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RESEARCH ARTICLE

Determinants of Moral Distress Among Mental Health Professionals

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Abstract:

Background:

It is assumed that understanding moral distress and its correlated factors among mental health professionals would enhance understanding of the ethical dilemmas that mental health professionals are confronting.

Objectives:

To identify moral distress determinants among Jordanian mental health professionals working in psychiatric in-patient settings.

Methods:

A cross-sectional descriptive design was used, employing self-administered questionnaire.

Results:

Two- steps multiple hierarchical regression analysis showed that model 1 that includes the demographic characteristics, was significant with $R^2 = .151$, while in model 2 that included demographics and the psychological characteristics of stress factors, it was found to be also significant $R^2 = .243$.

Conclusion:

Morally distressing environments might diminish the quality of psychiatric care provided as well as the job satisfaction among healthcare providers.

Keywords: Moral distress, Mental health, Determinants, Psychological characteristics, Hospitalization, Psychiatric professionals.

Article History

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1. INTRODUCTION

Moral distress is widely recognized as one of the most substantial issues affecting mental health professionals [1]. Studies reported that moral distress among mental health professionals (MHPs) are reciprocally and negatively affected by job stress and work environment [2, 3]. This may lead to job dissatisfaction, withdrawal from the moral issues related to patient care, burnout, turnover, and early retirement [4]. Over the last decades, several definitions have been offered for moral distress that causes conceptual confusion. Moral distress is best defined as “*the experience of frustration and failure that arises from a professionals’ struggle to fulfill their moral obligations to patients, families, and the public*” [5]. Although

moral distress is considered important to improve quality performance among general health practitioners, it is assumed to be more significant to mental health professionals [6, 7]. Therefore, moral distress would influence the quality of care provided by MHPs and their relationships with patients.

Moral distress is gaining significant attention in the psychiatric literature [8]. Several studies reported that moral distress is prevalent among psychiatric professionals [6, 9, 10]. In 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. Moreover, issues related to involuntary admission, inappropriate hospitalization, and neglectful or abusive treatment are also other factors that signify moral issues among psychiatric professionals [11].

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Therefore, it is assumed that understanding moral distress and factors that contribute to it among MHPs would enhance and better understand the decision-making process and ethical dilemmas that MHPs are suffering.

The literature provided evidence that a number of psychological factors might contribute to moral distress among MHPs; amongst which are the psychological ones [9, 12]. It has been found that psychological factors that contribute to moral distress are also enabling MHPs to recognize ethical conflicts and to comprehend patients' situations more deeply, leading to a higher levels of awareness of the ethical consequences of their conducts and decisions [11]. Lützn & Ewalds-Kvist mentioned that moral sensitivity is one of the tools used by MHPs to make an appropriate decision and avoid moral distress [13]. Studies have also shown that stress of conscience is an important factor that contributes to moral distress [2]. Glasberg and colleagues asserted that healthcare providers are experiencing stress of conscience in their everyday practice evoking attention to the role of perceived stress in the development of moral distress among healthcare providers [14].

Psychiatric care transcends the medical model, and requires intimacy and trust in order to provide the appropriate course of intervention and improve psychiatric patient outcomes [15]. This requires a high level of awareness towards intimacy, building trust relationships, and engagement in healthcare plans [16]. This speculates that such factors are contributing to a higher level of moral distress among MHPs that might compromise the quality of care provided. Although the moral distress concept is well-established; however, among MHPs, little attention has been evident in the literature [17]. A number of studies have addressed job stress, work-related stressors, attitudes, and quality of psychiatric care among psychiatric professionals [18 - 21], while its connection to moral distress has not been addressed. Hamaideh (2014) asserted that there is a need to further examine moral distress among MHPs and explore its contributing factors [22]. Hence, to generate a more robust understanding of moral distress in MHPs, this study was carried out to identify determinants of moral distress among MHPs. Identifying these factors and their contribution to moral distress would enable MHPs to work in more less-stressful and less threatening environments leading to better and improved quality of psychiatric mental health care outcomes. Thus, the purpose of this study was to identify the psychological characteristics of perceived stress, stress of conscience, individual characteristics- mastery, and resilience associated with moral distress among Jordanian mental health professionals working in psychiatric in-patient settings. Research questions were:

(1) What is the level of perceived stress, stress of conscience, individual characteristics- mastery, resilience, and moral distress among Jordanian mental health professionals working in psychiatric in-patient care settings?

(2) Is there an association between psychological characteristics and moral distress among Jordanian mental health Professionals working at psychiatric in-patient care?

2. MATERIALS AND METHODS

2.1. Design

The study used a cross-sectional correlational design. Data collected using a self-administered questionnaire from mental health professionals working at inpatient psychiatric units in Jordan.

2.2. Sample and Settings

A total of 245 MHPs have been recruited using the convenience sampling technique. MHPs recruited from the four mental health care sectors in Jordan; two governmental, one military, and one private. Inclusion criteria included: 1. titled as one of the mental health team staff, 2 providing direct care to patients at the inpatients' psychiatric units for at least 3 months to ensure adequate knowledge and awareness about working policy. No exclusion criteria have been used to maximize participation. Sample size estimated using G. power 3.03 using medium effect size of 0.25, at power of 0.80 at 0.05 two-tailed level of significance using linear multiple regression; fixed model; R2 deviation from zero, the sample size was planned to be at least (207). Considering that 50% is the expected agreement rate for survey studies, at least 261 was planned to be approached to reach the targeted sample size. However, this study included 245 response from different cities in Jordan.

2.3. Ethical Consideration and Data Collection

All needed steps were taken in order to ensure human rights for the participants. First of all, ethical approval will be obtained from the scientific research committee and the ethics committee at the School of Nursing, the University of Jordan. Next, approval was obtained from the administration of each psychiatric hospital and from general hospitals that have inpatient psychiatric units. All subjects received a cover letter before data collection. The cover letter contains the consent to participate in the study, a description of the study purpose, and the participant's rights. The data collection procedure is designed to ensure the ethical principles of participants' voluntary participation, privacy, confidentiality, anonymity, and the right to withdraw from the study at any time without any consequences. Data was collected using a self-reported questionnaire. Before questionnaires were distributed to mental health team members, the study was explained to the IRB department in each hospital, then explained to each units' head, and finally explained to each health team member. After that, an appointment was scheduled with each health team member to re-collect completed questionnaires.

2.4. Instruments/Tools

A pilot study was conducted to test the instruments' psychometric properties and discover difficulties that might be encountered during actual data collection, and check the tools' convenience to Jordanian culture. The piloting was done using the responses of 38 participants, which constitute approximately 15% of the actual study sample size. Convenience sampling was used, and the inclusion and exclusion criteria for the pilot sample were the same as the actual study sample. Also, validity is maintained through the

approach of translation as WHO guidelines of translation, and which is equivalent to face validity. The translation and back translation have granted the cultural appropriateness, the language issues, the grammar issues, the comprehension, the understandability, and the clearance. Data were collected using the Arabic versions of the tools. Tools not available in the Arabic version has been translated into Arabic language, following WHO's format of translation, which is the formal language in Jordan to overcome any language barrier with the study participants. The self-reporting questionnaire contains six parts as follows.

(1) **Demographics:** included eight questions regarding age, gender, social status, institution's sector, work experience, working shift, educational level, and financial status.

(2) **Moral Sensitivity Questionnaire (MSQ):** The revised Moral Sensitivity Questionnaire (MSQ) was used to measure assumptions about Moral Sensitivity. It consists of 27 items, and a score of 1 ("total disagreement") to 7 ("total agreement") issued. The overall possible score ranges from 27 to 189. A higher score indicates a higher nurse's moral sensitivity and vice versa. The scale has good reliability measure with Cronbach's alpha of 0.815 [23]. In this study, Cronbach's alpha was 0.80.

(3) **Perceived stress scale:** the Arabic version of the Perceived Stress Scale (PSS) was used [24]. Each item has five response alternatives ranging from "never" (0) to "very often" (4). Higher scores indicate a high amount of Perceived Stress; the maximum score is 56. The psychometric properties of the scale have been well documented [25]. The scale has a good reliability measure with Cronbach's alpha of 0.80 [24]. In this study, Cronbach's alpha was 0.79.

(4) **Stress of conscious questionnaire:** Stress due to a troubled conscience was assessed using the Stress of Conscience Questionnaire SCQ [26]. This scale includes nine items and includes two parts for each item. Part A asks how often the participant has experienced a certain situation in the workplace, using a six-point Likert scale ranging from "never" (0) to "every day" (5). The scale items showed good validity, and by adding more items to the original tool validly, the current tool was better, no measure with Cronbach's alpha was reported in the study [26]. However, in this study, Cronbach's alpha was 0.82.

(5) **The Mastery scale:** The Mastery scale is a self-report scale, developed to measure the participant's feeling of having control over his/her life [27]. The scale consists of seven items that are rated according to a four-point response format, ranging from "strongly agree" (1) to "strongly disagree" (4). The sum of the seven items constitutes a total Mastery index. Satisfactory internal consistency (Person Separation Index was 0.7) was previously determined in previous studies [27]. In this study, Cronbach's alpha was 83.

(6) **Brief resilience scale (BRS):** Brief Resilience Scale by Smith and colleagues, 2008, was used, which consists of 6 items. Each item has five-point Likert scale ranging from "1= strongly disagree; 2= disagree; 3= neutral; 4= agree; 5= strongly agree". Scoring for this scale by adding the responses varying from 1-5 for all six items giving a range from 6-30, then dividing the total sum by the total number of questions answered. The scale has good internal consistency with Cronbach's alpha ranging from .80-.91 [28]. In this study, Cronbach's alpha was 0.86.

2.5. Data Analysis Plan

Data entry and statistical analysis were conducted using Statistical Package for Social Sciences SPSS version 26. A descriptive analysis was performed, including frequencies, percentages, ranges, means, and standard deviations (SD). Inferential analysis independent *t*-test, one way ANOVA, and multiple linear regression were used to measure the difference and relationship between score means of different variables. In this study, the level of statistical significance was set at $P \leq 0.05$ for all analyses.

3. RESULTS

3.1. Sample Characteristics

The analysis (Table 1) revealed that 52% (n= 132) of the sample were females, 62.8% (n= 68) aged between 30-34 years old, 81.5% (n= 207) were married, and 72.4% (n= 184) were holding bachelor's degree. Regarding working experience, 27.2% (n= 69) of participants have 1-3 years of experience, and the highest participants' portion of MHPs work on A shift only (46.5%, (n= 118) between all working shifts were 37.8% (n= 96).

Table 1. Sample's demographic characteristics.

Demographic characteristics		n	%
Gender	Male	122	48.0
	Female	132	52.0
Age	20-24	9	3.5
	25-29	58	22.8
	30-34	68	26.8
	35-39	36	14.2
	40-44	31	12.2
	45-49	32	12.6
	50-54	17	6.7
	55-59	3	1.2

(Table 1) contd.....

Demographic characteristics		n	%
Social status	Single	41	16.1
	Married	207	81.5
	Divorced	4	1.6
	Widowed	2	.8
Financial status	<366	23	9.1
	367-400	55	21.7
	401-500	78	30.7
	501-750	60	23.6
	751-1000	38	15.0
Educational level	Diploma	46	18.1
	BCs	184	72.4
	Masters	21	8.3
	Doctoral	3	1.2
Work experience	less than one year	44	17.3
	1-3	57	22.4
	3-5	47	18.5
	5-10	37	14.6
	more than 10 years	69	27.2
Working shift	A	118	46.5
	B	9	3.5
	C	6	2.4
	DAY	14	5.5
	NIGHT	11	4.3
	ROTATING	96	37.8

3.2. General Description of Study Variables

Participants’ scores related to moral sensitivity ranged from 48 to 155 with a mean of 113.0 (SD = 18.8). Out of which 27.2% (n = 69) of participants have a low level of moral sensitivity (high moral distress), and 22.8% (n = 58) of participants have a high level of moral sensitivity (low moral distress). Also, participants’ scores related to the stress of consciousness ranged from 10 to 46, with a mean of 22.71 (SD = 8.82). In that, 27.2% (n = 69) of participants have a low level of stress of consciousness, and 24.8% (n = 63) of participants have a high level of stress of consciousness. Moreover, participants’ scores related to perceived stress ranged from 10 to 45, with a mean of 30.4 (SD = 4.78). Where scores revealed that 57.9% (n = 147) of participants have moderate levels of stress. Concerning participant’s resilience level, scores ranged from 35 to 112 with a mean of 74.12 (SD = 12.77). Results indicated that 28.7% (n = 73) of participants have a low level of resilience, and 24.8% (n = 63) of participants have a high level of resilience. Mastery index scores indicated that scores ranged from 7 to 28 with a mean of 16.61 (SD = 3.75). Participants’ scores revealed that 62.2% (n = 158) of them have a low level of mastery index (control over individual

characteristics) (Table 2).

3.3. Regression Analysis

Two- steps multiple hierarchical regression analysis was performed to examine the prediction power of psychological characteristics stress factors (perceived stress, stress of conscience, individual characteristics- mastery, and resilience) on moral sensitivity controlling for selected demographic characteristics. The analysis Table (3) showed that model 1 that includes the demographic characteristics (age, gender, institution’s sector, work experience, educational level, and financial status) was significant (F = 7.32, p < .001) with R² = .151 (15.1%). Then in model 2, by adding the psychological characteristics of stress factors (perceived stress, stress of conscience, individual characteristics- mastery, and resilience), the model was also found to be significant (F = 7.82, p < .001) with R² = .243 (24.3%). The R² change from model 1 to 2 was 0.9 (9%). This shows that model two has the most significant contribution to moral sensitivity. The results indicate 24% of the variations in participants’ moral sensitivity are explained by model 2 that contains psychological characteristics stress factors controlling selected demographic characteristics.

Table 2. Descriptive of the general description of study variables.

Variables	M	SD	MIN	MAX	P ₂₅	P ₅₀	P ₇₅
Moral sensitivity	113.03	18.82	48	155	103	116	128
Stress of consciousness	22.71	8.82	10	46	16	22	27
Perceived stress	30.41	4.78	10	45	27	30	34
Resilience	74.12	12.77	35	112	68	74	81
Mastery index	16.61	3.75	7	28	15	16	19

Table 3. Three- steps multiple hierarchical regression (N=254).

Variables	Model 1			Model 2		
	B	β	p	B	β	p
Sector	-3.393	-.144	.062	-9.293	-.394	<.001
Age	.978	.088	.335	.905	.082	.350
Education	4.072	.120	.067	3.726	.110	.080
Financial status	-3.907	-.246	<.001	-3.594	-.226	.001
Work duration	1.511	.118	.136	.962	.075	.323
Gender	7.286	.194	.003	10.469	.278	<.001
Resilience				-.138	-.094	.115
Perceived stress				-.019	-.005	.934
Stress of consciousness				.831	.389	<.001
Mastery index				.202	.040	.010
R^2	.151			.243		
Model fit	7.322			7.423		
R^2 change	.151			.092		

* Significant at $\alpha=0.05$.

Giving that model 2, which contains psychological characteristics stress factors (perceived stress, stress of conscience, individual characteristics- mastery, and resilience) and demographic characteristics were significant, some of the demographics were significant predictors (gender, financial status, and institution's sector). Institutions' sector was negative predictor ($B= -9.293$, $p < .001$). This indicates that the psychiatric health care members who are working in the private sector are more likely to have lower moral sensitivity levels and thus higher moral distress levels. Financial status was negative predictor ($B= -3.594$, $p = .001$). This indicates that psychiatric health care members with better financial status are more likely to have lower moral sensitivity levels and thus higher moral distress levels. Gender was positive predictor ($B= 10.469$, $p < .001$). This indicates that the female psychiatric health care members are more likely to have higher moral sensitivity levels and thus lower moral distress levels.

Also, mastery index and stress of consciousness were significant predictors in model 2. Stress of consciousness was positive predictor ($B= .831$, $p < .001$). This indicates that psychiatric health care members with higher stress of consciousness levels are more likely to have higher moral sensitivity levels and thus lower moral distress levels. Mastery of life was positive predictor ($B= .202$, $p = .010$). This indicates that psychiatric health care members with a higher mastery index are more likely to have higher moral sensitivity levels and thus lower moral distress levels.

4. DISCUSSION

The dramatic changes in healthcare systems, globally due to dependence on advanced technology and the pandemic of COVID-19 require harmonization with patients' rights and ethical and legal considerations related patients' care and quality of healthcare services [29, 30]. Ethical and legal aspects of care are considered as human multifarious progression, and the process of understanding and accepting this progression is a vital role of mental health team members [31]. The ethical decision-making process consists of four mechanisms; moral sensitivity, moral judgment, moral motivation and moral

character [32]. Furthermore, ensuring quality of psychiatric care requires that mental health professional assume their responsibilities in stress-free working embroilment. However, stress is an inevitable factor that MHPs need to recognize and manage. Moral distress is one type of stress that MHPs need to be aware of and its negative consequences. This study emphasized the role of psychological factors and their correlates to moral distress among MHPs working at the in-patient psychiatric units. The study found, in general, that stress of consciousness and individual characteristics-mastery were significant predictors of moral distress, while perceived stress and resilience were not a significant predictor of moral distress. This indicates that stress of consciousness and perception of environmental mastery are considered risk factors that contribute to a higher level of moral distress. The results infer that MHPs who are at a higher level of perception of stress of consciousness, which is actually produced from their sense of responsibility and willingness to produce and perfect their work, would increase their moral distress. In addition, MHPs' perception of their control on their endowment would have increased their moral distress. This is one novel finding of this study and adds to the body of knowledge. We have found that mental health professionals who had the perception that their environment is under their control and they have the willingness to make changes and use available resources will increase their moral distress believing that this is one core component to perfect their quality of care. On the other hand, MHPs might struggle to use the available resources to facilitate and fulfill their moral obligations to patients that actually might result in frustration and feeling of failure. The results support previous reports that lack of resources and burden do associate with higher levels of moral distress [33, 34]. The stress of consciousness among MHPs has also been reported to associate with moral distress [35]. One explanation is the stress of consciousness is assumed to create a perception of ethical and moral dilemmas resulting in further conciseness-related stress. Thus, a higher level of ethical and legal dilemmas would create a level of moral sensitivity and moral distress [35].

Perceived stress and resilience were found not to associate with moral distress. This could be interpreted in terms of the general perception of stress that has not been connected to the work environment, and rather, to their personal matters. This is also connected to resilience, where MHPs might not consider working with psychiatric patients as a stressful situation. Resilience would indicate bouncing back after being traumatized. In this situation, MHPs have not assumed the working environment as traumatized one. The results counteract findings from previous national studies [19] where mental health professionals reported high stress levels and suffer secondary traumatic stress due to working with their psychiatric patients. This infers that connecting stress and resilience to moral distress need to be considered within the context of working environment at the in-patient psychiatric units. This is supporting our aforementioned findings that environmental mastery is associated with moral distress.

Also, from psychological characteristics stress factors, it found that stress of consciousness and individual characteristics- mastery were also significant predictors for moral sensitivity ([moral distress. This means that having a high level of stress of consciousness is considered as a safeguarding factor that decreases moral distress level. One possible explanation is that individuals with a high level of moral sensitivity might have more clear and conspicuous ethical burdens, which may lead to a troubled conscience [14]. Also, it was found that working in environments that suffer from resources deficiency is associated with high moral sensitivity [33]. Hence, resources deficiency put more burden on mental health care team members to provide standardized care that matched with their ethical beliefs, thus being exposed to moral distress. These results support previous study results, which indicated that moral sensitivity and stress of consciousness among mental health teams are highly associated and influenced by each other [35]. In addition, this study implies that having a high level of mastery is also considered as safeguarding factor that decreases moral distress level. This is congruent with previous study results, which showed that a high sense of individual mastery led to a high level of moral sensitivity (lower moral distress) [34, 36]. The higher sense of individual characteristics- mastery level implicates a higher sense of control, accordingly a lower sense of individual characteristics- mastery level could induce feelings of powerlessness and helplessness [35, 37]. As well as contributed to mental health team member's perception of ethical and moral dilemmas creating further conciseness-related stress, and thus decreasing moral sensitivity level (higher moral distress) [35, 38]. This explanation is in the same vein as the previous study, which signaled that higher moral distress is co-occurred among mental health members who have higher stress of consciousness and at the same time have lower individual mastery levels [39 - 42].

CONCLUSION

Mental health professionals in Jordan are suffering from moral distress in their day-to-day work. Stress of consciousness and individual characteristics-mastery were significant predictors of moral distress, while perceived stress and resilience were not. Findings from this study pose a challenge

for researchers in conducting additional research to fully understand the effect that moral distress has on mental health professionals, and to develop evidence-based interventions designed to decrease the moral distress and its associated factors among healthcare providers.

IMPLICATIONS FOR PSYCHIATRIC NURSING PRACTICE

Moral distress has significant implications for the mental health professionals and the psychiatric workforce. Morally distressing environments might diminish the quality of psychiatric care provided as well as the job satisfaction among healthcare providers, lead to physical and emotional illness, burnout and turnover. This study highlights the need to conduct comprehensive interventional programs related to how mental health professionals cope with morally distressed situations. Furthermore, personal and institutional factors that might be associated with moral distress should be taken into consideration when preparing and conducting such programs.

LIMITATION

In this study, we did not have IRB approval from all health sectors that have in-patient mental health institutions, so there was a limitation to data access.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval is obtained from the scientific research committee and the ethics committee at the School of Nursing, the University of Jordan. Participants submitted informed consent.

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All human research procedures were followed in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Informed consent has been obtained from all the participants for the study's publication.

STANDARDS OF REPORTING

STROBE guidelines methodologies were followed in this study.

AVAILABILITY OF DATA AND MATERIALS

The authors confirm that the data supporting the findings of this study are available within the article.

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CONFLICT OF INTEREST

Dr. Ayman Hamdan-Mansour is the Editorial Board

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