Psychological Trauma or Moral Distress? A Response to Foli's Middle-Range Theory of Nurses' Psychological Trauma

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Abstract

Objective: To discuss the significant similarities between Foli's psychological distress theory and the moral distress literature.
Background: Foli presents a middle-range theory to conceptualize the issues nurses face personally, professionally and within healthcare organizations as types of psychological trauma. In presenting their theory, Foli's goal is to facilitate nurses' communication about their experiences and analyze the organizations' responsibility for these traumas. However, other scholars have described the issues nurses face personally, professionally and within their organizations as moral distress. We believe that there are significant similarities between Foli's psychological distress and moral distress, potentially creating confusion for researchers and theorizing about critical issues facing nurses.
Methods: In this discussion paper, we highlight the ethics and morality inherent to the nursing profession, define moral distress and the impact it can have on the nurse and their patients, and discuss the types of situations/issues that cause moral distress. We then contrast moral distress with Foli's psychological trauma theory. Finally, we then discuss the literature about psychological trauma theory and Foli's suggestions to nurses in comparison to moral distress literature
Results/Conclusion: There appears to be no difference between the psychological trauma theory and the moral distress literature. We recommend conceptional clarity about how the theory of psychological trauma is different from moral distress. Otherwise, we wonder if scholars' time will be spent trying to determine whether the issue is a psychological trauma or moral distress, rather than building on existing research that exists in the moral distress body of literature.
Keywords: nursing, ethics, moral, moral distress, psychological trauma

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Nurses are working at the front lines of healthcare, warnings of an upcoming nursing shortage, recently exacerbated by the COVID-19 pandemic (Baumann & Crea-Arsenio, 2023; Buchan & Catton, 2023; Canadian Federation of Nurses Unions, 2022; Turale & Nantsupawat, 2021). Ongoing nursing workforce shortages are worsening existing pressures on both the health systems and nurses (Buchan & Catton, 2023), due to insufficient resources and unmanageable workloads which create unsafe workplaces (Aiken et al., 2002; Buchan & Catton, 2023; Haddad et al., 2023; Marć et al., 2019; Nantsupawat et al., 2017). Nursing shortages, insufficient resources and unmanageable workloads placing nurses at risk for trauma and burnout have been described as moral distress by many scholars (e.g. Austin, 2012; Deschenes et al., 2020; Jameton, 1984). In contrast, Foli (2022) conceptualizes these experiences through a middle-range theory of nurses' psychological trauma. Foli's (2022) theory includes seven types of psychological traumas aimed at giving nurses a way to communicate their experiences of trauma.

We believe that there are significant similarities between Foli's psychological distress theory and moral distress, potentially creating confusion for researchers and theorizing about critical issues facing nurses. Confusion can take attention away from the real issues that nurses face. In this discussion paper, we highlight the ethics and morality inherent to the nursing profession, define moral distress and the impact it can have on the nurse and their patients, and discuss the types of situations/issues that cause moral distress. We then contrast moral distress with Foli's psychological trauma theory. Finally, we then discuss the literature about psychological trauma theory and Foli's suggestions to nurses in comparison to moral distress literature and conclude that we see no difference between the psychological trauma theory and the moral distress literature and recommend conceptional clarity about how the theory of psychological trauma is different from moral distress.

Background

Ethics and Morals

Though morals and ethics are separate concepts, the terms are often used interchangeably as they are interrelated, and both are concerned with what is "right or wrong" (Canadian Nurses Association, 2017; Utley, 2018). "Ethics is a branch of knowledge that deals with principles that underlie moral behaviours, as well as a branch of philosophy concerned with establishing criteria for evaluating the goodness or desirability of a behaviour" (Utley, 2018, pp. 111- 112). Morals are a personal expression of ethics that outlines one's commitment to principles and values one believes to be right or wrong (Austin, 2012; Deschenes & Kunyk, 2020; Utley, 2018; Wilkinson, 1988). "To distinguish between morals and ethics, it may be helpful to think of ethics as the science of morals and morals as one's practice of ethics" (Utley, 2018, p. 112).

The vital role of ethics and morals in nursing is widely acknowledged in the literature (e.g. Austin, 2012; Deschenes & Kunyk, 2020; Jameton, 1984; Larson et al., 2017; Rodney, 2017; Utley, 2018; Wilkinson, 1988). "The stated goals of the profession of nursing are *demonstrably ethical* [emphasis added]: to protect the patient from harm, to provide care that prevents complications, and to maintain a healing psychological environment for patients and families" (Corley, 2002, p. 637). Nurses are moral agents and are expected to engage in ethical behaviours (Canadian Nurses Association, 2017; ICN, 2021).

Moral Distress

Andrew Jameton (1984) first defined moral distress in nursing as when one knows the correct action, but institutional constraints make it difficult, if not impossible, to do the right thing. This definition of moral distress is often critiqued as restrictive and limiting (e.g., Corley, 2002; Deschenes et al., 2020; Pauly et al., 2009; Rodney, 2017; Webster & Baylis, 2000). Other scholars have suggested expanded definitions for moral distress (e.g. Jameton, 1993; Webster & Baylis, 2000). Of note, not all scholars (e.g. Morley, Bradbury-Jones, & Ives, 2021) believe that nurses experiencing moral distress know the right thing to do, as healthcare situations can be ambiguous. Using feminist empirical bioethical analysis, Morley, Bradbury-Jones and Ives (2021) present an expanded definition of moral distress as "the experience of a moral event…the experience of psychological distress [and a] direct causal relationship" between the two (p. 63). The authors define a moral event as encompassing "moral tension, moral conflict, moral dilemma, moral uncertainty or moral constraint" (p. 63). They also define *psychological distress* as a term that encompasses a variety of negative emotions and how individuals may express them. In this paper, we define moral distress using Morley, Bradbury-Jones, and Ives's (2021) definition as it identifies a direct causal relationship between moral events and psychological distress, which we use later to explore Foli's (2022) middle range theory.

Moral distress, sometimes called ethical distress, has been identified as a significant ethical issue experienced by many healthcare workers (Greenberg et al., 2020; Henrich et al., 2016; Tigard, 2017). It is suggested that nurses' experiences of moral distress vary from those of other healthcare professionals (Larson et al., 2017), likely related to the intimate nature of the nurse-patient relationship (Prentice et al., 2016). For example, nurses have been noted to experience more moral distress than physicians (Dodek et al., 2016; Hamric & Blackhall, 2007) and report a higher intensity of moral distress than their physician counterparts (Larson et al., 2017). Moral distress can manifest in nurses through anger, frustration, and guilt, which can contribute to developing a negative view of self and negatively impacting personal relationships (Austin, 2012; Morley, Field et al., 2021; Wilkinson, 1988). Some may experience negative psychological and/or physical effects, including depression, nightmares, diarrhea, and headaches, which are detrimental to nurses' short-term and long-term health and may potentially impact their ability to care for patients (Austin, 2012; Wilkinson, 1988).

Common sources of nurses' moral distress are often related to their work in the healthcare environment (Austin, 2012; Corley et al., 2005; Deschenes et al., 2020). Scholars suggest that nurses are often more ethically distressed by daily issues related to their work as opposed to the larger, more dramatic events (Corley et al., 2005; Epstein & Delgado, 2010; Epstein & Hamric, 2009; Henrich et al., 2016). Nurses often report moral distress around the quality and amount of care provided; inadequate or unclear communication between healthcare providers, patients, and their families; inadequate staffing, or staff that are not appropriately trained to provide the level of care needed; witnessing pain and suffering experienced by patients; challenging team dynamics; observing unsafe care practices; insufficient resources; a lack of managerial supports; and organizations that prioritize efficiency over care (Austin, 2012; Corley, 2002; Henrich et al., 2016; Vig, 2022).

Not only is moral distress associated with unwanted physical and psychological effects, ~~but~~ it is also linked to diminished quality of care, including patient safety, and high nursing turnover (Čartolovni et al., 2021; Corley, 2002; Deschenes et al., 2020; Sheppard et al, 2022; Wilkinson, 1988). A study performed during the COVID-19 pandemic by Sheppard et al. (2022) revealed that moral distress related to registered nurses' work environment and patient quality and safety were significant factors in their intent to leave their positions. Some have suggested that some nurses may attempt to cope with moral distress by simply avoiding morally distressing situations, though their lack of engagement negatively impacts patient care (Nathaniel, 2006; Wilkinson, 1988). If avoidance does not successfully reduce nurses' moral distress, they may opt to change positions or resign from the profession altogether (Sheppard et al., 2022; Wilkinson, 1988). Others have noted that moral distress can cause frustration, job dissatisfaction and burnout, resulting in nurses exiting their position or the profession entirely (Corley, 2002; Deschenes et al., 2020; Jameton, 1993; Pauly et al., 2012; Sheppard et al., 2022; Wilkinson, 1988). Experiences of moral distress are suggested to be a contributing factor to the current global nursing shortage (Deschenes et al., 2020).

Foli's Middle Range Theory of Psychological Trauma

Although Foli (2022) does not identify moral distress, the definition of psychological trauma significantly overlaps with moral distress. Foli's theory of psychological trauma is defined as:

> Experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and has lasting adverse effects on the individual's physical, social, emotional or spiritual well-being" (Substance Abuse and Mental Health Administration, 2014, as cited in Foli, 2022, p. 88).

Foli's (2022) middle-range theory of nurses' psychological trauma aims to "describe, predict and begin to control for the psychological trauma experienced by nurses" (p. 87). The theory outlines seven traumas: (a) vicarious/secondary, (b) historical/intergenerational, (c) workplace violence, (d) system-induced, (e) insufficient resources, (f) second victim, and (g) trauma from disasters. These traumas are classified as avoidable and/or unavoidable and may occur at the individual, professional, and/or organizational levels. Similarly, a concept analysis of moral distress describes the antecedents of moral distress as external (imbalances of power, situational, legal or healthcare institutional aspects) and/or internal (individual's values, beliefs, and characteristics that contribute to their moral judgement) to the individual experiencing moral distress (Deschenes et al., 2020). In what follows, we will contrast moral distress literature with each of Foli's seven traumas that demonstrate that they fall within the moral distress literature. Then, we present a critical reflection of Foli's theory and our search for how other scholars have used Foli's theory.

Vicarious/Secondary Trauma

Foli (2022) defines vicarious/secondary trauma as a result of the nurse's empathy for their patient(s), causing a shared experience of suffering for both the nurse and patient that can ultimately alter the nurse's worldview leading to compassion fatigue and burnout. Burnout is defined as a form of mental exhaustion due to workplace stress, characterized by a reduced

ability to perform one's professional duties, a loss of empathy, and pessimism related to one's job (British Medical Association, 2021). Though burnout does not necessarily include moral components, burnout is a consequence of moral distress (Deschenes et al., 2020; Larson et al., 2017; Maunder et al., 2023). Foli (2022) questions "whether there is a temporal component to trauma [and] burnout…with trauma being the precursor" (p. 89). In a longitudinal study to explore the relationship between burnout, moral distress, and job attrition in healthcare workers, Maunder et al. (2023) found that burnout "both amplifies moral distress and occurs because of moral distress" (Discussion section, para. 1). Pre-existing burnout was strongly associated with more severe experiences of moral distress. Though we are unable to determine temporality, there is clearly a relationship between Foli's (2022) proposed vicarious/secondary trauma, moral injury and moral distress that is unexplored.

Historical/Intergenerational Trauma

Foli's (2022) second type of trauma is historical/intergenerational trauma. Foli (2022) frames nurses as an oppressed group of "employees of an organization …situated within a hegemonic domain where they are grouped and anonymized" (p. 91). Similarly, Deschenes et al. (2020) noted that power imbalances (perceived or defined) and legal, administrative or policy constraints may lead to moral distress. Similarly, moral distress authors have noted that power imbalances (perceived or defined), as well as legal, administrative or policy constraints may lead to moral distress (Austin et al., 2005; Deschenes et al., 2020; Jameton, 1993; Nathaniel, 2006; Wilkinson, 1988). Moreover, moral distress authors have noted that power imbalances (perceived or defined), as well as legal, administrative or policy constraints may lead to moral distress (Austin et al., 2005; Deschenes et al., 2020; Jameton, 1993; Nathaniel, 2006; Wilkinson, 1988). Varcoe et al. (2012) explored nurses' experiences of moral distress, stating that it is apparent that "moral distress is inherently about power and differences in power" (p. 59). Epstein and Delgado (2010) note that the subordinate position of nurses leads to an inability to communicate with their superiors, which restricts their ability to act according to the ethical values held by the profession and their morals to advocate for themselves and/or successfully have their moral issues addressed. Furthermore, this perceived inferiority held by nurses within the healthcare organization may cause them to believe that they lack the power to enact changes needed to achieve ethical and moral congruence in their practice (Austin et al., 2005; Austin et al., 2009). Morley, Bradbury-Jones, & Ives (2021) selected feminist empirical bioethics to ensure that their expanded definition of moral distress encompassed issues of power, constraint, and justice that are central to nurses' experiences of moral distress (Peter & Liaschenko, 2013).

Moral distress scholars have studied and made suggestions on how organizations could support nurses rather than oppress them. Rathert et al. (2016) found that nurses' who felt supported by managers, senior physicians and administrators to access formal ethical support were less likely to report moral distress to their managers. Ensuring staff are able to address their vulnerable feelings, connect and reflect on particularly challenging situations creates safe moral spaces for nurses (Morley et al., 2022). These types of interventions can create and support an ethical environment, noted as an important factor related to experiences of moral distress (Corley et al., 2005; Pauly et al., 2009; Rathert et al., 2016; Silverman et al., 2021).

Workplace Violence

The third trauma, workplace violence, includes "verbal, written or physical abuse/assault from patients and visitors directed at nurses" (Foli, 2022, p. 91). Foli suggests that symptoms of historical/intergenerational trauma within the profession (mainly bullying and lateral violence) be viewed as workplace violence and is clear that the organization plays a significant role in this trauma. Scholars who examine moral distress concur that it often occurs due to the institutional context in which nurses work (Austin et al., 2005; Corley, 2002; Jameton, 1984; Tessman, 2020; Morley, Field et al., 2021).

A concept analysis on workplace violence in nursing by Al-Qadi (2021) identifies power and powerlessness as a distinct quality of workplace violence in the profession. Furthermore, Copeland and Arnold (2021) used situational analysis to explore the qualitative experiences of nurses who were physically attacked by their patients. This analysis reveals that in situations of workplace violence, the power dynamic between nurse and patient "is temporarily flipped rendering the nurse vulnerable and the patient more powerful" (Copeland & Arnold, 2021). Deschenes et al. (2020) also describe power imbalances as an external antecedent to moral distress in their conceptual clarification. Additionally, Varcoe et al. (2012) present moral distress as "inherently about power and differences in power" (p. 59).

A multifaceted approach is required to address the many complex factors that contribute to nurses' experiences of moral distress. We believe that Rodney (2017) has found a balance between the contextual relationships nurses have and the need to recognize the nature of power dynamics in work settings. Rodney suggests examining nurses' experiences of moral distress through a relational ethics lens, "allow[ing] for a deeper appreciation of the interconnectedness between people and structures…" (p. S9), while also acknowledging the power and hierarchy inherent in health care organizations.

We found theoretical models developed for moral distress that nurses experience (Amos & Epstein, 2020) suggesting that these issues are recognized and addressed within the moral distress literature. However, as Foli (2020) wrote, nurse leaders and healthcare organizations must foster a just organizational culture to address the pervasive issue of workplace violence leaving the suggestion that it is not adequately addressed in healthcare institutions. Surprisingly, his exploration of workplace violence fails to address the influence of power.

System-Induced or Treatment-Induced Trauma

System-induced or treatment-induced trauma is defined as the result of co-experiencing the patient's trauma through provided care (Foli, 2022). We believe that these experiences significantly overlap with what we have discussed in the moral distress section in that nurses' experiences of moral distress are likely related to the intimate nature of the nurse-patient relationship (Prentice et al., 2016). Thus, moral distress scholars have highlighted that what Foli considers the fourth trauma has already been addressed within moral distress literature. Foli's system-induced trauma does not appear to present anything new or different from what is reported in the moral distress literature, providing a different perspective nor clarifying how it shapes contextual nursing practice.

Insufficient Resource Trauma

The fifth trauma, insufficient resource trauma, refers to insufficient knowledge, staff, supplies, and other personnel (Foli, 2022). As identified above in our description of the types of circumstances nurses identify as morally distressing, many researchers have reported these types of insufficient resources can create moral distress. Nurses report experiencing the highest frequency and intensity of moral distress when they view staffing levels as unsafe (Corley et al., 2005; Pauly et al., 2009). Viewing nurses' experiences with insufficient resources as a potential contributor to moral distress helps explain why nurses are frustrated, burnt out and quitting their positions or leaving the profession (Corley, 2005; Denham et al., 2023; Deschenes et al., 2020; Pauly et al., 2012).

Second-Victim Trauma

The sixth trauma is second-victim trauma describing experiences after "a medical error or adverse event" (Foli, 2022, p. 91). Other scholars have noted that these events are related to burnout and moral distress. For example, research exploring physicians' experiences shows a strong relationship between medical errors and burnout (Robertson & Long, 2018; Shanafelt et al., 2010). In a study of physicians primarily, the strongest predictor of moral injury was burnout, followed by having performed a medical error within the last month (Mantri et al., 2021). Though nursing-specific research is limited, a mixed-methods study examining certified critical care nurses identified moral distress and compassion fatigue as contributing and related factors to medical errors (Maiden et al., 2011).

Trauma from Disasters

The seventh and final trauma is nurses' trauma from disasters where "nurses are often first responders" (Foli, 2021, p. 92). One example of a disaster provided by Foli (2021) is the COVID-19 pandemic. While many nurses experienced trauma during this time, many studies have characterized these experiences as moral distress (e.g. Denham et al., 2023; Silverman et al., 2021; Stephenson & Warner-Stidham, 2024; Vig, 2021). A systematic review found that the factors related to moral distress, mainly futile care and end-of-life care, were the primary causes of moral distress in critical care nurses both before and during the COVID-19 pandemic (Beheshtaeen et al., 2024). However, fear of contracting and spreading the virus correlated strongly with moral distress during the pandemic. This fear was deeply distressing to nurses (Lake et al., 2022). As the moral distress literature has already addressed all of Foli's trauma, we are concerned that Foli's theory of psychological trauma contributes to conceptual confusion, taking scholars and researchers attention away from the issues nurses face. We wonder if time will be spent trying to determine whether the issue is a psychological trauma or moral distress, rather than building on existing research that exists in the moral distress body of literature.

Applications of Foli's Theory of Psychological Trauma

We also reviewed the literature that used Foli's (2022) theory of psychological trauma and found only two studies (Gill & Foli, 2024; Yu-Chin et al., 2023), for both of which Foli was a co-author. This could be due in part because the theory is relatively new. Gill and Foli applied the psychological trauma theory to a composite case study of Nurse Practitioners experiences with patients. Unfortunately, the methods of inquiry or how the composite case study was

derived were not presented. Yu-Chin et al examined the types of traumas experienced by nurses who had probably had post-traumatic stress disorder (PTSD). They found these nurses were more likely to have experienced disaster or system induced traumas. We found one integrative review of psychological trauma that examined data using Foli's theory (Boyden & Brisbois, 2023). They conducted a thematic analysis of nurses' trauma in studies that examined PTSD type symptoms in nurses during the COVID 19 pandemic. Although they discuss Foli's theory in the background and in the discussion section, it does not appear to have been applied to their analysis. In addition, Hood and Copeland (2024) conducted a grounded theory study that examined the prevention of psychological trauma for student nurses and drew on Foli's theory in the background section and discussion of their findings. They identified the need for faculty to support students experiencing psychological trauma, otherwise it could be a traumatic experience they take with them into their nursing practice. Of note there was no evidence of Foli's theory being incorporated in the study.

Discussion

Mitigating Psychological Traumas (or Moral Distress)

In order to prevent and mitigate psychological traumas, Foli (2022) suggests turning to The Nursing Manifesto (Cowling et al., 2000). Cowling et al. (2000) argue that nursing sovereignty must align with organizational practices, noting that current healthcare system conditions render us incapable of providing care congruent with the profession's fundamental values. The manifesto does not offer prescriptive actions but rather encourages nurses to share their position by using storytelling, promoting change, reflecting on their experiences, engaging in participatory research, and collaborating with patients (Cowling et al., 2000). Interestingly, these suggested actions are notably similar to interventions currently used to address moral distress in nurses.

Moral distress researchers have identified several interventions to guide nurses in working through their psychological/moral distress. A systematic review of the literature identified several interventions to reduce moral distress, including facilitated discussion; self-reflection; narrative writing; multidisciplinary rounds; and specialist consultation service programs (Morley, Field et al., 2021). Education sessions were the most commonly used interventions and had encouraging outcomes, with four of the seven studies reporting statistically significant reductions in participants' moral distress. While these interventions require further scientific validation, they offer a promising direction to better support nurses (Morley, Field et al., 2021). Morley et al. (2022) identify additional interventions for moral distress within their 'Moral Distress Model'. The authors explain how compounding factors impact nurses' experiences of moral distress and utilize the model to tailor approaches, actions and measures to mitigate and address moral distress. Proposed strategies include nursing involvement in clinical decision-making and team communication; advocacy; ethics education; and provision of safe moral spaces (Morley et al. 2022).

Notably, there are decades of research and scholarship related to moral distress. We believe that moral distress literature addresses all elements of Foli's (2022) psychological trauma

and that it is important to draw on the decades of work that has developed around moral distress and suggestions to prevent and support nurses experiencing it. We advocate for the use of relevant terminology when describing moral distress:

> "Using [the term moral distress] … can help us to speak to the moral domain of our practice…naming and understanding the distress that arises when we are blocked from answering the call of our patients is a first step toward empowering ourselves to action" (Austin et al., 2003, p. 183).

Ensuring the use of relevant terminology will also ensure that organizations can provide appropriate supports by normalizing nurses' reactions to morally distressing events and facilitating access to mental health supports (Vig, 2022).

For example, Missouridou (2017) posits that nurses' experiences of psychological trauma are connected to moral distress. Just as Foli highlights the importance of healthcare organizations in recognizing nurses' trauma and providing resources, Missouridou (2017) highlights that organizational norms can affect how moral distress is processed and thus, emotional responses to trauma are a social process. If there is some significant difference between psychological distress trauma and moral distress, we suggest a need for conceptual clarification

While we appreciate Foli's desire to provide a framework for nurses to communicate their issues, we believe that Foli's seven psychological traumas are encompassed within scholarly descriptions of moral distress. We believe that psychological distress and moral distress are interrelated, as defined by Morley, Bradbury and Ives (2021). Given that Foli's (2022) theory is relatively new, it is unknown if it will be useful to other researchers, or if they, like us, will seek further conceptual clarity that delineates how it differs from moral distress.

When nurses are unable to speak about their moral distress, they will continue to leave their jobs and/or the profession. It is important to support nurses' physical and mental health, all of which impact their ability to deliver quality, safe, ethical care to patients. We applaud organizations that introduce unit-specific and/or hospital-wide moral distress interventions that create and foster a culture of epistemic justice, improve moral consciousness and support healthcare providers experiencing moral distress (e.g. Epstein & Delgado, 2010; Morley et al., 2022; Rodney, 2017; Vig, 2022; Wocial et al., 2017).

Conclusion

Foli (2022) presents a middle-range theory to conceptualize nurses' challenging experiences as psychological traumas to provide nurses with a way to communicate their lived experiences to management and the organization. Their experiences are multifactorial and often associated with organizational practices that affect nurses' ability to provide safe and ethical care. We have highlighted the similarities in Foli's theory of psychological trauma and moral distress. We call for conceptual clarity of Foli's theory as we are unclear of the utility of having two similar streams of research, particularly when decades of research and scholarship have been directed towards moral distress. We agree with Foli, as do moral distress scholars, that

healthcare organizations have a responsibility to enact change to support nurses' ethical practice, which can aid in retaining nurses within their organizations and the profession. Without these types of changes, our healthcare systems will continue to see a decrease in patient care quality and will lose nurses, one of our most valuable resources.

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