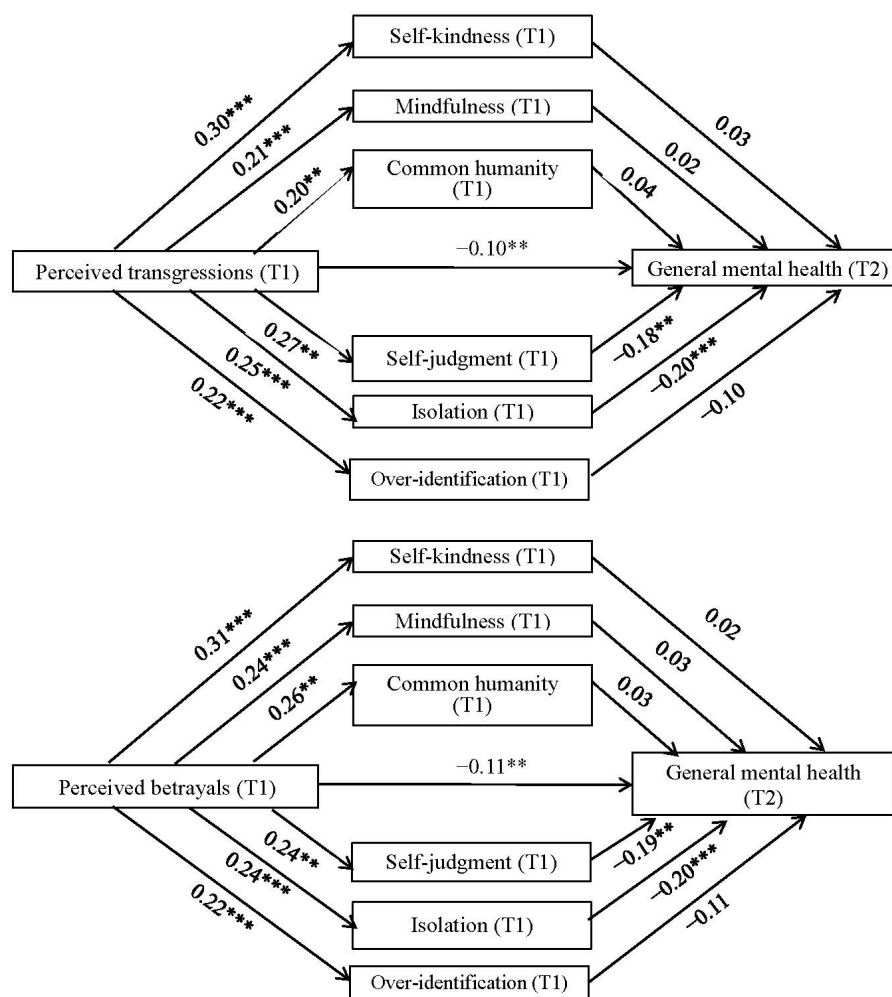


Figure 1. Standardized regression coefficients from the mediation model testing the effects of morally injurious events on general mental health through self-compassion. All models were adjusted for gender and general mental health at Time 1.

Notes: "T1" indicates Time 1, whereas "T2" indicates Time 2. ** $p < 0.01$ and *** $p < 0.001$ indicate statistical significance.

between MIEs and mental health. Although the mediating effect of over-identification was non-significant, its indirect influence was greater than that of the other positive components. Consistent with Brophy *et al.*,¹⁶ psychological distress appears to lessen as these negative self-compassion factors decrease, rather than solely through increases in positive ones. This pattern is consistent with recent evidence indicating that negative (reversed) components of self-compassion are more strongly and consistently associated with anxiety and depressive symptoms than positive components, particularly among adolescents and young adults.¹¹

These results underscore the potential value of self-compassion-based interventions in alleviating the long-term consequences of moral injury. Because moral injury

disrupts an individual's moral identity, interventions that address only cognitive distortions or behavioral symptoms may not fully capture its moral and emotional dimensions. Cultivating a compassionate stance toward the self can promote acceptance and emotional balance. Approaches such as compassion-focused therapy³⁰ or mindful self-compassion training³¹ may be particularly beneficial for young people experiencing strong self-judgment or isolation after morally distressing events.

In collectivist cultures such as South Korea, moral experiences are often interpreted through relational and role-based frameworks that emphasize harmony and responsibility to others. Within this context, morally injurious events may intensify self-judgment, as moral failure can threaten one's relational identity rather than

Table 3. Direct and indirect effects of self-compassion subcomponents ($n = 726$)

Variable	β	t	p	95% confidence interval
Perceived transgressions (T1) → mediators (T1) → outcome (T2)				
Indirect effect of self-kindness (T1)	0.01	8.63 ^b , 0.66 ^c	<0.001 ^b , 0.512 ^c	[−0.02, 0.04]
Indirect effect of mindfulness (T1)	0.00	5.85 ^b , 0.50 ^c	<0.001 ^b , 0.624 ^c	[−0.01, 0.02]
Indirect effect of common humanity (T1)	0.01	5.32 ^b , 0.90 ^c	<0.001 ^b , 0.378 ^c	[−0.02, 0.02]
Indirect effect of self-judgment (T1) ^a	−0.05	8.28 ^b , 3.46 ^c	<0.001 ^b , <0.001 ^c	[−0.08, −0.02]
Indirect effect of isolation (T1) ^a	−0.05	8.25 ^b , 3.88 ^c	<0.001 ^b , <0.001 ^c	[−0.08, −0.02]
Indirect effect of over-identification (T1)	−0.02	6.72 ^b , 1.88 ^c	<0.001 ^b , 0.062 ^c	[−0.05, −0.00]
Perceived betrayals (T1) → mediators (T1) → outcome (T2)				
Indirect effect of self-kindness (T1)	0.01	8.68 ^b , 0.50 ^c	<0.001 ^b , 0.625 ^c	[−0.02, 0.04]
Indirect effect of mindfulness (T1)	0.01	6.78 ^b , 0.59 ^c	<0.001 ^b , 0.559 ^c	[−0.01, 0.03]
Indirect effect of common humanity (T1)	0.01	7.08 ^b , 0.66 ^c	<0.001 ^b , 0.511 ^c	[−0.01, 0.03]
Indirect effect of self-judgment (T1) ^a	−0.05	7.32 ^b , 3.67 ^c	<0.001 ^b , <0.001 ^c	[−0.08, −0.02]
Indirect effect of isolation (T1) ^a	−0.05	7.66 ^b , 3.90 ^c	<0.001 ^b , <0.001 ^c	[−0.08, −0.02]
Indirect effect of over-identification (T1)	−0.02	6.73 ^b , 2.01 ^c	<0.001 ^b , <0.05 ^c	[−0.05, 0.00]

Notes: ^aSignificant indirect effect. ^b t -test of predictor and mediator. ^c t -test of mediator and outcome. “T1” indicates Time 1, whereas “T2” indicates Time 2.

being experienced solely as an individual shortcoming. Isolation may also be particularly salient, as youth may withdraw socially due to shame or concerns about burdening others, which can amplify internal distress instead of promoting shared coping. In addition, perceived betrayal may be experienced as a violation of moral trust embedded in social roles or institutions, eliciting guilt and shame alongside anger. Together, these cultural dynamics suggest that interventions in collectivist contexts should explicitly address moral emotions and relational meaning-making, supporting processes of moral repair rather than focusing solely on symptom reduction.

4.3. Other implications

Previous studies have shown that self-compassion tends to be lower in women¹³ and increases with age.³² This gender difference has been attributed to women's greater tendency toward depression and rumination.¹⁵ In contrast, no significant differences were observed by education or age in the present study, likely because all participants were in their 20s, resulting in limited age variability.

The general increase in self-compassion with age may help explain the positive correlations observed between MIEs and both positive and negative self-compassion

components. Consistent with this interpretation, Jang¹⁷ found positive associations between MIEs and self-compassion among South Korean youth. These findings may reflect how young people respond when confronted with distressing moral situations: positive elements such as self-kindness and mindfulness are activated to maintain emotional balance, while negative tendencies such as self-judgment and isolation also rise as they attribute responsibility for the events to themselves or others. Consequently, the coexistence of these opposing reactions may reflect a more complex and conflicted self-compassion profile among young adults compared with older individuals.

In addition, the present findings align with recent mental health policies that emphasize social connection and relational support over individual isolation. Given that MIE experiences among young adults are associated with heightened feelings of isolation alongside self-critical tendencies, intervention models that promote interpersonal connectedness—such as peer-based support programs, community engagement initiatives, and relationally oriented counseling services—may be particularly effective in mitigating the negative dimensions of self-compassion while reinforcing adaptive coping.

Table 4. Path coefficients and explained variance (R^2) for the mediation model of perceived transgression

Variable	Predictor	β	t	p	R^2
Self-kindness (T1)	Perceived transgressions (T1)	0.30	8.63	<0.001	0.18
Mindfulness (T1)	Perceived transgressions (T1)	0.21	5.85	<0.001	0.16
Common humanity (T1)	Perceived transgressions (T1)	0.20	5.32	<0.001	0.06
Self-judgment (T1)	Perceived transgressions (T1)	0.27	8.28	<0.001	0.31
Isolation (T1)	Perceived transgressions (T1)	0.25	8.25	<0.001	0.38
Over-identification (T1)	Perceived transgressions (T1)	0.22	6.72	<0.001	0.32
General mental health (T2)	Self-kindness (T1)	0.03	0.66	0.51	0.46
	Mindfulness (T1)	0.02	0.50	0.62	
	Common humanity (T1)	0.04	0.90	0.37	
	Self-judgment (T1)	-0.18	-3.46	<0.001	
	Isolation (T1)	-0.20	-3.88	<0.001	
	Over-identification (T1)	-0.10	-1.88	0.06	
	General mental health (T1)	0.44	11.77	<0.001	
	Gender	-0.03	-0.54	0.59	

Note: "T1" indicates Time 1, whereas "T2" indicates Time 2.

Table 5. Path coefficients and explained variance (R^2) for the mediation model of perceived betrayal

Variable	Predictor	β	t	p	R^2
Self-kindness (T1)	Perceived betrayals (T1)	0.31	8.68	<0.001	0.18
Mindfulness (T1)	Perceived betrayals (T1)	0.24	6.78	<0.001	0.17
Common humanity (T1)	Perceived betrayals (T1)	0.26	7.08	<0.001	0.09
Self-judgment (T1)	Perceived betrayals (T1)	0.24	7.32	<0.001	0.29
Isolation (T1)	Perceived betrayals (T1)	0.24	7.66	<0.001	0.37
Over-identification (T1)	Perceived betrayals (T1)	0.22	6.73	<0.001	0.32
General mental health (T2)	Self-kindness (T1)	0.02	0.50	0.62	0.46
	Mindfulness (T1)	0.03	0.59	0.55	
	Common humanity (T1)	0.03	-0.66	0.51	
	Self-judgment (T1)	-0.19	-3.68	<0.001	
	Isolation (T1)	-0.20	-3.90	<0.001	
	Over-identification (T1)	-0.11	-1.90	0.06	
	General mental health (T1)	0.44	11.74	<0.001	
	Gender	-0.04	-0.62	0.54	

Note: "T1" indicates Time 1, whereas "T2" indicates Time 2.

4.4. Limitations and future directions

This study has several limitations. First, this study focused on MIEs experienced by non-clinical youth in everyday contexts rather than by veterans exposed to combat. Thus, the type, frequency, and intensity of MIEs likely varied across individuals but were not specifically identified.

Second, because MIEs and self-compassion were measured concurrently, the observed findings should be interpreted as mediated associations consistent with a mediation model rather than as evidence of a temporally ordered or causal mediation process. Accordingly, the associations may partly reflect shared variance among these variables, and future longitudinal studies with temporally separated assessments are needed to clarify directionality. In addition, the nine-month interval between the assessments of MIEs, self-compassion, and mental health outcomes warrants careful consideration when interpreting the longitudinal relationships. Although this interval was selected to examine meaningful psychological change over time, it may not fully capture more immediate or short-term dynamic processes linking these constructs.

Moral injury and self-compassion are generally conceptualized as relatively stable psychological processes that evolve gradually rather than as rapidly fluctuating momentary states,³³ which provides some justification for the chosen design. Nevertheless, future studies employing multiple assessment points with varying intervals would be better positioned to capture more fine-grained temporal dynamics and to disentangle reciprocal and nonlinear relationships among moral injury, self-compassion, and mental health.

Third, several potentially important confounding factors were not included in the present study and should be considered when interpreting these findings. Specifically, unmeasured socioeconomic stressors (e.g., financial instability, employment disruption) and COVID-19-related exposures (e.g., infection experiences, quarantine duration, loss of significant others) may have influenced both moral injury experiences and levels of self-compassion. These contextual stressors were particularly salient during the pandemic and may have contributed to individual differences in psychological adjustment beyond the variables assessed in this study. Although the primary focus was on the longitudinal association between moral injury, self-compassion, and mental health, the absence of these factors limits the ability to fully parse their independent and interactive effects. Future research would benefit from incorporating broader contextual and structural stressors to provide a more comprehensive understanding of the mechanisms underlying moral injury-related psychological outcomes.

Finally, the attrition rate between Time 1 and Time 2 was relatively high. Attrition analyses showed that non-completers were younger, more likely to be men, and reported higher levels of mindfulness and common humanity at baseline, indicating non-random dropout. Although these differences were considered in interpreting the results, attrition may still have affected sample representativeness and statistical power. Therefore, future longitudinal studies should prioritize strategies to minimize attrition and to enhance sample representativeness, such as employing shorter assessment intervals, targeted retention efforts for high-risk subgroups, or analytic approaches that explicitly model non-random dropout. Accordingly, the substantial attrition between Time 1 and Time 2 warrants additional caution in interpreting the present findings, particularly with regard to their generalizability and robustness.

5. Conclusion

In conclusion, this study suggests that moral injury is associated with enduring youth mental health outcomes, and that the manner in which individuals relate to themselves—with compassion or self-condemnation— influences whether these moral wounds are linked to persistent distress or recovery.

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Conflict of interest

The author declares no competing interests.

Author contributions

This is a single-authored article. The author approved the final version of the manuscript and agrees to be accountable for all aspects of the work.

Ethics approval and consent to participate

The study adhered to all relevant ethical guidelines for research involving human participants, including institutional, national, and international standards. The author conducted all procedures involving human participants in accordance with the ethical standards of the institutional research committee of Honam University. Ethical approval for the initial data collection was obtained on July 26, 2019 (IRB No. 1041223-201907-HR-08), and additional ethical approval for the subsequent data collection was obtained on August 13, 2021 (IRB

No. 1041223-202108-HR-12). All procedures were also conducted in accordance with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Because data were collected through an online survey, informed consent was obtained electronically from all participants prior to participation. All survey responses were collected anonymously, and no personally identifiable information was obtained. Anonymity and confidentiality were fully guaranteed.

Consent for publication

All participants consented to the publication of their anonymized data for academic purposes.

Availability of data

Data supporting the findings of this study are not publicly available due to ethical restrictions but are available from the corresponding author upon reasonable request for academic purposes only.

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