Moral Distress in Acute Psychiatric Nursing

An insider perspective of sources, responses and ways of coping.

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Trine-Lise Jansen

Preface

"For my part, being part of a system I find to be inadequate makes my ethical anguish grow day by day." (Nurse interviewee)

Nurses working within acute psychiatric settings – that is, giving treatment and care during an acute phase of mental illness – often find themselves facing multifaceted moral dilemmas and incompatible demands. Moreover, within the field of psychiatry there are ideological and professional differences which may lead to professional, ethical, and personal dilemmas in the carer. Furthermore, structural changes, economic restrictions, and a growing criticism of the use of coercion/restraints and of psychiatric treatment in general creates the risk of pangs of conscience and moral distress among the healthcare staff. Any and all of these factors may cause moral distress.

My dissertation is a contribution to a deeper understanding of how moral distress is experienced and coped with by nurses working within acute psychiatric nursing care. I wish to contribute to the conversation about this phenomenon within a field where only a limited number of studies so far has been published. By highlighting moral distress in the context of acute psychiatric nursing my hope is that moral distress will be more readily addressed. This may support nurses in the field and through this improve the mental health care offered a vulnerable group of patients.

The text is written with British English spelling. Hence, the sparse use of letter z – except where quoted authors have utilised other kinds of English language spelling.

Summary

The main objective for this thesis is to describe and discuss moral distress as experienced by nurses working in acute psychiatric settings. Providing care to acutely mentally ill patients is demanding as nurses are confronted with multifaceted challenges and ethical dilemmas on a daily basis. Among these are dilemmas re prioritising, for instance who needs the nurses' attention more when a lot is going on in the patient group, varied understanding of the degree of illness, and patients' disagreeing with their diagnosis and treatment. Reorganisations, economic restrictions, growing criticism of the use of restraints and psychiatric treatment in general, all increase the danger of pangs of conscience and moral distress among the staff. Even so, there exists limited knowledge about how nurses working in acute psychiatric contexts experience and cope with moral distress. The four papers presented in this thesis collectively answer the dissertation's overarching research question: How do nurses perceive the moral distress they face working with acute psychiatric patients and how do they cope with this experience?

In an introductory study (Paper I) healthcare workers' understanding of the concept of patient participation and why the ideal of patient participation may create moral distress in psychiatric healthcare workers are explored. In Paper II sources of moral distress and what characterises moral distress in acute psychiatric care nursing settings are described. How nurses working in acute psychiatric settings attempt to cope when in moral distress, is focused in Paper III. Finally, in Paper IV is explored whether the ideal of reduced use of restrictive and coercive treatments within mental health care may lead to moral distress, and if so, in what way this may lead to moral distress.

The entire study has a qualitative design. Methods used were in-depth interviews with a total of 16 nurses (Papers II-IV) and focus group interviews (Papers I, III and IV) with a total of 23 nurses. The results presented in Paper III and IV is based on both in-depth interviews and focus group interviews. As three of the nurses participated in both individual interviews and focus group interviews, the total of registered nurses interviewed is 36 representing three hospitals in the south-eastern part of Norway. A Gadamer-inspired hermeneutic thematic analysis was chosen for the analysis of the interview texts.

A central finding is that the interviewees face multifaceted ethical dilemmas, and incompatible demands which combined with their proximity to the patient's suffering make nurses exposed to moral distress, not the least as it often is difficult or impossible to know what the right cause of action is.

Insufficient resources, mentally poorer patients, and quicker discharges lead to superficial treatment. Few staff on evening shifts/weekends make nurses worry about the quality of the follow-up of the most ill, like suicidal patients, or of those with heightened risk of violence. Coercive treatment measures that might be avoided if adequately staffed, and resistance to the use of coercion, are all morally stressful circumstances, and the provision of good care when exposed to violence is physically, emotionally, and morally challenging. The moral challenges are acerbated or coloured by contemporary discussions, trends, and therapeutic, political, and ethical ideals within the field. Psychiatric nurses working in acute psychiatric care are involved in a complex interplay between political and professional ideals to reduce the use of coercion while being responsible for the safety of both patients and staff as well as creating a therapeutic atmosphere. The interviewees found that the aim to reduce the use of coercion exposed some patients to greater risk of violence. External constraints like inadequate resources may furthermore hinder the healthcare workers/nurses from realising the treatment ideals set before them.

The nurses' moral sensitivity seems to be both a premise for and cause of moral distress although they held divergent views and had different experiences of moral concerns. Feelings of inadequacy, being squeezed between ideals and clinical reality, and failing the patients, create moral distress. Moral distress causes bad conscience and feelings of guilt, shame, frustration, anger, sadness, inadequacy, mental tiredness, emotional numbness, and feeling fragmented. Others feel emotionally 'flat', cold, and empty, and develop high blood pressure and problems sleeping. Moral distress may lead to reduced quality care, which again may generate a bad conscience and cause moral distress.

The impression is that loyalty to doctors' orders, to the 'system', and to the current treatment philosophy is stronger than a regard for the nurses' own conscience, their role as patient advocates, and in some cases also for a safe and therapeutic environment. The interviewees attempted to cope with their moral distress in various ways, for instance mentally sorting

through their ethical dilemmas or bringing them to the leadership, not "bringing problems home" after work, or loyally doing as they were told and trying to make themselves immune. Not facing their moral distress seemed to come at a high price. Based on the empirical findings, the rationale behind a broader definition of the concept of moral distress is presented in which caregivers face moral dilemmas or experience moral doubt is included.

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List of publications

A brief overview of this dissertation's papers is presented in Table 1. The papers will in this text be referred to by their roman numerals given below:

Table 1. The dissertation's papers; authors, title, and where published.

	Authors	Paper title	Journal
Paper I*	Trine-Lise Jansen, Ingrid Hanssen	Patient participation: causing moral stress in psychiatric nursing?	Scandinavian Journal of Caring Sciences, 2017; 31(2): 388-394
Paper II	Trine-Lise Jansen, Marit Helene Hem, Lars Johan Danbolt, Ingrid Hanssen	Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands	Nursing Ethics, 2020; 27(5): 1315-1326
Paper III	Trine-Lise Jansen, Marit Helene Hem Lars Johan Danbolt, Ingrid Hanssen	Coping with moral distress on acute psychiatric wards: A qualitative study	Nursing Ethics, 2022; 29(1):171-180
Paper IV	Trine-Lise Jansen, Lars Johan Danbolt, Ingrid Hanssen, Marit Helene Hem	How may cultural and political ideals cause moral distress in acute psychiatry? A qualitative study	BMC Psychiatry, 2022 Published 23. March

* In Paper 1 there is a misprint on page 388: "quantitative" instead of "qualitative" study. This misprint was pointed out to the journal's representative before the paper was printed but was unfortunately not corrected.

List of tables

Table 1. The dissertation's papers; title, authors and where published.

Table 2. Initial literature research at the start of the main project.

Table 3. An overview of the interviewees' education and psychiatric nurse experience.

1. Introduction

In this dissertation moral distress as experienced by nurses working in acute psychiatric units are presented and discussed. Acute psychiatric units are specialised places for persons needing voluntary or involuntary short-term treatment during an *acute* phase of mental illness. Admission to such units depends on the severity of the mental symptoms, the person's level of distress, and the risk of harm to self or others (health.gov.mt., 2020). A significant proportion of the patient population is involuntarily committed (Helsedirektoratet, 2018; 2020, compiled from sevral sources), and coercion is in general more utilised in acute psychiatric units than in other in-patient psychiatric wards (Paradis-Gagné et al., 2021).

Providing psychiatric care to patients in acute care settings is demanding both from a psychological and a moral perspective. The patients tend to be at their most vulnerable (Tveitstul et al., 2020) and their mental state may be grave, for instance with a high risk of suicide. Caring for these patients calls for a high level of empathy and the ability to give emotional support, while at the same time to be alert to the fact that challenging situation may arise at any time and the nurses are quite often subjected to aggressive behaviours from patients. Thus, the nurses are daily confronted with multifaceted ethical challenges. Among these are the use of coercive or restraining means and treatment, dilemmas re prioritising, for instance who needs the nurses' attention more when a lot is going on in the patient group, differences in opinion and understanding of the degree of illness, and patients' disagreeing with their diagnosis and treatment. Shehadeh et al. (2022, p. 1) point out that "[i]n order to understand the relationship between moral distress and mental health practices, one must recognize that mental health practitioners use therapeutic self as the primary tool. Thus, their moral system would affect their conduct and decision related to the care of their patients."

This dissertation contributes to deeper insight into a field of nursing where there currently exists limited knowledge about how nurses who work in an acute psychiatric context experience and cope with moral distress. Scientifically my research is situated within the field of nursing ethics. Exploring moral distress and ways of coping can lead to the knowledge necessary to understand what kinds of support, skills, structure etc. are needed for nurses to find strategies that can mitigate the negative effects of moral distress.

1.1 Background

My interest in moral challenges in acute psychiatric care is shaped by having worked several years as a psychiatric nurse in this field. As a nurse I have been concerned with how healthcare personnel experience and cope with the moral/ethical challenges they face in their clinical practice. The concept and phenomenon of moral distress resonated with experiences I recognised within myself and others.

I have only been able to find a small number of studies that illuminate the experiences of moral distress in nurses and other healthcare personnel within psychiatric care either in a Norwegian context or internationally (Table 2). According to Austin et al. (2003, p. 179), "the topic of moral distress is underserved in psychiatric discourse". This in spite of that "few solutions have been proposed for alleviating a problem that is only expected to escalate as healthcare becomes more complex" (Rushton et al., 2017a, p. 55). In line with this, various interview studies of mental healthcare workers indicate that the challenges within acute psychiatric care are escalating (Paper II, Alfarnes, 2021; Wyder et al., 2017; Øvrebø, 2018). Another theme that is sparingly investigated is how nurses in acute psychiatric care cope when repeatedly being exposed to moral distress in their clinical practice. Thus, these are research areas where my study adds empirical and theoretical knowledge.

The project has developed in stages:
Stage 1. I was invited by nurses on a subacute psychiatric hospital ward in South-Eastern Norway to help them study how to accommodate for patient participation as they saw this as an ever-present ethical challenge. Patient participation is part of patients' autonomy and is a formal right as well as a therapeutic tool (Seljelid, 2016; Skjeldal, 2021). It is a problem, however, that guidelines for and descriptions of patient participation in clinical practice are rather diffuse, not the least concerning psychiatric treatment and care (Hamann et al., 2008). The lack of guidelines may lead to confusion and uncertainty. I found that although the concept 'moral stress' was never mentioned by the interviewees, this was a phenomenon that came strongly to the fore through the focus group interviews (Paper I). This resulted in new insights and a different focus from what was originally envisioned. A second research question was therefore developed during the data analysis: Why may the ideal of patient participation create moral stress in psychiatric healthcare workers?

This first study may be seen as an introductory study as it was conducted before I entered the Norwegian School of Theology, Religion and Society's (MF) PhD programme. Even so, it is

important for the PhD project as it stirred my interest in the phenomenon of moral distress in mental nursing care. At this stage I chose the term *moral stress* rather than moral distress as I at the time found it more suited to explore and highlight the moral dimensions at stake.

Stage 2. In stage 2 in-depth individual interviews were conducted with nurses working on four different acute psychiatric wards in two different South-Eastern Norwegian mental health hospitals than in stage 1. During the analytic work I found myself fluctuating between which concept would suit my discussions better, 'moral stress' as in Paper 1, or 'moral distress'. Both concepts are used to describe reactions to morally challenging situations. However, as will be discussed in chapters 2.2 and 5.1, the term moral distress was chosen. The complex settings in which the caregivers find themselves often make it difficult or even impossible for them to know what the morally right course of action is. People may feel morally compromised when faced with these kind of moral dilemmas (Campbell et al., 2018; Fourie, 2015; Kälvemark et al., 2004; Morley, 2018; Morley, Bradbury-Jones, et al., 2021). In Paper II, I present a somewhat broader understanding of the concept of moral distress by including situations where nurses are confronted with moral dilemmas or experience moral doubt. This will be discussed further in chapter 5.

Stage 3. This part study was conducted on the same hospitals and wards as in stage 2. During the individual interviews of stage 2 it became clear that the nurses wondered and even worried about the consequences of the implementation of the *Law on Patients' Rights* of 2017. The practical consequences of this change in legislature and how the ideal of reduced use of restraints and coercion influenced their practice, became a focal topic. This, together with how the nurses cope when repeatedly being exposed to moral distress in their clinical practice became themes I found interesting to study further. In the project's Stage 3, therefore, focus group interviews were organised to gain deeper knowledge into these issues (Papers III and IV).

Both research literature (Ward, 2011) and my study highlight acute psychiatric wards as environments fraught with pressure and stress, and identify several key factors contributing to job dissatisfaction, including greater patient acuity, an unpredictable and challenging workplace, violence, increased paperwork, and reduced managerial support. Moreover, professionals within acute psychiatric care work with patients with a wide variety of mental problems, like psychoses, traumas, sharp mood swings, drug-related problems, personality

disorders, serious eating disorders, high suicide risk, and problems in connection with self-harm.

1.2 The organisation of this dissertation

Acute psychiatric units were briefly introduced in chapter 1 together with an overview of the literature on moral distress. My background as psychiatric nurse and researcher was also described together with this study's three developmental stages.

In chapter 2, concepts, and theories basic for my study are introduced focused on psychiatric nursing, moral distress, and moral responsibility and interhuman relationships. The philosophical background for the chosen research approaches is then presented before a review of previous empirical studies on moral distress in mental health care.

The study's literature research and clinical methodological approaches are presented in chapter 3 together with the four papers' research questions.

In chapter 4, the study's findings are presented; first briefly paper by paper, followed by a thematic overview of the results across the papers to show the overall scope of the project.

Chapter 5 is a discussion of the study's findings. The main topics are why an expanded understanding of moral distress is found to be useful, why external and internal constraints may create moral distress, and nurses' psychosocial responses to moral distress. The personal, professional, and/or organisational cost of unresolved moral distress are discussed followed by the value of moral distress and the interviewed nurses' coping with the phenomenon. Chapter 5 ends with a discussion on the empirical research methods utilised.

Chapter 6 is a conclusion, points to implications of the findings, and gives suggestions to further research within the field of moral distress in acute psychiatric nursing.

2. Concepts and theories

The many-faceted phenomenon moral distress in acute psychiatric nursing is described and discussed. This phenomenon will be illuminated from a variety of perspectives. In this chapter the focus is on psychiatric nursing, moral distress, responsibility and interhuman relationships.

2.1 Psychiatric nursing

In a resent Danish clinical psychiatric nursing textbook Paaske and Gilberg (2021) describe psychiatric nursing as a relational enterprise with a therapeutic aim to improve, help and support the patients in their effort to cope with their illness and life in general. Reciprocal trust and a safe environment are prerequisites for achieving this kind of therapeutic relationship (Hummelvoll, 2012; Paaske & Gildberg, 2021). Among the influential factors in the patient-nurse relationship Hummelvoll (2012) describes equality and being present – the ability to be present in an authentic manner.

According to the Australian professor of nursing, Cynthia Stuhlmiller (2003), mental health nurses are professionals who assist people who have suffered traumas or some other form of mental distress regain a sense of coherence in what happens to them. According to her, the unique contribution of mental health nurses is in “the simple elegance of ‘being there’ and to bear witness and mitigate the negative side effects of illness-alienation and a feeling of being out of touch with the self and social context” (p. 1). In line with this, Ward (2011) found in a study on the lived experiences of female mental health nurses, that being a mental health nurse involves assisting patients through what could potentially be their life’s most critical moment.

Thus, in psychiatric nursing the emphasis is placed on the importance of using one’s own personal qualities in a therapeutic manner and to create and maintain a therapeutic relationship with the patient. The quality of this relationship is imperative to the outcome of mental health work (e.g. Geirdal & Varvin, 2017; Gilburt et al., 2008; Pazargadi et al., 2015). The therapeutic relationship is widely accepted as the basic core and essence of psychiatric nursing generally (Pazargadi et al., 2015; Peplau, 1991), as well as in acute psychiatric care (Wyder et al., 2017).

Contemporary psychiatric nursing can be said to follow two different 'tracks' or approaches. One track seeks to revitalise basic humanistic values (i.e., a holistic, existential approach), the other is a developmental approach which adopts the traditional scientific approach, characterised by biomedical research (Hummelvoll & Granerud, 2010). This indicates that mental health professions currently go through changes regarding treatment, demands for increased patient participation, focus on patients' rights, the patients' own experiences, and human rights (Husum et al., 2017).

In recent years the understanding and use of the terms psychiatric nursing and mental health nursing has been debated. The debate concerns whether we are psychiatric nurses, practicing psychiatric care, or whether we are mental health nurses, that focus on mental health rather than mental illness (Pryjmachuk, 2011, p. 30). This debate is among other things influenced by tensions between psychiatry and anti-psychiatry, and the recent upsurge in conceptualisations and models of psychiatry/mental health that focus on wellbeing and health rather than the traditional focus on disease and ill-health (ibid.). What term to use in this dissertation has been debated with my mentors. 'Mental health nurse' may perhaps be said to be the more forward-looking term and is the one used in Paper IV. Even so, from what I can ascertain, 'psychiatric nurse/psychiatric nursing' still tends to be the terms used in clinical practice in most countries. Moreover, 'psychiatric nurse' is the term used in most of the studies referenced in this dissertation. I have therefore landed on this term without taking 'sides' in the debate on which term is the most appropriate one.

2.1.1 Coercion

Although 'coercion' is used in a variety of ways throughout the nursing literature, it is a complex concept to define (Paradis-Gagné et al., 2021). In this dissertation the concept is used in connection with what is often described as 'formal coercion'. Formal coercion is regulated by mental health legislation, protocols, and professional guidelines (García-Cabeza et al., 2017; Paradis-Gagné et al., 2021). In the framework of formal coercion, different types of coercive measures are included, namely involuntary admission, forced medication/pharmacological treatments, use of physical and mechanical restraint, and isolation (Paradis-Gagné et al., 2021; Sampogna et al., 2019).

The interviewees also described 'grey zone' coercion and 'concealed' coercion, settings often described as 'informal coercion'. Informal coercion is a subtle coercion that is less obvious (Andersson et al., 2020). It includes any type of coercion that is not formal, as use of power,

control, or manipulation (Hem, Gjerberg, et al., 2018). Examples are different actions where care providers use their power to put pressure on patients to behave in a certain way and comply with treatment plans (Andersson et al., 2020; Elmer et al., 2018; Jaeger et al., 2014), including persuasion (Paper IV, García-Cabeza et al., 2017; Pelto-Piri et al., 2019).

2.2 Moral distress

Although the exact term 'distress' is not used, the concept of moral distress is associated with the work of a number of philosophers concerned with the harms that may be experienced by individuals in circumstances where there is moral challenge, conflict and discomfort (McCarthy & Deady, 2008). Willis (2015) points to several of these circumstances when he holds that:

> "Moral distress seems to include nurses being ascribed moral agency, both by themselves and others, implicitly and explicitly through professional practices, academic literature, codes of conduct and, of course, wider societal beliefs and expectations; the assumption that moral responsibility applies, even in conditions where nurses' freedom to act is constrained; and that nurses' inactions and omissions, even when obstacles block alternative action, are proper objects of moral responsibility ascriptions." (p. 15)

The demand on nurses' professional values seems constantly to be growing (Austin, 2012; Kjølsrud, 2019). As decades of research have shown that nurses experience moral distress, the term has become increasingly familiar (Ulrich & Grady, 2018; Wilson, 2018). Moral distress is well documented in nursing literature (Lamiani et al., 2017; Morley, Field, et al., 2021; Wilson, 2018) as research has shown that this phenomenon may affect the quality of healthcare delivery, the well-being of the providers themselves and even influence the healthcare organisations or system negatively (e.g. Burston & Tuckett, 2013; McAndrew et al., 2018; McCarthy & Gastmans, 2015; Oh & Gastmans, 2015; Rodney, 2017).
The Covid-19 pandemic has particularly drawn attention to this phenomenon as it has exacerbated healthcare personnel's experiences of moral distress and highlighted this phenomenon (e.g. Cacchione, 2020; Godshall, 2021; Guttormson et al., 2022; Miljeteig et al., 2021; Morley et al., 2020; Norman et al., 2021; Silverman et al., 2021).

Research on moral distress has traditionally mainly been focused on nurses working in somatic critical care settings (Deady & McCarthy, 2010; Lamiani et al., 2017; Oh & Gastmans, 2015). However, during the last few years research on this phenomenon has expanded to include various healthcare contexts and disciplines such as physicians, pharmacists, social workers, nursing students, chaplains and policemen (Davis et al., 2018;

Jones-Bonofiglio, 2020; Papazoglou & Chopko, 2017). The majority of this research has been conducted in North America, but research is now also emerging from South America, Europe, The Middle East, Africa, and Asia (Ashida et al., 2022; Morley et al., 2019; Prompahakul et al., 2021). According to Jones-Bonofiglio (2020), there is now "abundant support for the claim that nurses all over the world experience moral distress in their practice" (p. 7).

The term "moral distress" was originally coined by the American philosopher Andrew Jameton to describe the experience of individuals who feel morally constrained. Jameton (1984) stated that moral distress occurs when a nurse "knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Jameton lectured on ethics to nursing students in Nebraska in the 1980s, and the concept emerged from the experiences they shared with him (Jameton, 1984, 2017). The label of *moral* distress connotes an experience of anguish or suffering, whereby the adjective *moral* indicates what kind of suffering it is (Hanna, 2004, p. 74).

Musto and Rodney (2018, p. 10) hold that in identifying moral distress, Jameton put into words "a collective experience that occurred when nurses confronted situations that created conflict in their professional values — a conflict that often ultimately left the nurses with the sense that they have failed to live up to their moral obligation to the patient".

Jameton (1984) distinguished moral distress from *moral dilemmas* – defined as involving two or more conflicting principles that could be applied to a single situation – and from *moral uncertainty*, being unsure what moral principles or values to apply, or even what the moral problem is. Later (1993) Jameton also distinguished between initial and reactive distress. Initial moral distress is the feeling of anger, frustration, and anxiety when individuals are first prevented from doing what they see as the right thing to do. Reactive distress is the emotional anguish that remains after the event has passed. Reactive distress has since been linked to the concept "moral residue", which according to the Canadian ethicists Webster and Bayliss (2000) is constituted by accumulated moral distress due to repeatedly having experienced moral distress and seriously having had to compromise with their personal moral ideals. This may cause increasing levels of moral distress, described by Epstein & Hamric (2009) as "the crescendo effect", an effect that makes the experience of future episodes of moral distress more intense.

According to Epstein and Hamric (2009), the hallmark of moral distress is a perceived violation of one's core values and duties' which, left unaddressed, can lead to an erosion of moral integrity[1] (p. 331). Also other authors tie moral distress to challenges or violations of moral integrity (Burston & Tuckett, 2013; Rushton, 2018; Thomas & McCullough, 2014), which may be defined as being faithful to one's deepfelt considerations, having fairly consistent internalised moral ideals and principles, and living and acting according to these (Magelssen, 2012). Beauchamp & Childress (2001, pp. 35-36) hold that "moral integrity means soundness, reliability, whole, and integration of moral character".

Judith Wilkinson (1987), a nurse researcher, carried out the very first empirical study on nurses' experiences of moral distress which employed Jameton's definition. She defined the concept as an experience of psychological disequilibrium and the negative feeling state "experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by the decision" (p. 16). In her qualitative study, she interviewed nurses in acute care and identified situations that gave rise to moral distress, for instance providing treatment believed to be futile, and lying to patients. Wilkinson supported Jameton's claim that nurses were externally constrained and added internal constraints, that is, "being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt and lack of courage" (1987, p. 21). Further studies, such as Huffmann & Rittenmeyer (2012), support Wilkinson's findings.

Corley (1995) expanded our understanding of moral distress further by adding the seriousness of the situation and the frequency at which it occurs as two characteristics which impact on the severity of moral distress. She developed a measurement to assess moral distress in nurses working in critical care settings, the Moral Distress Scale (MDS), based on Jameton's theoretical definition and Wilkinson's (1987) results. Although other tools exist, a revised version of their Moral Distress Scale seems to be the most commonly used (McCarthy & Gastmans, 2015). A new version of MMD-HP (The Measure of Moral Distress for Health Care Professionals) represents the most currently understood causes of moral distress (Epstein et al., 2019).

[1] According to the American philosopher Mark Wicclair (2011, pp. 25-26), violation of moral integrity may have grave consequences for the person, leading to feelings of quilt, shame, and loss of self-respect. Not protecting staff members' moral integrity may lead to their moral character being eroded.

Thus, researchers continue to seek to refine the definition of moral distress. According to Musto and Rodney (2018, p. 11), our full understanding of the concept remains "under construction". McCarthy and Deady (2008) suggest that moral distress is best understood as "a kind of umbrella concept that captures the range of experiences of individuals who are morally constrained" (p.254). Jameton's (1984, 1993) original and modified definitions continue to provide a common ground for many contemporary studies on moral distress in the academic literature (Jones-Bonofiglio, 2020; McCarthy & Gastmans, 2015) although some scholars have recently argued that Jameton's definition is too narrow and needs a broader understanding based on conceptual arguments, empirical data, or both (Campbell et al., 2018; Fourie, 2015; Morley, 2018; Morley, Bradbury-Jones, et al., 2021), for instance through sub-categorising it into "moral constraint distress" or "moral-conflict distress" etc. (Morley, 2018). Sub-categorisation of the concept is a path not followed further in this dissertation.

Several researchers, for instance Peter and Liachenko (2013), Morley (2018), and Barlem and Ramos (2015), criticise the lack of theoretical grounding when moral distress is discussed. Some nursing scholars have, however, examined moral distress in novel ways to bring more theoretical depth to the concept (Musto & Rodney, 2018, p. 15). In a paper, Lützen and Kvist (2013), for instance, draw on Victor Frankl's existential philosophy, Morley (2018) uses a feminist interpretive phenomenology to explore and analyse critical care nurses' experiences of moral distress, and Peter and Liaschenko (2013), in a theoretical paper, adopt a feminist ethics framework, arguing that moral distress is a response to constraints on nurses' moral identities, responsibilities, and relationships. As seen in Paper II and in chapter 5, I found it necessary, in line with Morley (2018) and Kälvemark et al. (2004), to extend the definition of the concept to cover the various aspects of the experience of moral distress as expressed by the nurses I interviewed.

I failed to find a holistic theoretical perspective that covers the entire specter of my findings. In Paper III I initially attempted to explore what coping strategies psychiatric nurses use when in moral distress in light of Lazarus & Folkman's (1984) transactional model. Although psychological stress and moral distress have much in common, also this theoretical perspective turned out to be insufficient to explore ways of coping with *moral* distress. I have found the use of a variety of perspectives a gainful way to illuminate the phenomenon.

2.3 Moral responsibility and interhuman relationships

Responsibility was a concept that weaved in and out of the nurses' descriptions and narratives. During my work with this dissertation, my realisation of the influence responsibility has on the interviewees' experience of moral distress has matured. Whether the nurses can manage their moral responsibility towards their patients in accordance with their values or not, seems to be closely tied in with the experience of moral distress. The interviewees described deepfelt responsibility toward patients, co-workers, and having power. This made me look to a more existential basis for the phenomenon of moral distress. The Danish philosopher and theologian Knud Ejler Løgstrup for instance, attempts to describe the moral basis for interhuman relationships and points to the ethical demands or the basic prerequisites for leading a moral life, and helps in the understanding of the "emotional and physiological suffering that nurses experience when they act in ways that are inconsistent with deeply held ethical values, principles or commitments" (McCarthy & Gastmans, 2015, p. 132).

2.3.1 Responsibility

According to The Chambers Thesaurus (2015), responsibility may mean "duty, obligation, burden, care, role, task, authority, power, trust, guilt, answerability, accountability, dependability, reliability, conscientiousness, trustworthiness, honesty, and soundness", all concepts that were mentioned during the interviews. This indicates that nurses have a wide range of responsibilities: toward their patients and co-workers, toward their professionalism, and their ethical responsibilities as recorded in the nurses' Ethical Codex. Løgstrup (2020) holds that responsibility is tied in with being human beings, and that mankind's basic condition as being 'entwined', one person with the other, and that this is a basic ontological fact of human existence. From this interdependency springs the ethical demand that bids every human being to protect the other person's life when entrusted in our hands. This means that inter-human relationships are always power relationships. As seen in chapters 4 and 5, this is very much the case in the nurse-patient relationship in acute psychiatric wards, as with power comes responsibility. Løgstrup says that our mood, attitude and behaviour may have a profound effect on the people around us and adds rather poetically that it thus "is simply up to the individual whether the other person's life flourishes or not" (ibid, p.15).

Hatab (1997, in Austin 2012) claims that "without a sense of responsibility or obligation, one will not experience moral distress. It is a sense of responsibility that animates ethics" (p. 29). Consequently, moral distress is dependent on a person's ability to recognise his or her moral responsibility.

Both Walker (2008) and Lindemann (2019) write about 'doing' responsibility. Lindemann (2019, p. 114) describes a rich variety of actions that fall within this category: *taking* responsibility, *accepting* responsibility, *redirecting* responsibility, *deflecting* responsibility, *assigning* responsibility, *renegotiating* responsibility, and *contesting* responsibility. Our moral responsibility defines us, Schoeman (1987, p. 1) holds that "[i]t matters to us whether we are responsible because being responsible suggests our potential – that we are engaged as active and self-aware beings with perspectives on what we do and with a contributing and creative role to play in what we become."

How we handle our responsibilities is an expression of who we are, and what kind of power we have in a given setting and how we use it. The crucial ethical and moral question is not how we may avoid this power, but how we use it (Christoffersen, 1999, p. 29). Hylen et al. (2019, p. 148) hold that:

> "[a]ll healthcare could be described as asymmetrical with regard to power, insofar as the patient is truly dependent on the knowledge and decisions made by the healthcare provider. This asymmetry is even more obvious in psychiatry".

2.3.2 Trust, demand, and moral practice

Trust is an important aspect within all caring disciplines, not the least within acute psychiatric nursing (Hem et al., 2008). "Trust is used to describe the nature of therapeutic relationships, an intrapersonal attribute, as well as quality of interprofessional relationships. It is thought of as a need, an obligation, and a virtue" (Hupcey et al., 2001, p. 283).

Trust as obligation and virtue is clearly seen in Løgstrup's (2020) philosophy as the ethical demand presupposes that all interaction between human beings involves a basic trust. According to him, "it is integral to human life that we normally meet each other with natural trust" (Løgstrup, 2020, p. 9). However, to trust is "to deliver oneself up" (p.11) to expose oneself. This makes us vulnerable. By approaching me as a person I am shown a kind of trust that demands of me to take care of that person. By surrendering, the other gives me power over them that opens up for either care or destruction, and I do the same when I approach

them. This power should be used to develop trust and act in a positive manner toward the other person (Faulkner, 2017).

Although he describes what is demanded of an ethical or moral person, Løgstrup does not provide specific rules or guidelines on how to act. The ethical demand does not inform us about how we best may care for the bit of the other's life that we hold in our hand:

> "The individual to whom it is addressed must decide for themselves from relationship to relationship what it consists in. This does not mean that the individual themselves can arbitrarily, whimsically, and at their own discretion give it whatever content they like. In that case, there would be no demand at all … It is integral to the demand that the individual on whom the demand falls, with whatever they might have left in terms of insight, imagination, and understanding, must work out for themselves what the demand involves" (Løgstrup, 2020, pp. 20-21).

According to this ethical stance, mankind is equipped with pre-moral spontaneous and sovereign life manifestations, like love, compassion, candid speech, trust, and hope (Løgstrup, 2013). These manifestations are relationally lived and experienced and enable us to live our lives together. They cannot be applied, like rules or principles, they draw their content from the specific situation and relation to the other.

On the clinical level, professor of medical anthropology Arthur Kleinman (2012) seems to be in harmony with Løgstrup when he describes caregiving as "a moral experience". The Norwegian nurse philosopher Kari Martinsen (2003) holds that all nursing situations are moral as one faces the challenge of doing what is good and right, that is, to do what is best for the patient. Also Corley (2002) holds that the explicit goals of nursing are demonstrably ethical, as nurses work to protect patients from harm, provide competent and timely care, and maintain a healing environment. Thus, nursing can be defined as "a moral practice based on the moral requirement to promote the well-being of the patient by caring for him or her by a personal relationship" (Bishop et al., 1990, p. 104), a statement that reflects the 'entwined' relationship between patient and nurse. Being thus 'entwined' with the patient creates a strong ethical demand that bids the nurse protect the patient's life that is entrusted to her/him. This position may leave the nurse with a myriad of moral and ethical dilemmas (e.g. Corley, 1995; Oh & Gastmans, 2015).

2.4 Philosophical background for the methodical approaches

In chapter 3 the research methods are described and in chapter 5.8 the methodology is discussed in detail. In this section I will have a closer look at Hans-Georg Gadamer's philosophy of hermeneutics as it has been important to explore both communalities and variations in the causes of moral distress and the interviewed nurses' coping thereof. As hermeneutics invites the researcher to be creative and to understand the complexities of the phenomena studied, an Gadamer-inspired hermeneutical approach was found to be a 'good fit' for my data analyses as the intention has been to understand how the concept and phenomenon of moral distress present itself from various perspectives and to discuss my findings in light of various theoretical perspectives.

The German philosopher Hans-Georg Gadamer (1900-2002) has inspired a variety of scholastic disciplines from aesthetics to theology (Regan, 2012). According to him, our relationship with understanding is not external. Instead, understanding is a basis for our way of being, or as Heidegger puts it, our "being in the world" (Vetlesen & Stänicke, 1999). The task of hermeneutics is to clarify the conditions in which understanding and interpretations take place (Gadamer, 2004). In suggesting that understanding is interpretation and vice versa, Gadamer identifies language as the medium of understanding and a means of sharing the complexities of human experience. He suggests that all interpretations are derived from a basic level of understanding or pre-judgement. He points to the central importance of historic and individual conditions and experiences, which he describes as our pre-understanding. Our pre-judgements and pre-understanding are keys to our entering the hermeneutic circle (Vetlesen & Stänicke, 1999).

Central to hermeneutical philosophy is that understanding is achieved through a circular interpretation process, where one moves back and forth between the text as a whole and its individual parts. Construing the meaning of the whole involves making sense of the parts and grasping the meaning of the parts is dependent on having some sense of the whole. "Thus the movement of understanding is constantly from the whole to the parts and back to the whole again. Our task is to expand the unity of the understood meaning centrifugally" (Gadamer, 2004, p. 302). The focus is on the whole to avoid the interpretation being random and misleading (Krogh, 2009). Gadamer (2004, p. 305) emphasises that the hermeneutical circle is not a "methodological circle, rather it describes an element of ontological structure of understanding". In the so-called 'alethic' hermeneutics, which also Gadamer represents, a

second circle is described, a circle between pre-understanding and understanding (Alvesson & Sköldberg, 2017). Heidegger made a point of this second circle where the reader herself becomes part of the circle and becomes pulled into it. As the French philosopher Paul Ricouer puts it: "to understand is to understand oneself in front of the text" (1981, p. 143).

Gadamer claims that our pre-judgements are necessary and furtive – a prerequisite for all understanding although they also may impede our ability to perceive the truth and recognise inherent relationships in the data we study. Rather than disregarding one's pre-judgement, it is important to be open for the perceptions presented by the other person or the text. "But this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it" (Gadamer, 2004, p. 281). Thus, our understanding presupposes openness and willingness to revise our pre-understanding.

Gadamer (2004) perceives the encounter between the text and the interpreter of the text as a "fusion of horizons". To achieve this, one must use intuition and empathy (Alvesson & Sköldberg, 2017). In an empirical study like mine, this 'fusion' took place between me and the nurse interviewees as our horizons met both during the interviews and during my reading and re-reading of the transcribed interviews as texts. Gadamer holds that through this process the world of the text becomes familiar or one's own, resulting in one's horizon being expanded. To achieve this, it has been important to me to "remain open to the meaning of the other person or text" (Gadamer, 2004, p. 281) and to immerse myself in the interviewees' situation.

2.5 Empirical studies on moral distress in mental health care

As mentioned in chapter 2.2, the literature searches show that the number of interprofessional papers on moral distress are scanty, and only a few are written specifically within acute psychiatric nursing (Table 2). With Lützén et al.'s (2010) study as the only exception, where the term 'moral stress' is used, all the studies found have adopted Jameton's original definition of moral distress, with the psychological discomfort when they could not follow their moral choices as a central underlying feature.

Table 2. Initial literature research at the start of the main project.

Author(s)	Sample	Method	Findings
Austin et al. 2003	9 Canadian nurses.	Qualitative hermeneutic phenomenological study. Individual in-depth interviews.	Described moral distress experienced by nurses working in mental health settings.
Austin et al. 2005	6 Canadian psychologists.	Qualitative hermeneutic phenomenological study. Individual in-depth interviews.	The moral distress of psychologists working in psychiatric and mental health care settings was explored.
Austin et al. 2008	6 Canadian psychiatrists.	Qualitative hermeneutic phenomenological study. Individual in-depth interviews.	Experiences of moral distress encountered in psychiatric practice were explored.
Deady & McCarthy, 2010	9 Irish psychiatric nurses working in acute psychiatric care.	Qualitative descriptive study. Semi-structured one to one interviews.	The study investigated situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress.
Lützén et al. 2010	49 Swedish mental health workers working in acute psychiatric hospital wards.	Data was collected using three scales, Hospital Ethical Climate Survey, Moral Sensitivity Questionnaire and Work-Related Moral Stress.	The association between work-related moral stress, moral climate and moral sensitivity in mental health nursing was investigated.
Ohnishi et al. 2010	391 psychiatric nurses working in six hospitals in Japan.	Cross-sectional and quantitative research. Data obtained through questionnaires. Developed and evaluated MDS-P (Moral Distress Scale for psychiatric nurses) and used Maslach Burnout Inventory.	Examined the intensity of moral distress in Japanese Psychiatric nurses and explored the association between moral distress and burnout.
Musto & Schrieber, 2012	12 Canadian nurses working in adolescent mental health.	Grounded theory. Semi-structured one to one interviews.	Explored the process used by mental health nurses to ameliorate the experience of moral distress.
Hamaideh, 2014	130 Jordan psychiatric nurses.	Descriptive correlation cross sectional design. MSD-P, Maslach burnout inventory and job satisfaction scales were used for data collection.	Identified levels of moral distress and relationships to related factors and predictors of moral distress.
Wojtowicz et al. 2014	7 Canadian nursing students	Naturalistic qualitative design. Group interview.	Evaluated the experience of moral distress during psychiatric rotation in baccalaureate nursing students
Delfrate et al. 2018	228 nurses of mental health services of four hospitals in Italy (acute inpatient units, rehab. and territorial services).	Multicentre survey. Moral Distress Scale for Psychiatric Nurses Italian revised (MDS-P) and the Maslach Burnout Inventory (MBI) were used for data collection.	Assessed the presence of moral distress among mental health nurses in Italy and verified a relationship between moral distress and burnout.

Austin et al. (2003; 2005; 2008) studied the experience of moral distress within different groups of mental health workers. The nurses reported on several factors that could trigger moral distress, especially overwhelming experiences as lack of time and resources affected the quality of patient care negatively. This resulted in sadness, anger, and frustration. In some nurses their experience of moral distress caused by inability to meet their patients' needs seemed to make them stop listening to "the call of the patients" (Austin et al., 2003) and make them compromise their professional integrity due to systemic demands.

The Irish nursing professors Deady and McCarthy (2010) studied sources for, characteristics of, and ways of coping with moral distress on an acute psychiatric ward. Moral distress seemed especially to be linked to settings where the nurses found that their professional assessment were not heard or ignored, and when they felt that their work was unappreciated. It was also morally challenging when the patient care was below their personal and professional standard of best practice, for instance when lack of resources led to more use of psychopharmaca. The participants experienced self-doubt, guilt, frustration, anger, and depression. Unease and anger were commonly experienced when "there was a lack of opportunity to discuss or resolve moral conflicts or concerns" (p. 215). Among the coping strategies found were compartmentalisation and attempts to make themselves immune to moral conflicts.

In their study of the coping strategies among nurses working with youths with psychiatric problems, Musto and Schreiber (2012) found that dialogue and formal and informal talks were the most common way to work through moral distress. Those who chose dialogue and found that their moral distress was validated, stayed on in their jobs, while the probability for those who did not communicate their challenges or experienced to be 'silenced' quitting their jobs was much higher. In this study was also found that inability to secure a physically and mentally safe environment for patients and healthcare personnel alike, triggered moral distress.

In their Canadian study on nursing students' experience of moral distress during their praxis placement on psychiatric wards, Wojtowich et al. (2014) found that to witness that the nurses had few and not very meaningful talks with the patients was a particular trigger. Other triggers were the hierarchical system, nurses' powerlessness when faced with ethical challenges, and their inability or lack of courage to contribute to change in their clinical

practice. Wojtowich et al. found a clear link between the students' experience of moral distress during this praxis placement and not choosing a career within psychiatric nursing.

Ohnishi et al. (2010) developed the *Moral Distress Scale* (Corley et al., 2001) further and tailored it for psychiatric contexts. Using this questionnaire (*MDS-P*) and a burnout scale (*Maslach Burnout Inventory – General Survey*), they studied both the experience of moral distress among Japanese psychiatric nurses and the link between moral distress and burnout. They found relatively low levels of moral distress even though the nurses were often confronted with morally challenging situations. The main triggers of moral distress were included in the factor 'low staffing', but also lack of other resources that affected the quality of healthcare were important. Frequent exposure to moral distress was a significant factor in burnout. Similar results were found by Delfrate et al. (2018), *particularly* that lack of resources created moral distress and a relationship between moral distress and burnout. These authors also found a modest, but significant correlation between moral distress and two dimensions of MBI, emotional exhaustion and depersonalisation.
Hamaideh (2014) conducted a similar study in Jordan. She found that the level of moral distress was moderate. The item with the highest score was *'Avoiding taking any action when I learn that a nurse colleague has made a medication error and does not report it'*.

Lützén et al. (2010) explored the association between work-related moral stress, moral climate, and moral sensitivity in mental health nursing in Sweden. For this purpose, the Work-Related Moral Stress Questionnaire (WRMS) was produced. The results indicated that moral stress to some degree was determined by the workplace's moral climate as well as by aspects of the mental health staff's moral sensitivity.

3. Methodological approaches

The overarching aim for my PhD study (papers I-IV) is *to study the interviewed nurses' insider perspective on the moral challenges and moral distress in acute psychiatric treatment and care and how they cope with moral distress*.

The overarching research question is: *How do nurses perceive the moral distress they face working with acute psychiatric patients and how do they cope with this experience?*

This overarching research question is answered by the four sub-studies. The research questions of these sub-studies are as follows:

Paper I
How do psychiatric healthcare workers understand the concept of patient participation in their clinical practice?

Why may the ideal of patient participation create moral stress in psychiatric healthcare workers?

Paper II
What sources of moral distress are found within psychiatric acute care settings?

What features of moral distress are expressed by nurses working within psychiatric acute care settings?

Paper III
How do nurses working in acute psychiatric settings cope with moral distress?

Paper IV
May the ideal of reduced use of restrictive, restraining, and coercive treatments within mental health care lead to moral distress? If so, in what way may this lead to moral distress?

3.1 Literature research

Several structured electronic searchers were conducted with the assistance of an expert librarian 2014–2015 and 2017-2021 through the databases PubMed, Psychinfo, Cinahl, Oria, Norart, Swemed and Google Scholar. We also used 'snowballing' from papers found. Initial

search words were patient/use/consumer/client participation, communication, and psychiatry in various combinations in English and the Scandinavian languages. As new papers/research questions were added during the analytic process, new searches were conducted. For Paper II the search words were moral distress, psychiatric/mental health nursing, mental health hospital, conscience, burden, predicament, dilemma, mental disorders, with synonyms. In subsequent searches this moral distress element was collated with concepts based on the paper's focus, with the search words coercion, nursing ethics, moral obligation, workplace violence, coercion, restraint, attitude of health personnel, ethics nursing, moral obligation, professional ethics, workplace, organisational culture (Paper IV) and coping, manage, emotional adjustment, handle, deal (Paper III). In the searches both subject words and text words were used. Within each focus synonyms like cope and coping were expanded with the boolean operator OR.

Regardless of search engines, the searches tended to give rather corresponding results. The literature found on moral distress is therefore mostly generic in character.

In principle, a hermeneutic approach to a text is an infinite process, and in a way my literary research could very well have become a 'never-ending story'. I had to draw the line somewhere to be able to proceed with the next step of my project. But, as seen above, my literary research did not end as the empirical work began but continued throughout the entire process. This continuous literal work is supported by the British sociologist and research methodologist Martyn Hammersley et al. (1996), who point out that:

> "[t]he development of generic concepts demands a broad and eclectic reading of textual sources (formal and informal, factual and fictional) on different substantive topics. It is, however, important not to start searching out documentary sources only when 'writing up'. Wide and comparative reading should inform the generation of concepts throughout the research process" (p.162).

While I was working on Paper I, I became aware of Elisabeth S. Kjølsrud's (2013) PhD dissertation on challenges concerning professional ethics in a Norwegian regional Health Trust. Moral distress was a finding in her interviews with nurses and managers in acute psychiatric units, especially in connection with lack of time, when they had to set aside their personal standards and ideas, and when their assessments were ignored.

Two American PhD studies, Sharon Milne's qualitative study *Understanding Moral Distress Among Psychiatric Nurses* (2018) and Stacey Lambour's (2016) quantitative study *The*

Experience of Moral Distress in Psychiatric Nurses, both examined moral distress in psychiatric nurses. Milne (2018) found that "clashing ethical decisions" like the use of coercion and power, treating patients against their will, refusing them privileges, trusting in reports given by others, legislation, and to follow the hospital's rules and regulations were among the most potential causes of moral distress. Also doubt concerning the efficacy of treatment or inadequate follow-up of patients created moral distress. So did conflicts with patients, co-workers, and with one's conscience and values. Lambour (2016) used the MDS-P questionnaire. She found low levels of moral distress and judged this to be connected to these patients not being hospitalised and thus did not have the same restrictions concerning autonomy. Also, in her study reduced manpower and inadequate time to talk with patients were the most common sources of moral distress.

Important books on moral distress, although not focused on mental healthcare were also found, like *Moral Distress in the Health Professions* (Ulrich & Grady, 2018) and Rushton's (2018) *Moral Resilience: Transforming Moral Suffering in Healthcare*.

3.2 Empirical research approaches

The overall aim of this project was to explore how nurses working in acute psychiatric units experience and cope with moral distress. The intention was to study how this concept and phenomenon presents itself from various perspectives. There is more or less a 'rule of thumb' that the less is known about the area that is to be studied, the more important it is to do a qualitative study that will produce the knowledge needed if one later would wish to develop quantitative instruments (Žydžiumaite, 2007). Moreover, Oh and Gastmans (2015) found through conducting their quantitative review on moral distress that a quantitative design is insufficient to explore diverse and meaningful psychological reactions or coping strategies by nurses. Quantitative methods do not catch local work culture and how different understanding of professional roles influence nurses' moral distress (Hamric et al., 2012; Oh & Gastmans, 2015). Hence, moral distress is studied qualitatively as an unfamiliar phenomenon rather than as something that is permanent and well-known (Haavind, 2000). This approach was chosen as moral distress – as noted in chapter 2.5 – has been scantily studied in the context of mental health settings. This (lack of) finding(s) is supported by Lamiani et al.(2017).

It is important "that the theoretical framework and method match what the researcher wants to know, and that they acknowledge these decisions, and recognize the choice *as* decisions"

(Braun & Clarke, 2006, p. 80). A combined hermeneutic and thematic research approach was chosen with special emphasis on Gadamers' hermeneutics (see chapter 2.4) and the method of thematic analysis developed by the psychologists Virginia Braun and Victoria Clarke. In Paper I we have used a thematic analysis based on hermeneutics alone. In Papers II-IV Braun & Clarke's (2006, 2013) approach to thematic analysis was utilised. This is a reflexive approach through which one seeks to develop 'patterns' (themes, categories) across cases.

A circular investigation between particular parts of the interview texts and the data corpus as a whole was needed to create depth of understanding of the data material at hand. The data corpus was furthermore read and re-read again and again to identify themes both within each interview and across the data sets. The use of a circular investigation was also necessary between my empirical findings and other researchers' studies as I repeatedly found that I needed more knowledge on the various themes as they developed.

During the interviews and the reading of them I focused on the interviewees' experiences and self-understanding. In the findings or result sections of Papers I-IV quotations are presented. On one level these represent the interviewees' self-understanding. However, as a researcher I impose my interpretation of the meaning of what is being said upon these texts. This moves the analysis on to the level of *critical common-sense understanding* (Brinkmann & Kvale, 2015). Interpretations on this level "may include a wider frame of understanding than that of the subjects themselves, be critical of what is said, and may focus on either the content of the statement or the person making it" (ibid., p. 243).

Braun and Clarke (2006; 2022) propose two possible ways for identifying themes: inductive (bottom-up) based on what is in the data, or in a more 'top-down' fashion. The latter is analysis-driven, guided by the researcher's theoretical or analytical interest in the subject area. In the former the researcher "uses the data to explore particular theoretical ideas or bring those to bear on the analysis being conducted (Braun & Clarke, 2013, p. 178). In all the analyses in this dissertation both ways to identify themes were utilised. Braun and Clark (2006; 2022) also present two different types of data analyses: semantic level or latent level analysis. Semantic themes are identified within the explicit or surface meanings of data, latent level analysis identifies or examines the underlying ideas, assumptions, conceptualisations, and ideologies that shape or inform data's semantic content. These latter themes analysis come to the fore after extracting what is *actually* articulated in the data. Moral distress is such a latent theme.

Regarding the methodology of the interpretations arrived at, Gadamer (2004) says that when we try to understand a text, we do not try to transpose ourselves into the speaker's mind but try to:

> "…transpose ourselves into the perspective within which he has formed his view. (…) we are moving in a dimension of meaning that is intelligible in itself and as such offers no reason for going back to the subjectivity of the [speaker]. The task of hermeneutics is to clarify this miracle of understanding, which is not a mysterious communication of souls, but sharing in a common meaning" (p. 303).

In the same way as I through the years have developed a horizon unique to myself, so have the interviewees. "[U]nderstanding is always the fusion of these horizons supposedly existing by themselves" (Gadamer, 2004, p. 317). In this fusion, 'reality' does not immediately appear; it is constructed through the encounter and through discourse. During the interviews, then, the nurse interviewees and I created meanings that, through the interplay of questions and answers, extended beyond our original horizons. Hence, an interview is something the interviewed and interviewer produce together through their talk, and the analysis is an interpretated representation of that talk. One may put different perspectives on the analysis and interpretation of this 'representation of that talk', however. This is shown as the various research questions required re-analyses of the data creating a variety of focus.

3.3 Recruitment strategy and sampling

In all the interviews a purposive sampling strategy (Polit & Beck, 2020, p. 265) was applied to identify potential participants. As I wished to learn how nurses perceive the moral challenges they face working with acute psychiatric patients and how they cope with these challenges, the sampling was "theoretically driven" (Miles & Huberman, 1994) as it was "driven by a conceptual question, not by a concern for 'representativeness' " (ibid, p. 29). My main concern was to invite interviewees with experience from the field I was interested in learning more about. The heads of the acute psychiatric wards and units in question were all informed about the study's content, purpose and aims both in writing and orally and they were the ones who chose what potential interviewees to invite as participants.

Inclusion criteria: The participants were Registered Nurses working on acute psychiatric wards. I wanted to interview participants with varied length of work experience and wanted to interview both men and women.

In the introductory study (Paper I) three focus group interviews were conducted with a total of nine interviewees, three men and six women (distribution: four, two and three interviewees). The PhD project sample (stages 2 and 3) included a total of 30 interviewees, 5 men and 25 women (Table 3). The gender distribution shows a clear majority of female interviewees, which is in accordance with the fact that nursing still is mainly a female profession. The majority of the interviewees were psychiatric nurse specialists with many years' experience from acute psychiatric care.

Table 3. An overview of the interviewees' education and psychiatric nurse experience

Years of psychiatric/ nursing experience	Focus group interviewees (Stage 1)	Individual interviews (Stage 2)	Focus group interviewees (Stage 3)	No. of psychiatric nurse specialists
0-5 years	2	2	4	2
5-10 years	1	6	6	9
10-15 years		2		2
15-20 years	2	2	2	4
20+ years	4	4	2	9

3.4 Data collection

Two qualitative methods were used for the data collection: individual in-depth interviews and focus group interviews. Both forms of interviews were conducted face to face. The interviews were conducted in a room at their respective places of work. Before each interview we/I introduced ourselves and repeated the information already given in writing about the study's aim, the interview procedure, that the interviewees were free to answer or not according to their own wish, and that they were free to pull out of the study at any time.

Independent of interview method the goal was to learn about the interviewees' thoughts and experiences concerning moral concerns and challenges in their clinical practice expressed in their own word, allowing the generation of thick descriptions. An open interview approach was chosen which left room for unexpected perspectives to come to the fore, perspectives that were not part of our "pre-judices" or prior "horizons of understanding" (Gadamer, 2004). According to Malterud (2017) this approach creates empirical material that invites the audience or readers to adopt the narrator's perspective.

Follow-up questions and 'mirroring' of statements were used to develop, clarify, and verify statements. During the interviews we/I tried to listen as objectively as possible and understand

the words uttered and their meaning. When uncertain how to understand what was being said, the interviewees were asked to clarify, and we/I would describe my understanding for them to confirm or disconfirm. This is part of what Lincoln & Guba (1985) describe as *member checking*, a strategy to establish credibility. This is what the Norwegian psychologist and methodologist Steinar Kvale (Brinkmann & Kvale, 2015) calls to establish *self-understanding,* that is *"what the subjects themselves understand to be the meaning of their statements"* (p. 242).

3.4.1 The focus group interviews

Focus group interviews were conducted in project's stages 1 and 3. These took form of semi-structured discussions where the interviewees were encouraged to share their experiences and perspectives and through this explore ethical challenges regarding patient participation (Tong et al., 2007). Rich data on moral and ethical thinking can be found in such discussions which provide knowledge about genuine experiences occurring in actual care settings (Jakobsen & Sørlie, 2010). Focus group interview is a particularly well-suited research method when studying attitudes, experiences and dominant values in specific cultures or subcultures (Tong et al., 2007). According to Krueger and Casey (2015), focus groups are suited for instance when the purpose of the focus group interview is "to uncover factors that influence opinions, behaviour, or motivation" (p. 21). Statements from one participant may furthermore produce association in another, producing an inter-participant synergy effect that may help data and ideas come to the fore that would possibly not be mentioned during individual interviews. Thus, one obtains rich data that often is somewhat different from individual interviews (Malterud, 2012). One of the major advantages of a group format is also that it is efficient as "researchers obtain the viewpoints of many people in a short time" (Polit & Beck, 2020, p. 515).

The moderators did their best to create a friendly and open ambience where the interviewees felt free to express personal and contradictory points of view on the topic discussed (Brinkmann & Kvale, 2015). We experienced that the participants were greatly committed and candid in the focus groups, with the result that the material obtained was highly informative and comprehensive. Particularly during one of the focus group interviews the lively discussion brought spontaneous and expressive viewpoints to the fore, which according to Brinkmann & Kvale (2015) to a greater extent is created in focus group interviews than in individual, often more cognitive interviews. The focus group interviews lasted about 90 min.

3.4.2 The individual in-depth interviews

For the main project individual in-depth interviews was the primary choice to acquire insights into the interviewees' subjective experiences, attitudes, and thoughts (Brinkmann & Kvale, 2015; Malterud, 2017; Polit & Beck, 2020). Through in-depth interviews one is given a unique insight into the interviewees' subjective experience, attitudes (Brinkmann & Kvale, 2015; Malterud, 2017) and thoughts concerning their work and working conditions generally as well as ethical challenges and dilemmas in particular. In-depth interviewing creates a picture of inter-human communalities and variations in a varied and controversial world (Brinkmann & Kvale, 2015).

Individual in-depth interviews provide the participants with an opportunity to share their stories and be heard in confidence, something which we presumed would be important in this study. Moral challenges are potentially a sensitive question. It may be stressful and even shameful to for instance admit or accept one's emotional reactions, failure in patient care, moral doubt, or not having acted according to one's values. Our experiences from the stage 1 focus group interviews pointed in the same direction, as two of the participants expressed that to speak about moral qualms, dilemmas and conflicts in the workplace could be difficult in the presence of co-workers. Their willingness to do so depended on the co-interviewees being people they trusted.

A total of 16 nurses were interviewed, an adequate number to secure information power (Malterud et al., 2016) as the interviewees all possessed the specific characteristics needed to answer the study's research question. The first set of individual interviews I conducted on my own (eight interviews, spring 2017). Either Professors Marit Helene Hem or Ingrid Hanssen joined me during the rest of the interviews (spring/autumn 2018). They participated actively in the conversation. The interviews lasted 60-90 minutes.

I had transcribed the first eight interviews and had initiated the coding of the data before the second set of in-depth interviews was commenced. Already at this very early stage I found that the data was rich on experiential descriptions that could be interpreted as indications of moral distress. Experiences from these initial interviews showed that we in the subsequent interviews could delve more deeply on statements regarding moral questions like conscience, guilt, loyalty etc. Themes that had come up during the initial interviews, for instance coercive administration of medication, were furthermore introduced for the second set of interviewees form them to reflect upon and discuss. As Polit and Beck (2020) point out: "Qualitative

researchers use an emergent design that takes shape as they make ongoing decisions reflecting what they have already learned” (p. 471).

3.5 Data analyses

During the analytic process you try to understand in a different way than when conducting the interviews, you put critical questions to the transcribed text and try to go beyond the self-understanding of the respective respondents. In qualitative research projects, analysis means creating patterns or structures and coherence in the data material. Within a qualitative paradigm there is no right way of analysing data because there is no single truth (Terry et al., 2017). Below I therefore will elaborate upon how the analyses was handled, what I was looking for and how and why the choices that were made were made. Transcribing the data is included here as it is seen as part of the data analysis. Some researchers even argue that data transcription should be seen as “a key phase of data analysis within interpretive qualitative methodology” (Bird, 2005, p. 227).

All interviews were electronically recorded and transcribed. Doing the transcribing work myself was part of familiarising myself with the data, and initial analytic ideas were written down. Transcribing the data facilitated a close reading of the interviews (Lapadat & Lindsay, 1999) in addition to having conducted the interviews myself. This made it possible for me to read the interviews with the individual interviewee’s voice, expressions etc. clearly in mind. In transcribing the data I tried to produce orthographic transcripts, (focusing on *what* was said, not *how),* that were rigorous and thorough, “a ‘verbatim’ account of all verbal, and sometimes nonverbal (e.g., laughter) utterances” (Braun & Clarke, 2006, p. 88). At the same time being aware that a transcript is a *representation,* rather than seeing a transcript as raw data, it can be seen as what Sandelowski (1994, p. 312) terms “partly cooked”.

In alle the papers both/all authors took part in the analyses. The analyses were directly rooted in the interview data and depth of understanding was attained through a circular investigation of the interviews and research literature texts were used to compliment, substantiate, and discuss the findings.

Rigor was obtained by being two (Paper I) and four analysts (Papers II-IV) with different professional backgrounds, two with an insider view as psychiatric nurses with experience from acute settings and two from other fields of expertise, thus having little previous

knowledge about the topic. This also helped avoid analytic bias, have strengthened trustworthiness, (see chapter 5.8) and added to the depth of reflection and thus to the value of the analysis (Gair, 2012). To avoid researcher subjectivity (Polit & Beck, 2020), the analysts read the interviews separately before discussing the data and agreeing on the results. Reflective discussions were carried out throughout the planning stage, data collection and data analysis (Finlay, 2002).

Analytic credibility is obtained through presenting quotations to show the reader individual interviewee's own description of their thoughts and experiences. Dependability is obtained through these experiences and feelings expressed, which show communalities as well as individual variations (Polit & Beck, 2020).

In Paper I a Gadamer-inspired hermeneutic analytic approach was chosen. We first read the texts to get a holistic view of the themes discussed. We found the theme 'moral stress' significant and therefore selected it for this paper. This concept reflects what the interviewees said during the interviews, although the term 'moral stress' was never explicitly mentioned. Rather, we found this theme to be hidden behind the words, a feature identified by Ricoeur (1976), as "surplus of meaning". Hence, the theme 'moral stress' was not, so to speak, lifted 'straight off the pages' of the transcribed interview texts, although it definitely grew out of the meanings expressed in the interviews. As described in the Background section, the concept 'moral stress' was changed to 'moral distress' in the subsequent papers.

Gadamer (2004) teaches us to be open, curious, communicate authentically and realise the fusion of horizons through the reading of texts leads to the creation of something new. Through this process, themes were elicited from each interview based on the interview statements (van Manen, 2016). Van Manen (2016) claims that the formulation of a theme always is a simplification, and that one interpretation is not "necessarily more true than another" (p. 94). Even so, a content-focused approach was chosen where we attempted to formulate themes that touched the core of the situations or meanings found in the texts (ibid). The various interviews' themes were then compared, and related themes were coalesced into common themes.

In Papers II-IV Braun and Clarke's (2006) method of thematic analysis was used. These authors define thematic analysis as "a method for identifying, analysing and reporting patterns

(themes) within data" (p. 79), a flexible method that "can be applied *across* a range of theoretical and epistemological approaches" (p. 78).

Braun and Clarke (2006) describe thematic analysis in six phases: (1) familiarisation oneself with the data sets, (2) coding, (3) collating codes into potential themes, (4) reviewing themes, (5) defining and naming themes, and (6) writing the paper text. This process tended not to be linear but rather, we moved back and forth between the various phases.

Phase 1: Data familiarisation: Doing the interviewing and transcribing work myself was for me the first step of familiarising myself with the data, which according to Clarke and Braun (2016, p. 90) involves reading and re-reading the data "to develop a deep and familiar sense of the semantic, obvious meanings of the data". All the authors read through the transcripts to get a holistic view of the themes discussed. Thoughts were documented along the way, including embryotic ideas concerning coding and themes. Additionally, for each interview thoughts, atmosphere and impressions were registered as part of the initial analytic process. All the analysts tried to adapt an attitude that allowed the text to 'speak to us' and be willing to go where the data led us.

Phase 2: Generating initial codes: According to Braun and Clarke (2013, p. 213) "[a] code captures the essence of what it is about that bit of data that interests you". This is "an organic and flexible process, where good coding requires a detailed engagement with the data" (Terry et al., 2017, p. 20). A code can be words containing obvious meaning, either descriptive or more interpretative, based on latent and conceptual ideas; "coding is the systematic and thorough creation of meaningful labels attached to specific segments of the dataset – segments that have meaning relevant to the research question" (Terry et al., 2017, p. 26).

My coding started by copying all text fragments containing a promising theme in full into a document and giving it a colour code. Some chunks of text could be placed under more than one colour code as they potentially could belong to more than one theme. Interview by interview all promising chunks of text were gathered under a colour code. Then each 'colour' was read and re-read before the text were distilled into shorter chunks of text while making sure meaning and context were not lost. At this point the coding proper started. Not losing track of the context during this somewhat roundabout coding process was something I found particularly important as I wanted to be true to what the interviewees actually had been saying.

Interesting features were coded in light of the research question(s) for each paper. Potentially relevant data were also coded as we at this stage were focused on not ignoring or losing any data. Particularly during the analyses for Papers I and II we wanted to code widely and comprehensively concerning moral stress/moral distress to provide a rich thematic description of the entire dataset. This gives the reader a sense of the predominant and important themes and is a useful method for investigating an under-researched area (Braun & Clarke, 2006, p. 83).

In papers III and IV the goal was to provide a more nuanced and detailed account of these sub-studies' particular theme: whether ideals may cause moral distress and how nurses cope with moral distress. This required more selective data coding. The authors met to discuss our initial ideas and finalise the codes. Although the aim in this phase was to analyse the data from the bottom up, the analysis will always to some extent be shaped by the researchers' standpoint, disciplinary knowledge and epistemology (Braun & Clarke, 2013). Concurrently with this inductive approach where we asked what this text was all about, we conducted a focused reading of the interview transcriptions to learn more about distress as a phenomenon. Thus, we worked inductively on Paper I through phases 1- 4, while in phase 5 the work became more deductive as concepts from the research literature were adopted to label the inductively developed themes generated in the previous phases.

Phase 3: Searching for themes: According to Braun and Clarke (2006) a theme "captures something important about the data in relation to research question and represents some level of *patterned* response or meaning within the dataset" (2006, p. 82). Codes were clustered together "to identify features of similarity and relationship across a range of different codes that means they can be clustered together into a possible theme" (Terry et al., 2017, p. 28).

More instances of a theme do not necessarily mean that the theme is more crucial, and the 'key-ness' of a theme is not dependent on quantifiable measures: "While frequency is an important factor, it´s also about capturing the different elements that are most *meaningful* for answering the research question" (Braun & Clarke, 2013, p. 223). Thus, thematic analysis is about meaning rather than numbers. In determining what should count as a theme our focus has therefore been how crucial the theme is in relation to the research question.

Phase 4: Reviewing themes: This phase involved determining the fit between candidate themes and coded data, or as expressed by Clarke and Braun (2016): "to check the candidate

themes against all coded data relevant to each theme" (p. 94). The themes were checked against all the dataset and reviewed. Using theory to shed light on the themes was part of the review process. The interpretations became deeper, moving beyond manifest meanings (Brinkmann & Kvale, 2015). Braun and Clarke (2013) recommend that there should be no more than two to six themes per analysis, a recommendation we have adhered to.

Phase 5: Defining and naming themes involves refining "the focus and scope of your analysis and determine the exact 'story' you will tell for each theme and overall" (Clarke & Braun, 2016, p. 97). As to this, after identifying the themes the interviews were re-read to identify relevant quotes. In this phase finding excerpts that were vivid and illustrative of the analytic points were central. It was important that the labels given the various themes mirrored the content in a meaningful way. Many of these labels changed several times during this process as we worked to catch the essence of the various statements in the best possible way. During this process we returned both to the codes and entire data sets. We wanted to make sure that the story told was faithful to the data, even if it was beyond the surface meaning (Braun & Clarke, 2013).

Phase 6: Writing up thematic analysis/producing the report means to finalise the process by writing a paper based on the research question(s), the empirical data acquired and the analysis, with the discussion based on the researched scholarly literature. Through the writing of the paper one returns to the bigger picture of the overall project (Terry et al., 2017). For each paper my preliminary text was discussed with my mentors/co-authors and developed further collaboratively.

3.6 Ethical considerations

In all four sub-studies the participants were informed beforehand about the study's content, purpose, and goal both orally and in writing. All interviewees were also informed orally and in writing that participation was confidential and voluntary, and that they were free to withdraw from the project at any time. They all signed an informed consent form.

Institutions and interviewees were anonymised during the transcription process and have only been available for the authors of the papers. Transcriptions and recordings are stored according to Ethical Research Guidelines of 16.12.2021 by the Norwegian National Committee for Research Ethics for Social Science and the Humanities. Recorded interviews

will be deleted on conclusion of the project. All the sub-studies were approved by Norwegian Centre for Research Data (NSD) (Ref. No. 49981, No. 57299 and No.188755).

The study is motivated by an uneasiness based on clinical experiences indicating that nurses may experience moral distress without recognising it. In the development of the research questions, it has been important that the results will benefit the nurses who experience moral distress. Thus, the researcher has a moral duty to have a solid background for her study and the methods used (Hewitt, 2007). Brinkmann and Kvale (2015, pp. 81-82) accentuates that a qualitative interview study is a moral undertaking as the person-to-person interaction during the interview influences the interviewee and the knowledge that is produced influences our perception of the human condition.

According to Guillemin and Heggen (2009), negotiating the ethical relationship between researcher and participant is paramount in maintaining ethical rigour in qualitative research. They propose that a focus on what Løgstrup called the 'zone of the untouchable', combined with the notion of 'ethical mindfulness' as concepts may help the researcher understand how the ethics of research relations are negotiated in practice. In the planning of the qualitative interviews and in the interview setting I/we tried to appreciate and respect the interviewees' need of both proximity and distance when discussing potentially difficult themes as in the case of their personal experiences of facing moral challenges. I attempted to create trust during the interview sessions without inviting the interviewees to divulge things that they later would find difficult to have talked about. I also avoided pushing themes that the interviewees did not want to talk about, thus attempting to be constantly aware of their vulnerability. This had to be balanced out with what Brinkmann and Kvale (2015, p. 96) describe as the danger of wishing to be so respectful that the empirical data only "scratches the surface".

4. Results

"I think it is these pangs of conscience that lie there like a kind of uneasiness from when one participated in coercive administration of medicines when one did not totally agree, when one did not get to discuss … those kind of things. Such things are hard to live with."
(Nurse interviewee)

In this chapter the results are first briefly presented paper by paper and with their relationship to each other in light of the study's three developmental stages (chapter 1.1). The results are then presented thematically across the papers to show the overall scope of the study. The four studies collectively answered the dissertation's overarching or main research question: How do nurses perceive the moral distress they face working with acute psychiatric patients and how do they cope with this experience?

The use of a hermeneutic approach has created a picture of the scope of causes of moral distress and the great variation in how moral distress is experienced and handled.

4.1 Separate presentation of each paper in light of the study's three stages

Stage 1. Patient participation and moral stress.

Paper I. Patient participation: causing moral stress in psychiatric nursing?

A study on ethical challenges regarding patient participation at a sub-acute psychiatric hospital. Although patient participation was seen as important for relationship building and treatment outcomes, it was described as a problematic ideal to realise as the vagueness of its aim and content makes it difficult to put into clinical practice. Time was described as an important influencing factor on patient involvement as lack of time made it necessary first and foremost to focus on immediate tasks. Feeling ashamed for not more actively supporting patients' wishes and fighting for making it more possible for them to take part in decision-making processes was reported. Findings show that although the concept 'moral stress' was never mentioned by the interviewees, this was a phenomenon that came strongly to the fore.

Stage 2. From moral stress to moral distress; sources of and responses to moral distress.

Paper II. Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands.

The interviewees felt squeezed between their ethical values and the ‘system’. Reduced staffing, a higher number of patients, and quicker discharges made it more difficult to assess the situation and meet the patients’ needs. Admitted patients tend to be increasingly ill with a greater tendency to physical violence, like spitting, scratching, kicking, and hitting as well as serious verbal threats. It was often difficult to know where to draw the line, for instance how to act towards boundary testing or violent patients as the current philosophy is to let patients ‘defume’ to avoid restraints. It was difficult to find needed time to reassure patients, supervise secluded patients, time for therapeutic and meaningful conversations, motivation, relationship building, and for prevention of self-harm, suicide and disruptive behaviour, and clinical assessments. The nurses described feelings of frustration, anger, sadness, mental tiredness, and loss of meaning. Some felt mentally tired, without initiative, and wanting to pull away from social settings when off duty. Several experienced emotional numbness and feeling fragmented. Others talked about being emotionally ‘flat’, cold and empty. Moral distress was also seen as causing high blood pressure and problems sleeping. They could feel inadequate, being squeezed between ideals and clinical reality, and that they failed their patients. In spite of such negative feelings, several reported that they were drawn towards this work which they liked doing and found to be meaningful.

Stage 3. Ideals and coping with moral distress

Paper III. Coping with moral distress on acute psychiatric wards: A qualitative study.

The interviewees attempted to cope with their moral distress in various ways. Many discussed the importance of “sorting” their thoughts and feelings in connection with experiences at work. Thus, taking time to reflect on things that had happened seemed to be central for being able to process and cope with their experiences. Others claimed that they did not think about work after hours. Even so, several admitted that thoughts about work affected their temper and made them feel listless and without initiative. Thoughts about various incidents could keep churning or disturb their sleep. Some coped by filling their private life with good and beautiful things, others by making themselves physically exhausted, by binging on TV-series or periodically taking sleeping medication. Some took a day off or went on sick leave when work became too much. Another coping strategy was to speak out and ask critical questions concerning their clinical practice. For others, loyalty seemed to be a way of coping through trying to make themselves immune to moral conflicts. Many of those who found their work to be meaningful and gratifying, oriented themselves towards *caritas* to keep them going. For others, the thought of being able to quit their job enabled them to stay on the job.

Paper IV. How may cultural and political ideals cause moral distress in acute psychiatry? A qualitative study.
During stage 2 concerns about the consequences of the implementation of the *Law on Patients Rights* (2017) had become a focal topic together with how the nurses cope when repeatedly being exposed to moral distress in their clinical practice. In Paper IV the ways in which the current ideal of reducing coercion may raise morals issues and create experiences of moral distress in nurses working in acute psychiatric contexts were explored further.

The combination of high expectations to minimise the use of coercion and an increasingly ill patient population with a greater tendency to violence created moral doubt and dilemmas regarding how much nurses should endure on their own and their patients' behalf. The expectation to minimise the use of coercion or restraints comes from politicians, the hospital, and unit leadership, from co-workers, and also from themselves. This expectation had developed in them a higher threshold for administering physical restraining measures.

While some felt regret, and qualms about previously having taken part in restraining and coercive measures, they also worried that new legislation and ideals might prevent acutely mentally ill and vulnerable patients from receiving the treatment they need. Inadequate resources were external constraints that also could frustrate the nurses from realising the treatment ideals set before them. They expressed discomfort, guilt, bad conscience, and a feeling of inadequacy when unable to protect patients and staff during episodes of psychological and/or physical violence.

4.2 A presentation of the study across the papers

The interviewees faced complex moral challenges and incompatible demands; situations which may cause moral distress. Their moral sensitivity seems to be both a premise for and cause of moral distress although they held divergent views and had different experiences of moral concerns.

The unique nature of acute psychiatric nursing provides important contextual factors that contribute to moral distress. There is growing public criticism of the use of coercion. Demands for strengthened patient participation and prevention of coercive measures in mental health care has become a priority for care professionals, researchers, and policymakers in Norway, as in many other countries. The interviews indicate that current political, legal, and

therapeutic ideals for the treatment of psychiatric patients may be a source of moral distress (Paper I, II, IV).

4.2.1 Dilemmas between nurses' perceptions of capacity and patients' needs

Most of the interviewees found insufficient time a source of moral distress. They felt squeezed between their ethical values and the 'system' (Paper I-IV). Reduced staffing, more patients, and pressure for quicker discharges made it more difficult to assess the situation and meet the patients' needs. Time was described as essential for giving quality acute psychiatric care: time for therapeutic and meaningful conversations, time to reassure patients, relationship building, for prevention of self-harm, suicide, and disruptive behaviour (Paper II). Inadequate time for therapeutic conversations and for follow up of patients made the interviewees doubt the quality of their own clinical assessments. Many worried about being unable to sense changes in patients' condition, to misconstrue signals or be inattentive or dismissive. Untrained personnel and inadequate staffing made task delegation and follow-up of suicidal patients, patients in need of seclusion or with heightened risk of violence difficult. Untrained personnel may neither understand the gravity of situations, sense changes in patients, nor feel the same kind of responsibility as the permanent staff (Paper II).

4.2.2 Risk of violence and dilemmas concerning coercion

An increasing number of patients have serious mental problems because of synthetic drug use. This, in combination with reduced number of beds in psychiatric units, have resulted in the admitted patients being increasingly ill with a greater tendency to physical violence, like scratching, kicking, blows and strangle-holds as well as psychological violence like verbal threats. Patients spitting at the nurses and throwing object were not uncommon. Violent episodes had moreover resulted in broken curtains, pictures, and lamps. Sometimes even co-patients were hurt (Paper II and IV).

Episodes like these created an apprehensive mood on the ward and were hard on vulnerable patients and made them retire to their rooms. This made it difficult for the nurses to offer the kind of therapeutic and beneficial environment they needed. Several interviewees described feelings of guilt when unable to safeguard patients who were mentally or physically attacked by co-patients. Having to prioritise threatening or very resource-intensive patients, left less time to follow up on other seriously ill patients like for instance, psychotic patients with negative symptoms.

Thus, the nurses found that the aim to reduce the use of coercion exposed some patients to greater risk of violence (Paper IV). Moreover, this aim tended to make doctors hesitant to prescribe restraining or coercive treatment measures. This had at times placed the nurses in a potentially dangerous situation (Paper IV). Ethical challenges in the interprofessional collaboration were held to be under-communicated (Paper I).

Even so, the nurses' expectation to avoid coercive or restraining treatment was strong. They would go to great lengths to meet the patients in a therapeutic way and to avoid coercive or restraining measures, even when they themselves experienced great fear and were exposed to serious threats against themselves or their loved ones (Paper IV).

The interviewees found it emotionally stressful to participate in coercive measures even when convinced that the patient needed the treatment, and it was draining to be on the receiving end of patients' despair, anger, and frustration in connection with treatment. Even so, doubts rarely made the interviewees refuse to participate in treatment. Loyalty and adherence to instructions were emphasised (Papers I-IV). While some interviewees had qualms and perhaps even doubts about participating in coercive or restraining treatment, especially coercive administration of medicines, others reflected that the responsibility lay with the physician and that they themselves only followed orders (Paper II).

Use of coercion in settings which could have been otherwise solved if they for example had been better staffed, made the nurses uncomfortable. Some talked about having regrets and qualms about previously having taken part in restraining and coercive measures, such as placing patients in belts over longer periods of time (Paper IV).

4.2.3 Responsibility, ideals and legal changes may frustrate treatment

The interviewees talked about responsibility in different ways; being responsible for patients, especially the most vulnerable, conflicting responsibilities, and shying away from responsibilities. They described themselves as patient advocates, being responsible for clinical assessments, untrained colleagues, the safety for everyone on the ward, for patient participation, reduction of coercive treatment measures, and for the ward's expenses.

Due to the new legislation's strict criteria for being involuntarily committed to hospital, patients who previously had been committed were now admitted on a voluntary basis. It was sad and frustrating to witness the gradual decline in patients who refused to receive help,

particularly when this made children suffer because ill parents could not be retained on the ward against their will. Several interviewees often felt personally responsible for motivating patients to stay in hospital and accept treatment. Several experienced doubt and discomfort as their attempts to motivate voluntarily admitted patients to stay on longer at times could almost be seen as persuasion or coercion (Paper IV).

One of the nurses said that her greatest moral challenge at work was to witness how obviously psychotic patients had to wait for days without medicines and adequate treatment (Paper IV).

Patient participation was described as a problematic ideal to realise as the vagueness of its aim and content makes it difficult to put into clinical practice (Paper I). Thus, patient participation could become a source for moral distress. The interviewees described themselves and nurses in general as patient advocates. In spite of this, lack of time made it necessary first and foremost to focus on immediate tasks: "There are demands concerning how long patients may stay on the ward, treatment is based on diagnoses and requests from the leadership. We often have to choose the quickest solution". Time was altogether described as an important influencing factor on patient involvement – or rather, none-involvement – in treatment decisions.

4.2.4 Experienced physical and mental reactions to moral distress

Although moral distress could be positive as it could make the nurses more alert to moral dilemmas, such stress mainly seemed to have negative consequences both in the interviewees' professional and private lives. The nurses describe a great variety of emotional as well as physical reactions to the moral distress they experience at work (Paper II). Some suffered from tension headaches, others found that exhaustion made them to be irritable at home and in need of rest and quiet (Paper IV). Several had been – and still were – plagued by bad conscience and feelings of guilt, of being uncomfortable, and of doubting their own actions (Paper II and IV). Inability to support patients in relation to autonomy and treatment participation could lead to shame (Paper I). Some also experienced shame when having used restraints or coercive measures and having been unable to solve the situation differently (Paper IV).

Criticism of psychiatric care from various media, the descriptions of psychiatric units as torture chambers, and accusations of violation of human rights, were experienced as difficult (Paper IV). The interviewees described feelings of isolation because society, family and

friends were unable to appreciate what it is like to work on an acute psychiatric ward, the intense experiences, the dilemmas, and the fear. They expressed discomfort, guilt, bad conscience, and a feeling of inadequacy when unable to protect patients and staff during episodes of mental and/or physical violence (Paper IV).

4.2.5 Coping mechanisms

The interviewees attempted to cope with their moral distress in various ways (Paper III). The importance of "sorting" their thoughts and feelings in connection with experiences at work was discussed by many. This "sorting work" could take time and effort whether they reflected on episodes on their own or discussed their thoughts and feelings with colleagues or family, and it seemed to be central for being able to process and cope with their experiences. Some found that they spent the rest of the day thinking about incidents that had happened at work, particularly when there was no time to do so during work hours. For some, discussing moral challenges with a pastor/priest or in a mentoring group was a helpful coping strategy. Not every unit offered mentoring groups, though, and it was sorely missed by those who had previously taken part in such groups.

Many of the interviewees claimed that they did not think about work while at home. Avoiding bringing work with them home, as they expressed it, was seen as being "flink" (Norwegian)/doing well, and a skill they strived to master. Even so, several admitted that although they tried not to bring thoughts about their work home with them, they often did, and this affected their temper and made them feel listless and without initiative. Several described being hard on themselves and thoughts about how situations at work could have been handled differently/better often popped up or kept churning in their mind in the evenings. The danger of violence and the threatening episodes at work could furthermore disturb their sleep. Some coped by making themselves physically exhausted by working out, by binging on TV-series or watching "a bad movie" or taking sleeping medication. Some took a day off or went on sick leave when work became too much. Some coped by filling their private life with good and beautiful things. Many of those who found their work as meaningful and gratifying, oriented themselves towards *caritas* to keep them going. Other ways of coping were to speak out, talk openly, and ask critical questions concerning their clinical practice. Others did not experience the kind of ethical atmosphere or having a leadership that gave them the recognition needed to make this possible.

Several interviewees described the use of coercion or restraints and to participate in coercive administration of medications and to be exposed to violence as just being "inherent to our job". Others coped by seeing themselves as loyal cogs in the machinery or "part of the system". Trying to make themselves immune to moral conflicts through loyalty, for instance by placing the responsibility on the physicians alone, also seemed like a coping mechanism for some. For others, the knowledge that they could quit their job was a way to keeping going. Several of the nurses were in a real process of assessing whether they should change jobs.

5. Discussion

Moral distress – an expression of fidelity to moral commitments seen as imperiled or compromised.
(Carse and Rushton, 2017, p. 15).

The growing body of moral distress research points to a variety of causes and effects of moral distress. Certain root causes of this phenomenon, first identified by Wilkinson (1987), namely external and internal constraints – whether real or perceived – together with clinical situations (Hamric, 2012; Jones-Bonofiglio, 2020; McCarthy & Gastmans, 2015; Walton, 2018), are found across many healthcare settings and cultures. Even so, on acute psychiatric wards nurses face challenges to which nurses working in other fields of the profession rarely are exposed. Examples are the use of coercive treatment, treating patients against their will, informal coercion, denying patients privileges, and being exposed to threats and violence. In the back of their mind many also harbour a constant worry that patients might self-harm or commit suicide. Acute admissions may furthermore create situations where the nurses must cope with ethical dilemmas and challenges which require quick decision-making.

In this chapter I will deliberate upon why the term moral distress was broadened. Then this study's findings on causes of and responses to moral distress will be discussed together with ways of coping. Finally, the quality of the study will be discussed.

5.1 The development of an expanded understanding of moral distress

Researchers point both to the risk of a too narrow definition of the concept moral distress (Fourie, 2015) and of over-inclusivity in that the term may be used to describe completely different phenomena (McCarthy & Monteverde, 2018). A lack of conceptual clarity causes conceptual problems and inconsistencies in the literature (Sperling, 2022). To demarcate the concept from related phenomena, some authors emphasise for instance the difference between moral distress and emotional distress. McCarthy and Deady (2008) explain this distinction by the following example: "[P]sychiatric nurses may, for example, be emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong" (p. 256).

Based on the empirical data my understanding of moral distress as a phenomenon and as a concept has developed during this research project. In Paper I the understanding of the concept was close to that of Jameton's original definition. Even so, I chose to use the term 'moral stress' inspired by the works of Lützén et al. (2003) and Lützén and Kvist (2012). They suggest that inadequate attention has been paid to the unravelling of the ethical components of moral distress and claim that in most other studies of moral distress the focus mainly has been on 'distress', that is, on the psychological reactions. I found this to be an important perspective for understanding and addressing moral distress. Furthermore, Lützén and Kvist (2012) argue that employing the term 'stress' rather than 'distress' signifies more clearly that the impact of moral stress may be both positive and negative. This resonates with my understanding of moral distress – that if the distress does not persist – it may also be a valuable resource (see chapter 5.6).

As the project developed it gradually became clear that 'stress' as a concept is difficult to define and that its meaning is too imprecise in this study's context. Moreover, I find that the valuable moral component is present in both the concept of moral distress and moral stress. Lützén et al. (2012) also acknowledge the difficulty in bringing clarity to the difference in meaning of the two concepts. Furthermore, as the term *moral distress* is with few exceptions the designation used by researchers internationally, to use this concept is important when communicating with others within this field of research. Hence, in Papers II-IV the term *moral distress* is used, understood from a psychological perspective *as well as* from a moral/ethical perspective.

During the analysis of the individual in-depth interviews (Paper II), it became obvious that in many circumstances it was difficult if not impossible for the interviewees to decide what is the right course of action. In other settings the interviewees experienced a troublesome feeling that something was not right, or they did not know or were uncertain whether something was morally right or justified. Moreover, decisions on actions must often be made under complex and unpredictable conditions, which adds to the difficulty in providing care.

Jameton's (1984) original definition of moral distress seemed not to allow for such complexities of moral decision making and the variety of moral events which were described. Based on the empirical findings, it became necessary to find a more robust and sensitive definition to accommodate for the challenges that nurses must contend with in acute psychiatric settings. Thus, a broader understanding of the 'umbrella term' of moral distress

was needed to include contexts where caregivers face moral dilemmas or experience moral doubt[2]. A more nuanced understanding of the phenomenon and the concept has therefore been important to pinpoint more precisely what moral challenges nurses face in acute psychiatric contexts even if this means moving away from Jameton's (1984) original definition. This, then, is the definition on which Papers II-IV are based.

Experiences of moral distress may involve both strong emotions and psychological reactions, but they are not reducible to them (Hanna, 2004; McCarthy & Deady, 2008). Willis (2015) argues that one probably should not place too much emphasis on this distinction based on an explicit or tacit association between morality and feelings/affect as for instance empathy seems to play a part in the experience of moral distress. This is in line with my findings. The study's results indicate that the distinction between moral conflict, moral dilemmas, and moral doubt may be problematic and difficult to identify. This is supported by Fourie's (2015) conceptual analysis of moral distress.

As the intention was to study how moral distress is manifested, experienced, and coped with in clinical practice rather than to develop a conceptual theory, no further elaboration on the understanding of the concept will be forthcoming in this text. It has, however, been important to take notice of the debates and controversies found in the research literature within this field.

5.2 External constraints creating moral distress

Being morally constrained because of limited resources and interprofessional conflicts are themes that can be found throughout the literature on moral distress. Moral distress seems predominantly to be conceptualised as arising from external constraints on action (Morley et al., 2017).

In the following the text is divided into *external constraints* (chapter 5.2) and *internal constraints* (chapter 5.3) although the division between the two is not always clear cut. My

[2] Moljewijk et al., 2017, present the following "working definition": moral doubt develops when "not knowing or being uncertain whether something is morally right or justified". I find this definition to be close to the terminology used by our interviewees.

findings show that phenomena like altruism and loyalty may have both external and internal constraints.

5.2.1 Being rushed for time

In settings where one has to priorities between the need of the one patient and the needs of the many, it may be difficult to allocate resources and balance the ethical demand as they all may be affected by the nurses' choices and actions. Examples of this were time and responsibility, which were central themes during the interviews. Being rushed for time may not only hurt the patients, but also those who are there to help them. In their book on how to care for the carers, Haavik and Toven (2020) illustrate how constantly working in such close proximity to the users that one feels that one carries their problems and pain upon oneself – that is, being in what the authors call the "empathetic zone" – without being able to help, can be the toughest part of the job.

Martinsen (2012, 2021) highlights how time is needed to give room for spontaneous expressions of for instance trust and mercy. However, phenomenologically based ethical frameworks of which Løgstrup's philosophy is an example, "is primarily concerned with the meeting between me and the Other, but this leaves out of consideration … any third person to whom I may hold obligations or duties" (Holm, 2009, p. 33). Thus, philosophy helps us reflect upon the ethical challenges we face in clinical practice but does not offer a recipe for how to act or handle such challenges.

The ideal of creating a therapeutic setting, is often thwarted by lack of time. The nurse needs to respond to the trust shown her by the patient when he or she voices a need, thought, or opinion. The latter point is an example of time being fundamental for central tasks within psychiatric nursing, like building trust. Trust is a prerequisite for a therapeutic interpersonal relationship, and trust-building requires time (Killingmo, 1999).

The interviews strongly indicate that lack of time and human resources are underlying factors that feed a myriad of sources for moral distress. Among such factors are the provision of superficial and inadequate treatment, and the use of avoidable coercive measures and 'grey zone' or informal coercion. The nurses clearly saw a relationship between such factors and patients' violent and aggressive behaviours. With a plethora of tasks needing immediate attention and inadequate time to deal with them, rushed decision-making processes may

create moral doubt while blocking the nurses from soliciting advice from colleagues. The result was often a bad conscience and feelings of guilt.

Lack of time is a well-known source of moral distress in nurses independent of nursing field. In this study's context is found that this external constraint may cause different, little described, serious, and in some cases, fatal, consequences. Examples are the importance of sensing changes in the patient's illness when there is danger of self-harm, suicide, or patients acting out. One also clearly sees the moral strain when one only can offer short time supervision when one assesses that the patient needs someone to talk to, a therapeutic conversation that may influence the patient in a positive manner or even prove decisive for the treatment outcome. Also other studies show that patients receive limited therapeutic interaction with nurses in acute psychiatric settings (McAllister & McCrae, 2017).

A patient's trust in the system may disintegrate if his/her needs are not met. The healthcare personnel have power and are central in building and keeping a trustful relationship. How this relational power and trust may be used, is to a large extent dictated by the setting. The nurses are faced with moral expectations from their patients, but must also work within the rules, regulations, and conditions set by the hospital. A mismatch between their professional and moral responsibility and the available resources may become quite a burden.

Statistics show that the number of patient beds within psychiatric units have been radically reduced over the last couple of decades. While the number of patients who receive psychiatric healthcare has increased, nearly four out of ten beds have disappeared (Drabløs & Trædal, 2022). The reduction in patient beds is caused by politicians' wish to move patients from inpatient to polyclinical treatment (Bachmann et al., 2019), to make it possible for them to live at home while receiving treatment (Haugsgjerd, 2022). Haugsgjerd holds that this reduction is also partly motivated by economics (ibid.). According to our interviewees, this situation is combined with ever stricter economic regimen. This have resulted in the healthcare personnel being increasingly pressed for time, for arrange quicker discharges, and for making tougher choices. This may undermine ethical practice and exacerbate moral distress.

When practical challenges stay unsolved, they tend to become ethical problems (White, 1983). Moreover, restricting working conditions, including overcrowded wards, may in some patients exacerbate symptoms which again may lead to more restraining or coercive treatment

measures. This points to a combination of organisational and ideological changes within the healthcare system and reforms inspired by efficiency focused New Public Management theories (Austin, 2012; Haugsgjerd, 2022; Kjølsrud & Clancy, 2013; Kleinman, 2012; Vetlesen, 2010), which may contribute to a rise in moral distress among healthcare personnel. The American sociologist Daniel Chambliss (1996) argues that moral problems in hospitals cannot be separated from the organisational setting they arise from. Lützén et al. (2003, p. 313) point out that although the nurses are held accountable for the quality of care they provide, "they are rarely involved in the healthcare policy making that structures their practice".

5.2.2 Inadequate staffing and unskilled personnel

The interviewees complained about inadequate staffing. Unsafe staffing levels, which affect the quality of patient care, seem to be a universal moral distress trigger (Austin, Lemermeyer, et al., 2005; Corley et al., 2001; Deady & McCarthy, 2010; Delfrate et al., 2018; Huffman & Rittenmeyer, 2012; Kleinknecht-Dolf et al., 2015; Kälvemark et al., 2004; Lake et al., 2021; Lambour, 2016; Ohnishi et al., 2010; Pergert et al., 2019; Pijl-Zieber et al., 2018; Silverman et al., 2021; Tavakol et al., 2022; Zuzelo, 2007). Burston and Tuckett (2013) even claim that this external constraint has been found to contribute to the highest intensity and frequency of moral distress. The interviewed nurses described how limited human resources caused by economic restraints, hampered their ability to care for their patients in a way they as professionals wanted. One may argue that this impeded their ability to act according to what Løgstrup (2020) would have perceived as their ethical demand.

The extensive use of unskilled or incompetent staff seems to predict moral distress, something also pointed out by Oh and Gastmans (2015), Burston and Tuckett (2013), and Morley (2018). Employing unskilled personnel is a way of reducing expenses which may result in unsafe patient care and burden on the nurses with greater professional and moral responsibility, particularly when caring for high-risk patients. In a systematic review Flodgren et al. (2017) found that no-one seemed to have studied the impact of a high proportion of unskilled personnel on the quality of patient care and safety.

5.2.3 Asymmetric power

In line with other studies (Deady & McCarthy, 2010; Huffman & Rittenmeyer, 2012; Kjølsrud, 2013; Lamiani et al., 2017; Mills & Cortezzo, 2020; Milne, 2018; Pijl-Zieber et al.,

2008; Silverman et al., 2021; Tavakol et al., 2022; Wojtowicz et al., 2014), I found moral distress linked to asymmetries in power and authority, and to moral challenges in interprofessional collaboration. This seemed particularly to be the case when the nurses' professional assessments neither are given equal weight to those from other professions nor respected despite of the fact that nurses spend more time with the patients and thus have considerable insight into their needs and symptoms.

The interviewees reported that treatment philosophies were hardly ever discussed in the multidisciplinary teams. Deady and McCarthy (2010) found similar trends in their study on Irish psychiatric nurses, as "doctors and some allied professions were viewed as having greater power over clinical decision-making, either because of their status within mental health law or perceived status within the professions" (p.213). Conflicts relating to professional judgement or clinical decision-making within multidisciplinary teams led to moral distress. Pijl-Zieber et al. (2008) hold that the nurse-physician relationship and their collaboration is one of the main components of an appropriate ethical climate.

5.2.4 Experiencing unease, doubt, and moral dilemmas

Being a moral agent within acute psychiatric care nursing is a complex task as it often is difficult or impossible to know what the right cause of action is. Nurses must navigate moral challenges and even moral dilemmas, for instance if they have to choose between using coercive measures to prevent harm or refrain from intervening in the hope that the patient will 'defume' when given enough 'space'. The interviewees also described moral doubt, for instance concerning 'concealed' or informal coercion. Others experienced discomfort and doubt when participating in coercive administration of medication. Paper IV as well as Molewijk et al. (2017) furthermore show that moral doubt may lead to action paralysis which may increase the risk of the development of dangerous situations for both patients and staff. The mental health nurses and researchers Gadsby and McKeown (2021) go as far as to hold that "forced treatment with drugs is arguably the most ethically suspect and least defensible of a range of coercive practices employed within psychiatric services"(p.1).

Even so, not all the interviewed nurses experienced moral anguish over such events. Austin et al. (2008) holds that perception is a key component of moral distress. According to Aadland and Askeland (2017), something has to be valuable to us for us to experience moral distress; values must be at stake. Hence, values and beliefs vary and influence moral distress experiences differently. As to this, Fulford et al. (2013) claim that in the field of psychiatry,

people's values are usually more diverse than in other fields as psychiatry is concerned with areas of human experience and behaviour where absolute consensus regarding values are rare.

As shown in Table 1, existing studies on moral distress in the context of mental healthcare tend to build on Jameton's narrower definition of moral distress, and therefore do not describe the sources of moral distress I here have discussed.

5.2.5 Worries related to new legislation and ideals

The unique setting and context of acute psychiatric healthcare are mirrored in the sources of moral distress recognised in this study. These moral challenges are acerbated or coloured by contemporary discussions, trends, and therapeutic, political, and ethical ideals in the field. Additionally, there are serious questions related to collisions between human rights, disability rights, and mental health. Thus, moral distress may be seen as a phenomenon closely entwined with the culture from which it arises.

Changes in clinical practice that leads to reduced use of coercion may be experienced as a relief and thus alleviate moral distress[3] (Paper II and IV). The interviewees expressed frustration and worry about the society not adequately meeting the needs of the most seriously ill patients; those who are most vulnerable and unable to take care of themselves. Two serious instances of public violence created by mentally ill persons in Norway during the autumn of 2021, have caused debate about treatment and available recourses within Norwegian mental health care. Several psychiatrists have mirrored our interviewees' concerns regarding the 'official' description of, and ideals about, psychiatric healthcare versus the situation as experienced by healthcare personnel and seriously ill patients' family members. Randi Rosenqvist, an experienced forensic psychiatrist, for instance, criticises the ideology that coercion within psychiatry is always horrible, that everything ought to be voluntary, and holds that "in a way we have failed the ones with the poorest functioning" (NRK.no, 15.10.21). She points out that we must realise that some patients need long-time care, also involuntary care (NRK P1,10.11 2021).

The interviewees felt that the media and the politicians do not fully understand the seriousness of the acutely mentally ill patients' suffering and the complexities of the moral challenges

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[3] New approaches like 'open-door policies' (e.g., Efkemann et al., 2019; Indregard et al., 2022), may perhaps help reduce moral distress in in the future.

faced by the health professionals who care for them. This lack of insight may cause failure to care for "the ones with the poorest functioning", a situation which may be seen as a form of using power by omission. Løgstrup points out that it is impossible to avoid wielding the power we have over others:

> "We might really feel disgusted at having just the tiniest piece of another human being's life in our power, and perhaps feel that it is unworthy of both of us, as we wish that all contact between human beings were a free meeting of spirits; nevertheless, this is wishful thinking and has nothing to do with reality" (Løgstrup, 2020, pp. 46-47).

Therefore, although the suggested law and guidelines focused on patient autonomy and the avoidance of coercive treatment methods, and furthermore, that the parliamentarians have the best of intentions, wishing to protect the patients' integrity within an acute psychiatric context, the changes in the legislature (Paper IV) might in some cases have the opposite effect[4]. The interviews clearly indicate that the nurses' moral responsibility – whether as part of the job description or self-imposed – is more comprehensive and varied than what is stated in the legislature.

The interviewees were concerned that the current ideals and new legislation together with the development described above, will continue, and perhaps even impair the situation for acutely mentally ill and vulnerable patients, in which case some patients will be prevented from receiving the treatment they need (Paper IV). This seems to mirror what Campbell, Ulrich, and Grady (2018, p. 69) describe as "anticipatory distress", that is, when believing that one in the future will be involved in a morally undesirable situation leads to distress in the present. It seemed to make matters worse that it was perceived as politically incorrect to problematise these issues. This points to the rhetorical power that is to be found in an ideal so loaded with positive values that they may become immune to criticism.

5.2.6 Facing challenging behaviour and risk of violence

When facing challenging behaviour and the risk of violence the nurses move within what Liland, Haugen and Dokka (2019) would characterise as a 'risk zone' where ethical values are at stake by way of difficult choices and ethical dilemmas. An example is how to manage to simultaneously give adequate care to patients who are agitated, aggressive, or boarder-testing

[4] Issues concerning complex ethical and legal challenges related to the use of coercion will not be elaborated on any further in this text.

and to patients who are anxious and in need of a safe environment, while at the same time making sure that co-workers are secure. And what about your own needs and security? How should these issues be weighed? Patients on acute care wards are often severely ill, and their vulnerability together with the risk of violence make for a difficult balancing act with the potential of serious consequences. Basic ethical values may be at stake, and the health professionals run the risk of abusing their power and of violating the patients' dignity (Husum et al., 2022). In these kinds of charged situations there tend to be no good answers or right solutions.

As seen in Paper IV, to reduce the use of coercion by compromising the psychological and/ or the physical safety of patients or co-workers may lead to moral distress. That patients may experience to be verbally or physically violated by co-patients is also described as disgraceful and worrisome. Wedervang-Resell et al. (2017) have found that the number of violent and threatening episodes toward co-patients seems to be on the rise. There seems to be a tendency for such episodes neither to find their way into official statistics nor become part of the public discourse. That many patients are involuntarily admitted and have minimal opportunity to shield themselves from unpleasant episodes is even more problematic. To provide a safe space for patients is an aim for acute inpatient units (Cutler, 2021; Wyder et al., 2017). An important question here is whether the price co-patients may have to pay for other patients' actions and behaviour is adequately emphasised.

The interviewees did not verbalise any responsibility for themselves. One interpretation is that it reflects a culture where it is important to do well/be "flink"[5] (Paper III). Another is that it is difficult to know where to draw the line for disruptive behaviour as these nurses at times are used to what one of them described as a boundaryless and surrealistic work situation coupled with few opportunities to calibrate such episodes with people outside this culture. Moreover, we have all a great capacity to adapt to our surroundings and push the boarders of what we perceive as normal. In acute psychiatric nursing this ability might inhibit action. Normalisation helps us endure experiences and episodes that others would not have been able to tolerate (Isdal, 2017). Although one may gradually become accustomed to verbal abuse and

[5] The Norwegian concept of being "flink" – clever, resourceful; it is not quite translatable in this context – was much used among those who claimed that they did not think about work while at home, or "bring it home with them," as they usually expressed it.

treats, those victimised will still affect (Isdal, 2017; Jacobowitz, 2013). How much can nurses be expected to endure?

To what extent the nurses may focus on their own safety and well-being, what Fowler (2018) describes as nurses' duty to self-care, comes to a point when facing patients who act out or behave dangerously. By caring for their own safety, moral worth and/or dignity, the nurses might violate the patient's dignity. This creates a moral dilemma that may lead to moral distress.

5.2.7 Boundless altruism versus self-care

Løgstrup (2020) holds that the ethical demand is radical, one-sided, non-reciprocal, unconditional and absolute. Historically, this kind of radical altruism has been a basis for nursing care (Martinsen, 2000). Although Slettmyr, Schandl, and Arman (2019), based on their Swedish study, claim that present-today nurses do not fully respond to the ethical demand of their patients, the interviewees seemed to be willing to go the extra mile to give their patients competent care also when they are verbally or physically threatened or violated by them.

The altruistic concept of care can, according to Hem and Pettersen (2011), be understood as an unselfish, spontaneous, and compassionate act during which the immediate interests and needs of the particular other takes precedence over the interests of the carer. Although praised as heroic, particularly currently during the Covid-19 pandemic, altruistic care may perhaps contribute to blurred boundaries as it tends toward self-sacrifice or may easily lead to self-sacrifice.

Even so, altruism does not necessarily mean neglecting the interest of the caregiver. The American philosopher Lawrence Blum (1980) holds that "to say that an act is altruistic is only to say that it involves and is motivated by a genuine regard for another's welfare; it is not to say that in performing it the agent neglects his own interest and desires" (p. 10). According to Fink (postscript in Løgstrup, 2017, p. 318) the ethical demand does not require self-sacrifice either, "but a forgetting of oneself through the preoccupation of what is needed by the other person". Where one should draw the line between forgetting oneself and self-care, even self-preservation, is a difficult question. Thus, a balance is needed. This is discussed by Gilligan (2003), Pettersen (2012) and Hem (2008) using the concept of "mature care". Mature care intends to take into account the needs and interests of both parties in the caring relationships

and the essence of mature care is an emphasis on reciprocity. Although an interesting contribution to care ethics, this will not be expanded on in this text.

Nordhaug and Nordtvedt (2011) problematise this emphasis on reciprocity as “it is essential that the professional role relationships should be asymmetrical”, and “the principal matter in professional care is always concern for patients, not concern for self” (p. 212). Cöster (2014), in the same vein claims that “professional self-effacing” is a basic condition and an absolute ethical demand in professions where one holds the other person’s life in one’s hands. He also points out that the line between professionalism and destructive self-effacement is narrow.

In spite of tolerance for threatening and disruptive behaviours being both an internal and external constraint, where the limits of one’s tolerance should be drawn, is a theme that seems to be little discussed and left to the individual nurse for private deliberation. Also, questions concerning the moral responsibility to self needs to be raised, not only the ethical demand for others.

Schofiled (2015) holds that we have moral duties to ourselves and that this has been given little focus within contemporary moral philosophy. Munoz (2022) finds that the topic in the new century has “enjoyed a renaissance”. Historically there has been an emphasis on duties to self, or self-regarding duties in nursing’s ethics literature (Fowler 2018). This emphasis was lost when nursing education shifted to university settings and society and nursing moved away from a virtue-based ethics to a duty-based ethics (ibid.). This emphasis seems to have been somewhat restored as several nursing codes of ethics, for instance the American Nurses Association’s Code of Ethics for Nurses (2015), state that the nurse owes the same duties to self[6] as to others. In the Australian Code of Ethics there is an explanation of self-respect, which encompasses valuing the moral worth and dignity of oneself (Nursing and Midwifery Board of Australia, 2010). In the Norwegian version of the Nurses’ Code of Ethics duty to self is not mentioned.

To find a balance between selflessness or even self-sacrifice and self-care seems at times to be difficult when the situation on the ward is at its most “boundaryless and surrealistic”, though.

[6] “The aggregate duty or principle of ‘duties to self’ includes attention to personal health, safety, and well-being, preserving one’s wholeness of character and integrity, maintaining competence, and continuing personal and professional growth” (Fowler, 2018, p.152).

5.2.8 Loyalty – both an external and an internal constraint

The relationship between loyalty and moral distress is thematised in all the four papers presented in this dissertation. The term loyalty was used by many of the interviewees and thus emerged as a prominent value. It seemed to be a term with a purely positive connotation. The expectations regarding loyalty are both internal and external and seems to create moral challenges. The impression is that loyalty to doctors' orders, to the 'system', and to the current treatment philosophy is stronger than a regard for the nurses' own conscience, their role as patient advocates, and in some cases also stronger than for a safe and therapeutic environment. This is supported by Kjølsrud (2013) who found that nurses within acute psychiatric healthcare act true to the system and are loyal to their work-place's praxis even when they sometimes disagree with its ideology. In line with this Sweetmoore (2021) found that mental health nurses perceived it as professional to support the psychiatrists' decisions, which may be at odds with their own values and beliefs.

Historically, loyalty have been seen as part of the role as a nurse (Austin, Lemermeyer, et al., 2005; Masters, 2018), something which is reflected in this quotation from Peter and Liaschenko (2013): "… nurses are responsible for carrying out the orders of physicians, albeit not in an unquestioning manner, they are also responsible for enacting orders with which they might not agree" (p. 342). Professor of ethics Knut Ruyter (2011) describes loyalty as an important virtue for a business with concerted tasks and goals, but, as this study shows, it may be tested in relation to other virtues like integrity and courage.

To be loyal may have a variety of functions. Loyalty may be a way to soothe the conscience. In a study on coercion on a locked psychiatric ward Terkelsen and Larsen (2014) found that being loyal to the system seemed to remove feelings of guilt and shame in staff. The interviews indicated that for some, the expectation or wish to be loyal may be an internal constraint which may inhibit their voicing moral concerns. Some seemed to avoid being answerable for restraining or coercive treatment by, placing the responsibility on the physicians alone. Thus, while some nurses may find that loyalty shields them from moral distress, in others a ridged demand for loyalty may cause moral distress.

The way in which the interviewees seemingly uncritically refer to loyalty is thought provoking. History has taught us what in extreme settings the result may be from refusing to face one's personal responsibility. An example is Nazi nurses' refusal to take responsibility for their active participation in the Nazi regime's euthanasia program during World War II.

After the war many claimed loyalty and duty to follow their superiors' orders as their defence (Benedict & Kuhla, 1999; Benedict & Shields, 2014; McFarland-Icke, 2021). This serves as a reminder of how blind loyalty and obedience may undermine personal responsibility. This is underscored by Sørlie (2001, p. 34), who with reference to Løgstrup, holds that "[h]uman existence in interdependence and under historical conditions does not absolve the individual human being from taking responsibility or making decision, rather the contrary. As human beings we must accept and bear the consequences of our decision-making".

Rushton (2018) claims that by displacing responsibility and blame onto others, nurses risk "reinforcing a sense of helplessness, a perception of oneself as a mere pawn in the system devoid of choice" (p. 16). The vulnerable and even threatening situations in which acute psychiatric nurses may find themselves, make them dependent and interwoven with their colleagues in a very special way. To question whether the actions of or the decisions made by colleagues, the leadership, physicians/psychologists – those in charge of patients' treatment – are morally correct or defensible may easily be perceived as criticism. Silence may be motivated by fear of disconnection (Austin, 2016).

5.3 Internal constraints may create moral distress

As seen above, it seems to be easier to focus on organisational factors and detrimental structures when discussing moral distress, than on issues like lack of knowledge, moral failure, avoidance of problems, or not standing up for ones' values. Such internal constraints have received limited attention within the literature on moral distress (Morley et al., 2019).

Dudinzki (2016) points out that when the constraints are internal, the blame is self-directed, leading to remorse and guilt. In the literature on moral distress the authors point to lack of moral courage, socialisation to follow orders, perceived powerlessness, inability to identify ethical issues, self-doubt, and general doubt (Burston & Tuckett, 2013; McCarthy & Gastmans, 2015; Tavakol et al., 2022; Tiedje, 2000; Walton, 2018; Wilkinson, 1987). This mirrors our findings.

As highlighted in chapters 5.2.7 and 5.2.8, it is important to maintain a focus on nurses' personal responsibility. Even so, too great a focus on internal constraints may lead to the issues listed above being reinforced and to individualisation of problems that are too great, and which often in their origin are organisational. As to the latter point, our interviewees

reported how they repeatedly discussed issues important to the quality of patient care with the leadership. For some, this had led to a sense of powerlessness, a classic indication of moral distress, as they found that their complaints neither were validated nor resulted in any change. Others felt they were being silenced. Also, loyalty seemed to function as an internal constraint deterring the nurses from voicing their moral concerns. This exemplifies how external and internal constraint may be interrelated.

5.3.1 Lack of moral linguistic competency

Although lack of moral competency is perceived to be an internal constraint (e.g. Burston & Tuckett, 2013; McCarthy & Gastmans, 2015; Tavakol et al., 2022) which may lead to moral distress, our interviewees' descriptions and narratives were permeated by moral reflection. Their ethical reflection was very clear although they tended to refer to legislation rather than to a professional code of ethics or to ethical principles. Even so, for some it seemed challenging to elaborate on their ethical thinking. This might be understood as a lack of ethical *linguistic* competence. This is in line with Kjølsrud and Clancy (2013) who found that the nurses who worked on acute psychiatric wards were focused on being professional and on doing a good job, but did not seem to reflect on their actions in terms of their professional ethics. Kjølsrud and Clancy (2013) speculate whether this is so because legal language is more tangible and that ethical reflections remain a silent issue which each must cope with privately.

Also, other studies indicate that nurses tend to lack the linguistic and communicative acumen needed to verbalise ethical challenges and participate in ethical discussions (e.g. Hanssen, 2010; Hem et al., 2014; Pelto-Piri et al., 2012; Storaker et al., 2017). This situation may be acerbated by professional codes of ethics being rather abstract and therefore providing little guidance for clinical practice (Risjord, 2011). Another explanation might be that the interview questions were asked in such a manner that it was not natural for the informants to speak of moral challenges on a theoretical level.

When nurses have difficulties articulating their thoughts, this limits their ability to express their opinions and concerns. This may influence their moral courage negatively. In Wojtowich et al.´s (2014) Canadian study among nursing students on moral distress in a mental health context, they found that students became morally distressed from their nursing instructors lacking the competency needed to encourage ethical change in the units.

5.3.2 Being responsible and vulnerable

Awareness is a key element in moral distress (Austin, Lemermeyer, et al., 2005). As to this, as we pointed out in Paper II, nurses with high moral sensitivity seem to suffer more from moral distress (Lützen et al., 2010; Lützén & Ewalds-Kvist, 2013; Ohnishi et al., 2019; Wilkinson, 1987). Moral sensitivity is a complex phenomenon which may be described as both an awareness of patients as vulnerable and of the moral implications of decisions made on their behalf (Lützén et al. 2010).

As mentioned above, the interviewees reported a deepfelt responsibility for their patients' well-being and a will to go to great lengths to give them competent treatment and care. They were especially concerned about their responsibility to their most vulnerable patients – those who are unable to take care of themselves and voice their needs and wishes – that is, the patients most dependent on how they are met by the nurses. These patients' emotional and cognitive vulnerabilities together with the obvious power asymmetry between healthcare personnel and patients, make patients particularly reliant on being able to trust the nurses. For persons with mental health issues trust is often a major issue (Grace, 2018; Townsend & Morgan, 2017).

Through their attitude nurses can set the 'tone' for their communication with patients. Their attitude contributes to colour the other person's – the patients' – world, whether making the other's world secure or threatening (Løgstrup, 2020, p. 17). The nurses did their very best to balance their decisions between various ethical principles like the patients' autonomy on the one hand and beneficence and non-maleficence on the other, as well as "whether the category of autonomy is applicable at all" (Radden & Sadler, 2010, p. 27).

The interviewees' description of themselves and nurses in general as patient advocates or spokespersons seems to amplify their sense of professional responsibility. Finding themselves to be ineffective advocates seems to create moral distress (Paper I, Erlen, 2001; Foster et al., 2022; Huffman & Rittenmeyer, 2012; Milne, 2018; Morley, 2018; Silverman et al., 2021; Sundin-Huard & Fahy, 1999). If the nurse is co-responsible for actions and interventions which goes against the patient's wishes, this may complicate the perceived role as patient advocate severely. Thus, the restrictions on patients' rights and freedom in mental health settings may lead to moral distress among the healthcare personnel (Austin et al., 2008; Deady & McCarthy, 2010; Kjølsrud, 2013; Milne, 2018).

Patients, too, have power over each other through their behaviour. Acting out and violence create angst and powerlessness in those who are the butts of such behaviour. Patients have power over the nurses, too, as also the nurses are vulnerable when they are being threatened and devaluated and when patients use physical violence. This may create fear, self-doubt, powerlessness, and feelings of being outmaneuvered. The interviewees also reported that such episodes could create feelings of guilt and troubled conscience.

Thus, patients and staff seemed to be entwined with each other, to use Løgstrup's expression, woven together, nurses with nurses, nurses with patients, and patients with patients. They coloured each other's days through their behaviour toward each other.

Psychiatric nursing's emphasis on the development of positive relationships with patients and on the therapeutic use of self, adds to the nurses' vulnerability, not the least in those working on acute psychiatric wards. The nurses' proximity to their patients seems to make them particularly vulnerable to moral distress (Deady & McCarthy, 2010; Milne, 2018). This may affect their moral decision-making, for instance when witnessing obviously psychotic patients who due to the system may go without adequate treatment for days. Peter and Liaschenko (2004) argue that nurses feel particularly vulnerable to moral conflict as they are ever-present during client conflicts/crises. This in contrast to physicians and members of allied disciplines who have the option to step away from the immediate consequences of their actions and decisions. Nurses on acute psychiatric wards are placed in a direct contact with patients in several ways, both what Malone (2003) has named physical proximity, narrative proximity (understanding the patient's story), and moral proximity.

5.4 Moral distress responses

Responses to moral distress may be similar to closely related phenomena like burnout and compassion fatigue, as for instance sadness, anger, irritability, reduced self-esteem, helplessness, tension symptoms, insomnia, emotional and physical exhaustion and increased number of sick-leaves. Forster (2009) for instance proposes that compassion fatigue is more correctly understood as a form of moral distress. Moreover, repeated experiences of moral distress are found to create emotional exhaustion and depersonalisation (e.g. Burston & Tuckett, 2013; Delfrate et al., 2018; Meltzer & Huckabay, 2004; Oh & Gastmans, 2015; Rushton, 2018) which are components of burnout (Maslach et al., 2001). Also repeated exposure to violence may cause similar symptoms as the ones found in this study relating to

moral distress, namely guilt, self-blame, shame, and PTSD symptoms like anger, frustration, feeling emotionally numb, avoidance, nightmares (Cranage & Foster, 2022; Jacobowitz, 2013; Stevenson et al., 2015; Wedervang-Resell et al., 2017). Although these phenomena may cause similar symptoms as the ones found in this study relating to moral distress the moral component of moral distress distinguishes moral distress from them.

Research findings that moral distress affects nurses both personally and professionally (e.g. Deady & McCarthy, 2010) are echoed in my study. Even episodes of what may be seen as "mild distress"(Campbell et al., 2018) or "ethics of the ordinary" (Worthley, 1997) may have a cumulative effect when they occur regularly (Campbell et al., 2018; Corley, 1995). Also when occurring infrequently, episodes of moral distress may have a great impact as unprocessed moral distress begin to accumulate in our bodies, psyche, and minds (Rushton, 2018, p. 39). The effects of moral distress are systemic; that is, they affect the nurses' entire being (Oh & Gastmans, 2015). Feelings of anger, angst, frustration, guilt, sadness, powerlessness, nightmares, and despondency are among the symptoms or characteristics of the responses to moral distress (e.g. Burston & Tuckett, 2013; Gutierrez, 2005; Huffman & Rittenmeyer, 2012; Milne, 2018; Oh & Gastmans, 2015; Rushton, 2018; Wilkinson, 1987). These findings are in line with this study's results. Related physical symptoms like fatigue, exhaustion, tension-headaches, sleeplessness, muscle pain and palpitations are also described (De Villers & DeVon, 2013; Delfrate et al., 2018; Fry et al., 2002; Gutierrez, 2005; Hanna, 2004; Milne, 2018; Rushton, 2018). My interviewees furthermore described how moral challenging situations had activated responses like respiratory distress, feeling that their chest hurts, and clammy hands. Hanna (2004) claims that instead of talking about moral distress in terms of personal moral failure or inability to overcome institutional barriers, nurses speak of ailments like anguish, nausea, and migraine headaches. Knowledge about such symptoms and reactions from the autonomous nervous system is important to enable recognition of moral distress.

Both my findings and previous research indicate that unresolved moral distress may lead to self-criticism, self-doubt, and resentment, and produce personal and professional disillusionment (e.g. Burston & Tuckett, 2013; Deady & McCarthy, 2010; Elpern et al., 2005; Rushton, 2018). Other serious consequences are depression and emotional exhaustion (e.g. Corley, 2002; Deady & McCarthy, 2010; Huffman & Rittenmeyer, 2012; Lamiani et al., 2017; Oh & Gastmans, 2015), or cynicism, bitterness, and sarcasm (Elpern et al., 2005;

Rushton, 2018), responses which did not come to the fore in my study although some interviewees expressed concern about becoming cold, losing their humanity, and/or becoming institutionalised. Similarly, reflecting my data, other researchers find consequences like tending to withdraw emotionally from patients (Fry et al., 2002; Gutierrez, 2005; Huffman & Rittenmeyer, 2012; Morley, 2018; Oh & Gastmans, 2015) and disconnect from themselves and others (Hamric et al., 2012; Hanna, 2004; Rushton, 2018).

Such maladaptive coping mechanisms may compromise professional principles of nursing care and lead to emotional immunisation, "involving moral blindness and immunity in relation to being emotionally touched" (Storaker et al., 2017, p. 556). Moreover, they may impinge upon the nurses' sensitivity and ability to connect with others and feel empathy, closeness, and care, qualities imperative in the treatment and care of persons with mental illnesses (e.g. Hummelvoll, 2012; Radden & Sadler, 2010). The numbing and distancing effect may furthermore affect nurses' ability to create and maintain an effective therapeutic alliance with their patients. Patterns found in patients' histories illustrate the importance of the healthcare personnel's ability to create rapport with their patients and letting themselves be touched by them while reflecting upon their own personal feelings and inadequacies (Skjeldal, 2015).

Martinsen (2005, p. 145), holds that proving oneself worthy of the other person's trust demands a form of "exposure, sensitivity, vulnerability, and emotional involvement that enables one to gain insight into the other person's situation". As opposed to this, emotional disengagement may create a cumulative dynamic, a destructive spiral. My data indicates that having become disengaged in a setting where trust and relationship building are conditional on physical and mental presence, creates a feeling of discomfort that furthers moral distress. Similarly, Rushton (2018) describes how clinicians who are aware of the detrimental moral effects of their own moral distress may experience a compounded sense of deficiency and shame.

Although many of our interviewees found meaning in their work or ways to cope with work-related challenges through an orientation towards *caritas,* others experienced loss of meaning. Together with for instance crises of faith, disrupted religious practices, and a dampened moral sensitivity, Rushton (2018) sees this as spiritual responses to moral distress.

5.4.1 Feelings of shame, guilt, and discomfort

Being conscious of the consequences of one's moral distress may cause the nurse to feel shame (Rushton 2018), which furthers the feeling of inadequacy. Shame is connected to a person's internalised moral standards and, according to Tangney et al. (2007), evoked by self-reflection and self-evaluation. Shame may be triggered by the other person's critical eye; factual or imaginary (Gullestad, 2020). An example of this is a story told by one of our interviewees. She and her colleagues had had to restrain a patient by placing him in belts. Initially she had felt that she and the others had coped well with this challenging task, but when she the next day saw her colleagues' reactions, she became ashamed of what they had done.

Another described how reflecting on how she had not done more to enable patients to participate in their treatment, made her shameful. This latter nurse's shame seemed to stem from her feeling of not having been the person or professional she had wanted to be. The British philosopher Gabriele Taylor (1985, p. 57) holds that shame does not only stem from feeling exposed or being seen through the eyes of another but may also, as the latter example seems to indicate, "to have let themselves down without any real or imaginary audience". According to both Carlander and Wedeen (2019) and Skårderud (2001b) the feeling of shame is often activated either by unrealistic ideals and high expectations created by us ourselves or adopted from others.

Carlander and Wedeen (2019) claim that how the presence of shame and its impact on professionals who work with and for people through physical encounters, often are ignored. When one's person is one's work instrument, criticism of one's work is easily seen as a criticism of oneself (ibid.). To experience shame is painful as shame "informs us of an internal state of inadequacy, unworthiness, dishonour, regret, or disconnection" (Lamia, 2011). Furthermore, "feelings of shame are typically associated with a sense of powerlessness, as well as sensations of shrinking, feeling small, being exposed and wanting to disappear" (Dearing & Tangney, 2014, p. 4). Thus, shame may be a response to moral distress (Carse & Rushton, 2017; Palmer, 2021; Rushton, 2018) as well as creating moral distress.

The feeling of shame corresponds with attempts to deny, hide, withdraw, disappear or escape the shame-inducing situation (Nathanson, 1992; Tangney et al., 2007). Shame may furthermore disrupt our empathetic ability (Dearing & Tangney, 2014; Silfver et al., 2008; Tangney et al., 2007). However, it is important to note that the feeling of shame may also

have a positive influence if it for instance makes us reticent and gentle when faced with a patient's vulnerability (Martinsen, 2012) as this can stop us from regretful actions and help us to choose that which is good (Farstad, 2016).

Both shame and guilt are moral emotions[7], representing "a key element of our human moral apparatus, influencing the link between moral standards and moral behaviour" (Tangney et al., 2007, p. 345). Haidt (2003, p. 276) perceives moral emotions as "linked to the interests or welfare either of society as a whole or at least of persons other than the judge or agent". According to (Kroll & Egan, 2004), moral emotions create the power, energy, and motivation to do good and avoiding negative or hurtful actions. These feelings are also described as "emotions of self-assessment" (Taylor, 1985).

The feeling of guilt when unable to prevent a serious incident is presumed to be one of the reasons for the under-reporting of violence in the health and social sectors (Arbeidstilsynet, 2022). Inability to prevent violent episodes seems to be closely tied in with personal qualities like positive and caring attitudes to patients and communication skills (e.g. Başoğul et al., 2019; Björkdahl et al., 2013; Bowers, 2014; Hylén et al., 2019). Hence, it is understandable if inability to be mentally 'present' and manage their fear (Carlsson et al., 2004) may contribute to moral distress.

Through guilt, which many of the interviewees referred to in relation to what they have done or not done to patients, a person feeling shame becomes conscious not merely of what she is doing, but of herself. Shame involves a negative evaluation of one's global self, it is one's core self, not simply one's behaviour that is at stake (Herman, 2014; Lewis, 1971; Skårderud, 2001a; Zahavi, 2014). Hence, the cause might be difficult to identify. Guilt is often described as more tangible. One may realise what one is guilty of and ask for forgiveness, which is a reparative action (Doris & The Moral Psychology Research Group, 2010; Martinsen, 2012). In shame there is no clear path from the person who violates someone's feelings to the person who feels violated. Thus, shame is morally speaking both introvert and passive (Mesel, 2014).

[7] The relationship between shame and guilt is broad and I cannot here do it justice. As seen from my discussion, shame and guilt tend to be intertwined.

The secrecy and concealment induced by shame (Bartky, 1990) – Skårderud (2001a) calls this the shame-related silence – and the fact that shame tends to be neither clearly linguistically expressed nor consciously recognised by those experiencing it, makes one wonder whether shame might be a more common response to moral distress than thus far recognised. In instances where our interviewees had experienced being violated, this violation may have created shame as a response to the violation (Herman, 2014). However, rather than blaming the patients – perhaps that would go against the grain – the interviewed nurses blamed themselves, something that seems to create a feeling of shame. Additionally, the feeling of inadequacy, of not being robust enough, of inability to accomplish what others are able to do, may induce shame (Paper IV, Vesterager, 2019). As to this latter point, a system as such is unable to take shame to heart; the leadership needs to give room within the system for shame to be put into words. Otherwise, it is the more or less sensitive persons/staff who have to carry and cope with the shame they might feel on their own.

Feelings of discomfort were something the interviewees mentioned often. Some of them seemed to connect discomfort to experiencing uncertainty or perhaps doubt. Willis (2015) suggests that feelings of discomfort are a specific form of knowledge: a feeling or idea that something is wrong. Feelings of discomfort have in some circumstances the potential to develop into moral distress if action is not taken to address the error or wrongdoing (Willis 2015). Perhaps 'discomfort', which is a rather diffuse concept, was used by the interviewees in lack of a vocabulary that would have enabled them to express their feelings about coping with moral challenges more clearly?

5.4.2 Having a troubled conscience

The word conscience arises from Latin, *conscientia*, and French, *conscience*. There are a variety of conceptualisations of conscience. It is often understood as an inner voice. In a theological context this voice is the voice of God. In the field of psychology, Freud for instance, saw conscience (superego) as an integration of one's parents' and other authorities' values. Conscience can be defined as the internal sense of what is right and wrong, "viewed as acting as a guide to ones's behaviour" (*Oxford English Online Dictionairy*, 2022).

The interviewees often referred to their conscience as an asset or as a safeguard, but most importantly, retrospectively, as a troubled or negative response to moral distress. Several scholars link the concept of 'conscience' to moral distress (Lützén & Kvist, 2012; Rushton, 2018). With reference to the Catholic theologian Thomas Aquinas, Hanna (2004) holds that

conscience is a mode of knowing that enables us to distinguish between right and wrong, good and evil, and makes us feel accused and rebuked, and even tormented in cases of wrongdoing. Rushton (2018) refers to moral distress as "the troubled call of conscience", and the conscience is perceived as a faculty that sensitises the individual to the morally salient features of distressing situations (Rushton et al., 2013).

According to Sulmasy (2008), conscience involves a duty to be true to one's deepest moral convictions; a duty to understand what is at stake when choices are to be made and to the best of one's ability work out what is the morally right action. Conscience is furthermore "the activity of judging that an act one has done or which one is deliberating would violate that commitment" (ibid, p. 135).

Thus, our conscience can trigger moral distress when moral values are in conflict or are compromised. Some of the interviewees' narratives may be described as stories of "delayed distress" (Campbell et al., 2018). This may for instance be expressions of anguish and regret about having assisted at the restraining of patients like placing them in belts over longer periods of time, a clinical practice which according to current treatment philosophy is to be avoided as much as possible.

My literature research indicates that empirical studies on moral distress rarely refer to the conscience. I find this interesting as this was a central term in our interviewees' narratives and descriptions. Perhaps this is so because conscience is a more unmanageable concept than guilt, and that guilt is a 'translation' of conscience in the moral distress literature, as this tends more towards having a psychological perspective (Lützén & Kvist, 2012) while stress of conscience might be more theoretically connected to a theological-philosophical perspective. Glasberg et al. (2006) define 'stress of conscience' as "a product of the frequency of the stressful situation and of the perceived degree of troubled conscience as rated by healthcare personnel themselves" (p. 636).

5.5 The cost of unresolved moral distress

The costs of unresolved moral distress are high, including negative personal, professional and/or organisational outcomes. It may ultimately lead to reduced patients care, even to the point of patients being avoided (Burston & Tuckett, 2013; McCarthy & Gastmans, 2015; Oh & Gastmans, 2015; Redman & Fry, 2000). There seem to be a consensus among researchers

that an elevated level of moral distress may lead to decreased job satisfaction and burnout (e.g. Burston & Tuckett, 2013; Delfrate et al., 2018; Fumis et al., 2017; Johnson-Coyle et al., 2016; Meltzer & Huckabay, 2004; Neumann et al., 2018; Piers et al., 2012; Rushton et al., 2015). Not surprisingly, moral distress is perceived as a significant cause of increased turnover of nursing staff (e.g. Austin et al., 2017; Hally et al., 2021; Hashemi et al., 2020; Lamiani et al., 2017; Piers et al., 2012; Sheppard et al., 2022; Trautmann et al., 2015; Whitehead et al., 2015) as well as nurses leaving the profession altogether (Burston & Tuckett, 2013; McCarthy & Gastmans, 2015). This is echoed in my data, as several interviewees contemplated seeking employment elsewhere, and one was going to take a year off. The choice to quit one's job may be based on a variety of reasons. However, the impression was that moral distress was an important factor. This is worrying both because of the unique challenges in recruiting and retaining nurses (Barlow & Zangaro, 2010; Neville, 2022; WHO, 2021b; Yun et al., 2010) and because mental health services globally are already considered inadequate (WHO, 2021a). In several countries mental health nursing faces an acute workforce crisis and reports on poor staffing levels (British Medical Association, 2022; Milne, 2018). Within acute inpatient psychiatric healthcare facilities, recruitment and retention of mental health nurses is a perpetual issue (Ward, 2011).

Staff in mental healthcare settings report poorer well-being and a higher absence rate than in other sectors (Johnson et al., 2018) and burnout is a significant problem among carers within this field (Jenkins & Elliott, 2004; Johnson et al., 2018; Maila et al., 2020; Morse et al., 2012). As I see it, not recognising moral distress as a problem may be among the influencing issues.

5.6 The value of moral distress

In international research literature the negative consequences of moral distress tend to be highlighted. This is so also in this study's results. Nonetheless, I find that being morally challenged even to the point of experiencing moral distress, may be valuable if the negative feeling does not persist over time. The interviewees reported that they at times found that the moral distress experience kept them alert to moral dilemma settings, led to ethical reflection, and served as a driving force for voicing moral concerns and working for change. However, it is difficult to determine why moral challenges for some or in certain contexts lead to introspective ethical reflection and why/at what point they create moral distress. How the

nurses' concerns are met, and their personal moral resilience (see chapter 5.7.1) might be among the deciding factors.

Also, other researchers point to the value of moral distress and that it may include an opportunity for personal growth. According to several researchers (e.g. Lützén & Kvist, 2012; Tigard, 2019; Webster & Bayliss, 2000), moral distress may be a warning signal, a reminder of moral obligations and prevent moral blindness. Howe (2017) suggests that those who are able to identify and make others aware of moral conflicts may best be regarded as having a gift. They may be more perceptive and intellectually open, and more able to feel the pain of others. This can only enhance the quality of the care that is provided (ibid.). Cars and Rushton (2017) hold that to recognise and deliberate upon the feeling of moral distress represent positive moral attributes, a moral compass, and a cognisance of their own ethical values.

It reveals moral investment, and if individuals cope with moral distress successfully, personal transformation and growth can be achieved (Hanna 2004). Bauman (1993) asserts that anxiety and uncertainty is fundamental to being ethical: "The moral self is a self always haunted by the suspicion that it is not moral enough" (p. 80).

5.7 Coping with moral distress

Several authors (e.g. Amos & Epstein, 2022; Deschenes & Kunyk, 2020; Morley, Field, et al., 2021; Rushton, 2018) hold that the knowledge about how to deal well with moral distress is meagre. This study's results indicate a need to find more adaptive coping strategies and to avoid private solutions of often shared dilemmas and of a problem that often is organisational. This is important both for the quality of the treatment given and to mitigate nurses' moral distress. Knowledge about the nurses' strategies in the face of an ethical and moral challenging praxis is needed to recognise what support they need, to maintain a moral praxis, and to help them stay on in their jobs over time. Moral distress cannot be eliminated, but it is important to be able recognise it and to address harmful moral distress.

As coping strategies are often unconscious choices, what may be an effective or ineffective coping strategy is a complex question (Carver et al., 1989). Going for a run after work or binging on TV-series might function as a kind of anaesthesia and ease the nurse's distress for a little while but did not seem to help nurses cope with tomorrow's moral challenges. Thus, as

discussed in Paper III, their attempts to 'leave' their problems behind at work seemed to be rather unsuccessful. It seems essential to nurses working in acute psychiatric settings to identify and address the moral issues they face instead of trying to ease or for some, literally run away from vague and unidentified feelings of unease.

To be able to share their moral distress openly with colleagues, seem to be an important tool to avoid of harmful moral distress (Paper III, Carlander & Wedeen, 2019; Forozeiya et al., 2019; Musto & Schreiber, 2012; Silverman et al., 2021). As to this, Glasberg et al. (2008, p. 249) hold that "[i]n order for conscience and moral sensitivity to become an asset instead of a burden, healthcare employees need to be able to express their moral concerns".

The relationship between the work-place's ethical climate and the experience of moral distress is well documented (e.g. Paper III, Bayat et al., 2019; Corley et al., 2005; Pauly et al., 2009; Whitehead et al., 2015). Mack (2013) argues that to avoid moral uncertainty becoming moral distress, you need to know that you are not the only one with these feelings, and that there are forums for debate and room to pause. This requires safe moral spaces (Hamric & Wocial, 2016; Walker, 1993), where reflection is welcome and disagreements and uncertainty are honoured. In such moral spaces the healthcarers may explore and communicate their values, ethical obligations and responsibilities, and their experiences of moral distress. If it is possible to create interdisciplinary ethical forums, this will additionally provide valuable insights into the moral perspectives of the members of other healthcare professions. Hem et al.'s (2018) focus group study points to how such groups reflecting on ethics potentially may create a moral space in the workplace that promotes critical, reflective, and collaborative moral deliberations.

Several interviewees pointed to the importance of having leaders who are caring and appreciative of their inputs rather than leaders who silence the nurses when they point out moral challenges. Also, other researchers have advocated for managers who value discussing and addressing the moral conflicts that inevitably emerge in psychiatric nursing care (Deady & McCarthy, 2010; Pachkowski, 2018). Bell and Breslin (2008) argue that organisational strategies for leaders to promote an ethical climate should be expanded to include interventions to deal with healthcare provider's moral distress. According to Carlander and Wedeen (2019) open conversation is the best tool to avoid ethical stress caused by both external demands and internal expectations. Todaro-Franceschi (2019, p. 101) holds that (as far as she can tell) the greatest contributor to moral distress in nursing is either that the nurse

is unable to find (or use) her voice or that she works in a place where her voice does not seem to matter. Studies indicate that interventions designed to enhance nurses' ability to name and frame ethical issues may have a positive effect on moral distress (Allen & Butler, 2016; Browning & Cruz, 2018; Chiafery et al., 2018; Hamric & Epstein, 2017; Wocial et al., 2017).

The interviews indicate that harbouring impossibly high expectations to oneself may create the feeling of shame (see chapter 5.4). The nurses seemed for instance to expect to be able to act therapeutically even when threatened, take full responsibility for everything that happens even when the ward is inadequately staffed etc. Moreover, the expectations towards nurses by the institution and the society also seem to be unreasonably high. For instance, the demand to use less restraining and coercive treatment methods is rather paradoxical when the conditions for such reductions are not facilitated. When there are requirements as to how one *ought* to act, this demands real opportunities to act in this way (Mesel, 2014, p. 38).

Moral distress stemming from external constraints like inadequate staffing and a poor skill mix is a situation that can be corrected if the necessary funding and resources are allocated. The question is what constraints it is possible for nurses to do something about and which they have to cope with without making themselves pawns of the 'system'. When nurses perceive themselves as actors who can influence their work environment in a positive manner, this may counteract feelings of powerlessness and of being a victim in the face of moral distress (Johnstone & Hutchinson, 2015; Paley, 2004). It is also important for nurses to be able to safeguard their moral integrity through being able to follow their conscience (Davis et al., 2012). As an example of this, Gadsby and McKeown (2021) discuss the possibility for mental health nurses to claim conscientious objection for instance when being involved in the enforcement of pharmaceutical interventions. Jones-Bonofiglo (2020) found that nurses' responses to experiences of moral distress and ethical concerns often lead to no further actions.

5.7.1. Moral resilience

The clinical ethicist Cynthia Rushton (2017b) points to the cultivation of moral resilience as a path towards enabling nurses to respond to ethical challenges in ways that minimise distress and preserve integrity. She defines moral resilience as "a person's capacity to sustain, restore, or *deepen* her or his integrity in response to moral complexity, confusion, distress, or setbacks" (p.17). According to her, moral resilience is cultivated through the fostering of self-awareness, the development of self-regulating and ethical capacities, speaking up with clarity

and confidence, finding meaning in the midst of despair, engaging with others, and contributing to a culture of ethical practice (Rushton, 2016). This constitutes a shift in narrative, from distress and powerlessness to one of possibilities and solutions, which comes across as important and fruitful. A connection to meaning and purpose (caritas) seems for instance to contribute to resilience or coping in this study's participants (Paper III) although I find, as did Wocial (2020) and in a webinar (Children's Mercy Kansas City, 2020), that a focus on moral resilience is incomplete as long as one does not also address the cause(s) of moral distress. To solely highlight resilience may amplify the nurses' individual responsibility instead of focusing on the respective institution's responsibility to mitigate moral distress and facilitate ethical practice (Traynor, 2018). Individualisation of moral burdens run like a red thread through this dissertation, whether the focus is on treatment quality, ideals, or coping strategies. Responses like bad conscience, guilt, and shame emphasise this.

In line with this, Kälvemark et al. (2004) highlight that reducing moral distress through individual coping strategies is not enough. Addressing moral distress requires serious attention to the environments and systems in which the nurses care for patients. Austin (2016) insists that the notion occasionally raised that the antidote to moral distress is greater moral courage on the part of the healthcare professional, needs to be rejected: "It is an oppressive expectation in which the cost is borne by the lone individual" (p.132). This is supported by Fjeldbraaten (2010) who found that nurses chose individual solutions when their professionality was threatened, like working part-time, pulling back, and considering changing jobs. Other studies indicate that nurses to a great extent personalize problems that are caused by framework conditions (Olsvold, 2010).

5.8 A discussion on method

As seen in chapter 4.1, the heads of the respective acute psychiatric wards and units chose what potential interviewees to invite as study participants. It is impossible to say whether other participants would have given somewhat different results. Thagaard (2013), and Gullestad (1996) both hold that what interviewees choose to share with the interviewer may be influenced by how they wish to present themselves. Factors like inner constraints and the wish to present themselves as moral, reflecting, and altruistic might have influenced their responses. Although they all came across as open, truthful, and sincere, and I have no reason to doubt their sincerity, this may to some extent comprise the study's trustworthiness. However, the fact that the data presented stem from interviews with a total of 36 experienced

nurses from two different hospitals and four different wards, points to a sample size that creates adequate information power (Malterud et al., 2016). Malterud et al. (2016) suggest that information power is achieved when the sample size is sufficient in relation to the aim of the study, sample specificity – here: registered nurses experienced in acute psychiatric care – the use of established methods, and the quality of the dialogue and the analytic strategy. The latter is discussed below. The information power was also strengthened by all the interviews contributing to a rich material and to what Malterud et al. (2016) describe as "strong dialogues".

5.8.1 Researching one's own field

Sharing a professional background with the interviewees has both its pros and cons. My background as a registered psychiatric nurse, means that I have a set of "pre-understandings", "pre-judices", and a "horizon", as Gadamer (2004) calls it. Although one's pre-judices constitute one's basis for understanding, one needs to be aware of these through conscious reflection for them to evolve into something new (Gadamer, 2004). Thus, it was important for me to clarify my pre-understanding and pre-judices, all the while endeavouring to have the reflective attitude needed during both the interviews and during the analytic process.

Brinkmann and Kvale (2015) hold that being knowledgeable in the field one studies is important for the quality of the study's result. I found that sharing a professional common background with the interviewees made communication easier for several of the participants. Some of them expressed that it made them trust me and helped them speak openly and unguarded. Hence, my knowledge of the field contributed to a richer data material with a multitude of perspectives. Especially in the individual in-depth interviews which I did on my own, this was evident in comments like "you understand what I mean".

Even so, I cannot ignore that my insider knowledge may have influenced my analysis of the interviews. I have had the same kinds of experiences and can understand the challenges they are facing and their 'language'. I will, however, hold that it made me able to catch important episodes and themes which 'outsider' researchers without this kind of experience might have missed. The shared background created a particular insight and understanding that may have helped making the interviews more focused and relevant. This insider perspective may furthermore have made discussions on themes which transcended the more obvious and 'politically correct' ethical challenges, like the use of coercion, possible.

However, Repstad (2007), points to the importance of upholding academic distance and being self-critical throughout the entire process. Based on our shared background, both the interviewees and I may misleadingly have taken a shared understanding for granted. A researcher without this experience might perhaps have asked different questions which might have given answers and insights I missed. Moreover, the 'insider' researcher may ignore experiences that do not correspond with her own (Thagaard, 2013). But being two interviewers thorough many of the interviews, may have contributed to possible insider effects being reduced through the co-interviewer's inputs during the interviews and discussions afterwards.

5.8.2 The interviews

Despite considerable clinical experience, several interviewees reported that they had never before been asked how they felt about having to cope with moral challenges and how being exposed to such challenges affected them. Some came prepared with written notes on experiences and thoughts they wanted to share with us. Several expressed relief at being able to tell someone about their experiences and feelings, and to reflect on and voice their moral concerns. Birch and Miller (2000) suggest that a qualitative interview may be a therapeutic opportunity, that is, a way of making sense of experiences. This seemed to be the case for some of our interviewees.

Some interviewees shared stories; others recounted more generalised experiences. While many of the interviewees offered rich practical descriptions of moral distress and seemed to find the concept to hold explanatory power and describe their lived experience, a few found this to be a theme that was difficult to verbalise. These wanted to be asked questions or be given examples of possible moral challenges to help them get going. Once they 'got going' they shared their own experiences with ethical challenges far beyond the examples they were given. Even so, to help participants express their experiences may rise the question of reactivity. Reactivity may be defined as the reciprocal response between researcher and research participants during the research process (Paterson, 1994) exemplified by a research participant who replies in ways she assumes will please the interviewer. Paterson (1994) points out that this is a significant consideration in the provision of rigor in qualitative research in the occurrence of reactivity.

5.8.3 Data analysis

As pointed out by Gadamer (2004), the researcher's pre-understanding will necessarily colour both what she reads into her data and how she interprets it. To consciously reflect on one's pre-understanding is part of assuring the quality of qualitative studies (Malterud, 2017). Even so, whether it really is possible for a researcher to develop awareness of one's pre-understandings and pre-judices and the ability to truly articulate one's choices, is a much-discussed question. According to Gadamer (2004), it is impossible to become aware of all one's pre-judices. There will always be blind spots (Fangen, 2010; Malterud, 2017). Alvesson and Sköldberg (1994) point out that "[w]hen researchers talk about pre-understanding they have usually only paid attention to limited parts of all they carry with them into a research project" (p. 221). I have, however, tried to be conscious of my pre-understanding and pre-judices to the best of my ability. During the analytic process I therefore endeavoured to maintain an inner dialogue, not only asking *what do I understand*, but also, *why do I understand this in this way*? (Haavind, 2000).

As a psychiatric nurse, I had a rather clear picture of how many-faceted and complex acute psychiatric nursing can be as I embarked upon this project. My clinical experience enabled me to understand and partly recognise the interviewees' experiences. The open interview approach combined with my best effort to be open to what I was told by the interviewees were therefore crucial for being able to discover things that exceeded my pre-understanding. I also needed to continuously be on my guard to avoid reading more into my data then what was truly there, and not to over-identify with (some of) the participants, and thus put undue weight on some findings and overlook others (Kvale, 2001, p. 143).

As the majority of the interviews were conducted with two researchers present and all four authors of papers II-IV were included in the analytic process, this helped avoid distortion, narrow-mindedness, and biased interpretations in the hermeneutic process and offered inputs and different points of view (Repstad, 2007), which strengthened the study's trustworthiness. Also, the discussions on preliminary paper drafts by members of the research group for psychology of religion at MF, contributed to new perspectives on my findings.

5.8.3.1 Trustworthiness

Although what constitutes quality in qualitative research and how this may be determined, is much debated, an international consensus is not so far achieved (Leegaard, 2015; Mays & Pope, 2000; Sandelowski, 2015; Sandelowski & Barroso, 2002). However, to strengthen the

quality of this study, steps were made throughout the research process to strengthen or establish trustworthiness. Trustworthiness is related to whether a study is conducted in a way that inspires confidence (Thagaard, 2013). Lincoln and Guba (1985) refined the concept of trustworthiness by introducing the criteria of credibility, confirmability, dependability, and transferability to parallel the conventional quantitative assessment criteria of validity and reliability. These criteria partly overlap.

Credibility refers to whether the study investigates what it is intended to investigate. This implies that the reader has confidence in the trustworthiness of the data and how they are interpreted. Both in the individual in-depth interviews and in the focus-group interviews credibility was strengthened with the use of open-ended questions, where the participants were free to express their views in their own words.

As described on page 25, member checking was a strategy used during the interviews to establish credibility. The findings and interpretations in Paper I were additionally discussed with the participants (Lincoln & Guba, 1985), and in the project's stage 3 (see pages 3 and 34), several of the stage 2 findings were discussed in focus group interviews. Credibility was also strengthened by continually focusing on the research questions, to ensure that all steps of the research process were related to what the study was intended to accomplish. The use of both individual and focus group interviews contributed to the development of a more comprehensive understanding of the phenomenon moral distress in an acute psychiatric context. Also, the description of my professional background and pre-understanding contributes to the study's credibility (Patton, 2015; Polit & Beck, 2020).

Confirmability is concerned with how one can establish the degree to which findings of an inquiry are determined by the data and not by the biases or interests of the researcher (Lincoln & Guba, 1985; Polit & Beck, 2020) and refers to how consistent the findings are. Exact word by word transcriptions done shortly after the interviews were conducted, helped to ensure the authenticity of the data. I continuously returned to the raw data to check for referential adequacy and correctness, so that we stayed close to what was being said by the interviewees, which is important to establish confirmability and dependability. *Dependability* was achieved by keeping the entire research process logical, traceable, and clearly documented (Tobin & Begley, 2004). To achieve this, I have attempted to describe the process of coding and analysis in sufficient detail (Nowell et al., 2017).

Transferability refers to whether findings are applicable in similar contexts and settings. This was sought by providing the description of the data collection, the participants, and the analysing process so that readers may judge whether our findings can be transferred to their own setting and context (Lincoln & Guba, 1985).

Through these measures, intensive and multiple readings of the text, investigator triangulation and presenting verbatim quotations from the interviewees, I will hold that trustworthiness was achieved (Polit & Beck, 2020).

5.8.4 Strengths and limitations

According to Musto & Rodney (2018, p. 11), our full understanding of the concept moral distress remains 'under construction' – a 'constructional' work I have continued and developed further through this project. I have found it necessary to extend the concept's definition to cover the various aspects of the experience of moral distress as expressed by the nurses I interviewed.

Several theoretical approaches have been used as a variety of perspectives were needed to describe a setting so complex as the one discussed in this dissertation. This made it possible to discuss moral distress both as a concept and as a phenomenon considering both philosophy and clinical acute psychiatric nursing experiences. This has enriched the study. The multi-faceted theoretical frame of reference was developed along the way and helped to see the many faceted reality of moral distress in acute psychiatric settings. This may also be a limitation, as a narrower scope may have made a more thorough discussion possible.

As seen in chapter 3.2, qualitative methods were utilised in this study to create the depth of data needed to answer the study's research question. A problem, although internationally recognised data gathering and analytic methods were used, is that these research approaches cannot tell us whether the findings could be replicated among nurses working in other acute psychiatric settings. Even so, I see it as probable that my findings are transferable to other similar settings (Polit & Beck, 2020) but only questionnaires answered by an adequate percentage of acute psychiatric healthcare workers would give us a better answer as to whether this truly is the case. A quantitative study with a questionnaire based on this present study's findings would therefore be very useful and interesting as a next research step. Moreover, for some health carers an anonymous questionnaire may be easier to answer openly than a face-to-face interview.

Some of the incidences reported to us were 15-20 years old. This might have created so-called recall bias in the nurses conveying these stories. Even so, this study captures pivotal ethical concerns among nurses working in acute psychiatric settings and provides new insights into moral challenges experienced when attempting to solve the tension between clinical realities and the society's ideals, policies, and legislation.

Although this study is limited and local, I believe the insights offered are transferable to other acute care psychiatric nursing contexts and thus may help decrease the current paucity of knowledge within this field.

6. Conclusion and implications

This study adds new insight to the existing research literature on moral distress as a phenomenon, more specifically to the experience of moral distress in nurses working in a Norwegian acute psychiatric context. The study expands our understanding of what may create moral distress, consequences of moral distress, and how nurses cope with it. The project's empirical approach has given insights into relationships between and consequences of ethical challenges in acute psychiatric care and nurses' experiences of internal and external constraints in clinical practice. These insights, which I find to be basic for the understanding of moral distress in acute psychiatric care, I have not seen previously described. I furthermore argue for a broader definition of the concept of moral distress, which can contribute to a deeper understanding and further development of the concept.

My study clearly shows that a clarification of the concept of moral distress and the study of the experience of the phenomenon moral distress is relevant within current acute psychiatric nursing. The interviews indicate that moral distress is related to nurses' moral being, their conscience, identity as nurses, and implicitly: a strongly felt interpersonal ethical demand.

Both external and internal constraints may lead to moral distress. Multifaceted ethical dilemmas and close proximity to the patients' suffering make acute psychiatric care nurses particularly exposed to moral distress as they find themselves squeezed between their patients' needs, personal and professional standards, their strong feeling of responsibility and loyalty to the 'system'. External constraints like inadequate resources may hinder the nurses from realising the treatment ideals set before them. They are furthermore exposed to violence, the use of coercion and insufficient recourses which make giving quality care difficult. The findings indicate that also the provision of good care in the shadow of violence may lead to moral distress. Internal constrains as doubt, loyalty and lack of courage and energy to oppose the 'system' may furthermore stop nurses from voicing their moral concerns.

Thus, moral distress impacts upon the patients as well as the well-being of the healthcare professionals experiencing moral distress. Although moral distress may lead to a positive moral awakening and creativity, the study shows that it also may cause negative mental, spiritual, and physical reactions. As seen in chapter 5.7, the interviewees reported on various ways in which they endeavoured to cope with their moral distress for instance through sorting their thoughts and experiences and finding meaning in their work. Even so, more adaptive and

less private coping strategies seem to be needed. Not facing their moral distress seemed to come at a high price, as how they attempted to cope with moral distress seemed to influence both the nurses' clinical practice and their private life.

Acute psychiatric nurses face moral challenges when attempting to solve the tension between ideals, policies and legislation concerning the use of restraining and coercive treatment measures on the one hand and clinical realities on the other. This way they find themselves caught in the middle. The high expectations combined with vague guidelines on where to draw the line may also create moral doubt and dilemmas. The nurses even worry that new legislation and ideals may prevent acutely psychiatric ill and vulnerable patients from receiving the treatment they need. They are also concerned that their ability to create a psychologically and physically safe environment on the ward may be compromised. This may expose patients and healthcare personnel to greater risk of violence.

Through a clearer understanding of what causes moral distress, this study's findings may contribute to the development of a richer vocabulary and help nurses be better prepared for putting their feelings into words and thus, more accurately express the complex moral challenges they face within this field. In naming our experiences, we can come to a better awareness (van Manen & Li, 2002) as it makes us more able to act upon what we can put into words. What used to be implicit or incognisant is thus made more explicit and consciously focused upon. This may help the nurses name the sources of and responses to moral distress they experience. It may furthermore contribute to the nurses becoming more aware of moral distress *as* moral distress, and lead to the phenomenon becoming more readily thematised within the field of psychiatry/mental health.

6.1 Implications

A central question is how healthcare professionals may make use of the knowledge put forth in this and other studies on moral distress. As seen in this dissertation, moral distress is a complex human experience and an inherently contextualised, relational concept. Varcoe et al. (2012, p. 59) point out that although "[a] phenomenon that is experienced by individuals, but shaped not only by the characteristics of each individual (e.g., moral character, values, beliefs), but also by the multiple contexts within which the individual is operating, including the immediate interpersonal context, the health care environment and the wider socio-political and cultural context."

This dissertation's findings point to the following implications for practice:

- Attention needs to be given to the strain caused by moral challenges.
- Equip the wards with the needed number of adequately trained and competent staff and recourses, and physical surroundings that makes high quality therapeutic and ethical practice possible.
- The leadership needs to listen to, validate– and when possible – act on the nurses' ideas, concerns, professional judgement and their call of conscience.
- Facilitate safe moral spaces where the nurses/members of the healthcare team may share and discuss ethically challenging situations, uncertainties about how to act, clarification of the assignment of responsibility, and share feelings of vulnerability and experiences of moral distress.
- Increase the attention to nurses' duties to themself, to their personal and professional boundaries and limitations. The importance of self-compassion deserves a greater focus.

6.2 Further research suggestions

The sources for moral distress found in this study are previously little described and point to the importance of doing more research on this phenomenon in acute psychiatric contexts as the moral challenges within this field seems to be underestimated.

More research is for instance needed regarding:

- The prevalence and sources of moral distress among acute psychiatric nurses. This may be done through a quantitative study with questionnaires based on this qualitative study's findings.
- An inter-professional study of communalities and differences in how members of different professions within the field of psychiatry experience moral distress and its sources.
- How moral distress may be recognised and followed up in groups for ethical reflection or group mentoring of staff

- What makes nurses, despite all the challenges identified in this study, continue to work in acute psychiatric care?
- Connections between shame and moral distress.
- Nurses' perception of loyalty.
- Acute psychiatric patients' experience of safety/insecurity during their hospital stay. What makes them feel safe/unsafe?

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Patient participation: causing moral stress in psychiatric nursing?

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Patient participation: causing moral stress in psychiatric nursing?

Aim: The aim of this study was to explore psychiatric nurses' experiences and perspectives regarding patient participation. Patient participation is an ambiguous, complex and poorly defined concept with practical/clinical, organisational, legal and ethical aspects, some of which in psychiatric units may cause ethical predicaments and moral stress in nurses, for instance when moral caring acts are thwarted by constraints.
Methods: An explorative quantitative pilot study was conducted at a psychiatric subacute unit through three focus group interviews with a total of nine participants. A thematic analytic approach was chosen. Preliminary empirical findings were discussed with participants before the final data analysis. Ethical research guidelines were followed.
Results: Patient participation is a difficult ideal to realise because of vagueness of aim and content. What was regarded as patient participation differed. Some interviewees held that patients may have a say within the framework of restraints while others saw patient participation as superficial. The interviewees describe themselves as patient's spokespersons and contributing to patients participating in their treatment as a great responsibility. They felt squeezed between their ethical values and the 'system'. They found themselves in a negotiator role trying to collaborate with both the doctors and the patients. Privatisation of a political ideal makes nurses vulnerable to burn out and moral distress.
Conclusion: Nurses have a particular ethical responsibility towards vulnerable patients, and may themselves be vulnerable when caught in situations where their professional and moral values are threatened. Unclear concepts make for unclear division of responsibility. Patient participation is often a neglected value in current psychiatric treatment philosophy. When healthcare workers' ethical sensibilities are compromised, this may result in moral stress.

Keywords: patient participation, psychiatric nursing. focus group interviews, ethics, patient's spokespersons, moral burden, moral stress.

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Introduction

Patient participation is an ideal within mental health care in many parts of the world (1–3) and an expectation within British, American, Finnish, Swedish and Norwegian regulations. Even so, and although patient participation is strongly connected to the ethical ideal of autonomy, the concept's content and meaning can be difficult to grasp because of its complexity and ambiguity (4).

This was one of the reasons why nurses in a subacute psychiatric hospital took the initiative for this study. They wanted help to study how to accommodate for patient participation among their patients as they saw this as an ever-present ethical challenge. The original research question was as follows: How do psychiatric healthcare workers understand the concept of patient participation in their clinical practice? Focus group interviews were organised to discuss this conundrum, and the feeling of moral stress shone through these discussions even if never specifically mentioned. A second research question therefore developed during the analytic process: Why may the ideal of patient participation create moral stress in psychiatric healthcare workers?

Background

In Norway, patient participation is an ethical and legal obligation for healthcare personnel. Patient participation

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is stated in health legislation, is a formal right and a therapeutic tool (5). Patient participation is to '[c]ontribute to patients being better informed about their own treatment and care', enable them to take part in 'their treatment and care as active participants'(5, p. 1) and to encourage or maintain their capacity for autonomous choices (6). Guidelines as to how to achieve this in clinical practice is lacking in the rather diffuse descriptions of patient participation. This is not the least the case within psychiatric treatment and care (1).

The lack of guidelines for achieving this legislated goal and ethical ideal may lead to confusion and uncertainty. Healthcare workers, who strive to achieve the ideal of patient participation but lack the tools and/or the knowledge to achieve it, may experience moral stress (7). Moral stress (8, 9) or moral distress (7, 10–16) is recognised as a significant factor in nurse turnover rates in health care (13) if they find themselves unable to do what they see as morally right. As the two concepts, moral *stress* creates a greater emphasis on the ethical component(s) that cause(s) the stress than does moral distress (15), and the former concept is used in this text. When nurses experience moral stress, it is a fair assumption that this has implication for the quality of patient care (14).

Method

This pilot study came about as a collaborative project between a psychiatric subacute hospital unit and a nursing college. The researchers, representing the nursing college, were invited to study the patient participation practice within this psychiatric unit and functioned as independent outsiders.

An explorative qualitative design was chosen to enable the interviewees to define patient participation and how they worked to achieve it. Three focus group interviews were conducted. These took form of semi-structured discussions where the interviewees were encouraged to share their experiences and perspectives and thusly explore ethical challenges regarding patient participation (17). Rich data on moral and ethical thinking can be found in such discussions that provide knowledge about genuine experiences occurring in actual care settings (18). Focus group interview is a particularly well-suited research method when studying attitudes, experiences and dominant values in specific cultures or subcultures (17).

The interviewees were recruited through an open invitation to the unit's healthcare personnel working 50% or more. Eighteen persons agreed to participate in the study, and three focus group interviews were scheduled. Only nine interviewees, three men and six women (distribution: four, two and three interviewees) were able to attend at the appointed time(s) (Table 1). Each interview lasted approximately 90 minutes. The interviewees were trained healthcare personnel, eight of whom were trained psychiatric nurse specialists.

Table 1 An overview of the interviewees' ages, education and psychiatric healthcare experience

	Age group	*Education*	*Years of psychiatric health care experience*
Interviewees 1 and 2	20–30	Psychiatric nurse specialists	Ca. 5
Interviewee 3	30–40	Psychiatric nurse specialist	Ca. 10
Interviewees 4 and 5	40–50	4: Psychiatric nurse specialist	4 : 20 years
		5: Therapist	5 : 15 years
Interviewees 6–9	50+	Psychiatric nurse specialists	20+

The first author functioned as interview moderator and headed the group discussions. The second author mentored the first author, but was free to ask questions during the interviews. The interviews were electronically recorded and transcribed verbatim.

Literature searches

Several electronic searchers were conducted with the assistance of an expert librarian 2014–2015 through the databases PubMed, Psychinfo, Cinahl, Oria, Norart, Swemed and Google Scholar. We also used 'snowballing' from papers found. Initial search words were patient/use/consumer/client participation, communication and psychiatry in various combinations in English and Scandinavian languages. When the second research question was added during the analytic process, the search words moral stress/distress were added. Regardless of search engines, the searches tended to give more or less identical results. Ten of the articles found to be relevant to our research questions were Scandinavian, the rest mainly from the UK and the USA.

Deady and McCarthy (9) found, as did we, few studies on moral distress among nurses and other healthcare personnel working within psychiatric care contexts, for example (8, 9, 19). The literature found on moral distress is therefore mostly more generic in character. Even so, it helped us address and substantiate the issue of moral stress found in our empirical data and offered a theoretical basis as shown in the background and discussion sections.

Data analysis

A hermeneutic analytic approach was chosen to place the research questions at the immediate locality of daily

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life (20) and to enable the exploration of the thoughts, feelings and meaning described. We did our best to attain depth of understanding through a circular hermeneutic dialogue with the texts studied based on the researchers' foreknowledge (21). Important to the analysis therefore was the first author's background as a psychiatric nurse specialist and the second author's background in ethics and qualitative research.

Hermeneutic analysis requires reflexive engagement within the hermeneutic circle of understanding. We first read the texts to get a holistic view of the themes discussed. We found the theme moral stress significant and therefore selected it for this paper. This concept reflects what the interviewees said during the interviews, although the term 'moral stress' was never explicitly mentioned. Rather, we found this theme to be hidden behind the words, a feature identified by Ricoeur (22) as 'surplus of meaning'. Hence, the theme 'moral stress' was not, so to speak, lifted 'straight off the pages' of the transcribed interview texts, although it definitely grew out of the meanings expressed in the interviews. By being two researchers who read and re-read, the data separately we helped each other to 'remain open to the meaning of the other person or the text' (21, p. 268) and to the best of our ability avoid bias.

Analytic credibility is obtained through presenting quotations to show the reader individual interviewee's own description of their thoughts and experiences. Dependability is obtained through the experiences and feelings expressed, which, although containing individual variations, showed many communalities (23). Furthermore, preliminary empirical findings were discussed with a larger group of the unit's healthcare personnel, including all the interviewees but one before the analysis was completed.

Ethical aspects

Permission was sought from The Norwegian Social Science Data Services. They concluded that as we were to speak with healthcare personnel only and would neither gather data about patients nor personal data about the interviewees, permission from them was not needed. The hospital unit leader gave permission to do the study. Participation was voluntary. All interviewees were informed in writing and orally and were free to withdraw from the project. Recorded interviews were deleted after transcription. Transcriptions are stored according to ethical research guidelines (24). Anonymity is secured in all parts of the project, from interviews to publication.

Results

The results show a certain amount of ambiguity and disagreement regarding patient participation. The impression is that this was among the factors leading to moral stress.

Ambiguity and different perceptions

Patient participation was described as a problematic ideal to realise as the vagueness of its aim and content makes it difficult to put into clinical practice. Although hardly any questions came to the fore concerning the meaning of the concept, the discussions disclosed diverse understandings of its content. Examples are as follows: patient participation means allowing patients to decide their own treatment; letting patients choose the injection site when forcibly medicated; asking patients about their thoughts and feelings when writing the nurses' notes or adjusting care plans. Any talk with patients was by some described as a form of patient participation.

Even though being involuntarily committed to hospital was seen as an inhibiting factor for patient participation, restriction, coercion, and control were themes barely discussed. Some interviewees held that patients have a say within the framework of restraints while others saw patient participation as superficial, as when allowing patients to leave the ward on the condition that they take their medication. It was emphasised that not all patients want to participate in treatment planning; they trust the system and are only focused on being discharged as quickly as possible. As an interviewee put it: 'While some patients couldn't care less about participating, others familiarise themselves with medicines and options'.

Although it became evident that there were various views as to how to encourage patients to participate in their treatment, patient participation was seen to be of great importance for relationship building and treatment outcomes. Enabling patients to participate and have a say in their treatment are described as motivating and meaningful. Even so, the degree of patient participation was reported as modest; it was in fact described as very limited and in need of improvement. Common practice was for the healthcare personnel to 'define the goal, then meetings where we decide what is to happen after discharge – without the patient present. That I would describe as non-participation'. Patients were rarely present at the meetings where their treatment was planned. Some interviewees saw patients' attendance in meetings as imperative: 'I really think that the patient needs to be present, but I have stopped trying – it is a big thing, it applies to all meetings – more and more often the patient does not come in until the end'. 'The patients become like packages sent hither and thither, the most important person is not present'. Others held that 'some patients probably would not want to be present at such meetings. They feel that they are not being heard, anyway, it is just a facade'.

Patient support

The interviewees described themselves and nurses in general as patient advocates, without defining what they

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meant by this concept. However, they saw themselves as co-ordinators of patients' participation, for example through asking patients about their thoughts and feelings, fighting for patients' right to be present at meetings, and being the patients' general spokesperson: 'It is our job to support those who don't have the mental tools needed to express what they want'. They felt responsible for helping patients take more part in the decision-making processes and saw the unit's general limited focus on patient participation as a problem and claimed that nurses are more focused on patient participation than other healthcare workers. Even so, there were interviewees who found that that some patients had more say regarding their treatment than others, had more frequent treatment sessions and were offered more varied medication. These were patients with personality issues as opposed to for instance patients with schizophrenia who often had greater difficulty making themselves heard.

According to the interviewees, patients' opportunity to participate in treatment decisions largely depended on the unit's psychiatrists and allied professionals. While some were focused on restrictions and restraints, others based their work on different philosophies. Regardless, patients' allotted time with the doctors (psychiatrists, physicians and psychologists) was very limited. Limited time with the doctor was seen as affecting the patients' opportunity to take an active part.

It was pointed out that the nurses needed to support their patients more strongly, for instance when discussing whether patients ought to participate in treatment meetings or whether one should follow a medicine regimen more in line with the patients' wishes. Some held that nurses ought to be more loyal to the patients than to the doctors: 'I feel that we play more on the patients' team, in many ways it becomes us against them [the doctors]. It is we who are at the patients' side 24 hours a day while the physician only sees them perhaps once a week'. In spite of this, nurses were in general terms described as passive, uncritical, and more loyal towards the system than towards their patients. These latter points were exemplified by nurses participating in coercive actions like forced administration of medicines and complying with restraining orders with no questions asked, and being uncritical to the professional judgement and values behind such procedures. This was described as nurses shying away from their professional responsibility. Despite this, 'everyone wishes to respect the patient'.

Ethical challenges in interprofessional collaboration were held to be under-communicated. In fact, one very experienced nurse said she never had participated in interprofessional meetings where treatment philosophies were discussed. Lack of time made it necessary first and foremost to focus on immediate tasks: 'There are demands concerning how long patients may stay on the ward, treatment is based on diagnoses and requests from the leadership. In reality, we often have to choose the quickest solution'. Time was altogether described as an important influencing factor on patient involvement – or rather, none-involvement – in treatment decisions.

Feeling ashamed for not more actively supporting patients' wishes and fighting for their opportunity to take part in decision-making processes was reported. To promote patient participation was associated with what energy they themselves were able to muster. The degree of patient involvement in decision-making was seen as depending on the individual healthcare worker's philosophy and ability to stand by his or her professional convictions: 'It often depends on those working with the patient, how engaged they are. We have to assert our opinions strongly if we want to support the patient; sometimes we succeed'.

Discussion

This study is conducted in one hospital setting only with a limited number of interviewees. Two- to three persons are below the recommended focus group size (25). However, as more healthcare personnel had indicated that they would participate then came to two of the interview sessions, we decided to go with those who did attend. Hence, conclusions are drawn on limited data although thick descriptions were obtained from the healthcare personnel who did participate in the interviews. As the interviewees had never really discussed the issue of patient participation thoroughly within the unit previously, the perceptions thereof seemed to change or develop somewhat during the group discussions.

Diffuse concept and conflicting values

The interviewees found the essence, aim and content of the concept patient participation to be vague and how to effectuate it in a subacute psychiatric unit unclear. Guidelines for patient participation, how it is to be measured or attained, are missing. When one is to work according to a diffuse ideal with no guidelines as to how to realise this ideal, the problem is moved from the systemic to the individual level. In line with Steinsbekk and Solbør's (26) study, our interviewees reported that patient participation was largely dependent on the healthcare personnel's initiative and that it was mainly the nurses' responsibility. Because of this, patients' participation in decision-making was described as rather incidental. Furthermore, what kinds of interaction with patients were seen as patient participation varied among the interviewees, from having a say in their own treatment to being allowed to choose the injection site when forcibly medicated.

Our impression is that it was the most experienced interviewees who saw the coercive side of their work as

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problematic in relation to their ethical ideals, while the lesser experienced seemed to reflect less on such dilemmas. This is in keeping with Lützén et al.'s (19) study which shows that nurses with 6–10 years experience were more morally sensitive than their less experienced colleagues.

The individuated responsibility to comply with a legalised ideal and obligation may be particularly problematic within psychiatric health care where involuntary hospitalisation and various forms of protective, controlling and coercive measures are common. This creates a conflict between official policy and clinical practice, a variety of perceptions regarding what patient participation is, and through this, uncertainty and moral stress. The interviewees perceived themselves as more focused on patients' decision-making and on enabling their making treatment choices than were the unit's doctors. They found that their treatment philosophy at times differed from the doctors', which made the nurses feel squeezed between what they saw as their responsibility towards their patients and the doctors' treatment policy, which they often felt inhibited patient participation. This exacerbated the feeling of being squeezed between expectations – their own and the doctors'/the 'system'. Such inter- and intraprofessional judgement or clinical decision-making conflicts cause frustration and moral stress (14). This seemed to affect the nurses the hardest as they were closer to the patients then the doctors and had a strong feeling of responsibility towards them.

Austin (10, p. 29) points out that if responsibility is not aligned with the necessary power, 'the responsibility can be too great and beyond the lone (and lonely) efforts of the individual. It must be recognised that the power of the professionals flows from the social structures and relationships in which they practice'. Situations in which the interviewees disagreed with the doctors' treatment decisions were perceived as morally challenging. Even so, they rarely protested or expressed a difference of opinion. This was described as nurses shying away from their professional responsibility. Also Kjølsrud's study (27) shows that nurses are loyal to the system even when disagreeing with the ideology behind that system. If nurses feel that their moral agency, their ability to think, act and be accountable for their actions are inhibited by conflicting values, this may be an important cause of moral stress (16).

Being mediators and patients' spokespersons

Enabling patients to participate in their treatment was something the interviewees described as a responsibility that mainly fell on their shoulders. They evaluated their role as facilitators of patient participation as important but challenging. Encouraging involuntarily committed patients to participate was particularly problematic. Even so, the fact that quite a few of the unit's patients were involuntarily committed was little discussed and the use of coercion was hardly touched upon. The interviewees perceived themselves to be in a negotiator role trying to collaborate both with the doctors and the patients, a challenging place to be in a unit where these two groups often are at odds when it comes to diagnoses and treatment and where restraints and coercion are common.

Providing patients with information, motivating them to take part in the planning of activities and treatment, and make the patients' views known within the treatment team were emphasised in different ways. These are initiatives also put forth in Seljelid's (5) study. However, there seemed to be a conflict between seeing themselves as patients' spokespersons and unit mediators and the interviewees' description of nurses in general as tending to be passive, ask few questions, and be more loyal to the system than to their patients. We found it interesting that those with the longest clinical experience seemed to be the most critical to their own efforts concerning patient participation.

Not all patients seemed to want to participate in treatment planning. Their focus was rather on being discharged as quickly as possible. Reasons for this were not explored in our study. Seljelid (5) emphasises the importance of respecting patients who do not wish to be involved in various decision-making processes and to be particularly attentive towards patients who either are unable or unwilling to express their needs. Time may play a part in how involved the healthcare workers become in patients who seem uninterested in engaging themselves in their treatment. In the subacute psychiatric unit, the nurses were challenged by rapid patient turnover, increasing standardisation of treatment and care, and an ever-growing number of reports to fill in (28). Time was a cause of stress both in relation to the various nursing tasks during the day and the relative brevity of the patients' stay on the ward. Having some patients who are complying and uncomplaining and therefore less time-consuming may be welcome.

Also the language used within psychiatry, particularly when it comes to diagnoses, may restrict patients' opportunity to become actively involved as the perception of a patient's functioning tended to be coloured by the diagnosis given (29). Patients with schizophrenia, for instance, were seen as tending to have greater difficulty making themselves heard. Roberts (30) finds that through focusing on patients' resources, possibilities and potential nurses may challenge the dominant and limiting diagnostic criteria that identify patients and with which patients themselves gradually identify. He sees this as nurses' challenge and chance to create more patient participation that boosts patients' resources, options and potential. Instead of being a 'reactive force' maintaining the current system and attitudes, he holds that nurses

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may be an 'active force', thereby becoming a force that encourages, supports, and affirms patients' potentials. To work this way, nurses need to reflect on their own suppositions, attitudes, interventions and prejudices in relation to patients. On a more negative note, to work this way may make the feeling of being squeezed even stronger, which again may exacerbate the feeling of moral stress.

The interviewees' perception of patient participation developed as they in the focus group interviews discussed and together mulled over it in the light of their own clinical practice. The discussion lead to the nurses questioning whether participating in shaping the care provided was a real option for their patients and whether their mental state would allow them to utilise this right if given the opportunity.

Individuation and moral burden

Expectations concerning being their patients' spokespersons and enablers for them to take part in 'their treatment and care as active participants' (5, p. 1), and to encourage or maintain their capacity for autonomous choices (6) may cause the difference between ideal and real life hard to cope with as illustrated by the interviewee who reported feeling ashamed by not being the kind of patients' spokesperson she would like to be. Also several other interviewees held that their effort to enable patient participation needed to be greater.

The individuating focus on caring in nursing may cause frustration, as it was obvious that the interviewees felt they carried a huge moral burden on their shoulders as they saw patient participation as the individual nurse's responsibility. This privatisation of a political and ethical ideal makes nurses vulnerable to burn out and moral stress (16, 29).

Studies show that ethics and moral stress are issues rarely discussed in clinical psychiatric practice (6). Musto (14) points to dialogue with co-workers as the primary means for nurses to work through the experience of moral stress. Although the term moral stress is not currently used by our interviewees, the term may help us speak to the moral domain of our practice. In naming our experience, we become more self-aware, and what we can put into words we are better able to act upon. To enable healthcare workers to share work experiences provides space for reflection and creates a supportive work environment and reduces frustration (16) as it enables psychiatric nurses to reflect over and discuss patient participation in their clinical setting. This is something the leadership of 'our' unit has been working on after the conclusion of this pilot study through revisiting the findings and discussing how to improve communication and work conditions in staff meetings, seminars, etc.

Conclusion

As seen from the result and discussion sections, there are several reasons why the psychiatric healthcare workers interviewed experienced moral stress. One factor was being squeezed between various doctors' treatment philosophies. Nurses are both physically and mentally close to patients, to their suffering and problems, and may feel particularly vulnerable when in moral conflict as they cannot step away from the immediate consequences of their actions and decisions the way the doctors can (13). Furthermore, our interviewees associated their patients' opportunities to participate in the decision-making process with the energy they themselves were able to muster together with personal characteristics like courage and willingness to fight for professional values, thusly making a systemic challenge into an individual moral burden.

The interviewees often took on the role of negotiators and tried to accommodate both patients and doctors, a role that tended to cause moral stress. This was particularly so when patients were involuntarily hospitalised and to follow doctor's orders meant to administer coercive treatment. The interviewees were aware of their patients' vulnerability and focused on their moral responsibility towards them. Even when the cause(s) of their moral predicament(s) were outside their control, they expressed that they felt personally responsible for the care provided and that they carried the greatest ethical responsibility towards the patients. We believe that these are rather universal predicaments for psychiatric nurses, even though healthcare systems may vary between countries, a fact which may influence what contexts create moral stress and the level of moral stress (14).

Unclear concepts make for unclear action guidelines. It is important to recognise and challenge factors that may lead to moral stress in psychiatric nursing care. One of these factors is the diffuseness of the concept 'patient participation' and the lack of tools for psychiatric healthcare workers to achieve it. This causes the gap between their ideals and their clinical practice performance becomes too great. When healthcare workers' ethical sensibilities are compromised, this may result in moral stress. This is something that needs to be studied further.

Author contribution

The first author designed the study and carried out the literature research. Both authors took part in the focus group interviews, which was headed by the first author.

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The first author also transcribed the interviews and carries the main responsibility for data analysis with the second author as mentor and co-analyser. The paper text is mainly written by the first author, but also the second author has contributed substantially.

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Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands

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Abstract

Background: In this article, the sources and features of moral distress as experienced by acute psychiatric care nurses are explored.

Research design: A qualitative design with 16 individual in-depth interviews was chosen. Braun and Clarke's six analytic phases were used.

Ethical considerations: Approval was obtained from the Norwegian Social Science Data Services. Participation was confidential and voluntary.

Findings: Based on findings, a somewhat wider definition of moral distress is introduced where nurses experiencing being morally constrained, facing moral dilemmas or moral doubt are included. Coercive administration of medicines, coercion that might be avoided and resistance to the use of coercion are all morally stressful situations. Insufficient resources, mentally poorer patients and quicker discharges lead to superficial treatment. Few staff on evening shifts/weekends make nurses worry when follow-up of the most ill patients, often suicidal, in need of seclusion or with heightened risk of violence, must be done by untrained personnel. Provision of good care when exposed to violence is morally challenging. Feelings of inadequacy, being squeezed between ideals and clinical reality, and failing the patients create moral distress. Moral distress causes bad conscience and feelings of guilt, frustration, anger, sadness, inadequacy, mental tiredness, emotional numbness and being fragmented. Others feel emotionally 'flat', cold and empty, and develop high blood pressure and problems sleeping. Even so, some nurses find that moral stress hones their ethical awareness.

Conclusion: Moral distress in acute psychiatric care may be caused by multiple reasons and cause a variety of reactions. Multifaceted ethical dilemmas, incompatible demands and proximity to patients' suffering make nurses exposed to moral distress. Moral distress may lead to reduced quality care, which again may lead to bad conscience and cause moral distress. It is particularly problematic if moral distress results in nurses distancing and disconnecting themselves from the patients and their inner selves.

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Moral dilemmas, moral distress, moral doubt, psychiatric acute care, psychiatric nursing

Introduction

All clinical nurses are confronted with multifaceted ethical dilemmas on a daily basis. However, psychiatric patients in acute care settings may be particularly vulnerable given their mental illness, which may cause patients to disagree with diagnosis and treatment; do self-harm and suicidal tendencies; have vague and varied understanding of the illness, coercive treatment, dilemmas re prioritising, patient participation, and conflicting interests with patients and relatives; and so on.[1–4]

Ideological and professional differences within the field may moreover lead to professional, ethical and personal dilemmas in the carer. Within Norwegian mental healthcare legislation, there is a strong focus on patient participation, patient dignity and minimal use of coercion. The latter issue is in line with European trends.[5] Although Norway is a welfare state with free medical care, structural changes and economic restrictions combined with a growing criticism of treatment in mental care may cause pangs of conscience and moral distress among healthcare staff.

Jameton[6] coined the term moral distress which he defined as negative feelings that arise ‘when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action’[6] (p. 6). Wilkinson[7] added internal constraints (as self-doubt, being socialised into following orders and lack of courage) as sources of moral distress. In line with other researchers,[8–10] we find that in complex care settings, it may be difficult to know what the morally right course of action is.

Based on our empirical findings, we therefore will argue for a broader definition of the concept in which contexts where caregivers face moral dilemmas or experience moral doubt are included. Moral dilemmas make people feel morally compromised. However, non-persistent moral distress may at times be a wake-up call and cause ethical reflection and thus prevent moral blindness and be a reminder of moral obligations and keep us alert to moral dilemma contexts.[11,12] Lack of moral distress in morally challenging situations may be seen as problematic as it may signify a lack of moral ‘antennas’.

The existential basis for our discussion is the understanding that we have a moral responsibility when meeting the other person. According to Løgstrup,[13] this is an ‘ethical demand which is given its content where one [person’s] life is entangled with another’s’ and one is ‘to care for the other’s life the way the entanglement dictates’ (p. 20). ‘A sense of responsibility animates ethics’ (p. 29, Hatab 1997 in Austin[14]).

Even episodes of mild distress may have adverse cumulative effect when occurring on a regular basis.[8] Unresolved moral distress may lead to feelings of guilt, powerlessness, shame, despondency, anger, angst and self-criticism.[15,16] Nurses who experience moral distress tend to withdraw emotionally from patients[17] and disconnect from themselves and others.[12] To frequently experience morally stressful situations may cause ‘moral residue’ resulting in increased levels of moral distress, the so-called crescendo effect.[18] Common related physical symptomatology are headaches, stomach pain, sleeplessness, weight changes and palpitations.[16,19,20] Thus, moral distress is a significant cause of staff turnover[17,21,22] and burn-out[20,23] and, ultimately, is harmful to patients.[23]

Main features distinguishing moral distress from other constructs, such as emotional distress, burn-out or post-traumatic stress, are the perceived violation of one’s professional integrity together with a feeling of personal core values and duties being violated.[18]

Although moral distress may strongly influence nurses within acute psychiatric care, an insider perspective on the moral challenges in psychiatric care and how nurses cope with these are insufficiently

studied.[20,21,22,24] Existing studies mainly focus on nurses working within critical and acute somatic care.[9,21,22] Researchers have studied ethical challenges experienced in relation to coercion and forced medication,[1,25,26] but there is insufficient knowledge on broader ethical challenges experienced by clinicians in mental healthcare.[27]

The number of interprofessional papers on moral distress in psychiatric care are sparse[28] and only few are written specifically within acute psychiatric nursing.[22,29] Our study focuses on nurses only.

This study is motivated by an uneasiness based on clinical experiences indicating that nurses may experience moral distress without recognising it. If unaware, we may fail to recognise underlying moral conflicts and the impact moral distress may have on patient care and on the individual nurse. Moral distress may cause even greater harm if not addressed.[30] In naming our experiences, we become more aware of them; what we can put into words, we are better able to act upon.[31] This article's aim is to describe sources of moral distress and what characterise moral distress in acute mental care nursing settings.

The research questions are as follows:

1. What sources of moral distress are found within psychiatric acute care settings?
2. What features of moral distress are expressed by nurses working within psychiatric acute care settings?

Research method

A qualitative design was chosen, with individual in-depth interviews. This to acquire insights into the interviewees' subjective experiences, attitudes, thoughts and motives.[32,33] A purposive sampling strategy was used to identify potential participants in two mental health hospitals in southern Norway. Inclusion criteria: registered nurses with varied length of work experience in the field.

A total of 16 nurses were interviewed (Table 1), an adequate number to secure information power[34] as the interviewees all possessed the specific characteristics needed to answer the study's research questions.

Table 1. Background and number of nurse interviewees.

Years of psychiatric nurse experience	Number of nurses	Psychiatric specialists	Male nurses	Female nurses
0–5 years	2		1	1
5–10 years	6	4	2	4
10–15 years	2	2		2
15–20 years	2	2		2
20+ years	4	4		4

The interviews were audio recorded and transcribed verbatim. Interviewees were encouraged to share their thoughts and recount experiences. Follow-up questions and 'mirroring' of statements were used to develop, clarify and verify statements.

Literature searches

Repeated electronic searches were conducted with the assistant of an expert librarian through PubMed, CINAHL, PsycINFO, Oria and Google Scholar. The search terms were variations of the terms moral stress,

moral distress, mental health, psychiatric care in general or mental health nursing, and psychiatric or mental health hospitals or units.

Data analysis

The analysis was thematic and hermeneutic in character where depth of understanding was attained through a circular investigation of the interviews and literature texts.[35] Braun and Clarke[36] define thematic analysis as 'a method for identifying, analysing and reporting patterns (themes) within data' (p. 79). Their six thematic analysis phases were used: (1) Familiarisation with the data sets, (2) Coding and (3) Collating codes into potential themes. Phases 4 (reviewing themes) and 5 (defining and naming themes) were done collaboratively by all authors. (6) The first author wrote a preliminary paper text which then was discussed and developed further collaboratively.

Rigour was obtained through four analysts. The researchers originated from different professional backgrounds, two with an insider view as psychiatric nurses with experience from acute settings and two from other fields of expertise, thus having little previous knowledge about the topic. This way the authors balanced each other and as a group avoided bias. This added value to the analysis.

Strengths and limitations

The majority of the interviewees were psychiatric nurse specialists with many years' experience from acute psychiatric care. As participation was voluntary, we cannot say whether the views presented are representative for all nurses in the hospital units in question. Although our study is limited and local, we believe the insights offered are transferable to other acute care psychiatric nursing contexts and thus may help decrease the current paucity of knowledge within this field.

Ethical considerations

The study was approved by the Norwegian Social Science Data Services. All interviewees were informed orally and in writing that participation was confidential and voluntary and that they were free to withdraw from the project at any time. All signed an informed consent form.

Results

The interviewees faced complex moral dilemmas and situations which may cause moral distress. This matches the broadened definition of moral distress on which this study is based. The interviewees' moral sensitivity seems to be both a premise for and cause of moral distress although they held divergent views and had different experiences of moral concerns. An interesting feature is how practical problems and institutional constraints created moral distress and at times also ethical dilemmas. Three main themes came to the fore: Experienced dilemmas between nurses' perceptions of capacity and patients' needs, risk of violence and dilemmas concerning coercion, and experienced physical and mental reactions to moral distress.

Experienced dilemmas between nurses' perceptions of capacity and patients' needs

Most of the interviewees found insufficient time a source of moral distress described as bad conscience and feelings of inadequacy and failing their patients:

> Those who shout the highest demand the most attention . . . this makes for little time for for instance patients with schizophrenia with many negative symptoms, who hear voices and retreat to their room . . . these are the patients who particularly give me bad conscience. (I13)

One described how she when tired became distant and unable to have the patient participation she wanted. Reduced staffing, more patients and pressure for quicker discharges made it more difficult to assess the situation and meet the patients' needs.

Time was described as essential for giving quality acute psychiatric care: time to reassure patients; to supervise secluded patients; and for therapeutic conversations, motivation, relationship building and clinical assessments. Potential suicide or self-harm were basic worries and were experienced as a great responsibility. Inadequate time for therapeutic conversations made the interviewees doubt the quality of their own assessments: 'It doesn't help much to check on someone sitting on her bed 20 times during a shift if you don't have time to figure out what goes on inside her head' (I6).

Untrained personnel and inadequate staffing made task delegation and follow-up of suicidal patients, patients in need of seclusion or with heightened risk of violence difficult. Untrained personnel may neither understand the gravity of situations nor feel the same kind of responsibility as the permanent staff:

> I have seen patients under permanent watch where the personnel are sitting with the door slightly ajar focusing on their mobile phone, while the patients are in bed with the duvet over their heads. (I4)

Thus, working with untrained colleagues greatly increased the nurses' responsibility and worry, a situation they had communicated to the leadership.

Many worried about being unable to sense changes in patients, to misconstrue signals or be inattentive or dismissive. Inadequate time for proper talks with patients during a watch, or to read the report or treatment plan, to go for walks with patients and so on created feelings of inadequacy, bad conscience and frustration.

Risk of violence and dilemmas concerning coercion

The interviewees found that patients tend to be more gravely ill with more use of synthetic drugs and lower threshold for physical violence than a few years ago. This is combined with fewer seclusion rooms and fewer staff. This made episodes of threats and violence more prolific:

> It is very difficult, it is the patients' safety and the staff's safety, while there is a continuous pressure to use as little coercion as possible – that is perhaps our greatest moral dilemma. (I2)

Several interviewees had faced serious verbal and physical threats and been hit, kicked and clawed by patients. Some seemed to belittle such experiences as something they had to expect or get used to, while others found the burden of being afraid under-communicated. The interviewees tended to blame themselves after episodes of disruptive behaviour and wonder if they could have been prevented.

Sometimes it was difficult to know how to act towards boundary testing or violent patients as the current treatment philosophy is to let patients 'defume' to avoid coercive treatment. This created ethical dilemmas as it influenced negatively on co-patients and could cause discord and doubt among the staff. Even so, the nurses wanted to be courageous and not guided by fear. Being responsible for co-patients' and colleagues' safety could, however, be exhausting. The strain was exacerbated by a strict economic regimen and having to defend engaging extra staff when needed.

Coercive treatment was mainly characterised as necessary and a caring measure towards patients who suffered greatly, self-harmed or were threatening. Anti-psychotic medication was understood as an important part of treatment during acute psychiatric phases and as a necessary evil. Yet, the interviewees found it

emotionally stressful to participate in coercive measures even when convinced that the patient needed the treatment, and draining to be on the receiving end of patients' despair, anger and frustration in connection with treatment:

> Coercive medical regimens when delusions are strong and patients suffer from side-effects, that is painful and stressful. (I6)
>
> Although I deep inside perhaps understand that she had to have that medicine, it is abusive towards her when so many people enter . . . at times I find that some cases are doubtful. (I5)

Even so, doubts rarely made the interviewees refuse to participate in treatment. Loyalty and adherence to instructions were emphasised: 'It is difficult to execute coercive [treatment measures] you do not agree with, but of course we do it . . . for me this is a moral dilemma' (I2).

While some interviewees had qualms about participating in coercive treatment, others reflected that the responsibility lay with the physician and that they themselves only followed orders. One said that she still regretted not having refused to coercively administer medicines which she and others felt should have been postponed. However, she admitted that she probably still today would not have refused to follow doctor's orders.

Use of coercion when the situation could have been otherwise solved if better staffed or the unit's routines had been more focused on individual patients' needs made the nurses uncomfortable. One related how he found it morally stressful when a patient who needed to be freed from straps was left too long due to the unit's routines. The use of coercion was also difficult if disruptive behaviour was caused by a co-worker's personality or communication style.

Refusing to limit patients' autonomy was another factor causing moral distress as this could lead to patients disgracing themselves in social media and thus damage personal and work relationships. This placed the nurses squeezed between the patients' wishes, their families' worry and the doctors' orders.

Decreased use of coercion is seen as strengthening patients' dignity through fewer limitations and less control of patients. Morally challenging situations made the nurses reflect on their actions and choice of coping strategies, a mental activity they saw as important to counteract violation of their patients' dignity when possible. One of the nurses said it was important to her to remain critical and not becoming institutionalised. Media's increased criticism of psychiatric treatment was found to be an extra burden and harmful for families' and patients' trust in the treatment system.

Experienced physical and mental reactions to moral distress

Moral distress mainly seemed to have negative consequences both in the interviewees' professional and private lives. Several had been – and still were – plagued by bad conscience and feelings of guilt, of being uncomfortable and doubting their own actions: 'Sometimes I find it difficult to know if medicating is the right thing to do; I will probably never be able to be sure what is best. That is uncomfortable' (I13).

Others described feelings of frustration, anger, sadness, inadequacy and loss of meaning. Some felt mentally tired, without initiative and wanting to pull away from social settings when off duty: 'I create a kind of shield between me and my surrounding' (I14). Several interviewees said they experienced emotional numbness and feeling fragmented. Others talked about being emotionally 'flat', cold and empty: 'It is a little scary, really, that I am a little cold, am able to not think about it. How humane is one then, basically?' (I13). Moral distress was also seen as causing high blood pressure and problems sleeping: 'I have been on sick leave due to stress, got high blood pressure. I sometimes feel that I cannot breathe, that no-one listens' (I4). Several had contemplated quitting their jobs, one was going to take a year off.

Discussion

In this study, moral distress is described in light of nurses' experiences. Our results support the presupposition that moral distress is present in acute mental healthcare and indicate that moral distress may be caused by multiple events.

Moral distress due to insufficient recourses

Although inadequate resources are a known phenomenon in healthcare settings, how this leads to moral distress in acute psychiatric contexts is little described. Our findings indicate that inadequate time and competency may lead to superficial treatment, reduced follow-up of suicidal patients, more disruptive behaviour and use of coercion. These practical problems and institutional constraints create moral distress. These constraints may also lead to moral doubt and ethical dilemmas, which again creates moral distress.

Although nurses are responsible for the quality of their nursing care, our interviewees found they had little influence on decision-making and framework factors. This is an acknowledged source of moral distress.[17,23,37] An increasing patient population with graver illnesses in combination with budgetary cuts and diminishing resources also lead to moral distress through frustrating nurses from adhering to their professional and ethical convictions. Irish nurses in acute psychiatric units were found to experience moral distress when they believed that the standard of care was below their personal and professional criteria for best practice.[22] Extensive use of auxiliary personnel forces nurses to spend their time keeping an eye on untrained co-workers rather than on patients which counteracts their utilising their professional competency.

As already indicated, lack of human and time resources is a root cause for moral distress in acute psychiatric nursing.[20,24] The consequences of inability to give patients the attention they need may be fatal as this is a high-risk patient group. The underlying risk of suicide and self-harm in patients may add to the nurses' feelings of vulnerability, worry and guilt.

Creating a therapeutic nurse–patient relationship is the core element of psychiatric nursing.[24,38] However, Hummelvoll and Severinsson[39] found that 'the acute and unpredictable character of the working situation in combination with short hospital stays result in a tentative and summary nursing care characterized by "therapeutic superficiality"' (p. 17). This gives rise to stress in nurses as it 'constitutes a hindrance to meeting the patient as a person'[39] (p. 17).

Hence, lack of time may result in the claims and wishes of patients who shout the highest and most clearly articulate their needs being given priority. So do patients who threaten or display disruptive behaviour. This may lead to other patients' need of assurance and feeling safe being ignored, placing the nurses in a squeeze between their professional and humanistic ideal and the reality of clinical practice. Nurses work in close proximity to vulnerable patients. Proximity ethics helps us focus on the moral obligation and responsibility that is created in the meeting with the other person, an obligation which Løgstrup[13] defined as a person's 'ethical demand'. Utility and efficacy considerations may lead to nurses having to compromise such demands.

With more human and general resources, many situations could have been otherwise resolved. The use of untrained staff and low staff ratio which gives little time for trained nurses to spend adequate time with patients might be factors in patients' violent and aggressive behaviours.[40,41] However, the effect of inadequate resources seems to be underemphasised, which is in line with findings from a nursing home study.[42]

Exposure to violence – a source of moral stress

Violent and disruptive behaviour are main causes of stress in acute psychiatric care, and exposure to violence can have an adverse effect on the psychological and physical health of staff.[40,43,44] Our study

shows that coping with disruptive patients may be both a stress factor and a moral concern which may lead to moral distress. With the exception of a study on adolescent mental health nursing[45] that shows that actual or perceived inability to maintain safety may lead to moral distress, this is a point we have not found described elsewhere in a substantive way.

Psychiatric nursing's ideals of assuring their patients, containing their own feelings and giving emotional support in the face of violence and manipulation are important to our interviewees. Violence and disruptive behaviour 'adversely affect patient outcomes in that staff may be reluctant to engage with such individuals because of anxiety about being hurt or experiencing further intimidation'[40] (p. 40). A Canadian study[43] shows that violent patients may make healthcare personnel less empathetic and compassionate towards their patients, which goes against nurses' caring ideals. After violent episodes, nurses may, as described by our interviewees, doubt their own care practice and question whether they could have acted differently and thus achieved a better outcome.

While our interviewees describe being responsible for colleagues' and patients' safety, they do not verbalise any such responsibility between themselves. The impression is that they see being brave, unafraid and uncowardly as moral qualities. Emotional dissonance is in itself a risk factor for developing health problems.[46]

In addition to caring for everyone's safety, the interviewees found a growing pressure to reduce the use of coercion and resources. Such incompatible demands may create moral distress. Thus, system-level responsibilities like political ideals and regulations become the individual healthcare workers' responsibility.[2]

Doubt, loyalty and moral distress

As in other studies,[25,47] coercion in general is rarely mentioned as a moral challenge. This is in line with Molewjik et al.'s[26] findings that nurses were among the professions who found it least problematic to utilise coercive measures. Long years of experience within acute psychiatric care may partly explain their pragmatic attitude. Interviewees with more experience agreed that coercion can be seen as care and a safety measure.[26] In line with the study by Hem et al.,[1] our interviewees seemed to find coercion to be necessary and even as good care at times. However, coercion could create moral distress when deemed to be excessive or inappropriate. New kinds of ethical dilemmas in clinical practice, as when patients disgrace themselves in social medias, unclear boundaries and divergent practices among staff may also lead to moral distress.

Coercive administration of medicine is a source of moral doubt and distress among our interviewees. In spite of their doubts and the emotional stress from forcing medication on patients, refusal to administer treatment ordered by doctors is rare. This may spring from the nurses working within a biomedical understanding where medications harbour a central place. However, the nurses are participants in a culture increasingly criticised for coercive treatment regimens and for a traditional understanding of psychiatric illness. Hence, trends within the psychiatric nursing profession may contribute to doubts concerning best practice caused by the counter-reaction to one-sided emphasis on biomedical research and revitalisation of humanistic values.[48] The participation in the present treatment culture will probably be met with more questions and criticism in years to come, something which might become an added source of moral distress.

We find the way loyalty is accentuated by our interviewees interesting. The impression is that loyalty to doctors' orders and to the 'system' is stronger than a regard for their own conscience and role as patient advocates, even when they disagree with the ideology the treatment represents.[2,49] We wonder whether this understanding of loyalty may cause moral distress.

Our interviewees hold that internal constraints as lack of energy and moral courage deter them from voicing their concerns. To experience lack of moral courage may also be part of moral distress. To question the treatment ordered or colleagues' actions may moreover seem threatening by co-workers and, as an interviewee pointed out, be difficult in a treatment culture where everyone is dependent on each

other. Staff members who actively try to influence decisions already made or the conduct of their colleagues are rare.[47] The need to fit in is strong as the consequences of not doing so result in professional isolation and further frustration.[22]

Other interviewees seemingly placed the responsibility of coercive treatment on the doctors and viewed themselves as 'only following orders'. One might query whether this is a coping mechanism to make oneself immune against moral conflicts? May loyalty in some shield them from moral distress, while blind loyalty in others may cause moral distress? In any case, a lack of responsibility and obligation would go against nurses' professional and moral integrity, and being mentally present, empathetic and emotionally supportive are abilities needed when caring for gravely ill psychiatric patients.

The features of moral distress

Our analysis indicates that psychological and/or physical reactions to moral distress may lead to poorer quality nursing care, which again may lead to a bad conscience and moral distress. Conscience is closely related to moral distress and harm to moral integrity. 'To have to deaden one's conscience in order to keep working in healthcare are statistically significantly related to the risk of becoming burnt out'[50] (p. 25). However, our findings also indicate that our conscience may function as a safeguard as it motivates to ethical reflection and to disclose unethical practice, unsafe treatment and care, something which illustrates that some, non-persistent moral distress may also be valuable.

Sundin-Huard and Fahy[51] found that nurses who experience moral distress and who attempt to be vulnerable patients' advocates without success experienced intensified moral distress, frustration and anger. Moral distress may furthermore lead to desensitisation to the moral aspects of care.[52] Hence, it is particularly problematic if moral distress results in nurses distancing and disconnecting from patients and themselves.[12] Interviewees' references to feeling numb, emotionally 'flat', cold and fragmented may be understood as such reactions. Rushton[16] holds that clinicians who experience 'emotional disengagement, shutting down, numbing, and disconnecting' (p. 37) carry unresolved moral distress.

To feel moral distress while being unable to put into words what causes these experiences may create an even stronger feeling of being uncomfortable and experiencing inadequacy. Our findings as well as those of other studies indicate that it can be difficult for nurses to verbalise their moral and ethical reflections.[1,42,47,53] Thus, detachment and physical moral distress 'symptoms' may be caused by inadequacy when it comes to express ones' feeling in words.

Conclusion

Moral distress may be caused by a variety of reasons and lead to a variety of reactions. Multifaceted ethical dilemmas and close proximity to the patients' suffering make acute psychiatric care nurses particularly exposed to moral distress as they find themselves squeezed between their patients' needs, personal and professional standards, and loyalty to the 'system'. They are furthermore exposed to violence, the use of coercion and insufficient recourses which make giving quality care difficult. Our findings indicate that also the provision of good care in the shadow of violence may lead to moral distress. Internal constrains as doubt, loyalty and lack of courage and energy to oppose the 'system' may stop nurses from voicing their moral concerns. Moral distress may lead to a positive awakening regarding moral dilemmas but may also cause bad conscience and frustration, anger, sadness, feelings of inadequacy, loss of meaning, mental tiredness, emotional numbness, sleeplessness and high blood pressure. This mélange of sources for moral distress are little described, and our study shows how important it is to do more research on this phenomenon in acute psychiatric contexts. It also shows the usefulness of the broadened and more robust understanding of the concept as used in this study.

This study's empirical approach has given insights into relationships between and consequences of ethical challenges in acute psychiatric treatment as well as nurses' experiences of internal and external constraints in clinical practice. These insights, which we find important to understand moral distress in acute psychiatric care, have not been previously described. Our findings indicate the importance of nurses listening to their moral disquiet and develop moral courage and a language for ethical discourse that may strengthen moral resilience and prevent moral distress.

Further research is needed on the broadened concept of moral distress presented in this study when experiencing moral dilemmas and moral doubt. As only 3 of the 16 interviewees were men, it may be interesting in a future study to look for gender difference where more male nurses are represented.

Conflict of interest

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Coping with moral distress on acute psychiatric wards: A qualitative study

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Abstract

Background: Nurses working within acute psychiatric settings often face multifaceted moral dilemmas and incompatible demands.

Methods: Qualitative individual and focus group interviews were conducted.

Ethical considerations: Approval was received from the Norwegian Social Science Data Services. Ethical Research Guidelines were followed.

Participants and research context: Thirty nurses working within acute psychiatric wards in two mental health hospitals.

Results: Various coping strategies were used: mentally sorting through their ethical dilemmas or bringing them to the leadership, not 'bringing problems home' after work or loyally doing as told and trying to make oneself immune. Colleagues and work climate were important for choice of coping strategies.

Discussion: Nurses' coping strategies may influence both their clinical practice and their private life. Not facing their moral distress seemed to come at a high price.

Conclusions: It seems essential for nurses working in acute psychiatric settings to come to terms with distressing events and identify and address the moral issues they face. As moral distress to a great extent is an organisational problem experienced at a personal level, it is important that a work climate is developed that is open for ethical discussions and nourishes adaptive coping strategies and moral resilience.

Keywords

Acute psychiatry, coping, mental health nurses, moral distress, nurses

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Introduction

Nurses working within acute psychiatric settings – that is, giving treatment and care during an acute phase of mental illness – often find themselves in situations facing multifaceted moral dilemmas and incompatible demands. This may cause moral distress.[1] Moral distress is an increasingly familiar term and a common phenomenon in many healthcare contexts and professional groups.[2] The concept is attributed to Jameton[3] and may be defined as an unpleasant feeling or a psychological imbalance which arises when one knows what the ethically right action is, but internal and/or external factors make it impossible to act accordingly. Moral distress may also arise when caregivers face moral dilemmas or experience moral doubt.[1,2,4]

Moral distress may be a positive reminder of moral obligation, keep us alert to moral dilemmas and help us maintain high standards of care.[5,6] However, moral distress tends to affect negatively both the quality of healthcare delivery and the well-being of the healthcarers themselves.[7] Unresolved moral distress may lead to feelings of guilt, bad conscience, sadness, powerlessness, emotional numbness, shame, cynicism, despondency, anger, angst, self-criticism and resignation.[1,8–10] It may violate one's integrity[8] and produce personal and professional disillusionment.[10] Nurses who experience moral distress tend to withdraw emotionally from patients[9,11] and disconnect from themselves and others.[9,12] Common physical symptoms are fatigue, exhaustion, headaches, stomach pain, sleeplessness, weight changes and palpitations.[8,9,13] Thus moral distress may cause staff turnover,[1,10,11,14,15] burnout[10,13,15,16] and is ultimately harmful to patients.[9,10,15,16]

Frequently experienced morally stressful situations may cause moral residue, 'that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised',[17] resulting in increased levels of moral distress, the so-called crescendo effect.[18] Rushton et al.[19] claim that 'few solutions have been proposed for alleviating a problem that is only expected to escalate as healthcare becomes more complex' (p. 82). In line with Rushton et al.'s findings, various interviews with mental healthcare workers indicate that the challenges within acute psychiatric care are escalating.[1,20] Increase in challenges may increase moral distress.

How nurses in acute psychiatric care cope when repeatedly being exposed to moral distress in their clinical practice is sparsely investigated. Rushton[8] points to moral resilience as a defence against moral distress, that is, 'the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks'. Exploring ways of coping can lead to the knowledge necessary to understand what kinds of support, skills, structure and so on nurses need to find strategies that can mitigate the negative effects of moral distress. Staff in mental care settings report poorer well-being and a higher absence rate than in other healthcare sectors.[21] It is clear that burnout is a significant problem in mental health.[22] Morse et al.[22] comment on the irony of 'the mental health field [having] paid relatively little attention to the health and well-being of its own workers' (p. 10).

Molewijk et al.[23] have 'found little information on how health care professionals actually deal with ethical challenges in health care' (p. 2). How to 'deal with' present and future legislation was very much on the interviewees' minds. To cope means to 'carry on, get by, make do, manage, survive'.[24] In this article, the question of 'dealing with' moral distress is seen in light of coping. The aim is to explore how nurses attempt to cope when in moral distress. Our research question is as follows:

> *RQ.* How do nurses working in acute psychiatric settings cope with moral distress?

Methods

A qualitative design with in-depth interviews and focus group interviews was chosen to acquire insights into the interviewees' subjective experiences, attitudes and thoughts[25,26] concerning coping with moral distress.

Qualitative research is well suited to study the complexities of this phenomenon and how moral agents experience moral distress in dynamic contexts.

This article is part of a larger study on sources, features and reactions to moral distress in nurses working in acute psychiatric settings.[1] Questions concerning coping were among the themes discussed. In-depth individual interviews were conducted with a total of 16 nurses in two different mental health hospitals. In addition, we did three focus group interviews with a total of 14 nurses working on acute psychiatric wards (Table 1). In these groups, the focal point was the sharing of common experiences and associations rather than group dynamics. This created somewhat different data and ideas than the individual interviews did.[27] In all the focus group interviews and about 50% of the individual interviews, two interviewers/moderators were present.

A purposive sampling strategy was used to identify potential participants. These were identified by the heads of the acute psychiatric units in question. These were all informed orally and in writing about the study's content, purpose and goal.

Inclusion criteria are registered nurses with work experience in the field. The interviews took form of electronically recorded talks where the participants were encouraged to share their thoughts and recount challenging experiences. Follow-up questions and the 'mirroring' of statements were used to develop, clarify and verify statements.

Data analysis

The first author, a psychiatric nurse specialist, transcribed the interviews verbatim. Two of the co-authors, both nurse ethicists, took part in the data collection. All authors participated in the data analysis. All the interview texts were analysed together in light of coping with moral distress. We used Braun and Clarke's[28] six analytic phases for thematic analysis: (1) the authors familiarised themselves with the interview data through reading and re-reading the interview texts. (2) Interesting features were coded and (3) collated into potential themes.[28] Phases 4 (reviewing themes) and 5 (defining and naming themes) were done collaboratively by all the authors. We kept returning to the transcripts to ensure that our interpretations were supported by the data. (6) The first author's preliminary text was discussed and developed further collaboratively.

Analytic credibility is obtained through quotations with interviewees' own description of thoughts and experiences. Rigour is obtained through being four analysts. The researchers having different professional backgrounds, two with an insider view as psychiatric nurses and two from other fields of expertise, add value to the analysis.

Ethical considerations

Approval was given by the Norwegian Centre for Research Data. All interviewees were informed orally and in writing that participation was confidential and voluntary, and that they were free to withdraw from the

Table 1. Background and number of nurses interviewed.

Years of psychiatric nurse experience	Individual interviews	Focus group interviews	No. of mental health/psychiatric nurse specialists among the interviewees
0–5	2	4	
5–10	6	6	8
10–15	2		2
15–20	2	2	2
20+	4	2	6

project. All signed an informed consent form. Interview transcriptions are stored safely according to Ethical Research Guidelines.[29] Recorded interviews were deleted after transcription.

Strengths and limitations

The majority of the interviewees were mental health specialists with many years' experience from acute psychiatric care (Table 1). As participation was voluntary, we cannot say whether the views presented are representative for all nurses in the hospital units in question. Although our study is fairly local, we believe the insights offered are transferable to other acute care psychiatric nursing contexts and thus may help decrease the current paucity of knowledge within this field.

Results

To care for persons who suffered greatly mentally was seen as meaningful and gratifying despite the fact that their work tended to influence their private life and even their well-being:

> This is what keeps you going, that you feel that you can do a lot of good for so many . . . although [they are] not totally cured, generally the patients are better on discharge. (N16)

However, in periods with inadequate staffing, and when work challenges and ethical dilemmas seemingly were piling up, some interviewees could find it necessary to take a day off or even go on sick leave. They realised that they were unable to do a good job without a respite when physically and mentally exhausted: 'You work with problems all the time; you cannot have problems yourself. You have to be rested and fresh' (N12).

The interviewees' coping mechanisms may be divided into three main themes: through 'sorting' their thoughts and feelings, not taking work home with them or loyalty versus speaking up.

Sorting thoughts and feelings

Lack of resources that frustrated the nurses' ability to give patients the care they needed was often mentioned. One of the nurses had furthermore witnessed 'unjustifiable' conduct that could escalate into dangerous situations both from unskilled extras and professional staff. The importance of 'sorting' their thoughts and feelings was discussed by many of our interviewees. They found this 'sorting work' as one of them called it essential both for being able to process and cope with their experiences and for finding their work meaningful and worthwhile over time, despite dilemmas and worry about the quality of treatment and care.

The need to work through their thoughts and feelings was handled differently on the different wards. It seemed particularly focused on one of the wards. There they talked about the positive effect of talking things through together:

> To talk together and use each other's experience and come to an agreement, that can remove stress. We are good at ventilating concerns, choices we have made. (N9)

N3 found that the

'best way to cope is to talk with my colleagues about how I experience what has happened. If I am going to cope with this job for years, I need help to sort things through. If not, there is a great danger of burnout'. On her ward they discussed ethical dilemmas on a near daily basis. Even if something could have been done

differently, it did not necessarily mean that it was done wrong. Therefore, it was important to 'be able to talk about things afterwards'. (N9)

For some, discussing moral challenges with a pastor/priest or in a mentoring group was a helpful coping strategy. The latter was a setting where all kinds of themes could be discussed, and the nurses felt free to 'talk about how it affects us' (N3). Not every unit offered mentoring groups, though, and it was sorely missed by those who had previously taken part in such groups.

Not taking their work home with them

The Norwegian concept of being 'flink' – being good at something; it is not quite translatable in this context – was much used among those who claimed that they did not think about work while at home, or 'bring it home with them', as they expressed it: 'I do not bring anything home with me, absolutely not' (N8). Even if there were a lot of things she disapproved of or saw as problematic at work, 'I do not bother to bring it home with me'. N28 agreed and said that she had 'learned to push it away when I get home'. Also, N6 claimed that she was quite 'flink' (good at) leaving her thoughts concerning work at work. Even so, some evenings, when in bed, she would think about certain episodes and wonder what she could have done differently. N2 held that 'I have become quite flink/good at leaving it behind me on my way home, otherwise it would hardly be possible to work here'. Although N16 held that frustrations and ethical challenges at work did not affect her mood at home, she did at times worry that things at work influenced her private life.

Thus, there was an obvious dissonance between these nurses' claim of not bringing their work home with them and what often occurred. Several interviewees admitted that although they tried not to mull over work when at home, they often felt 'tired and grumpy when I get home and I need to sleep' (N27.) And 'while one really would have wanted to go for a run or be among friends, just have fun, one lacks the strength, becomes without initiative' (N6). Others admitted that the thoughts 'kind of pop up' even when off duty because 'there are some things that stick with you'.

N14 said she often felt frail, empty and tired when she got home from work, that she created a shield between herself and her surroundings and felt emotionally numb and that she was losing her role in her own life. Her way of coping was to fill her private life with good and beautiful things. N11 coped with feelings of work-related inner disquiet and inability to sleep by trying to make herself physically exhausted by working out, or periodically taking sleep medication. She also found that it helped to 'stay in bed and binge on TV series or watch a bad movie'.

According to N13, years of experience as a psychiatric nurse had enabled her to 'rapidly disengage from the many difficulties [at work] when I get home. But it worries me a little, too, that I have become cold and blasé'. Becoming emotionally numb, cold and distant was a worrying thought for several interviewees. N14 said that she tended to disengage her feelings when she was more tired than usual. As many patients were very perceptive, she felt this was unfortunate as they could comment on her seeming abstracted.

Loyalty versus speaking up

Some interviewees coped with participating in treatment with which they disagreed by seeing themselves as loyal cogs in the machinery – as 'part of the system' – or by 'just doing as [the physicians] have decided'. As N10 put it, 'It is no problem for me that others have decided what I am to do, like giving coercive medication. I am no doctor, I cannot prescribe anything, I am to administer it'. Furthermore, 'I can say that I will not give this, but then one of my colleagues will have to do it' (N2). To participate in coercive treatments and to be exposed to violence were described as 'inherent in our job' by several interviewees.

The nurses clearly experienced and coped with these kinds of possible morally distressing situations differently. N9 found that when 'it is difficult to know what is the best thing to do, your hands become clammy . . . that is a stressor'. Tension headache was another rampant bodily symptom. N5 tended to develop headaches on days when she knew they were short staffed, which meant that she would have to shoulder extra heavy responsibilities. She tended to feel guilty when patients became aggressive or violent and the safety of patients and/or nurses was threatened. This made her feel that she should have acted differently, it was her fault, and she should have prepared herself better. This kind of self-criticism – even guilt and shame – was often mentioned in connection with the use of coercion or inability to prevent aggressive behaviour and violence.

On one of the wards, there was room for critical questions concerning their clinical practice, and the Head Nurse listened to them and acknowledged their experiences. On this ward, 'we are free to speak our minds. That helps' (N27). Another pointed out that 'if we should have kept it inside, we would have exploded a few times, I think, and not been able to stay on'. Freedom to be this candid about thoughts and feelings was not common on all the wards, though.

For some, the knowledge that they could quit their job somehow seemed to be an incentive to stay on. Several interviewees were seriously contemplating changing jobs. They had tried to speak up about problems like understaffing that could lead to inadequate patient care, but their complaints had neither been validated nor led to any change.

Discussion

In this article, we discuss how nurses attempt to cope with difficult moral challenges both in their psychiatric practice and when off duty.

Reappraising and seeking support from colleagues

Seeking support from colleagues has been identified as a common strategy for coping with moral distress.[14,30–33] This is in line with some of our findings. Especially on one ward, the nurses reported that they habitually shared thoughts, feelings and experiences. On this ward, the nurses had worked an average of 12 years and most of them had post-bachelor specialty training. This might indicate that their combination of experience, education and trust in each other's competency created the self-confidence needed to be honest and open with each other. These nurses' experiences indicate that staff involvement in ethical discussions should be supported and promoted by the leadership.

Engaging in dialogue with colleagues can be seen as a form of reappraisal.[34] Reappraisals may be among the most effective ways to cope with stressful situations as 'we alter our emotions by constructing a new relational meaning of the stressfull encounter' (p. 116).[34] Many of our interviewees 'alter [their] emotions' and construct 'a new rational meaning' to orient themselves towards *caritas*.[35] As a concept, caritas indicates the will to do good. Caring acts are coping strategies grounded in the nurses' orientation towards caring.[35] To do good may be an effective coping strategy as it may create compassion satisfaction.[36] Perhaps this can be seen as existential coping.

However, discussing moral concerns may by some psychiatric nurses be perceived as either threatening to the participants or jeopardising team cohesiveness.[14] Musto and Schreiber[37] found that nurses with positive experiences from on-the-job dialogue may be able to accept that they have done their best, an acceptance that enables them to work with a renewed focus on the therapeutic relationship. Those with negative experiences from such dialogues were unable to accept that their work performance in morally difficult situations 'is the best I can do'. This made them either leave the unit or talk about leaving.

Those of our interviewees who were thinking of quitting their jobs indicated having had negative experiences with dialogue in the workplace as their moral distress had been dismissed and silenced by H their unit Head. This illustrates the importance of fostering a positive ethical work climate where raising ethical questions is encouraged. This encouragement must come from the leadership who, if not in a position to address the morally challenging issues raised by staff members themselves, needs to provide resources which can facilitate ethics-related conversations.[19] Organisational conditions and practices influence the way in which ethical issues and concerns are identified, discussed and decided,[38] and engaging in dialogue may be the primary means for nurses to mentally work through the experience of moral distress.[37] Thus, the more positive the ethical climate is perceived to be, the lower the reported moral distress, and vice versa.[9,39,40]

Lack of control, but attempting to leave problems at work

Our interviewees often faced situations of moral distress in which they felt they had limited or no influence or control. While a strong sense of coping, or even mastery, reduces the risk for stress of conscience and protects against stress, 'a low sense of mastery may evoke feelings of helplessness, possibly affecting the way the nursing staff experience ethical and moral dilemmas and thus increase the stress related to a troubled conscience' (p. 15).[41] This is supported by Ando and Kawano[31] who hold that one of the reasons why psychiatric nurses fail to act in response to ethical problems is that some felt helpless while others felt gloomy and do not know how to cope with the problem. Of course, in some contexts, there may realistically speaking be few problem-solving possibilities.

Many nurses used compartmentalisation as a strategy to get on with their everyday life outside work. This was found also by Helmers et al.[42] in their study, expressed as 'shutting the door'. However, 'there is no on-off button for emotions, they are in themselves autonomous' (p. 31),[43] and the advice often given to healthcarers about not taking the job home with them and on self-care may constitute an extra burden.[43]

In many of our interviewees, moral distress tended to surface as uneasiness, numbness and/or physical symptoms. Some even had nightmares. Taking sick leaves or going for a run may be effective short-term avoidance strategies to regain the strength needed to cope with work challenges in a healthy way. However, the body 'tells tales' and this kind of 'self-care' may become an added problem.

Loyalty and make oneself immune as coping strategies

The interviews strongly indicate that nurses tend to be loyal and faithful to the system. Loyalty may stem from expectations from the workplace and its leadership and from the individual's identity as a nurse,[44] and loyalty is understood as a virtue. We found that loyalty also may be understood as a coping strategy, a way to disclaim responsibility, to mitigate moral distress. Through placing the responsibility on the leadership and on other professions, the nurses may abscond from their moral standards. This may be seen as an attempt to make oneself immune to moral conflicts one faces, a common coping strategy used by Irish psychiatric nurses.[14] To be immune means to be invulnerable, proof, protected and unaffected.[24] Our interviewees tried to achieve this by for instance arguing that other nurses would perform nursing actions if they themselves refused to do them. Others described feeling resigned, that they trivialised morally challenging situations or had distanced themselves from them, becoming more aloof, cold and blasé. Health and social workers who frequently experienced emotional dissonance, a discrepancy between felt and expressed emotions, reported higher levels of exhaustion, mental distress and absences from work.[45]

None of the nurses in the quantitative studies Oh and Gastmans[9] reviewed reported positive strategies for coping with moral distress. Among the mentioned strategies were leaving or considering leaving their job, as also seen in our study. However, '[s]ome nurses may become accustomed to moral distress as they gain

experience, and some may suffer from cumulative moral distress' (p. 27).[9] It is therefore important that '[h]ealth care workers can learn to respond positively to ethically challenging situations by building their capacity for moral resilience, and organizations can support them by creating a culture of ethical practice' (p. 82).[19]

Conclusion

Our interviewees reported on various coping strategies. For some, sorting through the ethical dilemmas they experienced seemed to lead to moral resilience, while others tried to solve problems by bringing them to the leadership.

None of those who sought to 'leave' their problems 'at work' seemed to succeed in doing so. Rather, not facing their moral distress seemed to come at a high price. And, loyalty as a coping mechanism might become a source of moral distress rather than a distinguisher. Thus, how nurses cope with moral distress may influence both their clinical practice and their private life. It seems essential for nurses working on acute psychiatric wards to come to terms with distressing events and identify and address the moral issues they face. Independent of coping strategies, caritas seems to be a driving force.

Moral distress is to a great extent an organisational problem, albeit experienced at a personal level. It is important for unit leadership to foster a climate for ethical discussions and reappraisals of experiences and treatment choices. More research is needed regarding what promotes adaptive coping strategies and moral resilience among nurses in the complex field of acute psychiatric care.

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RESEARCH

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How may cultural and political ideals cause moral distress in acute psychiatry? A qualitative study

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Abstract

Background: There is growing public criticism of the use of restraints or coercion. Demands for strengthened patient participation and prevention of coercive measures in mental health care has become a priority for care professionals, researchers, and policymakers in Norway, as in many other countries. We have studied in what ways this current ideal of reducing the use of restraints or coercion and attempting to practice in a least restrictive manner may raise morals issues and create experiences of moral distress in nurses working in acute psychiatric contexts.

Methods: Qualitative interview study, individual and focus group interviews, with altogether 30 nurses working in acute psychiatric wards in two mental health hospitals in Norway. Interviews were recorded and transcribed. A thematic analytic approach was chosen.

Results: While nurses sense a strong expectation to minimise the use of restraints/coercion, patients on acute psychiatric wards are being increasingly ill with a greater tendency to violence. This creates moral doubt and dilemmas regarding how much nurses should endure on their own and their patients' behalf and may expose patients and healthcare personnel to greater risk of violence. Nurses worry that new legislation and ideals may prevent acutely mentally ill and vulnerable patients from receiving the treatment they need as well as their ability to create a psychological safe climate on the ward. Furthermore, persuading the patient to stay on the ward can cause guilt and uneasiness. Inadequate resources function as external constraints that may frustrate nurses from realising the treatment ideals set before them.

Conclusions: Mental health nurses working in acute psychiatric care are involved in a complex interplay between political and professional ideals to reduce the use of coercion while being responsible for the safety of both patients and staff as well as creating a therapeutic atmosphere. External constraints like inadequate resources may furthermore hinder the healthcare workers/nurses from realising the treatment ideals set before them. Caught in the middle nurses may experience moral distress that may lead to physical discomfort, uneasiness and feelings of guilt, shame, and defeat.

Pressure on nurses and care providers to reduce or eliminate the use of coercion and reduction of health care spending are incompatible demands.

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Keywords: Moral distress, Acute psychiatry, Coercion, Cultural ideals, Political ideals, Psychiatric nursing, Mental health nursing

Background

Acute psychiatric units are specialised places for persons needing voluntary or involuntary short-term treatment during an *acute* phase of psychiatric illness. Admission to an acute in-patient unit depends on the severity of the psychiatric symptoms, the person's level of distress and the risk of harm to self or others [1].

The development of legislation concerning the mentally ill are closely related to the development within the society at large. With every new legal reform, the treatment of the «mad», «insane», and «mentally ill» has, as these labels imply, become more humane. The European Council has ambitious goals regarding discontinuation of coercive measures within psychiatric healthcare in Europe. This follows the United Nation's Convention on the Rights of Persons with Disabilities [2]. Concurrently there is growing public criticism of the use of restraints and coercion together with demands for strengthened patient participation, and scepticism toward medical treatment. Prevention of restraining or coercive measures has become a priority for care professionals, researchers and policymakers [3], and reduced use of seclusion is now widely identified as a quality issue for mental health services [4].

In Norway, restraining and coercive treatment measures are only to be used when unavoidable. In 2017 a new *Law on Patients' Rights* [5] was passed which established that only patients incapable of giving competent consent may be involuntarily admitted for psychiatric treatment. This law's aim is to strengthen psychiatric patients' autonomy and legal rights. In 2019 the *Coercion Restriction Law* was presented for the Norwegian Parliament. According to this legislative proposal the use of mechanical restraints should be discontinued within three years [6].

Although well intentioned, the proposed legislation with its aim to reduce the use of restraints and coercion is unspecific regarding when coercion may be used. Added to this, diffuse political and therapeutic ideals that are difficult to realise may increase the vulnerability and moral distress experienced by nurses working in mental health wards [7].

The concept *moral distress* is attributed to Jameton [8] (1984) and may be defined as an unpleasant feeling or a psychological imbalance which arises when one knows what the ethical right action in a certain situation is, but internal or external restraining factors make it not possible to act accordingly. Political and/or therapeutic ideals may be among these restraining factors. In line with other researchers [9, 10] we find that in complex care settings it may be difficult to know what the morally right course of action is. In recent years there has been an increasing debate about the conceptualization of moral distress [11]. Based on our empirical findings we will argue for a broader definition of the concept in which contexts where caregivers face moral dilemmas or experience moral doubt are included. Moral doubt might be described as not knowing or being uncertain whether something is morally right or justified [12]. Research indicates that the nurses find themselves in moral doubt over time, experience moral distress [13].

Unresolved moral distress may lead to for instance feelings of guilt, bad conscience, sadness, powerlessness, emotional numbness, shame, cynicism, despondency, anger, angst, self-criticism, resignation and may violate one's integrity [13–16]. Nurses who experience moral distress tend to withdraw emotionally from patients [15, 17] and disconnect from themselves and others [13, 14, 18]. Common related physical symptomatology are fatigue, exhaustion, headaches, stomach pain, sleeplessness, weight changes and palpitations [14, 19, 20]. Thus moral distress may cause staff turnover [17, 21, 22], burn-out [16, 20, 22, 23], and ultimately, is harmful to patients [15, 16, 22].

Aim and research questions

The aim of this paper is to investigate whether diffuse political and therapeutic ideals together with new legislations, may present nurses working within acute psychiatric care with conflicting interests and challenges that may cause moral distress.

Our research questions are: May the ideal of reduced use of restrictive, restraining, and coercive treatments within mental health care lead to moral distress? If so, in what way may this lead to moral distress?

Methods

This paper is part of a larger study on sources, features, and reactions to moral distress in nurses working in acute psychiatric settings [13]. Nurses' insider perspective on the moral challenges in psychiatric treatment and care and how they cope with this is so far insufficiently studied [20, 21, 23]. Hamric [24] points out that qualitative studies sensitise us to the more complete and nuanced understanding of moral distress and locates moral distress in the specific contexts in which it occurs.

A qualitative design was therefore chosen as we wanted to learn about the interviewees' subjective experiences, attitudes and thoughts [25, 26]. Such designs are well-suited to study this complex moral phenomenon and how moral agents experience moral distress in dynamic contexts [27]. The empirical data collection took place in two different hospitals in the south-eastern part of Norway.

This became a three-part study: Individual interviews were conducted in 2017 shortly before *Law on Patients' Rights* was implemented. Although not a planned topic, the possible practical consequences of this upcoming law was often discussed by the interviewees. The second set of individual interviews was conducted in 2018, after the implementation of the law. The practical consequences this change in legislature and how the ideal of reduced use of restraints and coercion influenced their practice, became a focal topic.

Three focus group interviews with a total of fourteen participants were organised to delve deeper into these matters. Also during these interview sessions moral distress were highlighted. Each interview lasted about 90 min. We chose this method to learn about the nurses' experiences working according to the political and therapeutic ideal of reducing the use of restraints and coercion and to utilise the synergy of thoughts and associations that focus group interviews may create [28].

During the individual interviews and the focus group interview sessions follow-up questions and «mirroring» were used to develop, clarify, and verify statements [13]. In total, 30 nurses were interviewed (Table 1), five of them men. For all three sets of interviews a purposive sampling strategy was used to identify potential participants. The heads of the respective acute psychiatric units in each hospital helped communicate the study's content, purpose, and goal to all members of their nursing staff orally and in writing. Nurses who were interested in participating, gave their names to the unit leader who forwarded a list to the first author. These were invited to participate in the study. The names of the focus group participants were not given beforehand. *Inclusion criteria were:* Registered nurses with varied length of work experience in the field. Most participants had postgraduate qualifications in psychiatric nursing (Table 1).

Data analysis

The analysis of all the interviews were thematic and hermeneutic in character. Both the transcribed individual interviews and the focus group interviews were analysed according to Braun and Clarke's [29], thematic analytic approach. These authors [29], p.79 define thematic analysis as "a method for identifying, analysing and reporting patterns (themes) within data". They propose two possible ways for identifying themes: inductive (bottom-up) based on what is in the data, or a more "top-down" fashion. The latter is analysis-driven, guided by the researcher's theoretical or analytical interest in the subject area where the researcher "uses the data to explore particular theoretical ideas or bring those to bear on the analysis being conducted" [30], p.178. Both ways to identify themes were utilised as the rationale for the focus group sessions stem from findings in the individual interviews about the use of restraints and coercion and the presupposed (set 1) and effectuated (set 2) new law.

Braun and Clarke [29, 30] present six phases for thematic analysis: 1) The authors familiarise themselves with the interview data. This we did through reading and re-reading the interview texts actively searching for meanings and patterns. During this first analysis reflective thoughts were documented to help find what main themes were identified in the data. Moral distress became one such theme although none of the interviewees used this term.

The interviews were then re-analysed theme by theme. During each re-analysis interesting features were coded (phase 2). We kept revisiting the interviews to make sure our coding was in line with the empirical data. During phases 2 and 3, the collation of potential sub-themes, our thoughts and ideas evolved from engaging with the data.

In phase 4 we reviewed this paper's main theme together with its sub-themes and collectively discussed whether they reflected the meanings evident in the data as a whole. Thus, phases 4 and 5 were closely related, as we in phase 5 discussed whether the sub-themes we had developed described the theme's content. 6) The first author wrote a preliminary paper text which then was discussed and developed further collaboratively. Finally, we returned to the transcripts to ensure that our interpretations were supported by the data material.

Table 1 Time of interviews. Background and number of nurses interviewed

Years of psychiatric nurse experience	Interviews before introduction of the *Law on Patients' Rights*	Interviews after introduction of the *Law on Patients' Rights*		No. of psychiatric nurse specialists among the interviewees
	Individual interviewees (2017)	Individual interviewees (2018)	Focus group interviewees (2019)	
0–10 years	3	5	10	8
11–20 + years	5	3	4	10
	8	8	14	

Analytic credibility was obtained through quotations with the interviewees' own description of thoughts and experiences [31]. This also strengthened confirmability and trustworthiness as the quotations show that the findings are based on our interviewees' responses and not on potential bias (ibid.). Trustworthiness is also strengthened through transferability being achieved by presenting thick descriptions to show that the study's findings can be applicable in similar contexts, circumstances, and situations.

Being four analysts with different professional backgrounds, two with an insider view as psychiatric nurses and two from other fields of expertise, also helped avoid analytic bias. This furthermore helped secure rigor as we initially re-read the interview texts separately, striving for depth of understanding through a circular investigation of the texts [32] and doing our best to "remain open to the meaning of the other person or the text" [32], p.281. This kind of openness is predicated on a willingness to 'listen' to the text and to go where the data lead. This, and our collective discussions of our findings added to the depth of our reflection and thus, to the validity of the analysis.

Ethical considerations

The study was approved by the Norwegian Social Science Data Services. All interviewees were informed orally and in writing that participation was confidential and voluntary and that they were free to withdraw from the project at any time. There was no pressure to accept the invitation to be interviewed and no negative consequences for those who chose not to sign up for the study. All participants signed a consent form. Institutions and interviewees were made anonymous during the transcription process. Transcriptions and recordings are stored according to ethical research guidelines [33]. Recorded interviews will be deleted on conclusion of the project.

Results

Through the individual interviews it became clear that the interviewees were preoccupied with the practical consequences of changes in the political, legal, and therapeutic ideals for the treatment of psychiatric patients, particularly the expectations concerning reduced use of restraints and coercion. This topic was expanded upon during the focus group sessions.

The interviewees found that the expectation to minimise the use of restraints or coercion came from politicians, the hospitals' policy, and unit leadership, and from co-workers. Several of the interviewees found that this gradually made them more open to explore other solutions than restraining and coercive measures. Moreover, their threshold for administering physical restraining measures had become higher.

Even so, the interviewees offered rich descriptions of how these ideals and new legal guidelines also could cause moral distress. Four areas regarding this will be discussed: 1) Challenging behaviour and risk of violence; 2) Minimising the use of restraints and coercion created uncertainty; 3) Legal changes may frustrate treatment; and 4) Consequences for the nursing staff.

Challenging behaviour and risk of violence

An increasing number of patients have serious mental problems due to synthetic drug use. The nurses found that this, in combination with reduced number of beds in psychiatric units, had resulted in the patients currently admitted being more ill than, say, ten years ago. They experienced a greater tendency to physical violence, like scratching, kicking, blows and strangle-holds as well as serious verbal threats.

One of the nurses had had her ribs broken several times when trying to calm patients down. Patients spitting at the nurses and throwing object were not uncommon. Violent episodes had moreover resulted in broken curtains, pictures, and lamps on the wards. This development was described thus: "We endure more challenging situation for longer than we perhaps should sometimes, with unrest, threats and destruction lasting for a long, long time."

The unpredictability and feelings of constantly «being on tenterhooks» were described as draining. Having potentially very violent patients moving freely among unsuspecting or anxious patients while they were waiting for transfer to a security unit was also seen as problematic. One of the nurses characterised the scenarios that could be played out on the ward as "limitless and surrealistic".

Sometimes even co-patients were hurt. Patients had been beaten, threatened, and exposed to co-patients who were "in their face". Once a patient pulled out another patient's urine catheter. Afterwards the attacker calmly sat down although the injured man was bleeding profusely. Once a young female patient was attacked by a male patient. He forced her onto the floor and held her down. Later this same patient also managed to enter her room. "When people are howling in the corridors and the ward is in a chaos and alarms go off left and right, patients often want us to lock their door, but this we cannot do as we are responsible for them. But I do understand them …" an interviewee said. "Such conditions are unworthy".

Unfortunate episodes created an apprehensive mood on the ward and were hard on vulnerable patients and made them retire to their rooms. This made it difficult for the nurses to offer the kind of therapeutic and beneficial

environment they needed. Several interviewees described feelings of guilt when unable to safeguard patients who were mentally or physically attacked by co-patients. As a consequence, the nurses' focus tended to shift from treatment and care to risk evaluation and safety.

Minimising the use of restraints and coercion created uncertainty

In spite of the patient population's increasingly poor mental state the expectation to avoid restraints and coercive treatment was strong. It was strong "regardless of whether a hospital uses coercion a lot or sparingly. It is to be reduced". Some held this to be a requirement coming from «the outside», without explaining this statement further. Others perceived the leadership and/or colleagues to be the source. However that may be, a dilemma arose when it came in conflict with safeguarding patients and staff. Many of the interviewees felt obliged to tolerate more challenging – even violent – behaviour then they previously had done. Restraints and coercion were no longer used until the risk of violence was imminent. Even so,

> *«It is difficult to know when we actually should use coercion. We try and try and try again all the measures at our disposal to avoid tight-holding or belts. When the patient in spite of this goes on and on and on ... You get to a point when this is enough [has to be stopped]. But you don't want to use coercion. Afterwards one may think what is right? What is wrong?».*

Thus, where to draw the line for patients' behaviour was seen as difficult:

> *«Where to draw the line? When does it become dangerous? When someone throws something in the wall? You never know if he'll attack someone else next time. There is a lot of frustration that is not turned against us, but someone who is screaming and yelling and perhaps throws chairs around is rather threatening. These situations affect us ...».*

A nurse fresh out of college worried that other staff members' expectations would make her «go too far» without elaborating this. Another found it difficult as «one does not know where one is supposed to draw the line as one handles things differently and have different limits». Sometimes the nurses wondered whether they or the patients were in control. Hindsight sometimes told them that they should have acted earlier to ensure everyone's safety. Some interviewees said they rarely discussed how much threats and violence they were expected to tolerate and endure.

The interviewees held that they lacked the predictability and clear limits they needed to make patients and staff feel safe and secure. According to them, it was also a problem that the doctors tended to hesitate to prescribe restraining or coercive measures even when patients potentially could be violent. An interviewee said that she experienced "that one tries to avoid give the order, decisions that are seen as violating personal integrity, even when it could be a very helpful". Some believed the reason for this could be that the doctors were expected to improve the statistics on the use of such measures and were worried about reactions from outside bodies like the Healthcare Complaints Commission if they did. This could lead to challenging and potentially dangerous situations for the nurses: «I have more than once experienced that the doctor on duty has ordered us to release a patient [from restraints] who still is in a drug induced psychosis and where nothing has changed during the last hour ... still as aggressive toward us.»

The nurses tended to "go the extra mile and endure a lot, a lot ... we also let co-patients endure a lot, really». Thus, the cost of limiting the use of restraints and coercion could limit the quality of patient care through letting innocent patients endure disturbances and violence on the ward, violence that could be aimed at them. This worried many of our interviewees.

The ideal of minimising the use of restraints and coercion seemed also to come from within. There seemed to be a general agreement among the interviewees that less use of such measures strengthened the patients' dignity. One described the changes in this area of clinical practice as a relief. She regretted that she previously had taken part in restraining and coercive measures such as placing patients in belts over longer periods of time.

Even so, they all had experienced that restraints at times were necessary to stop patients from hurting themselves, other patients, or staff members. When unavoidable, such measures were described as care, although «these days this is a politically incorrect view». The current therapeutic ideal tended toward letting patients «run off steam» to avoid acting out and violence. Patients who were being very loud but not threatening, who talked directly to co-patients and generally occupied a lot of «space» could make co-patients feel insecure. "Whether we should accept such verbal acting out" caused a lot of discussion among the nurses. "The other patients hear this, too ... there can be a lot of shouting, and several patients have said that this makes them anxious". One of the nurses thought that as a patient "I would never have felt safe on a psychiatric ward". Another held that being an acute psychiatric patient "is very terrible. To be locked in on an acute ward against one's will and then having such experiences! It weighs very much on my mind afterwards."

Having to prioritise threatening or very resource-intensive patients, left less time to follow up on other patients. Thus, the nurses found that the aim to reduce the use of

restraints or coercion exposed some patients to greater risk of violence.

Ideals and legal changes may frustrate treatment

According to the interviewees, due to the new legislation's strict criteria for involuntary hospital admission many patients who previously had been involuntarily admitted were now admitted on a voluntary basis. It was described as sad and frustrating to witness the gradual decline in patients who refused to receive help: "A great quandary which becomes more and more common, really, is concerning patients with mania who now tend to be admitted voluntarily, who perhaps are on the way "up" and very poorly." This was experienced as a particularly difficult dilemma when it made children suffer because ill parents could not be retained on the ward against their will. "Some family members are desperate and don't want their loved ones to be discharged, but there is no legal basis anymore on which to hold them the way we would have done a few years ago". Untreated patients' mental health may deteriorate to a point where their actions lead to «economic problems, poorer somatic health, and their messing up their lives quite severely before they are [involuntarily] admitted".

Several interviewees said they often felt personally responsible for motivating patients to stay in hospital and accept treatment. However, when pressed for time their communication tended more towards persuasion or pressure than motivation: "How hard can you motivate someone to stay, voluntarily, without it becoming, how should I put it, a kind of concealed coercion?".

Freer access to social medias through being allowed to keep their mobile phones on the ward made it possible for psychotic patients to socially disgrace themselves: "Our hands are tied until they have crossed the line, like when the patient has ruined a relationship, sent their employer nude pictures, for instance". Such actions may be difficult for the family, too, particularly the patients' children: "One thing is to disgrace oneself, but you have the family setting which may be totally on the breaking point".

According to the new legislation longer observation time is required before a decision on involuntary administration of medication can be made. This could result in more use of restraints and coercion and longer hospital stays than necessary. One of the nurses said that her greatest moral challenge at work was to witness how obviously psychotic patients had to wait for days without medicines and adequate treatment. She felt that many of her colleagues agreed with her, but she was one of the very few who discussed this with the leadership.

The nurses worried that the legislation and the ideals concerning reduced use of restraints could affect the most vulnerable patients negatively. They wondered whether politicians ever discuss the needs of this particular group of psychiatric patients when they make decisions on restraining or coercive measures in psychiatric care. As one put it:

> *«They [the patients] are unable to take care of themselves and many have suffered many losses because of their illness; they have lost their house, their family, their jobs, and finally friends and family cannot take it anymore ... I find that society does not take responsibility for the individual. [Politicians] hold that the individual may decide for themselves, basing their opinions on their own lives as resourceful people, and I find that I never would have liked to be treated like this. Would you have liked to lose everything, rejected, in the gutter?"*

The interviewees missed a greater focus on the quality of treatment, on dignity and on care when restraining or coercive measures are unavoidable. This perspective seemed to be overshadowed by the seemingly sole focus on reduction of the use of such measures.

Consequences for the nursing staff

Although restraining or coercive measures at times were necessary, using them often left the nurses with a very unpleasant feeling: «In the morning [after having worked the weekend] you sit together with all the doctors and healthcare staff and have to defend the use of restraints. You feel defeated and perhaps a little ashamed for having had to use such measures». This in spite of having followed doctor's orders and at the time assessed the measures used as unavoidable. Even though they were not directly criticised for having used restraints or coercion, the nurses could experience defeat and shame. While one claimed that he never had had such reactions, others held that such feelings were difficult to put into words and was something they had never reflected upon previously. One said that "it is the borderline between restraints/coercion, voluntariness, and participation which is so very difficult to contend with".

Criticism of psychiatric care from various media, the descriptions of psychiatric units as torture chambers, and accusations of violation of human rights, were also experienced as difficult. The interviewees described feelings of isolation because society, family and friends were unable to appreciate what it is like to work on an acute psychiatric ward, the intense experiences, the dilemmas, and the fear. Some were upset by the seeming lack of appreciation among the national political leadership of the severity of the patients' suffering and the massive challenges healthcarers faced on a daily basis on acute psychiatric wards. The nurses claimed

that the groups of psychiatric patients that were discussed in various contexts were far less ill and more resourceful than the patients our interviewees cared for. As their patients were unable to take part in discussions in the media they were hardly ever recognised or heard.

Several of the nurses were furthermore upset by the lack of attention paid to violence from patients and how this also made healthcarers suffer. The interviewees expressed discomfort, guilt, bad conscience, and a feeling of inadequacy when unable to protect patients and staff during episodes of mental and/or physical violence. Such episodes «made the chest physically hurt». Overcrowded wards, inadequate resources and economic saving schemes worried the nurses as it threatened to frustrate their ability to maintain good quality care. Several found that a low staffing ratio led to more use of restraints and coercion. "With more staff we could have solved this differently. It is a perpetual problem". Particularly on evening shifts and during the weekends, there could be low coverage of nurses and an extensive use of unqualified staff.

Time, competency, and experience were seen as decisive for being able to recognise signals in time to deescalate dangerous situations. However, this is «difficult when the unit is full to capacity». The ward's architecture and size were also seen as a hindrance for less use of restraints or coercion: "As the rooms are small, they tend to be overcrowded". All this could cause «growing qualms about being part of a system I do not find good enough». Reducing the use of restraining or coercive measures while saving on expenses was characterised as irreconcilable ideals. Some of the interviewees suffered from tension headaches, others found that exhaustion caused them to be irritable at home and in great need of rest and quiet.

Discussion

Our results indicate that the political and therapeutic ideal of reducing the use of coercive treatment measures in acute psychiatric care may have a twofold effect: While it may ease the experience of moral distress in nurses who perceive such measures as professionally and ethically problematic, the ideal is hard to adhere to in clinical practice and adhering to it may cause moral distress, as well. The discussion will be focused on 1) Moral doubt and dilemmas regarding how much they should endure on their own and their patients' behalf, 2) Bearing witness and trapped by the policy imperative; more severely ill patients and insufficient resources and 3) Experiences of guilt, shame, and defeat.

Moral doubt and dilemmas regarding how much they should endure on their own and their patients' behalf

That the interviewees' work environment is increasingly marred by fear due to offensive and violent behaviour from patients is a cause for concern. According to various interviews with mental healthcare workers violence and problems concerning patients acting out are escalating [34]. Repeated exposure to aggression puts nurses at risk of vicarious trauma, occupational stress, PTSD-symptoms, guilt, shame, self-blame [35], muscle and skeletal problems [36] and burnout syndrome [37], and may have significant implications for the quality-of-care provided [38]. The combination of a more seriously ill patient population and the non-restraining and non-coercive treatment philosophy makes it difficult for the nurses to know to what extent they should tolerate patients' disruptive behaviours. Uncertainty regarding where to draw the line probably causes nurses to be more exposed to threats and violence. Thus, the healthcare personnel have become burdened with the ethical dilemma incorporated in the non-restraining ideal: how much disquiet and psychological and physical violence must co-patients and healthcare personnel endure before the use of restraints is justified?

Internal constraints as socialisation to follow orders [27], loyalty [13], or compliance [39] may be among the reasons why our interviewees seemed faithful to new expectations even though this obviously may be costly to both themselves and patient safety.

Our interviewees seemed to see being brave, unafraid and uncowardly as moral qualities [13]. Being responsible for their own safety was never mentioned. Pettersen and Hem [40] point out that "[c]aring is viewed as an unselfish, spontaneous and compassionate act during which the immediate interests and needs of the particular other should take precedence over the interests of the carer" p217). Not showing feelings and coping with all kinds of situations is often seen as part of being a good nurse [41]. Inability to cope may lead to shame and guilt and to denial of symptoms of stress as «no-one wants to be the cripple of the pack» ([42, p.18]). These ethical, professional, and cultural ideals may contribute to it being challenging for nurses to recognise and put their own moral boundaries into words. Maybe we lack an ethical language to express the complex moral challenges within this area? Moreover, the ideal of reduced use of restraints and coercion is such a strong part of current mental health philosophy that problematisation has become politically incorrect, which may silence anyone who would like to discuss it. The interviewees were strongly focused on how these ideals exposed patients to greater risks of abuse, violence, and insecurity.

The desire to avoid restrictive practices and ensure that all other strategies were exhausted sometimes led the nurses to think that they might have prevented injury to others if they had used restraining measures sooner. This seemed to create moral distress. Even so, the ethical, professional, and legal requirements to keep people safe [43] and the obligation to protect the autonomy of each individual patient constitute a complicated 'moral enterprise'. Studies show that patients expect to be kept safe from harm and acts of aggression to themselves or others [44, 45]. Our findings indicate that the ambition to reduce the use of restraints and coercion at times may overshadow the ethical concern related to the safety of other patients and a therapeutic atmosphere. This moral dilemma seemed particularly present when a patient's behaviour created an atmosphere of insecurity and uneasiness, but no obvious threat is present. The moral defensibility of intervention seemed clearer in the presence of an obvious high threat of violence.

In her study on patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward, Stenshouse [45] found that the perception of threat from other patients was a key issue, highlighting the need to consider patient safety as more than physical safety. However, a treatment philosophy that dictates that nurses must tolerate more unrest among patients to avoid restrictive interventions seems to eclipse the psychological safety of co-patients. Our interviewees worried whether they endured too much on behalf of vulnerable patients who depended on being kept safe by the healthcare personnel.

Bearing witness and trapped by the policy imperative; more severely ill patients and insufficient recourses

If the idealistic focus on reducing the use of restraining or coercive treatment frustrates the nurses' ability to offer their patients the best possible care, this may create moral distress. Several interviewees talked about the burden of *bearing witness to* insufficient treatment, for instance patients who due to the longer observation time now required went unmedicated for days, who were in danger of serious decline because they refused treatment, who disgraced themselves, without being able to exercise what they saw as their responsibility and professional duty. The concept of bearing witness may be described as "attesting to the veracity or authenticity of something through one's personal presence" [46], p.289. Bearing witness while having one's hands tied may lead to moral distress.

Although the nurses wished to reduce the use of restraints and coercion, they seemed to feel trapped if their ethical and professional judgement told them that such measures were unavoidable. Moreover, while the wards often were overcrowded with increasingly ill patients, many of whom suffering from synthetic drug use and prone to violence, our interviewees found that they had to cope with reduced resources. This is in line with an Australian study where "the impact on ward safety with increasing acuity of consumers plus the presence of forensic consumers and those affected by methamphetamine was emphasized" [47], p.1511 was severe. Studies also show that mental health nursing in several countries face an acute workforce crisis and reports on poor staffing levels [48–51].

Concurrently with this development the ideal of reducing the use of restraints and coercion is gaining force, an ideal that could only be successfully implemented with increased resources, according to our interviewees. This is supported by other studies e.g [48, 52–54]. In line with our findings, several studies point to an "association between a lower staff-patient ratio (i.e. less staff members for each patient) and an increase in the use of coercive measures" [3], p.452, the importance of knowledge and competence for the reduction of such measures [55] and an association between high ward occupancy/crowding and aggressive incidents [56–58].

Lack of needed resources in clinical practice seems to be an external constraint which frustrate the nurses' ability to realise the ideal of reduced use of restricting measures. This creates a dissonance between their values and their actions, which may lead to moral distress. According to Shafer-Landau [59], moral standards that are impossible to meet are illegitimate. To expect healthcare personnel to contribute to the reduction of the use of restraints and coercion in settings with limited resources, where they are responsible for the safety of patients and colleagues while they themselves are scared, may perhaps seem to be an immorally high requirement?

Experiences of guilt, shame, and defeat

The ideal and expectation of reduced use of restraints and coercion seem in our society to create feelings of guilt, defeat, and shame in nurses after having participated in such treatment measures. Our interviewees described these same reactions when unable to protect patients and staff. These feeling are known features of moral distress. Also persuading the patient to stay on the ward can cause guilt and uneasiness. Andersson et al. [60] found that the use of informal coercion may cause guilt, shame, and self-accusations. According to Doedens [3] nurses more often report feelings of failure, guilt and regret associated with restraining and coercive measures. Others feel "trapped between the policy imperative for the nurses to protect themselves and others, with nurses ultimately 'being the scapegoats of

the system'" [47], p.1518. The media coverage of mental illness and the treatment of psychiatric patients have been influential in shaping the public's understanding and attitudes towards involuntary treatment, especially among people with no personal experience with mental illness [61]. Muir-Cochrane et al. [47] found that nurses were worried that society in the future will blame them both for using coercion and for the negative consequences of not using coercion.

The feeling of shame is often activated by unrealistic ideals and high expectations we ourselves create or adopt from others [62]. Shame has been found to be more painful than guilt as not only one's behaviour but one's core self is at stake [63]. Shame may also influence our empathic ability [63]. These kinds of emotional reactions tend neither to be clearly linguistically expressed nor be consciously recognised by those who experience them. Bartky [64] highlights the profoundly disempowering drive for secrecy and concealment induced by shame, which undercuts the possibility and solidarity with others, even those who may be struggling in similar ways.

Strengths and limitations

The majority of the interviewees were psychiatric nurses with many years' experience from acute psychiatric care. As participation was voluntary, we cannot say whether the views presented in this paper are representative for all nurses in the hospital units in question. Even so, this study captures pivotal ethical concerns among nurses working in acute psychiatric settings and provides new insights into moral challenges experienced when attempting to solve the tension between clinical realities and the society's ideals, policies, and legislation. Although our study is limited and local, we believe the insights offered are transferable to other acute care mental health nursing contexts and thus may help decrease the current paucity of knowledge within this field.

Conclusion

Mental health nurses working in acute psychiatric care are involved in a complex interplay between political and professional ideals to reduce the use of restraints and coercion while being responsible for the safety of both patients and staff as well as creating a therapeutic atmosphere. They often face moral challenges when attempting to solve the tension between ideals, policies and legislation concerning the use of restraining and coercive treatment measures on the one hand and clinical realities on the other. Our findings show that systemic factors like legislations and political and societal ideals may strongly influence on the individual healthcare workers' responsibilities and working conditions. Caught in the middle nurses/healthcare workers may experience moral distress that may lead to physical discomfort, uneasiness and feelings of guilt, shame, and defeat. High expectations concerning the avoidance of using restraints or coercion in treatment and care and vague guidelines on where to draw the line may also create moral doubt and dilemmas. External constraints like inadequate resources may furthermore hinder the healthcare workers/nurses from realising the treatment ideals set before them. The nurses even worry that new legislation and ideals may prevent acutely psychiatric ill and vulnerable patients from receiving the treatment they need. They are also concerned that their ability to create a psychologically and physically safe environment on the ward may be compromised. This may expose patients and healthcare personnel to greater risk of violence.

Although more research is needed within this field, our findings point to the following implications for practice:

- The leadership needs to be willing to listen to – and when possible – act on the nurses' ideas, concerns, and professional judgement.
- The leadership needs to actively encourage an ethical work climate through creating a safe and non-judgemental space for healthcare personnel to address the moral challenges and moral distress they face at work.
- Equip the wards with the needed number of adequately trained and competent staff to cope with the increasingly ill patient population and thus enable them to realise the treatment ideals set before them
- Develop clearer guidelines for how to cope with aggressive and violent patients, including when and how restraining and coercive treatment measures may be used.
- After having administered restraining or coercive treatment measures invite the patient to a conversation about the incident when the patient is ready for this.

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Authors' contributions
Authors' contributions TLJ conceived of the study and designed it together with all authors. TLJ, IH and MHH performed the individual interviews and MHH and TLJ performed the focus group interviews. All authors analysed the data. TLJ wrote the first draft which was discussed and further developed by all authors. All authors contributed to revision of the article, and all authors read and approved the final version.

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Availability of data and materials
To fully protect the identity of this study's participants the raw data are not available as the data are only deidentified, not anonymised.

Declarations

Ethics approval and consent to participate
The study was evaluated and approved by the Data Protection Officer at the Norwegian Social Science Data Services (Ref. No. 188755) which is the national ethical research approval institution (previously named Norwegian Centre for Research), the hospitals' Privacy Representative, and the local heads of the respective hospital units and wards. According to Norwegian regulation, no further research ethics approval was required. Respondents were informed about the project in writing and signed a voluntary, informed consent form before the data collection was started. All interviewees were informed in writing that participation was confidential and voluntary and that they were free to withdraw at any time. Institutions and interviewees were made anonymous during the transcription process. Transcriptions and recordings are stored according to ethical research guidelines (Helsedirektoratet 2009). Reference: Helsedirektoratet (2009). ***Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren [Subject protection and information security in research projects within health care].*** Oslo: The Norwegian Directorate of Health. Recorded interviews will be deleted upon the conclusion of the project.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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