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ISPN Perspectives in PSYCHIATRIC CARE

A Study of the Situations, Features, and Coping Mechanisms Experienced by Irish Psychiatric Nurses Experiencing Moral Distress

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PURPOSE. *The purpose of this study was to investigate moral distress in Irish psychiatric nurses.*

DESIGN. *A qualitative descriptive methodology was used.*

FINDINGS. *The study confirmed the presence of moral distress and the situations that gave rise to moral distress within psychiatric nurses working in acute care settings.*

PRACTICE IMPLICATIONS. *The findings indicate that while multidisciplinary teams appear to function well on the surface, situations that give rise to moral distress are not always acknowledged or dealt with effectively. Furthermore, unresolved moral conflict impacts upon the quality of clinical decision-making by not allowing open and transparent discussions that allow clinicians the opportunity to address their concerns adequately.*

Search terms: *Clinical decision-making, moral distress, psychiatric nursing*

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Health service practitioners often find themselves in situations in which they feel ethically constrained and like ineffective advocates for the patients they care for (Erlen, 2001). This inability to translate moral choices into moral action is described by some authors as moral distress. Originally coined by Jameton (1984), moral distress is the experience of individuals who are morally constrained; they make moral judgements as to the right course of action to take in a situation, but because of restraining factors, either internal or external, they find they are unable to act.

Subsequent research on this phenomenon by Corley, Elswick, Gorman, and Clor (2001), Fry, Harvey, Hurley, and Foley (2002), Kelly (1998), and Wilkinson (1987/8) suggested that initial distress occurs when an individual feels restrained from acting morally, resulting in feelings of anger, frustration, and anxiety. Unresolved moral distress can develop into "reactive distress," which is characterized by feelings of powerlessness, guilt, self-criticism, and low self-esteem. Physiological responses such as crying, loss of sleep, nightmares, and loss of appetite are also associated with reactive distress. In the main, research in this area concentrated on the dimensions and consequences of moral distress. In particular, the focus was on situations that give rise to moral distress in critical care environments such as triage nursing (Corley, 1995; Corley et al., 2001; Wilkinson, 1987/8). An exception includes Kelly's (1998) study of graduate nurses, which found that moral distress occurred when they felt practitioners were not meeting their own expectations or ideals of the nursing role.

Peter and Liaschenko (2004) argued that nurses, in particular, feel vulnerable to moral conflict as a result

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of being ever present during client conflict/crisis as compared with doctors and other allied disciplines that have the option of stepping away from the immediate consequences of their actions and decisions.

It is clear that the costs of unresolved moral distress are high, with some practitioners feeling the need to leave their posts in order to relieve the moral constraint they feel (Corley et al., 2001). Other consequences may culminate in nurses compromising their personal integrity by trivializing the wrong doing or denying any wrongdoing by suggesting that the problem is not significant or worthy of consideration. In addition, individuals may compartmentalize their work roles by distinguishing between their work personas and who they see as their true selves. Ultimately, an individual may abandon his/her principles altogether for reasons of fear, expedience, or self-preservation, resulting in the wounding of himself/herself in a way that is life changing (Rushton, 2006; Webster & Baylis, 2000).

The experience of moral distress is further compounded when practitioners perceive managers and administrators as not being adequately receptive or supportive during morally challenging situations (Hefferman & Heilig, 1999). Challenging questionable decisions, for many practitioners, is seen as a professionally risky strategy that could lead to punitive action, and consequently many practitioners kept their own counsel (Redman & Fry, 2000; Sundin-Huard & Fahy, 1999).

It would be a mistake, however, to think that all theorists consider moral distress to be a wholly negative experience. Hanna (2002, 2004) and others (Lützen, Cronquist, Magnusson, & Anderson, 2003) have argued that moral distress has been inaccurately linked only to the negative psychological and emotional impact of morally challenging situations. Alternatively, Benner (1991), Peter and Liaschenko (2004), Rushton (1992), and Hardingham (2004) suggested that some nurses find the experience of moral distress to be a positive catalyst for change and an experience through which nurses pass in order to understand their own moral values and their professional obligations with regard to standards of care and moral commitments.

The concept of moral distress, therefore, should be viewed as an umbrella concept that captures a range of experiences that an individual may experience when morally constrained (McCarthy & Deady, 2008). These constraints may be individual, institutional, or societal (Kopala & Burkhart, 2006).

Moral Distress and Psychiatric/Mental Health Nursing

While the performance of moral practice is an integral aspect of professional psychiatric nursing (Denieffe, Wells, & Denny, 2008), the main focus of situations that give rise to moral constraint has been within medical nursing environments such as critical care and acute care settings. Consequently, we found few studies investigating the prevalence, or otherwise, of moral distress among psychiatric nurses. Notable exceptions are Austin, Bergum, and Golberg (2003) and Austin, Rankel, Kagan, Bergum, and Lemermeyer (2005), who considered the experiences of psychiatric nurses, physicians, psychologists, social workers, and nonprofessional carers. Both of these studies noted that members of the multidisciplinary team did not always agree on the situations that gave rise to moral distress, while the nurse perspectives focused in the main on continuing care issues such as staff resources and quality of care.

Although there is limited research on moral distress in psychiatric nursing, research has identified a number of situations that can cause concerns for psychiatric nurses. These include the practices of restraining patients, forced medication, and coercion (Fish & Culshaw, 2005; Lakeman, 2003; Olofsson & Norberg, 2000; Olsen, 2003). While Olsen contends that the use of coercion by nurses can result in "moral discomfort" for the nurse who is torn between her/his professional obligations in law and her/his belief and commitment to the therapeutic benefit of nursing, Lind, Kaltiala-Heino, Suominen, Leino-Kilpi,

and Välimäki (2004) found that not all nurses perceived coercive measures as ethically problematic. The rationale as to why nurses adopt different moral perspectives and do not subsequently experience moral concern in the same way, for the same situation, is not clear; although Barker (2003, p. 512) suggested "moral complacency" as a mechanism for why moral concerns may not be addressed. More recent commentary (Fennell, Williamson, & Yeats, 2009) highlights the increase in policy and legal frameworks to protect patient rights as further sources of additional ethical challenges for practitioners.

Research Design

Part of the rationale for this study originated during a psychiatric research group discussion when one of the members began discussing the phenomenon of moral distress. The description gave rise to a discussion of familiar behavior in a previous study conducted by one of the authors (Deady, 2005) where Irish psychiatric nurses had shared their lived experiences. The incidents reflected some of the contextual elements of Austin and colleagues' (2003; 2005) findings and so suggested that moral distress may exist in this group. Furthermore, in light of the limited research on moral distress within psychiatric nursing, we felt that an investigation would be a useful addition to the debate and further delineate the nature of the phenomenon and the situations that give rise to it.

Methodology

The aim of the study was to explore psychiatric nurses' experiences of moral distress within acute care settings. The objectives of the study were (a) to explore the presence of moral distress among psychiatric nurses, (b) to identify the situations that gave rise to moral distress among psychiatric nurses in acute care settings, (c) to describe the features of moral distress experienced by psychiatric nurses working within an acute care setting, and (d) to describe ways in which psychiatric nurses cope with the experience of moral distress.

In order to achieve this, we carried out a qualitative descriptive investigation. We chose a qualitative descriptive approach as it was our intention to solely describe the features of moral distress as they were experienced by psychiatric nurses. This was particularly important as the literature search had not specifically identified moral distress within the field of mental health nursing in any substantive way.

Sampling

As previous studies in moral distress were largely focused in acute care settings within general nursing, we decided to focus this initial study within the equivalent acute care settings of the mental health services. Following ethical approval from the Clinical Research Ethics Committee of the teaching hospitals in the region, advertisements and invitations were circulated seeking a purposive sample of candidates who had had experiences they believed constituted moral distress as defined by Jameton (1984). The term "moral distress" was part of the explanatory text required by the Ethics Committee for participant consent. Although explicitly identifying the phenomenon under study may be considered to be introducing bias, our intention was not to develop theory about the phenomenon but to confirm incidences of it and to describe these incidences specifically. Nine registered psychiatric nurses (five males and four females) contacted the researchers and agreed to participate in the study; these were divided between the researchers for interview. One female participant subsequently withdrew, leaving eight participants.

Data Collection

A semi-structured interview was used by means of open-ended questions and prompts to expand expla-

nations. Following a reading of the consent form, which included an explanation of the phenomenon of moral distress, participants were asked whether they had had such an experience (knowing what the right thing to do was, but being unable to act), and if so, to describe the situation. Participants were also asked how they had felt during the episode and what they had been thinking at the time. Finally, they were asked how they had coped with the experience and to identify any obstacles that may have prevented them from acting otherwise. This method has been described by Pope and Mays (2000) as depth interviewing; a technique that allows two or three areas to be studied in depth and facilitates the discovery of new areas or ideas not anticipated at the outset of the research. No judgement was communicated by the researcher as to whether the participant's narrative constituted moral distress during the interview.

If not discussed by participants, issues that were identified in the literature, such as involvement in restraint or forced medication, were introduced for consideration by the participants. In addition, sequential analysis (Pope & Mays, 2000) took place as interviews were concluded and discussions took place between the researchers as to the themes that were emerging, and these informed the scope and focus of subsequent interviews. For example, the issue of suicide following discharge had not emerged as an area of moral concern for nurses in the literature; when this was identified by one participant as an area of concern, it became a potential issue for discussion at subsequent interviews.

At this point, the researchers discussed the incidents described by the participants and made judgements as to their validity in terms of meeting Corley and colleagues' study (2001), and those of Fry et al. (2002), Jameton (1984), Kelly et al. (1998), Wilkinson (1987/8), and criteria for moral distress. The interviews were taped (approximately 1 hr) and then transcribed verbatim, and their validity was authenticated by returning them to the interviewees.

Data Analysis

Pope and Mays' (2000) discussion on analyzing qualitative data was used to guide the analysis process. Through the transcription process and multiple readings of the transcripts, significant phrases or statements were initially identified independently by the two researchers from each of the interviews. The fact that the researchers originated from different professional backgrounds (philosophy and psychiatric nursing) added value to the independent analysis. This strategy allowed the researchers to test whether interpretations of the data were shared (e.g., whether both researchers agreed on what the data were saying). Statements were initially considered to be significant if they met Corley and colleagues' (2001), Fry and colleagues' (2002), Jameton's (1984), Kelly's (1998), Wilkinson's (1987/8), and criteria for moral distress and were related to the research aims and objectives. The identified statements were then assessed as to their representational validity by an external researcher with expertise in psychiatric nursing. Following this, the statements were further discussed by the researchers in terms of the core issues participants were discussing.

The themes that emerged from the analysis are presented under the research objectives and include (a) the presence of moral distress, (b) the situations that gave rise to moral distress, (c) the features of moral distress, and (d) coping with the experience of moral distress.

Findings

Moral Distress in Psychiatric Nurses

The study confirmed the presence of moral distress within psychiatric nursing in terms of the criteria outlined by Corley and colleagues (2001), Fry and colleagues (2002), Jameton (1984), Kelly (1998), and Wilkinson (1987/8). Participants reported moral constraint as originating from both internal and external

sources. In addition, both initial and reactive responses to moral distress were reported. The following content is reflective of the narratives in terms of their emphasis within the interviews (i.e., participants spoke at a greater length with regard to the situations that gave rise to moral distress, with less emphasis on their specific feelings and coping strategies).

Situations That Gave Rise to Moral Distress

The situations that gave rise to moral distress experienced by participants can be clustered into three themes: (a) professional and legal conflict; (b) professional autonomy and scope of practice; and (c) standards of care and client autonomy.

Professional and Legal Conflict

Some participants reported that conflict relating to professional judgement or clinical decision-making within multidisciplinary teams led to moral distress. 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. Furthermore, participants believed that, on occasion, their observations, such as illness deterioration or perceived client vulnerability, were not given equal weighting or significance, despite the fact that they spent greater time with clients. This situation gained greater significance, in terms of the impact upon the participant if clients did subsequently act out their vulnerability (i.e., attempted suicide following discharge) or the client's mental health deteriorated further. In addition, participants were further frustrated with the limitation or absence of postincident discussions by the team, which left participants feeling that the incident and their associated moral concerns were unresolved. In the words of two participants,

> The consultant carried on, because he is in charge. So I think it is one of those things that, what could you have done? Other than getting hold of the consultant and saying don't let this man go yet, there's something else that we need to do. There were no papers, he had no family as I can remember, and nothing happened. Coroner's inquest fine, that's the legal thing over in the community, but in the hospital nothing happened. (R2)

> I said surely be to God if someone went off and committed suicide like that, if a nurse had said to a doctor she should be admitted, that should be negligence, and she (a solicitor) said that it wasn't, that was a medical decision. (R3)

In summary, participants experienced moral distress when they had difficulty sharing their professional views on clinical decisions they disagreed with. In particular, this situation became more difficult when they believed colleagues did not value their views or senior colleagues would not act upon their concerns. This occurred when they believed that professional conflict and/or potential legal issues superseded the need to address the client's needs.

Professional Autonomy and Scope of Practice

All participants indicated they were comfortable with the practices of restraint, forced medication, seclusion, or electroconvulsive therapy, if they perceived them as being prescribed by medical staff, legal, and applied appropriately. Moral distress was experienced, however, when participants believed that they had to use coercive practices with clients because medical interventions were insufficient, late in being prescribed, or prescribed for nonmedical reasons. Participants believed that multidisciplinary team members outside of nursing were in a position to absent themselves from the clinical arena and the immediate ongoing client care. This often left the nurse as a mere observer of the client's deteriorating mental health status. This situation became more significant when participants believed that delayed medical inter-

ventions meant that they were left to deal with unnecessary and unwarranted levels of conflict with clients as a result.

> The doctor that met with the patient was only admitting her as a crisis intervention at the time and felt that there was no need for an admission, but it was so late at night she couldn't send her home. But about two hours later the patient became very erratic and disturbed. That was the problem we ran into then. The consultant on call refused to come in and review the patient and the Junior Doctor's attitude was "Right, I'll prescribe it (IM medication) but you give it." (J1)

> The duty doctor was refusing to do anything because he wasn't going to go over the consultant . . . We were kind of left to pick up the pieces really. (R5)

Some participants also experienced moral distress when they believed clinical decisions were imposing inappropriate restrictions on a clients' behavior that related to issues of lifestyle rather than issues to do with client safety or their mental health status.

> It was a lady who lived on her own for years and had a very nice life, functioned away . . . how she lived and her standard of living was fine, but for the team it was considered bad and poor, and it wouldn't have been up to the standard of us working here, and I guess coming from a country place and meeting people who live in the country, people have different standards of living, and I felt that it wasn't our place to impose our standards on her, and what was being done, really, was that she was being held as a prisoner until she conformed to our standards, which I thought actually was really wrong. (R3)

In summary, participants believed that unique insights gained from extended contact with clients were either undervalued or the participant's professional autonomy was reduced to that of a warden of client care while clinical decisions were made by other disciplines.

Standards of Care and Client Autonomy

Some participants reported that challenging a peer's standard of practice was a potentially distressing situation. Although participants would not tolerate illegal practices, there was a perceived need to get on with fellow colleagues even if their practice was viewed as poor. When they did concede to a colleague's lower standard of practice, it left them feeling morally conflicted.

> What stops me from acting was I am part of a team, which should be cohesive, but if I intervene in these situations I'm interfering with primary nursing, and I think I would be seen as splitting the team by taking the side of the patient. I think it would, because it was the practice that the majority of the staff use. (R4)

Some participants reported that they found it difficult to challenge a colleague's clinical judgement as they believed it could result in being isolated within the group. This isolation would often be subtle, such as indirectly questioning the participant's level of competence or withdrawing support at key moments leaving them isolated.

> A colleague who had had the same experience and who saw me being blamed, if you hadn't said this, if you hadn't said that, she wouldn't have done it. They were kind of blaming our observation . . . In fact we found it was extremely difficult to try and report incidences, that people were inclined to say, "Look, leave well alone." (R4)

In addition, all the participants reported experiencing moral distress as a result of the standard of care being offered by the service as a whole. Participants felt

they were under-resourced and that despite evidence for the efficacy of alternative treatments, clients and families were rarely offered choices as to the treatments or services they could access. As a result, medication became the most widely used form of treatment.

> It's the emotional feelings you have. The moral distress arises because the clients aren't getting a good quality service and that can lead to moral distress for me. So, how can I treat myself and how can a client who has his own moral distress, how can a chemical treat that kind of moral distress? (R4)

Situations where a client's level of autonomy was, in the participant's view, restricted were also seen to give rise to moral distress. According to one participant, a client, who was suffering from a progressive terminal illness, was prevented from discharge because he/she had indicated a wish to seek euthanasia abroad (illegal in Ireland). The participant felt that this action was being inappropriately interpreted as an expression of suicidal intent by the doctor and that the client should be allowed to make his/her own end-of-life decisions, rather than being incarcerated at this emotional time.

> I suppose when I thought of myself in that situation (slow and progressive terminal illness) I would rather be dead, and clearly she would rather be dead, and then again it comes back to like quality of life and like is it just a life or is it quality of life, is it existing or is it enough to just exist, or should you have some quality, which is more important? (R3)

In sum, participants experienced moral distress when they perceived the standard of care being offered fell below their own personal and professional criteria for best practice. Participants suggested that the inability of nurses to influence the decision-making of the mental health service system, at a personal, clinical, or organizational level, was a contributory factor. Finally, client self-determination was a principle that they viewed as important; however, practicing this was problematic when personal and professional beliefs clashed with colleagues' views and the law.

Features of Moral Distress Experienced by Nurses

The features reported as a result of moral distress were wide ranging and influenced both personal and professional aspects of the participant's life. Feelings of self-doubt, guilt, frustration, anger, and depression were common features; these comments are representative of the participants' views. "Sometimes you wonder did you do your best" (J3). "You always wonder what you could have done differently, or you wonder sometimes is it yourself or is it the service?" (R1). "I was very annoyed and angry over the situation and disempowered" (R3). "I suppose I vented my anger more so on management; they were so lax, and the consultant was so lax about it, and she had done it before" (J1). "So reflecting back on the whole thing, I went home on three nights quite distressed" (R4).

Initial feelings of unease and anger were common, particularly when there was a lack of opportunity to discuss or resolve moral conflicts or concerns. For example, one participant's experience of moral distress centered on hearing one of his own clients, who he believed was placed inappropriately in an acute unit, shouting. The shouting could be heard from a car park by members of the public. He felt embarrassed and disheartened that this was the image the public would have of the discipline and that there was little he could do to resolve the situation.

> We talk about trying to get rid of the stigma of mental illness . . . where you get out of your car in a general hospital to visit someone who has had their appendix out or whatever and they hear this patient shouting, and they say "What the hell is that?" And of course they say, "That's the psychiatric unit; oh yes it's typical of a psychiatric unit." I am trying then to give a good impression, to try and do my job, and try and present to families who come to us for a service, you know in the situation. (R1)

Another participant questioned the motives of the service provision by likening it to a visit he had made to a concentration camp museum:

> I look at my service where I work, ok it's not a fair comparison, but are we doing the same thing. . . . Are you just trying to control people? You are not giving people responsibility or choices. (J3)

Many of the narratives of the participants indicated that these feelings continued to upset them for long periods (in many cases years), resulting in reactive responses. These features were equally wide ranging and included feelings of depression, burnout, and guilt, as well as feelings of being overwhelmed and let down by the system, stigmatized by the media and public, and feelings of disempowerment. "I would be very angry about that; I would still be annoyed, yes" (R3). "It was the worst incident I have experienced in 5 years and that incident glows in my mind" (R4).

> I'd be reasonably good to leave my work at work, reasonably good. Now obviously we're all the same, there are times you wake up in the morning, maybe half an hour before the alarm clock goes off, you think this thing now is just too much. (R1)

On the other hand, some participants reported hardening or resolving themselves to the situation, in the words of two participants:

> Well, after 25 years you kind of lose that initial "My god, that's terrible." I mean if you want to evaluate by your own standards how you should react in a situation, well if it was my brother or my mother, my father, how would I feel if they were left out of hospital to sort of resume a life of poverty, deprivation, or distress. . . . Then, that's sort of the space in your head that you occupy or you evaluate by that standard, that inner template, so, at work you can't afford to indulge in that because you certainly wouldn't get your work done. (J2)

> The consultant was the person who made the decision, which I didn't think was the right thing, but then as a staff nurse, I could have refused and not given the medication, but then someone else would have given it. (R3)

In sum, while the participants demonstrated a wide range of emotions that occurred when they found themselves challenged, such as anger and guilt, one of the main features of these experiences were that they endured over long periods of time. Although they used many strategies to cope with the experience, these appeared to be limited in terms of extinguishing the memory and associated feelings. In some cases, this led to ongoing trauma and experiences of depression. It is not surprising then to find that all participants developed a range of strategies to immunize themselves from ongoing moral distress.

Coping Strategies

The strategy of immunizing oneself to the moral conflict was a common tactic. It took a variety of guises such as avoiding the conflict by adapting/acquiescing to the cultural pressure (going along), denying or trivializing the problem (turn a blind eye, rationalize), refusing to participate or work with a particular colleague, or move job or adopt a dual moral code of behavior: one for home and one for work. "I'd be upbeat about these things, I see some of my colleagues just wouldn't take it, they'd find it extremely difficult and they constantly go on about it" (R1). "So I suppose what ultimately happened really was that I did my best to be moved from that place, so I moved myself from the environment" (R3). "You go with the flow. . . . Chill out and do your own thing. You can't protect everyone all the time" (J1). "You're bearing witness to it and its unfortunate you're bearing witness to it, but that's life" (J2).

For many participants, compartmentalizing the problem appeared to be a necessary strategy in order to get on with their everyday work and life. In some

cases, there was evidence of coping mechanisms such as intellectualizing the problem or distancing oneself from the problem.

> I suppose you become aware of what's possible and you become aware of what you can do, and more important, you become aware of what you can't do. . . . You don't ever actually accept it, which is kind of odd, I hadn't thought of that before. (J2)

> Well you have to lock away your emotions, you could actually put your self down, and when you are dealing with people who are distressed, have problems, have loads of emotional psychological problems, you can't be walking around and saying I've loads of problems myself, you're telling me your problems, I know all about it I've the same thing myself, that's a lot of help to you isn't it? (R1)

Other more proactive coping strategies included reflecting on the problem personally, with family, peers, managers, supervisors, or counsellors. Other coping strategies included taking courses to gain further education or training, acting professionally, reassuring patients, empathizing with patients, and choosing to challenge moral concerns when it was perceived safe to do so. Ultimately, discussing moral concerns was not always seen as an option as this strategy was perceived either as threatening to the participant or jeopardizing team cohesiveness.

> I thought at the time, said, should I do more about this, this can't be right, compared with what's going on, so I just thought about it . . . and I spoke to I suppose a few close friends, colleagues about it, and the advice I got was, that if I had taken it further, that my life as a nurse working wouldn't have been worth it, it would have been made very difficult, and people in the past who had made comments . . . were outcast, so I thought an awful lot about it . . . but I didn't do anything about that. (R3)

> I would make it very diplomatically. I wouldn't force it. In as much that to force issues in a multidisciplinary situation you're disturbing the balance and the other thing is there is a breakdown in the process, a breakdown in the relationship, so you have to balance the thing. You have to be very diplomatic in putting forward these things, and that's another part, a contributory factor to my moral distress. (R1)

In addition, participants often believed that they had little or no power (e.g., low grade, inexperience, low discipline status) to challenge some senior nursing colleagues or medical staff. In particular, junior staff believed their moral concerns were not adequately addressed within multidisciplinary and nursing hierarchies. "Looking back it's you in the staff nurse position, not enough experience I suppose to say you can use the system" (R2).

In sum, participants either used avoidance strategies that they hoped would intellectually immunize them from the distress they felt or pursued strategies they hoped would allow them to physically distance themselves from the source of the problem. To acknowledge any problems was seen as inappropriate when working with vulnerable clients, and addressing any moral distress seemed impossible in the current climate. As a result, participants were more inclined to use personal and/or informal mechanisms of support such as talking with peers, friends, and family in order to cope.

Discussion

The findings of the study were generally consistent with those of other research into moral distress, with some interesting exceptions. Participants confirmed the existence of features reflecting both initial and reactive distress in response to moral distress as reported elsewhere (Corley et al., 2001; Fry et al., 2002, Kelly, 1998; Wilkinson, 1987/8). Features of initial distress included anger, anxiety, and frustration, and features

of reactive distress included feelings of powerlessness, guilt, self-criticism, and low self-esteem. A typical reactive response following long-term frustration was the "parking lot" incident reported earlier, which was similar to an incident reported in Austin et al.'s (2003) study in Canada, suggesting that frustration with mental health service provision is not a phenomenon unique to Ireland.

As with Hefferman and Heilig's (1999) study, the participants felt that the current healthcare system was not adequately receptive or supportive during morally challenging situations. Hierarchical management practices that led to the custom of "doctor knows best" frustrated many participants' efforts to assert their clinical expertise. This is reflective of Redman and Fry's (2000) and Sundin-Huard & Fahy's (1999) studies that reported that nurses believed their clinical insights were being undervalued. This perception left participants feeling unsupported, the consequence of which, as with Kelly's (1996, 1998, p. 1138) studies, was to acquiesce to the decisions made by multidisciplinary teams or the individual senior members (e.g., doctors, senior nurse managers) in an effort to "fit in." The need to fit in was a strong driving force for many participants as the consequences of not doing so resulted in professional isolation and further frustration. This belief often led to participants' disinclination to challenge multidisciplinary team decisions and inclination to keep their own counsel.

The study also supports Peter and Liaschenko's (2004) finding that nurses feel more vulnerable to moral conflict as a result of being ever present during client conflict/crisis. The participants believed that doctors and other disciplines had the option of stepping away from the immediate consequences of their actions and clinical decisions. This often left the participants feeling vulnerable to unwarranted risks that were not of their making and made them feel they had been abandoned by other team members who had the tools or power to deal with the crisis in a professional and timely manner.

Finally, the coping strategies employed by the nurses mirrored those reported in other studies (Jameton, 1984; Webster & Baylis, 2000). However, for a coping strategy to be successful, a resolution needs to be arrived at that adequately addresses the participant's personal and/or professional care philosophy. It is interesting to note that participants struggled to highlight more than a small number of incidents that fitted the moral distress criteria, despite having the opportunity to share as many as they wanted. Why this is the case is unclear, but it does appear to suggest that incidences of moral distress have an enduring nature in the participants' psyches. While for some participants this experience has resulted in negative consequences, it is clear that some participants have used their experiences as catalysts for change (Benner, 1991; Hardingham, 2004; Peter & Liaschenko, 2004; Rushton, 1992).

Nevertheless, a recommendation that nurses should seek support or challenge morally distressing situations with colleagues (Hanna, 2005; Kälvemark, Höglund, Hansson, Westerholm, & Arntz, 2004; Meaney, 2002) appears problematic for the participants in this study because they reported feeling threatened and vulnerable. Accordingly, the assertion by Kälvemark et al. (2004) and Austin et al. (2005) that there is dissatisfaction with the level of discussion of ethical challenges within disciplines employing multidisciplinary models is supported by our study.

Implications for Nursing Practice

The findings indicate that while multidisciplinary teams appear to function well on the surface, situations that give rise to moral distress are not always acknowledged or dealt with effectively. Furthermore, in the absence of open and transparent discussions that allow clinicians the opportunity to address their concerns adequately, unresolved moral conflict can impact on the quality of clinical decision-making. This, in turn, may also impact on the quality of care that clients ultimately receive. Moreover, the experiences of moral distress reported indicate that nurses can ultimately feel

morally damaged and, as a result, may respond by using strategies that do not necessarily enhance their personal and professional development or the quality of service provision.

While the current Irish policy document *A Vision for Change* (2006) cites multidisciplinary teamwork as key to the functioning of the service, this study indicates that there are difficulties with current multidisciplinary practices when morally challenging situations arise. Currently, within the Irish mental health services there is an absence of formal guidelines to direct the practices of multidisciplinary teams. As a result, decision-making frameworks have developed in an ad hoc manner; some teams foster mutual respect and encourage the sharing of moral concerns while others undermine and inhibit participation. Consequently, individuals find they require moral courage in order to act on their convictions. Miller (2005), in her critique of moral courage, argues that it is not an innate characteristic and so requires education and habituation, and for this to be successful, role models are needed to guide practice. However, this study has identified that role models are not always in evidence, and as a result, individuals often fear the consequences of acting alone. Therefore, a need exists for multidisciplinary programs that allow interdisciplinary discussions of common moral concerns in practice and agreement on protocols that achieve mutual goals.

Finally, future research will need to focus on a more complete explanation of the complex social processes that operate within multidisciplinary teams. Such an explanation will allow a greater understanding of the sociocultural and psychological mechanisms that create the conditions for the prevalence of moral distress. In addition, it may also point toward strategies to enhance the ability of nurses and other professionals to resolve moral distress in ways that make their own professional lives more bearable and, in turn, improve the quality of care that they provide.

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