Summary

The main objective of this thesis is to describe and discuss moral distress as experienced by nurses working in acute psychiatric settings. 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?

The introductory study (Paper I) explores healthcare workers' understanding of the concept of patient participation and why the ideal of patient participation may create moral distress in psychiatric healthcare workers. Paper II describes various sources of moral distress and what characterises moral distress in acute psychiatric care nursing settings. Paper III focuses on how nurses working in acute psychiatric settings attempt to cope when in moral distress. Finally, Paper IV explores 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 ways this could lead to such 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 are based on both in-depth interviews and focus group interviews. A Gadamer-inspired hermeneutic thematic analysis was chosen for the analysis of the interview texts.

A central finding of this research is that the interviewees face multifaceted ethical dilemmas and incompatible demands which, combined with their proximity to the patient's suffering, expose nurses to moral distress, particularly given it is often difficult (or impossible) to determine the appropriate cause of action. Insufficient resources, patients with increasingly poor mental health, and quicker discharges frequently lead to superficial treatment. Nurses worry about the quality of the follow-up care for the most ill, like suicidal patients, or of those with heightened risk of violence given inadequate staffing and unskilled personnel working evening shifts/weekends. Coercive treatment measures that might be avoided if adequately staffed, and resistance to the use of coercion, are both morally stressful circumstances.

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 patients and staff and maintaining a therapeutic atmosphere. The provision of good care when exposed to violence is morally challenging. The moral challenges are acerbated or coloured by contemporary discussions, trends, and therapeutic, political, and ethical ideals within the field. External constraints like inadequate resources may further hinder the healthcare workers/nurses ability to realise the treatment ideals set before them.

The nurses' moral sensitivity seems to be both a premise for and a cause of moral distress, although the interviewees held divergent views and had different experiences with moral concerns. Contributing factors of moral distress include feelings of inadequacy, being squeezed between ideals and clinical reality, and a sense of failing the patients.

Moral distress leads to a bad conscience and creates 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 sleep problems. Moral distress may lead to lower quality care, which again may generate a bad conscience and cause yet more moral distress.

The interviewees attempted to cope with their moral distress in various ways, including mentally sorting through their ethical dilemmas, presenting them to the leadership, choosing not to "bring problems home", or loyally doing as instructed and trying to make themselves immune. However, not facing moral distress seems to come at a high price.

Based on the empirical findings, a rationale is presented for expanding the definition of moral distress to include the moral dilemmas or moral doubt experienced by caregivers.