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Moral Distress in Iranian Psychiatric Nurses: A Content Analysis

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Abstract

Background: The complexities of the health care system have imposed complex ethical issues on nurses, resulting in moral distress in all categories of nurses with various specialties. Psychiatric nurses are also exposed to moral dilemmas because they care for vulnerable patients with delusions and suicidal ideation problems. Due to the different experiences of moral distress in different cultures, settings, and wards, we studied this phenomenon in Iranian psychiatric nurses.
Objectives: We conducted this study to investigate the causes of moral distress in Iranian psychiatric nurses.
Methods: This qualitative study was conducted based on a conventional content analysis on 12 psychiatric nurses selected by the purposive sampling method in 2020 in Shiraz, Iran, considering the maximum diversity. Data were collected through semi-structured interviews with participants for an average of 40 - 60 minutes per interview until data saturation.
Results: We obtained causes of moral distress from 7 categories and 20 subcategories. The categories included “lack of professional competence”, “organizational culture”, “individual factors”, “environmental and organizational factors”, “management factors”, “weaknesses in professional and effective communication”, and “observation of moral dilemmas by nurses”.
Conclusions: This study demonstrated various causes of moral distress that managers should consider by providing a safe environment and appropriate facilities for psychiatric nurses.

Keywords: Iran, Moral, Psychiatric Nursing, Qualitative Research

1. Background

Recent advances in technology and the complexities of the health care system have imposed complex ethical issues on nurses and other clinicians over the past decade (1). Professional and organizational conditions expose nurses to various stressors, leading to complex ethical issues (2). Reported moral distress in all categories of nurses with multiple specialties indicates a high prevalence of moral distress in nurses. Environmental, personal, and professional differences cause ethical problems experienced differently in nurses (3).

Psychiatric nurses are also exposed to their moral issues because they care for far more vulnerable patients than other patients. They care for their patients while forcing them to violate certain ethical principles such as independence, decision-making, and even patient freedom, to compel patients to take medication or physically restrain them (4).

They are the ones who experience the highest level of moral distress (3). Studies of psychiatric nurses have reported the causes of moral distress unethical behavior by caregivers, consent to patient rights violations (5), patients’ resistance to coercion, lack of resources, lack of staff, and caring for aggressive patients (3).

The concept of moral distress in nursing was first introduced by Jameton in 1980 cited in Campbell et al. (6). Jameton considers moral distress to be acting contrary to one’s moral values due to internal or external obstacles. Moral distress occurs when a person knows what is morally right but is prevented from doing it due to organizational barriers (6).

Repeated and unresolved periods of moral distress over time generate moral residue, predisposing individuals to vulnerability. If moral distress does not resolve and moral residue persists, new conditions of moral distress can provoke more destructive reactions (7).

Currently, the health care system in Iran faces severe economic sanctions. Nurses struggle daily with a lack of medicine, medical items, equipment, resources, and facil-

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ities, leading to poor nursing services and complex moral problems in nurses (8, 9).

Also, problems such as ambiguity of role definition, high workload, severe shortage of nurses (10), lack of participation in policies and decisions, traditional hierarchical system in the relationship between physicians and nurses (11), and lack of ethics committees to consult are ethical issues and challenges for nurses in Iran (12). These problems increase their moral distress. Studies in Iran have confirmed the moderate to severe severity of this phenomenon in Iranian nurses (13, 14).

Studies in Iran have examined moral distress in nurses in intensive care units (ICUs) (15, 16) and pediatric (10) and emergency departments (11). These quantitative studies have assessed the frequency and intensity of moral distress. A qualitative assessment of moral distress causes was needed according to Iranian nurses setting and their culture. To our knowledge, this phenomenon and its causes have not been evaluated in Iranian psychiatric nurses. The perception of moral distress varies from ward to ward, recommending the qualitative study of moral distress in the context of the beliefs and moral practices of the health care environment in which psychiatric nursing occurs (17).

2. Objectives

This study investigated the causes of moral distress in Iranian psychiatric nurses. An in-depth assessment of this phenomenon through qualitative research was done by a qualitative content analysis.

3. Methods

We performed a qualitative content analysis and semi-structured interviews with 12 psychiatric nurses. Nurses were selected using purposive sampling. Inclusion criteria were expressing feelings and experiences, working in psychiatric wards, and willing to participate in the study.

This study was performed in the winter of 2020 in a psychiatric center in Shiraz (southern Iran).

Nurses were interviewed in person in a suitable private place in the medical wards. The duration of the interviews was between 45 and 60 minutes. Participants were reassured about the confidentiality and the voluntary nature of the research.

All interviews were transcribed from a digital voice recorder. Audiotapes were transcribed verbatim. The written transcripts from each interview were read later during the analysis, and keywords and significant statements were highlighted throughout the script. The identified themes from each interview were reviewed, and similar themes were grouped together and reported as results. The interviews continued until data saturation so that no new codes were obtained in the last 2 interviews. In nurses' interviews, the following questions were asked:

(1) What do you think nurses' moral distress means?

(2) What factors cause moral distress in you during the care and treatment of mentally ill patients?

Interviews continued with follow-up questions such as "Explain more" or "Give an example" and, in the end, with the question "Is there anything left that I have not asked you?" It helped to clarify the experienced phenomenon better and remove ambiguities.

Interviews were analyzed using Graneheim and Lundman's conventional content analysis guidelines (18): (1) The recorded interviews were transcribed, (2) the researchers listened to the recordings and reviewed the transcripts several times to find the meaning units, (3) the meaning units from the statements of the participants were extracted in the form of initial codes, (4) codes were categorized according to the conceptual similarities to be minimized, and (5) this trend continued across all the analysis units until themes and subthemes emerged.

We extracted semantic units and initial codes from the participants' sentences for the initial coding; the same initial codes placed in subcategories. Categories were created by reviewing and merging similar subcategories.

The researcher showed authenticity in qualitative research through attention, information discovery, and confirmation (19). The goal was to provide a solid representation of the participants' experiences. To increase the acceptability and accuracy of the findings, the researchers combined several semi-structured interview methods, rechecking with the interviewees, and simultaneous analysis. The researchers did the reliability or stability of the results by copying as soon as possible, using colleagues' opinions, and reviewing the manuscripts by participants. The researchers identified and examined their judgments, and beliefs during the data collection process to establish reflexivity. An outside researcher examines the processes of the research study to establish dependability.

Also, for confirmability, the researcher made accurate interpretations and coding process, several experts (2 faculty members of Shiraz School of Nursing and Midwifery and 1 faculty member of the Medical Ethics School) and accurately recorded all steps and data extraction. Transferability was also made possible by providing direct citations, rich data explanations, and consulting with prominent professors in qualitative research.

The Ethics Committee of Shiraz University of Medical Sciences approved this study (code: IR.SUMS.REC.1399.1078). To observe ethical considerations, the researcher, in addition to introducing himself

Table 1. Demographic Characteristics of the Participants

Demographic Characteristics	No. (%)
Age (y)	
20 - 29	5 (41.66)
30 - 39	5 (41.66)
40 - 49	2 (16.66)
Gender	
Male	6 (50)
Female	6 (50)
Marriage status	
Married	7 (58.33)
Single	5 (41.66)
Educational background (highest degree)	
BSc	10 (83.33)
MSc	2 (16.66)
Work experience (y)	
1 - 5	5 (41.66)
6 - 10	2 (16.66)
11 - 15	3 (25)
16 - 20	1 (8.33)
21 - 25	1 (8.33)
Manager	
Yes	3 (25)
No	9 (75)

and explaining the research objectives to the participants, asked them to complete the informed consent form. Before starting the interview, they could record audio and take notes. An overview will be published, and we reassure them that they are free to leave the study at any research stage.

4. Results

We interviewed 12 nurses, of which 6 were female, and 6 were male. The average age of nurses was 31.5 $\pm$ 4.67 years. Seven were married, and 5 were single. Their average work experience was 8.8 $\pm$ 2.56 years. Three participants had a managerial background, and 9 did not have a management background (see Table 1).

The preliminary analysis led to the emergence of 168 primary codes, which finally extracted 20 subcategories and 7 categories in this study (see Box 1.).

In the category of "lack of professional competence", psychiatrists acknowledged that they suffered from moral distress due to working with colleagues or physicians who did not have the necessary professional competence. In the subcategory of "carelessness of colleagues in care", issues such as carelessness of colleagues in shifts about their duties, non-performance of patient care by colleagues, such as delaying the patient's blood sugar check, not giving the patient serum or medication, and not doing the patient dressing. Physician-related problems such as ignoring the patient's topics (such as insomnia), spending less time during visits, and paying little attention to patients were among these cases.

In this regard, participant 2 stated:

"For example, now is the time to check the patient's blood sugar, but my colleague is eating lunch, and the sugar that is measured later by the patient is not reliable blood sugar, and this makes me angry until the end of the shift. At the hands of my colleague... I get morally distressed at such times..."

Participant 9 also said:

"The patient has insomnia, and because I have experienced this feeling myself, I know how difficult it is... I re-

Box 1. Categories and Subcategories

Categories and Subcategories
Lack of professional competence
The carelessness of colleagues in the care
Poor team and interdisciplinary participation
Poor theoretical and practical knowledge
Organizational culture
Culture of physician professional dominance
Lack of nurse authority
Individual factors
Nurses' ignorance of ethical issues
Work conscience
Environmental and organizational factors
High workload
Lack of staffing
Facility and space constraints
Management factors
Improper division of labor
Inadequate monitoring and control
Weaknesses in professional and effective communication
Aggressive behavior
Improper interpersonal interactions
Observation of moral dilemmas by nurses
Discrimination in the treatment of homeless patients
View colleagues' errors

ported it to the resident... but he did not do anything for the patient... The resident can give a drug to the patient and calm the patient down, but because he is not bored or their level of information is not enough, he does not do anything, and seeing the patient in that situation makes me sad... I am suffering from moral distress..."

"Poor team and interdisciplinary participation" in psychiatric nurses are other issues. They complained about the "poor cooperation of nurses in patient care with each other", as participant 6 said:

"Nurses do not cooperate... everyone does their job... if I am sick... no one will help me... even if they have nothing to do... well this pressure I'm tired of work... and I'm suffering from moral distress..."

Psychiatric nurses also commented on the "non-consultation of nurses in the process of treatment by doctors", as participant 3 stated:

"For example, there are some patients who, based on experience, have proven to us that this drug has a greater effect on the patient, but when I tell the doctor, he does not pay attention... I have seen this several times. Well, this causes moral distress..."

Another subcategory of lack of professional competence is "poor theoretical and practical knowledge". Psychiatric nurses stated that colleagues' "low level of knowledge" causes them moral distress. Participant 4 said:

"Some colleagues do not have enough information about mentally ill patients. They do not know the drugs. They do not know the diseases. They do not give the necessary training to the patients. The quality of the patients' care decreases. Well, seeing these cases, I get moral distress…"

Also, insufficient knowledge of physicians causes moral distress in nurses. Participant 2 stated:

"Sometimes the doctor makes a mistake in diagnosing the aggressive patient's need for physical restraint... I understand from my experience that the patient becomes calmer if he is transferred to an isolated room, even for a limited time... But some physicians do not have enough knowledge and experience. Some physicians, repeatedly, in 1 day, change the dose of a patient's medication, and the problem of insomnia or other problems of the patient is not solved... Or there is much delay in starting shock therapy by doctors. Well, this shows the doctor's insufficient knowledge. These issues cause me anger and moral distress..."

Another category derived from the data is "organizational culture". In this category, psychiatric nurses referred to the "culture of physician professional dominance". In this regard, participant 6 stated:

"Doctors do not trust anyone but themselves... The nurse reports to the doctor several times that the patient has not slept for several nights and annoys other patients, but the doctor ignores the nurse's report. I have witnessed doctors' spicy behavior and harsh treatment of nurses many times, but the head nurse did not allow him to protest. Because he says, they are doctors. We do not have the power to protest against them. The doctor is late. Even his orders do not seal. The nurse has to do it. Well, these problems are causing me moral distress..."

Psychiatric nurses also noted a "lack of nurse authority". In this regard, participant 8 said:

"The nurse should be done everything the doctor says... The nurse has no power to protest. The nurse does not even have the authority to increase the dose of sleeping pills when I see that the patient has insomnia. These issues cause moral distress in nurses..."

Another category extracted from interviews is "individual factors". In this category, psychiatric nurses also described "nurses' ignorance of ethical issues". Participant 11 said:

"I think many of us do not know enough about moral issues. For example, many nurses are not familiar with this issue of moral distress at all. I do not know what to do in situations where moral principles are violated. I get confused sometimes; it gets challenging to recognize the right moral action that causes moral distress..."

"Work conscience" is also one of the factors that psychiatric nurses have named as the cause of moral distress. Participant 5 stated:

"Some colleagues are not sensitive to the performance of their duties. It all comes down to conscience. Someone who has a conscience does his job and does not suffer from moral distress. But someone who does not have a conscience does not respect the patient's rights, does not perform her duties, and then suffers from moral distress..."

The other category is "organizational and environmental factors". Psychiatric nurses cited "high workload" in this category as one of the causes of moral distress. Participant 12 believed that:

"We don't have enough time for our work. Many works include physicians' orders, answering patients' repetitive questions, admitting new patients, caring for aggressive patients, documentation, and taking care of patients who have undergone ECT. A high workload lowers the quality of care and then the feeling of moral distress and remorse..."

Regarding the subcategory of "staff shortage", participant 1 stated:

"The shortage of staff in psychiatric hospitals is very high... 32 patients with only 2 nurses, that night shift... sometimes I forget to give medicine... because there are too many works and few nurses... these cause moral distress..."

The other subcategory is "facilities and space constraints", as participant 10 said:

"The hospital space is not designed for psychiatric patients. Patients tell us that there is a prison here. There are not enough recreational and occupational therapy facilities because there is not enough space in the hospital. Patients are bored and feel helpless because they have no entertainment. The restlessness of the patients causes me moral distress..."

Another category extracted from the data was "managerial factors". In this category, the subcategory of "inappropriate division of work" was raised by psychiatric nurses. In this regard, participant 12 stated:

"One of the reasons for the high workload is not dividing the work of the case method. It happens that one does more work and the other does less work. The nurse in charge of the shift must be responsible for all the patients' affairs. It is not true at all. In addition, we should do the secretarial affairs and registration of patients' documentation. This kind of division of work has imposed a lot of pressure on us and has caused the quality of care to decline and ultimately caused moral distress in nurses..."

Another subcategory raised was "insufficient monitoring and control". Participant 8 stated:

"The reason why some nurses do not perform their duties is that managers do not have enough supervision over the work of nurses. There is no obligation on the part of the head nurse to perform their duties. This issue puts pressure on other nurses, and in the end, it causes moral distress..."

Another category is "weakness in professional and effective communication". In this category, psychiatric nurses referred to the subcategory of "aggressive behavior". Participant 11 said:

"How to treat aggressive patients is not appropriate at all. The patient is aggressive; he would not have been hospitalized if he had no problem. My colleague is aggressive with this patient. He can't control himself, and sometimes he has physical contact. It is not moral at all. I am suffering from moral distress..."

Psychiatric nurses also referred to "inappropriate interpersonal interactions" in this category. Participant 6 stated:

"I think we have poor communication skills. Some of our colleagues do not have a good relationship with patients. A mentally ill person needs a lot of therapeutic communication with a nurse. We do not have a good relationship with ourselves and with doctors. We do not have the trust or empathy we should have as colleagues. The physician argues with the nurse. The nurse challenges her colleague. They backbite each other. Well, this causes moral distress..."

The last category that psychiatric nurses raised about the causes of moral distress is "nurses' observation of moral dilemmas". Participant 4, regarding the subcategory of "discrimination in the treatment of homeless patients", stated:

"The homeless patients usually do not stay very long. Because they cannot pay for the hospital, the welfare office usually does not support them. The doctors quickly order the discharge without the patient getting better. Well, this is an unethical issue, and it causes moral distress..."

Psychiatric nurses also cited "observing co-workers' mistakes" as one of the causes of moral distress, as participant 5 puts it:

"Some colleagues, especially those who are inexperienced, make mistakes. Even experienced colleagues are not without mistakes. But most of the time, I do not report because either the work is not arranged by the authorities, and on the other hand, it makes my colleague upset and makes a difference... that there is nothing I can do about my colleagues' mistakes makes me feel guilty and morally distressed..."

5. Discussion

In our study, the causes of moral distress in Iranian psychiatric nurses were due to limitations such as lack of competence in colleagues and physicians, lack of interpersonal communication, insufficient authority of nurses, high workload, and shortage of nurses. Individual factors such as lack of moral knowledge that prevented them from acting ethically also identified caused the feeling of the torment of conscience and moral distress.

The results of this study are consistent with the results of most studies in this field. Still, the context, culture, structure, and laws governing the Iranian health system differed in some cases discussed below.

Jameton described the critical cause of moral distress as identifying limitations and the impossibility of doing the right moral action due to organizational constraints (20). In our study, psychiatric nurses focused more on systemic factors beyond their control, such as high workload, staff shortages, lack of space and facilities, and managerial factors such as inadequate division of work and insufficient monitoring and control as the leading causes of moral distress.

Peter and Liaschenko (2013) also acknowledged that organizations often block nurses' ethical identities, limiting their practice as independent individuals and moral agents and thus preventing them from acting on professional values and creating moral distress (21). In a study of psychiatric nurses, Delfrate et al. reported that lack of resources and facilities and working with low nursing staff were the most common causes of moral distress in Italian nurses (22). Ohnishi et al. also reported that the primary

sources of stress among Japanese nurses are those associated with staff shortages (5).

This issue requires more attention from managers and planners to provide sufficient nursing staff to reduce the workload of psychiatric nurses and provide the necessary facilities for psychiatric hospitals.

Also, in conditions of staff shortage, managers are needed with creative methods of staffing management (such as organizing the proper division of work and applying adequate supervision) and reducing the workload of nurses.

Psychiatric nurses acknowledged that colleagues' and physicians' lack of professional competence causes them to experience moral distress. Observing the negligence of colleagues in care, which is a sign of lack of professional competence and ultimately provides inadequate care to patients, causes moral distress in psychiatric nurses. These issues are due to insufficient theoretical and practical colleagues' knowledge or individual defects such as lack of conscience and responsibility reported in our study.

Observing the provision of under standard care by colleagues leads to moral distress and withdrawal from the group of colleagues (23).

Jansen et al. suggested that nurses' inadequate competence may lead to superficial treatment, reduced follow-up of suicidal patients, more destructive behavior and the use of coercion, and ultimately moral distress (3).

Lack of professional competence causes unwanted errors and consequent moral distress and burnout (9). Therefore, nurses' access to continuous professional development and training is essential to improve the quality of care and prevent moral distress and burnout.

We also identified the lack of nurses' awareness of the moral issue as one of the causes of moral distress in psychiatric nurses. Eskandari and Alizadeh stated that ethics education provides nurses with the necessary tools for decision-making and developing individual coping skills. It may also improve self-confidence, reduce fear, and cope with complex moral dilemmas (24). Therefore, teaching ethical issues and how to deal with them seems necessary for psychiatric nurses.

This study also identified poor team and interdisciplinary collaboration between nurses and physicians as one of the causes of moral distress in psychiatric nurses. They recognized that the relationship between nurses, especially the relationship between nurses and doctors, was inadequate and ineffective. In addition to the fact that doctors do not behave properly with nurses and there is no intimacy and trust between them, they also do not involve nurses in making treatment decisions, so nurses often prefer to ignore the ethical issues related to doctors instead of discussing with doctors and solve them.

Deady and McCarthy also acknowledged that professional judgment or clinical decision-making conflicts led to moral distress in multidisciplinary teams (25). They argued that moral distress arises when nurses' concerns and objections are rejected in the hierarchical system and they do not have the power to approve them (25).

Psychiatric nurses are more likely than other nurses to overlook patients' rights because they are unaware of their illness and are sometimes delusional and unable to make decisions for themselves. The observation of moral problems, violation of the rights of homeless patients, and observation of the mistakes of nurses and doctors on the patients without taking any action caused moral distress. A study of psychiatric nurses in Iran showed that when a nurse does not have the responsibility, ability, and confidence to support the patient and defend his rights, he suffers from moral distress (9).

Communicating with psychiatric patients is also one of the ethical challenges identified. Establishing therapeutic communication between nurses and psychiatric patients is critical for psychiatric nurses' care (26).

We identified a lack of proper therapeutic communication with patients and a lack of necessary skills to deal with violent patients as causes of moral distress. Psychiatrists acknowledged that they usually avoid these patients because of the risk of injury and even observed that their co-workers had to threaten and fight with aggressive patients to calm them down.

Studies have also stated that violent and destructive behaviors are the leading causes of stress and moral distress in acute psychiatric care, harming employees' mental and physical health (3, 27). Accordingly, it is recommended to strengthen the role and identity of mental health nurses and train them to manage their emotions in relationships with patients and other health care providers.

5.1. Limitations

One of the potential limitations of this study could be that the participants are only being recruited from Shiraz. The results of this study might not be generalizable to other hospitals in Iran that experienced moral distress.

5.2. Conclusions

Moral distress in psychiatric nurses is related to the ethical beliefs and practices of the health care environment in which psychiatric nursing occurs. Removing communication barriers or skills that disrupt moral functioning by changing rules or systems is necessary to facilitate moral functioning, help resolve care conflicts, and create an environment to reduce the risk of moral distress.

It is recommended to conduct ethical rounds. Ethical rounds can strengthen moral decision-making, and critical self-reflection and encourage nurses to process, evaluate, and understand the ethical dilemmas that cause moral distress.

Managers need to discuss and address the ethical conflicts that inevitably arise in psychiatric nursing care and provide more support for and provide a situation for the team and interdisciplinary participation of nurses.

Also, providing psychiatric care in a safe environment and with facilities appropriate to the needs of patients with adequate staffing has a significant role in reducing moral distress in psychiatric nurses.

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Footnotes

Authors' Contribution: Study concept and design: N. T. and Z. M.; analysis and interpretation of data: N. T., Z. M., M. R., and O. A.; drafting of the manuscript: N. T.; critical revision of the manuscript for important intellectual content: N. T. and Z. M.

Conflict of Interests: One of the authors (Dr. Asemani) is a member of the editorial board of Iranian Journal of Psychiatry and Behavioral Sciences who had no role in reviewing this article. Other authors declare that they have no competing interests.

Data Reproducibility: The dataset presented in the study is available on request from the corresponding author during submission or after its publication.

Ethical Approval: The Ethics Committee Shiraz University of Medical Sciences approved this study (code: IR.SUMS.REC.1399.1078).

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Informed Consent: To observe ethical considerations, the researcher, in addition to introducing himself and explaining the research objectives to the participants, asked them to sign the informed consent form.

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