Moral decisions, moral distress, and the psychological health of nurses

by

Martin E. H. Willis

Doctoral Thesis

Submitted in partial fulfilment of the requirements
for the award of
Doctor of Philosophy of Loughborough University

February 2015

ABSTRACT

The major focus of this thesis is the role of feelings and emotions in moral thinking/knowing, ethical conduct and, in particular, moral distress in nursing. Research has consistently found that the moral decisions nurses must make can sometimes lead to distress. However, such experiences are overly individualised in the literature. An alternative view of the person, drawing on the philosophy of Alfred North Whitehead (e.g. 1927-8/1978) and the recent work of Paul Stenner (e.g. 2008), sees human subjectivity or mind as processual and always embodied and in-the-world. The emphasis upon the body draws attention to the role of felt experiences – this thesis views feelings as integral to both *sense*-making – knowing and thinking – and *sensibility* or emotionality. The emphasis 'in-the-world' highlights that subjectivity is embedded within social contexts, which include relations of power and organisations of material and symbolic capital aligned with those relations. Influenced by 'deep empiricism' (e.g. Stenner, 2011a), this thesis develops a novel bricolage methodology based on a metaphor of 'diffraction' to explore nurses' experiences of moral distress. Nurses' feelings of discomfort, a particular form of 'feelings of knowing', appear to be the seeds of moral distress. Various situations seem to be important antecedents for these seeds to bloom into full moral distress, including certain clinical issues, ethical conflict with colleagues, and issues of competency. Nurses also experience some aspects of their job as systemic barriers to high standards of care, which can also be morally distressing. Such distress sometimes affects nurses' relationships, their physical health, and their mental health. Participants have found several strategies useful in coping with their distress. It is argued that these strategies are about altering one's feelings through changing one's activities and/or environment. Additionally, past distress may remain a dormant part of a person's subjectivity and re-emerge or become (re)enacted in the narrations of those past distressing experiences. It is suggested that subjectivity entails an organisation of past experiences in the present, for present purposes and in anticipation of the future. Six dominant thematic patternings, which recurred throughout the analyses, are discussed: (i) the centrality of feelings; (ii) the relationality of felt experiences; (iii) the complexity of morality, moral conduct, and moral distress – moral/ethical issues become entangled with identity, power, professional competency, and social relations; (iv) the prominence of power and interest; (v) nurses lives as afflicted by moral distress; and (vi) life-as-process. Discussion of these motifs leads to a rethinking of moral distress. Implications for nursing practice, moral distress research and the study of feelings, emotions, and affect are discussed.

KEY WORDS

Feelings; Emotions; Distress; Process Philosophy; Bricolage; Nursing; Morality; Ethics

DEDICATION

I dedicate this thesis to my mum, Trish Willis (1956–2009).

Your memory is never passing.

ACKNOWLEDGEMENTS

Sincerest thanks go to my supervisor, John Cromby, whose guidance, belief and trust must be recognised as the epitome of Vygotskian scaffolding – supporting and inspiring me to completion of the project, but with the freedom to do things my way. Thanks must also go to Gareth, Nick, Nicky and the other members of our reading group and the qualitative research discussion group for all of the interesting and thought-provoking conversations; and to Brett Smith for his helpful and encouraging advice. Thanks also to my beautiful girlfriend, Lauren, for her loving support, and to my dad, brothers, and extended family for their support. Thanks also go to the NHS Trust – in particular, the Head of Nursing Research – for supporting the project and assisting in the recruitment process, and to the School of Nursing for also supporting the project and aiding recruitment of participants. Last, but not least, a big thank you all of the participants who generously shared their time, their experiences, their feelings and emotional energy to make this project possible.

CONTENTS

1 INTRODUCING

The major focus of this thesis is the role of feelings and emotions in moral thinking/knowing, moral or ethical conduct and, in particular, moral distress, in the context of nursing in the United Kingdom. This introductory chapter contextualises the project with regards to current issues in the National Health Service, which inevitably impact upon nurses' experiences. There are many factors that constitute the context of nurses' experiences, with at least three over-lapping levels to consider. First, there is the macro-level, at which national (and international) politics and economics shape governmental health policies and budget allocations to the National Health Service (in the UK). Below this is a meso-level, which is closely related to the macro-level, at which institutional characteristics of NHS England, as it implements the decisions made by national government, come into play. At this level, there is also the intersection between NHS England and local NHS Trusts. The latter must implement the decisions made by NHS England within a specific locality. The Trust that participated in this research study operates two hospitals in a large city in the East Midlands region of England. At a micro-level – from the level of the Trust down to individual wards – there may be specific challenges faced by staff. Since this thesis is specifically concerned with the experiences of nurses, the next section shall discuss some of the ethical challenges and conflicts that are identified in the nursing literature. The section following that shall then focus on the political climate and associated changes to the NHS, which forms the backdrop to this research.

1.1 ETHICAL CHALLENGES & CONFLICTS IN NURSING

According to the literature, the nursing profession is fraught with difficult, often stressful, decisions about patient care. As the following quotations illustrate, these decisions often have an ethical dimension:

> When [nurses] consider whether an intervention is necessary, we are making choices about what to do for the best (including the possibility of doing nothing). These decisions require judgement about whether or how to act, and judgement

must be based on some ethical understanding and reasoning. (Unsworth Webb, 2008, p. 124)

Nursing is a noble profession but too often a terrible job. At its best, nursing is a calling, a physically and emotionally challenging, humanly fulfilling moral mission. Nurses encounter patients in their most vulnerable moments, sharing an intimacy found in few other human relationships. Sometimes they work with a personal commitment transcending technical performance, a commitment too rarely found in most careers. At the same time, nurses express frustration as their immediate, even dominant, emotional response to their work. "I can't do my job," they say. "There is no support from the higher ups." Lack of time, of support, of supplies, of respect are mentioned again and again. (Chambliss, 1996, p. 1)

It is apparent that nurses view their work as a moral endeavour. The quotations also reveal that nurses experience some aspects of their jobs as problematic. Not only is the work emotionally and physically demanding, there are also institutional demands that make the job even more challenging. Moreover, according to some nursing researchers, healthcare services are increasingly beset with uncertainty, risk and complexity. (This has led to the adoption of "complexity theory" as an approach to explanation in healthcare [e.g. McDaniel & Driebe, 2001; Paley & Eva, 2011; Plsek & Greenhalgh, 2001].) Healthcare reforms, changing roles and identities across and between professional boundaries (A. Williams & Sibbald, 1999), increases in patient acuity, multiple comorbidities, globalisation and use of technology (Vaismoradi, Salsali, & Ahmadi, 2011) are claimed to variously contribute to these complexities and uncertainties, rendering the task of decision-making by healthcare professionals increasingly difficult. These problems are likely to be exacerbated by ethical or moral issues regarding patient care. Issues such as insufficient staffing levels, inadequate staff training, inappropriate allocation of resources, situations in which patients are discussed inappropriately, and irresponsible colleagues can be counted among the many ethical problems which may clash with nurses' collective or personal values (Chambliss, 1996; Robinson Wolf & Zuzelo, 2006).

Ethical conflicts tend to be characterised by disagreement over the quality of care given to patients. Redman and Fry (2000) identified several ethical conflict themes, including differences in the definition of adequacy of care among professionals, the institution and society; divergences in the orientations of nurses, physicians, and other healthcare professionals; a lack of respect for the knowledge and expertise of nurses in speciality practice; and difficulty in carrying out the nurse's role as advocate for patients. Furthermore, Gaudine, LeFort, Lamb, and Thorne (2011a, 2011b) recently identified nine themes of clinical ethical conflict common to nurses and physicians (and a further three themes specific to physicians not listed here): (i) disagreement about care decisions or treatment options; (ii) others not respecting patients' wishes; (iii) patients not receiving quality end-of-life care; (iv) patient's or family's behaviour preventing safe or quality care

2

for self or others; (v) patient and/or family not having informed consent or full disclosure; (vi) not knowing "the right thing to do"; (vii) system deficit or deficiency preventing quality care; (viii) personal values conflict with patient's values or lifestyle choices; (ix) possible or perceived deficiencies in care due to lack of professional competency. What is apparent from this list is that many of these ethical conflicts reveal that despite the large body of work in nursing ethics and bioethics, which attempts to offer solutions to healthcare ethical problems, professionals face many practical difficulties and disputes which ethical theories simply do not address (cf. Austin, 2007).

Jameton (1984) proposed that there are three categories of moral or ethical 'problem' faced by nurses. "*Moral uncertainty* arises when one is unsure what moral principles or values apply, or even what the moral problem is" (p. 6, original emphasis). The individual may be ambivalent towards, or undecided about, what the correct moral judgement might be, what 'ought' to be done, or the right course of action to take. "*Moral dilemmas* arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" (p. 6, original emphasis); an apparent mental conflict between moral imperatives – a choice between two or more equally expedient or equally imprudent alternatives, the assignment of priorities in the fulfilment of responsibilities and obligations, or being unable to find a satisfactory solution to a problem (Georges & Grypdonck, 2002). Further, this may involve issues around the allocation of resources. Additionally, "[m]oral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6; original emphasis). Organisational rules and policies contravene the nurse's moral judgement and lead the individual to act contrary to their own values and principles.

Broadly in line with the findings of Gaudine and colleagues (2011a, 2011b) and Redman and Fry (2000), there are several other concepts, generally considered to be 'moral problems', which are used in the nursing literature. For example, 'moral outrage' is defined as "an emotional response to the inability to carry out moral choices" and is characterised by anger, frustration, and powerlessness (Pike, 1991, cited in Georges & Grypdonck, 2002, p. 157; cf. Jameton, 1984). Additionally, it is often argued that nurses encounter 'ethical' or 'value conflict', which has been defined as a clash between a healthcare professional's personal values and their perceptions of how patients are cared for and treated (Gaudine et al., 2011a, 2011b; Schluter, Winch, Holzhauser, & Henderson, 2008). There has also been a significant amount of work around the concept of 'moral integrity' (Cribb, 2011; Edgar & Pattison, 2011; Ekeberg, 2011; Hardingham, 2004; Kelly, 1998; Laabs, 2007, 2011; Tyreman, 2011). 'Integrity' refers to the truthfulness, honesty, or accuracy of an individual's actions, and/or the consistency of their actions with their values and

principles. It has been suggested that nurses may struggle to maintain their integrity when facing moral uncertainty, moral dilemmas, moral distress, or moral outrage. Other phenomena theorised and/or empirically investigated by nursing scholars include 'moral residue' and 'moral burden'. According to the literature, moral residue is a lasting trace or memory of a morally distressing situation in which an individual has seriously compromised themselves or has been compromised by outside influence (Hardingham, 2004). According to Schluter, Winch, Holzhauser, and Henderson (2008), although moral burden is related to moral distress, it is different from it; so the two should not be conflated. A sense of moral burden is distinct from economic, social, or psychological burdens since it is "caused by a problem or situation that involves moral values" (Lützén, Dahlqvist, Eriksson, & Norberg, 2006, p. 193).

Many of these 'moral problem' terms have been taken up in the nursing literature and there has been much blurring of the definitions. This, of course, causes conceptual problems and inconsistencies in the literature. This is hardly surprising: If healthcare environments are as complex as the literature would have us believe, it may prove difficult to maintain the distinction between these closely related concepts in empirical exploration of nurses' everyday experiences.

In sum, the nursing literature paints a picture of the nursing profession as one that faces many ethical challenges and conflicts, which may, in some circumstances, result in nurses becoming distressed. It is this distress that is the main focus of this research project and so the moral distress literature shall be reviewed in the next chapter. For now, it appears that healthcare ethics are socially organised and that ethical problems in healthcare are inseparable from the organisational and social settings in which they arise (Austin, 2007; Chambliss, 1996). The remainder of this chapter shall, therefore, briefly explore the recent political context and re-organisation of the National Health Service, which has inevitably impacted upon the experiences of the nurses who participated in the research reported in this thesis.

1.2 POLITICAL CLIMATE & CHANGES TO THE NATIONAL HEALTH SERVICE

1.2.1 Austerity Britain & Budgetary Reductions

A few years prior to the commencement of this research the world faced an economic crisis – also known as the '2008 credit crunch' – the likes of which had not been seen since the 'Great Depression' of the 1930s (Pendery, 2009). The crisis threatened the collapse of even the world's largest financial institutions, which was only prevented by bailout of the banks by national governments, with estimates between hundreds of billions and trillions of pounds paid from HM Treasury to private banks in the UK (Curtis, 2011). In 2010, one year before the project reported herein began, there was a general election in the UK. In the lead up to Election Day, there was a

particular focus on the state of the economy and the UK's budget deficit. Some – including the Conservative Party and the Liberal Democrats – blamed the then Labour government for the financial crisis and the large deficit brought about by bailing out the banks and dealing with the struggling economy. The election resulted in a hung parliament and, after what appeared to be intense negotiations, the Conservatives and Lib Dems formed a coalition government. When in government the two parties continued to "peddle the myth of the 'inherited mess'", as one online commentator puts it (Walker, 2012), reframing the financial crisis

> from an economic problem (how to 'rescue' the banks and restore market stability) to a political problem (how to allocate blame and responsibility for the crisis): a reworking that has focused on the unwieldy and expensive welfare state and public sector, rather than high risk strategies of banks, as the root cause of the crisis. (J. Clarke & Newman, 2012, p. 300)

Several years later, in the run up to the next general election in 2015 – at the time this thesis was being written – some politicians are still blaming unrestrained welfare and social services spending by the previous administration for the global economic crash (cf. Bennett, 2014).

With the stated aim of reducing the deficit, the coalition government set out on a programme of austerity measures, including a budgetary reduction of £40 billion (Elliott & Wintour, 2010). However, as Clarke & Newman note, austerity involves a form of 'magical thinking', including

> the belief that if one says things often enough, they will come true (visible in most UK chancellors of the last few decades) and a touching faith in the power of good feelings ('confidence' among consumers and investors). Paul Krugman nicely points to how such magical beliefs combine in the central role of the 'confidence fairy':

>> But don't worry: spending cuts may hurt, but the confidence fairy will take away the pain. 'The idea that austerity measures could trigger stagnation is incorrect,' declared Jean-Claude Trichet, the president of the European Central Bank, in a recent interview. Why? Because 'confidence-inspiring policies will foster and not hamper economic recovery.' (Krugman, 2011: 2)

> The alchemy of austerity, then, is not just a matter of persuading the populace to adopt a form of 'false consciousness'; alchemy, the investment in magical beliefs, is itself part of the strategy for recovery. At the heart of this austerity strategy is a belief that strategies of fiscal constraint can, counter-intuitively, produce expansionary effects in national economies, increasing private consumption and investment and producing growth in Gross Domestic Product (GDP). (J. Clarke & Newman, 2012, p. 301; quotation in original)

In effect, austerity is built upon a paradoxical belief in "expansionary fiscal contraction" (Guajardo, Leigh, & Pescatori, 2011, p. 3). In contrast to this view, however, the Office for Budget Responsibility – created in 2010 to provide independent analysis of the UK's public finances – has

stated that spending cuts and increases in tax will more than likely depress economic activity and, consequently, lower growth (Kirkup, 2013).

Until the coalition government took office the National Health Service had received a decade of record investment, which allowed it to improve care, meet ambitious waiting time targets, and achieve unprecedented levels of public satisfaction (Lister, 2013). Despite a pre-election pledge that "the NHS is safe in our hands" (BBC, 2006; Conservative Party, 2010; Daily Mail Reporter, 2010), the budget cuts encompassed NHS spending. While the NHS budget might have increased nominally, there were consecutive decreases in real NHS expenditure for 2010-11 and 2011-12 (Full Fact, 2013; HM Treasury, 2012a, 2012b). As a result of these decreases in expenditure, by August 2012, there were between 4,823 (Ramesh, 2012a) and 5,780 (Buchan & Seccombe, 2012) fewer nurses than when the coalition government took office. Furthermore, at the end of 2013, amid claims that the NHS had to make £20 billion of "efficiency gains" by 2015, the Department for Health disclosed that 4,620 frontline staff were made compulsorily redundant between 2010-11 and 2012-13, and a further 2,430 voluntarily redundant (Campbell, 2013). These figures include doctors, nurses, midwives, health visitors, ambulance staff and qualified scientific, therapeutic and technical staff; although how many of each type was not specified.

It was recently claimed that "exceptional pressures on [the] NHS mean key aspects of care are starting to deteriorate" (Campbell, 2014a). Cuts to the NHS budget and the staff redundancies mentioned above have likely resulted in "staff shortages", which in turn may have led to "lapses in safety, patients having to wait on trolleys in corridors and chronic bed shortages" (Campbell, 2014c; cf. Merrick, 2012), which were highlighted as problems in a recent report by, health and social care regulator, the Care Quality Commission (CQC, 2014). Writing in the *Nursing Times*, Jenni Middleton (2014) recently argued that "the NHS needs more nurses to make it safe". It is no wonder, then, that "NHS hospitals spent £2.5bn on part-time agency staff last year – far more than planned – in a bid to improve patient safety amid sharply rising demand" (Cooper, 2014). Nor is it surprising, given the funding cuts mentioned above, that the chief executive of NHS England, Simon Stevens, has told the government that the NHS needs an extra £8 billion by 2020 in order to safeguard its services (Campbell, 2014b).

So, at a time when demand for NHS services is rising, funding has been reduced. Moreover, simultaneous to carrying out those austerity measures, the coalition government introduced the Health and Social Care Act 2012, continuing a programme in which "Britain's National Health Service, which established health care as a right, has been progressively dismantled and privatised by successive governments over the past quarter-century" (Pollock, 2005, p. vii). This Act enables private companies and non-profit social enterprises to compete, as 'Qualified Providers', for

healthcare contracts. A recent newspaper report stated that over £10 billion had be spent on the "purchase of healthcare from non-NHS bodies", including companies such as Circle Partnership UK, Ramsay Health Care UK, Care UK and Virgin Care (Campbell, 2014d).

According to one campaign group, the inclusion of private providers in the NHS could be detrimental to service provision (NHAP, 2014). For example, it is possible that staff numbers will be further reduced in the quest for profits for shareholders. Additionally, as John Lister recently suggested,

> public sector (NHS) providers are being continuously cut and squeezed into downsizing, mergers, centralisation and closures. Cynical 'reconfiguration' plans [...] across England mean only a reduced number of short-staffed, demoralised, overloaded 'centralised' units will remain, covering only those services that the private sector does not wish to provide. (2013, p. 18)

That is, private companies 'cherry pick' the easy and profitable areas of healthcare, leaving the NHS to deal with the more expensive and more complicated cases, but without the income to do so due to decreased budget allocations and funds being diverted into private contracts. The combination of budgetary reductions and increases in private sector competition, then, could significantly impact upon the working conditions of NHS nurses, the kind of ethical issues and dilemmas they encounter and, thus, their experiences of moral distress.

1.2.2 NHS Scandals & the Drive for Compassion in Practice

Alongside the aforementioned budget cuts and restructuring of the NHS, there have been several widely publicised health and social care scandals in recent years. The most notorious of these involved the Mid-Staffordshire NHS Foundation Trust, which was investigated by a public inquiry chaired by Robert Francis QC (Francis, 2013a, 2013b, 2013c). The final report of the inquiry (AKA 'the Francis Report') identified "appalling suffering of many patients" caused by "an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities" (Francis, 2013a, p. 9). The report also flagged up

> numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:
> - A culture focused on doing the system's business – not that of the patients;
> - An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
> - Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
> - Too great a degree of tolerance of poor standards and of risk to patients;
> - A failure of communication between the many agencies to share their knowledge of concerns;

- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation (Francis, 2013a, p. 10)

All this points to, as one reporter put it two years before the Francis report was published, "a total system failure" (Lintern, 2011). The emphasis appears to be upon 'poor care' being the result of 'poor management', but for some the fault did not solely lie here. For example, in his evidence to the inquiry, Sir Bruce Keogh, medical director at the Department of Health, agreed that

> poor care "was inescapably" the fault of "incompetent management" but he added: "I don't want to put all the blame on managers. It's not the managers who see the patient.
> "It's not the managers who actually nurse the patient. When I look at this kind of failure, what I see is a failure of clinical leadership and professionalism." (Lintern, 2011)

The 'blame' has clearly been shifted onto the nursing team. This is a view shared by others. For example, some questioned whether there was a lack of compassion in nursing in the UK (e.g. Reed, 2012). At a national level, the NHS responded with the 'Compassion in Practice' strategy, authored by the Chief Nursing Officer for England, Jane Cummings, and Department for Health Director of Nursing and Lead Nurse for Public Health England, Viv Bennett (Cummings & Bennett, 2012). Addressing nurses, midwifes and other care staff, this strategy document focused on "our six fundamental values – care, compassion, competence, communication, courage and commitment (the "6Cs")" (Cummings & Bennett, 2012, p. 11), which should be "part of everything we do" (p. 9). Each of the 6Cs was defined by Cummings and Bennett, which were based on an engagement process with over 9000 nurses, midwives, care staff and patients.

Given the extent of the consultation exercise, it is a little surprising that the clarity of some of their definitions is lacking. Care, for example, is defined as

> our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life. (2012, p. 13)

Here we are told that care is the business of nursing, midwifery and other care staff and the organisations for which they work; what it does (i.e. helps people and improves health); that people have expectations of the care they receive; and, importantly, that it defines nurses and midwives. But it is striking that care – supposedly a fundamental value of healthcare professions,

which also supposedly defines those professions – is defined in business rather than ethical, moral or human terms.

Since 'care' is so central to nursing, a clear and explicit definition in moral, ethical or human terms should not be difficult to produce. Yet, it seems, none of the 9000 people consulted were able to do so. Is it possible that nurses, for example, do not have an unequivocal understanding of a key value of their profession? If so, this is especially problematic considering that 'care' or 'caring' is included in the definitions of the other five Cs. For example, compassion, which might be considered particularly important in nurses' ethical dilemmas and any experiences of moral distress, is defined by Cummings and Bennett as

> how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care. (2012, p. 13)

This definition has more clarity than the one for 'care': saying that compassion is "intelligent kindness" based on empathy, respect and dignity suggests that compassion is a deliberate approach to delivering care. This, however, does not necessarily equate with other understandings of compassion that see it as "a feeling of deep sympathy or sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering" (Dictionary.com, n.d.). The latter definition removes the deliberate or 'intelligent' aspect and is more in line with the findings of later chapters of this thesis[1].

Although compassion is only one of the 6Cs, it is apparent that it is seen as, perhaps, the most important and/or the most neglected of the 'six fundamental values'; Cummings and Bennett's strategy document is titled 'Compassion in Practice', after all. The response to poor standards at a minority of hospitals or NHS Trusts, therefore, might reasonably be considered to be a national drive for compassion in practice. The prominence of the NHS scandals, and events at Mid Staffs in particular, and the subsequent drive for compassion in nursing practice is likely to have impacted upon the experiences of nurses all over the UK. These issues also co-constitute both the institutional and rhetorical context in which interviews with nurses for this research project took place.

---

[1] There is more involved here than pedantry over, what some might consider, nuances of definitions. If the 6Cs are intended to be "part of everything that nurses do", how they are defined can have serious consequences for how they are implemented. If compassion is no longer deeply felt – as a sympathy or sorrow for another's suffering and as a desire to alleviate that suffering – but is instead an act of "intelligent kindness", is it still compassion?

1.3 SUMMARISING

In sum, a number of ethical challenges in nursing have been discussed. For example, the complexities and uncertainties of the National Health Service render the task of decision-making by healthcare professionals increasingly difficult; likely to be made harder by ethical concerns. Nurses and other professionals may also encounter conflicts of values and interests as they attempt to maintain high standards amid such complexity. Several 'moral problems' and associated concepts were also identified from the nursing literature. It was suggested that it may be difficult to distinguish between these problems in nurses' accounts of their experiences.

A discussion of the political context of this research, in terms of austerity and changes to the NHS and of recent NHS scandals and subsequent drive for compassion followed. It was pointed out that at the same time as there has been increasing demand for NHS services there has also been a reduction in funding of those services. It was also noted that the material and social conditions in which nurses work is inevitably shaped by these issues. In a context where resources are limited and expectations to "do more with less" are increasing, professional moral dilemmas are likely to become both more prevalent and more pressing.

1.3.1 Thesis Structure

Chapter 2 critically reviews the moral distress literature. The chapter discusses the sources, mediators and consequences of moral distress prevalent in the nursing literature; there is also a brief exploration of the role of responsibility in experiences of moral distress and consideration of criticisms of the literature. It shall be suggested that the literature has been too quick to individualise moral distress and that an alternative conceptualisation of the person may circumnavigate this problem. As a result, Chapter 3 shall detail a process-relational ontology, provided by the philosopher Alfred North Whitehead, which enables us to rethink human subjectivity as inherently dynamic and relational. As such, Chapter 3 shall also include discussion of Paul Stenner's recent work on subjectivity, which draws on Whitehead's philosophy. Following this, Chapter 4 shall draw together several strands of work on feelings and emotions. The chapter shall suggest that feelings are central components of subjectivity and that certain feelings are just one component of complex, multi-dimensional emotions.

With the outlining of this theoretical framework complete, attention shall be paid, in Chapter 5, to methodological matters. The chapter shall begin with a brief discussion of 'deep empiricism' as the guiding epistemological position for this research project. The chapter shall then discuss bricolage and diffraction as metaphors for putting deep empiricism into practice, before setting out the methods used in this thesis.

Chapter 6, the first empirical chapter, explores nurses' feelings of knowing. Gut feelings and feelings of discomfort shall be particularly emphasised. It shall be suggested that feelings of discomfort may be the seeds of moral distress. The following chapter is divided into two parts. The first part of Chapter 7 shall take a look at some common antecedents to experiences of moral distress, with a focus on clinical issues and relationships with colleagues. The second part of the chapter shall then discuss some of the feelings and emotions nurses associate with experiencing moral distress. The first part of Chapter 7 shall be built upon in Chapter 8 by exploring aspects of the job that some nurses experience as barriers to maintaining high quality care. Three such barriers shall be discussed: staffing issues, problems with paperwork, and policies experienced as antagonistic to care. Chapter 9 shall then focus on some of the consequences of moral distress along with some of the strategies nurses find useful in coping with distress. The last empirical chapter, Chapter 10, shall then explore distress as experienced and (re)enacted in the research interview. Finally, Chapter 11 shall discuss the analyses of the previous five chapters and, in light of this discussion, rethink moral distress. This final chapter shall also concern potential limitations of the project along with contextual, self-critical and linguistic considerations, and implications for theory and practice.

2 NURSE MORAL DISTRESS

2.1 INTRODUCING

Although Jameton's original concept of 'moral distress' (described in Chapter 1) became a working definition for many investigators (Hanna, 2004), it remains a continually evolving and shifting concept. Indeed, Jameton (1993), himself, developed his original concept to also include conflicts with co-workers as obstacles preventing nurses from acting congruently with their moral judgements. The literature suggests that, typically, nurses do not talk about moral distress in terms of overcoming institutional obstacles or in terms of personal failure, however (Hanna, 2004). This has led to a further redefinition: 'the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision' (Wilkinson, 1987/88, p. 16). In this definition, moral distress is conceptualised as mental turmoil, which is accompanied by an emotion, in situations where a solution to a morally complex problem cannot be pursued. The emphasis on psychological upheaval and the negativity of the feeling state or emotion indicates the potential for harm to the individual. This becomes evident when moral distress is described as painful emotions and feelings and as mental anguish, which result from knowing the morally appropriate action (knowing 'the right thing to do'), but, despite every effort to follow that course of action, being unable to do adequately do so (Corley, 2002; Hamric & Blackhall, 2007; Schluter et al., 2008).

Some authors also emphasise a difference between moral distress and emotional distress, or other types of stress: 'Psychiatric nurses may, for example, be emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong' (McCarthy & Deady, 2008, p. 256). There is, however, an

explicit or tacit association between morality and feelings/affect in much of this research. It may, therefore, be sensible not to put place too much emphasis on this distinction.

The remainder of this chapter shall review the moral distress literature. Particular attention shall be paid to claims about the sources, mediators and consequences of such distress. The role of responsibility in moral distress shall then be considered. Finally, the discussion shall turn to an exploration of criticisms of moral distress research.

2.2 SOURCES OF MORAL DISTRESS

Several sources of moral distress have been identified. According to the literature, these sources present real or perceived obstacles, which prevent nurses from pursuing what they judge to be the right course of action. Poor quality of care or futile care leading to harm, pain and suffering of patients have been found to be a major cause of nurse moral distress (A.-L. Glasberg, Eriksson, & Norberg, 2008; Hamric & Blackhall, 2007; Hefferman & Heilig, 1999; Meltzer & Huckabay, 2004; Sundin-Huard & Fahy, 1999). Similarly, treating patients as objects when trying to meet the requirements of the institution – for example, in terms of administrative work, limited resources, and economic concerns – has also been linked to the emergence of moral distress (A. L. Glasberg, Eriksson, & Norberg, 2007; Wilkinson, 1987/88). Relatedly, constraints of health policy (Redman & Fry, 2000) and inadequate levels of staff (Gutierrez, 2005; Hamric, 2000), which affect the level of care patients receive, are other possible sources of moral distress for nurses. Despite the possibility that these issues are faced by both doctors and nurses, it has been suggested that nurses experience moral distress more than physicians (Hamric & Blackhall, 2007).

Patient advocacy is a major concept in nursing ethics. The nurse as advocate acts on behalf of those (either actually or potentially) in need of care with the aim of empowering active and non-active, weak and vulnerable persons (Vaartio & Leino-Kilpi, 2005). Advocacy is based around patients' rights; the nurse acts for the interests and rights of individuals (MacDonald, 2007). Unsuccessful advocacy attempts can lead to, or intensify, moral distress (Sundin-Huard & Fahy, 1999). Sundin-Huard and Fahy (1999) found that when nurses repeatedly failed to successfully advocate for their patients by confronting physicians, strong feelings of anger and frustration were experienced. Relatedly, nurse moral distress can stem from situations in which incomplete or inaccurate information is provided to patients, which gives them or their family unrealistic hope regarding their prognosis (Schluter et al., 2008).

It is evident that feelings of empathy and sympathy are important triggers of moral distress. Once again, suggesting a strong link between affect and morality. This link becomes even more apparent when we consider some the consequences of moral distress below.

2.3 Mediators of Moral Distress

There are two significant mediators that have been found to influence the frequency and intensity of moral distress: level of education and peer support. For example, Meltzer and Huckabay (2004) found that nurses with higher levels of education scored significantly higher on measures of painful feelings using the Moral Distress Scale (Corley, Elswick, Gorman, & Clor, 2001) than those with lower education levels when dealing with futile or inadequate care. Likewise, if nurses are inexperienced or are unaware of alternative treatment options it is possible that they will experience less moral distress than those with more experience or more knowledge (Gutierrez, 2005; Hart, 2005). It has also been suggested that peer support mediates nurses' experience of moral distress (Schluter et al., 2008). If nurses receive more support when they encounter distressing situations, they are more likely to be able to develop more effective coping skills (Meltzer & Huckabay, 2004).

2.4 Consequences of Moral Distress

The literature suggests moral distress can affect both the physical and psychological health of nurses (Gallagher, 2010). Research has consistently found that moral distress can result in psychological disequilibrium, emotional distress, and physical stress with feelings of frustration, anger and guilt commonly reported (Cameron, 1986, 1997; Corley, 2002; A. L. Glasberg et al., 2007; Kopala & Burkhart, 2005; Pendry, 2007; Sundin-Huard & Fahy, 1999). Feelings of anger and frustration are frequently accompanied by other affects. Nurses have reported feeling resentment, sorrow, anxiety, helplessness or powerlessness, compromised integrity, shame, embarrassment, grief, heartache, misery, pain, sadness, dread, disgust and anguish (Gutierrez, 2005; Kopala & Burkhart, 2005; Ludwick & Cipriano Silva, 2003; Wilkinson, 1987/88). Loss of self-worth, depression, nightmares and/or loss of sleep have also been reported (Schluter et al., 2008; Wilkinson, 1987/88). Physical symptoms which have also been noted include headaches, neck pain, muscle aches, stomach problems and diarrhoea (Schluter et al., 2008; Wilkinson, 1987/88).

Moral distress may lead to reduced care for patients, even to the point of avoiding patients (Gallagher, 2010; Redman & Fry, 2000). It has also been linked to decreased job satisfaction (O'Donnell et al., 2008; Ulrich et al., 2007); "burnout" (Cameron, 1986; A. L. Glasberg et al., 2007; Juthberg, Eriksson, Norberg, & Sundin, 2008, 2010; Meltzer & Huckabay, 2004; P. Potter et al., 2010; E. Severinsson, 2003; Sundin-Huard & Fahy, 1999); and increased staff turnover (Corley, 2002; Fogel, 2007; Hart, 2005; Pendry, 2007; Wilkinson, 1987/88). Moral distress may also impact nurses' personal lives, in that they may also withdraw from friends and family (Schluter et al., 2008).

2.5 The Role of Responsibility

When a person performs a morally significant action, praise is often felt to be warranted. Conversely, when a person fails to perform a morally significant action, it is usually felt that blame or some other form of condemning is warranted. When agents are regarded as worthy of such reactions, the ascription of moral responsibility is involved (Eshleman, 2009). It is also possible to ascribe personal moral responsibility to oneself (e.g. to take responsibility for performing a morally significant action). In philosophy, a comprehensive theory of moral responsibility is considered to require several dimensions be elaborated: First, the concept of moral responsibility as such; second, the criteria of moral agency—who or what qualifies as being morally responsible; third, the conditions under which moral responsibility applies; fourth, possible objects of responsibility ascriptions (e.g. character traits, action/inaction, consequences, etc.; cf. Eshleman, 2009).

While theories of moral responsibility *per se* are not necessarily important to the experience of moral distress, some of the aspects of such theories may be enlightening. Moral distress seems to include nurses being ascribed moral agency, both by themselves and others, implicitly and explicitly through professional practices, academic literature, codes of conduct and, of course, wider societal beliefs and expectations; the assumption that moral responsibility applies, even in conditions where nurses' freedom to act is constrained; and that nurses' inactions and omissions, even when obstacles block alternative action, are proper objects of moral responsibility ascriptions. Indeed, Jameton (1993) distinguished between moral distress and moral outrage by suggesting that the former involves ascription of responsibility to self, whereas the latter involves ascription of moral responsibility to others. Therefore, responsibility is likely to be significant to the analysis of accounts of moral distress.

It is arguably an underlying individualising and (self-) blaming culture that gives rise to psychological distress. Even when (in the vast majority of cases) the individual is powerless to act, institutional and societal notions and ideologies of the person and of responsibility place pressure on them, leading to distress (Smail, 2005). As with other forms of psychological distress, this seems to be true of moral distress. To that end, 'responsibility' shall be a crucial analytic in this thesis.

2.6 Moral Distress Reconsidered

Moral distress research can be criticised in a number of ways: (1) with regards to conceptual clarity; (2) by problematizing the notion of "psychological disequilibrium"; (3) moral distress research has been accused of perpetuating hegemonic meta-narratives about nurses' professional identity; (4) it has been suggested that moral distress stems from "nurses' discomfort with moral subjectivity", rather than an inability to act on moral decisions; (5) moral distress research

reproduces a taken-for-granted notion of the bounded, self-contained individual. These criticisms shall now be discussed.

First, as hinted at above, as a concept 'moral distress' lacks clarity. The fact that there is no single, agreed upon definition of moral distress can be seen to be problematic. The issue is not "cluster concepts" *per se* – the ability of such concepts to capture different aspects of phenomena might be considered their strength (McCarthy & Deady, 2008). However, with regards to this conceptual imprecision McCarthy and Deady ask, "Is moral distress a situation? A set of beliefs or attitudes? A range of emotions? A group of symptoms?" (McCarthy & Deady, 2008, p. 259). This line of questioning implies that there is a risk of over-inclusivity, in that the term 'moral distress' may be used to describe completely different phenomena, which have nothing much in common (McCarthy & Deady, 2008). In drawing attention to the situation McCarthy and Deady also highlight the often ignored context in which moral distress occurs and from which it cannot be separated.

Second, using terms such as "psychological disequilibrium" or "disorientation" is problematic in itself. The use of these terms assumes that a state of moral 'equilibrium' or 'orientation' is attainable and/or desirable. The philosopher Michel Serres (1982/1980) suggests that equilibrium is rare. When it does occur it is transient, an emergent property of chaotic systems. Social reality, 'the realm of human engagement is in constant flux and is often challenging. Such flux cannot be stabilized' (McCarthy & Deady, 2008, p. 259). Disequilibrium and disorientation may, in fact, be the norm and equilibrium and orientation the exception. The extent of variation around the presumed point of equilibrium is what is at stake.

Third, some critics have suggested that moral distress research perpetuates hegemonic meta-narratives about nurses' professional identity, which they believe should be challenged (McCarthy & Deady, 2008; Paley, 2004). These authors suggest that moral distress research reproduces a "discourse of moral suffering" that encourages "whinging". From this perspective, nurses take the opportunity afforded by the research scenario to engage in "nursing's favourite metanarratives, including not-being-appreciated, powerlessness, and oppression by medicine" (Paley, 2004, p. 364). What this critique fails to realise, however, is that narratives of "not-being-appreciated, powerlessness, and oppression by medicine" may have their basis in the actuality of nurses lived experiences. Moreover, in broadly Wittgensteinian terms, the performance of these complaints (at least partly) constitutes the experience of moral distress.

Fourth, it has been suggested that moral distress stems from "nurses' discomfort with moral subjectivity", rather than an inability to act on moral decisions (Repenshek, 2009). The focus of this critique is on the wording of the Moral Distress Scale (MDS) used in a large proportion of research.

Some research using this scale indicates that there are six situations, which demonstrate the greatest levels of moral distress in terms of frequency and intensity (e.g. Elpern, Covert, & Kleinpell, 2005):

> 1) Continue to participate in care for a *hopelessly* ill person who is being sustained on a ventilator, when no one will make a decision to 'pull the plug';
> 2) Follow a family's wishes to continue life support even though it is not in the *best interests* of the patient;
> 3) Initiate *extensive* life-saving actions when *I think* it only prolongs death;
> 4) Follow the family's wishes for the patient's care when *I do not agree* with them but do so because the hospital administration fears a lawsuit;
> 5) Carry out the physician's orders for *unnecessary* tests and treatments for terminally ill patients; and
> 6) Provide care that does not relieve the patient's *suffering* because the physician fears increasing doses of pain medication will cause death (Repenshek, 2009, p. 737; his emphasis)

This list corresponds to the 6 items on the MDS (Corley et al., 2001), which had a mean item score of 15 or greater (possible range 0-36) in Elpern, Covert, & Kleinpell's (2005) study. All 6 items had a mean intensity score greater than 4 (possible range 0-7) and frequency scores between 3.26 and 4.63 (possible range 0-7). It has been suggested that the items contain terms, indicated by the italicised words and phrases, that "either necessitates definition or can be defined only in context" (Repenshek, 2009, p. 737). This builds subjectivity into the statement, at least to some degree, and therefore needs context to provide the precise meaning of terms such as 'hopeless' or 'unnecessary'. From this perspective, a distinction must be made between actual inability to act on behalf of patients and a "potential lack of clarity and decisiveness on the part of nurses regarding their more concrete ethical obligations" (Repenshek, 2009, p. 738). Consequently, Repenshek proposes, moral distress stems from a discomfort with moral subjectivity rather than from an inability to act.

Repenshek argues that phrases like "in the patient's best interests" may imply an objectivity that does not, in fact, exist. The central point of this criticism of moral distress research (using MDS) is that decision-making processes about what is in the patient's best interests are inherently subjective. The problem is that the argument is extended to suggest that nurses may be uncomfortable with this inherent subjectivity, or (more precisely) the fact that certain decisions cannot be worked out in objective terms is what nurses experience as distressing. Essentially, the suggestion is that nurses may be distressed by the fact that others do not hold the exact same values as themselves; a suggestion that individualises moral distress and does little to address the

actuality of ethical conflicts, which arise in healthcare environments. Moreover, this suggestion can be accused of belittling or marginalising the moral distress experiences of nurses; suggesting that they are not real.

The phenomenon appears, however, to be very real for those nurses who experience it. What's more, there are several related terms, which are used to refer to broadly similar issues and therefore (probably) the same phenomenon. These include: ethical distress (Cameron, 1997; CNA, 2003; West, 2007); ethical stress (Fox, 1981; O'Donnell et al., 2008; Speck, 1993; Ulrich et al., 2007); moral stress (Lützén, Blom, Ewalds-Kvist, & Winch, 2010; Lützén, Cronqvist, Magnusson, & Andersson, 2003; E. Severinsson, 2003; E. I. Severinsson & Kamaker, 1999); stress of conscience (A.-L. Glasberg et al., 2006; A.-L. Glasberg et al., 2008; A. L. Glasberg et al., 2007; Juthberg, Eriksson, Norberg, & Sundin, 2007; Juthberg et al., 2008, 2010); compassion fatigue (P. Potter et al., 2010; Sabo, 2011); and empathy fatigue (Stebnicki, 2000, 2007). This suggests that nurses do experience some kind of stress or distress related to the ethical and moral dimensions of their daily practice. The differences in terminology seem largely to relate to allegiances to particular research programmes. For example, much of the research conducted using this alternative terminology is conducted in various European countries; whereas the majority of the research conducted using the term 'moral distress' has been carried out in North America. The number of studies using the term 'moral distress' far exceeds those using any of the other terms. Therefore, without wishing to ally with any particular research programme, this research will use the term 'moral distress'.

Last but not least, the literature places moral distress firmly 'inside' nurses' heads. It is experienced by individuals who know the right thing to do but who are unable to act accordingly. This reflects the common-sense, everyday conception of the individual person as a bounded being, separate from its environment. It also individualises moral distress, treating it as a personal problem for individual nurses. However, this liberal individualist view of the person has been heavily criticised; often problematized in terms of several dualisms – mind/body; self/other; individual/society; biological/social; nature/culture; internal/external; and so on (e.g. Benson, 2001; Brown & Stenner, 2009; Cromby, 2004, 2005, 2006; Gergen, 2009; Harré, 1993; Markus & Kitayama, 1991; Mead, 1934; Sampson, 1993). Instead, in this thesis the person is reconceptualised in a way that attempts to avoid these reductive dualisms and thus provide a deeper, more complex understanding of what it is to be human. In line with this, an alternative approach to the person will be elaborated in later chapters. In order to better explain moral distress, this alternative approach to the person will entail recasting moral distress, not as an individual problem, but as an inherently contextualised, relational phenomenon.

2.7 SUMMARISING

This chapter has critically reviewed the moral distress literature with a focus on its sources, mediators and consequences. It was argued that moral distress is overly individualised in this research and that an alternative view of the person is necessary to recast moral distress as an inherently contextualised, relational phenomenon. The next chapter begins this task.

3 WORLD IN MOTION:
A PROCESS-RELATIONAL APPROACH

[T]he notion of an actual entity as the unchanging subject of change is completely abandoned. … The ancient doctrine that "no one crosses the same river twice" is extended. No thinker thinks twice; and, to put the matter more generally, no subject experiences twice. (Whitehead, 1927-8/1978, p. 29)

Connectedness is of the essence of all things of all types. It is of the essence of types, that they be connected. (Whitehead, 1938/1966, p. 13)

Each actual occasion—whether it be an occasion constituting an electron or an occasion constituting a human conversation—is a happening in which potentiality or 'the possible' is grasped into the form of some particular pattern, which pattern constitutes the actualisation of that potential. (Stenner, 2009b, p. 207)

[T]hings are definable as their relevance to other things and in terms of the way other things are relevant to them. (Brown & Stenner, 2009, p. 38)

3.1 INTRODUCING

This chapter shall begin to reconceptualise the person based on ideas taken from the work of A.N. Whitehead, whose later philosophy offers a metaphysical and cosmological system, grounded in the aesthetic experience of value, in which reality is defined in relational terms (e.g. Whitehead, 1927-8/1978; 1933/1967, 1938/1966; see also Mesle, 2008; Rose, 2002; Stengers, 2011). All 'things' are constituted by their various relations and all those relations are value-relations. Furthermore, the constitution of 'things' has a specific history or process. Whitehead's speculative philosophy, his process-relational approach, shall be fleshed out in the following section: First, creativity as the 'Category of the Ultimate' shall be discussed because this metaphysical concept informs the rest of Whitehead's system of thought; next, the notions of process and change in Whitehead's theory of actual occasions of experience shall be discussed with an emphasis on the temporal structure of actual occasions; finally, the theory of actual occasions, with its focus on process, requires us to rethink endurance and stability, which shall,

therefore, be discussed in terms of Whitehead's concepts of nexūs and societies. Following this explication of Whitehead's process-relational approach, its implications for understanding human subjectivity shall be discussed. Drawing on Stenner (2008), it shall be suggested that human subjectivity or personal experience is a temporal society of actual occasions. However, it shall be argued that by relatively downplaying the second part of Whitehead's notion of the subject-superject, Stenner implicitly privileges the subject as process of self-organisation over the superject as objective product of that process and, therefore, de-emphasises the superject's role within the ongoing flow of experience. It shall be suggested that by placing the superject on a par with the subject we arrive at a view of subjectivity that offers a starting point for a relational, embodied notion of the person.

3.2 WHITEHEAD'S SPECULATIVE PHILOSOPHY

3.2.1 Creativity: The Category of the Ultimate

Creativity, as 'The Category of the Ultimate', is, for Whitehead, the metaphysical category in terms of which all other categories, principles and conditions must be understood. Without creativity there would be no possibility of existence. Under the principle of creativity, actual finite things are defined as self-constructing or self-organising entities or occasions constituting space and time within a context of determinate and indeterminate relations.

Whitehead discusses three notions in relation to 'The Category of the Ultimate': 'Creativity', 'Many', and 'One': "The term 'many' presupposes the term 'one', and the term 'one' presupposes the term 'many'" (Whitehead, 1927-8/1978, p. 20). For Whitehead, the three terms are synonymous with the meaning of 'thing', 'being' or 'entity':

> 'Creativity' is the principle of novelty. An actual occasion is a novel entity diverse from any entity in the 'many' which it unifies. Thus 'creativity' introduces novelty into the content of the many, which are the universe disjunctively. The 'creative advance' is the application of this ultimate principle of creativity to each novel situation which it originates. (Whitehead, 1927-8/1978, p. 21)

'Creativity' is defined by Whitehead in terms of 'passing on', "in the dictionary sense of the verb *creare*, 'to bring forth, beget, produce'" (Whitehead, 1927-8/1978, p. 231). It is the productive condition which serves as the possibility of the existence of both 'many' and 'one'. It is not a mode of being, but is, rather, the transcendental requirement for any possibility of existence or being. Therefore, creativity can never be reduced to any particular instantiation. It is without character of its own. Existence is thus redefined, "not as a passive framework of ontologically fixed conditions, but as an active field of finite, ontologically evolving Entities or Occasions" (Rose, 2002, p. 22). 'Creativity' is the pure notion of activity. As such, creativity emphasises process and change.

3.2.2   Process & Change: Actual Occasions of Experience

Whitehead (1927-8/1978) begins with activity as the ultimate unit of natural occurrence. Reality is created from ongoing series of activities. These activities are what Whitehead calls 'actual occasions': "'Actual entities' – also termed 'actual occasions' are the final real things of which the world is made up. There is no going behind actual entities to find anything more real" (p.18). Actual occasions are occasions of experience. However, this is experience in the widest sense of the word: "it is important to recognise that experience does not necessarily entail consciousness – which is a component only in high-grade occasions" (Brown & Stenner, 2009, p. 26). Whitehead's system situates human intentional thought and lower animal consciousness on a continuum with other organic life (such as vegetation and single-celled life-forms) and, crucially, with inorganic matter, right down to sub-atomic particles: "Cognitive experience is nothing more than a highly evolved, complex instance of the self-constituting, self-organizing character of things in and of themselves" (Rose, 2002, p. 18). For Whitehead,

> [e]ach actual entity is conceived as an act of experience arising out of data. It is a process of 'feeling' the many data, so as to absorb them into the unity of one individual 'satisfaction.' Here 'feeling' is the term used for the basic generic operation of passing from the objectivity of the data to the subjectivity of the actual entity in question. Feelings are variously specialized operations, effecting a transition into subjectivity. They replace the 'neutral stuff' of certain realistic philosophers. An actual entity is a process, and is not describable in terms of the morphology of a 'stuff.' (1927-8/1978, p. 40)

Thus Whitehead privileges process and activity over substance and passivity. From this perspective, the actualities of the present inherit their characters from the process, and bequeath their characters to the future. Immediacy is the realisation of the potentialities of the past, and is the repository of the potentialities of the future. Actuality is a decision, in terms of a 'cutting off' or 'cutting out' from potentiality. This should not be mistaken for decision in terms of conscious, free choice:

> 'Actuality' is the decision amid 'potentiality.' It represents stubborn fact which cannot be evaded. The real internal constitution of an actual entity constitutes a decision conditioning the creativity which transcends the actuality. (Whitehead, 1927-8/1978, p. 43)

Through the activity of realisation potentiality becomes actuality – the potential is realised in a particular concrete form. This process of becoming concrete is termed 'concrescence': "An actual occasion – in which a subject concerns its objects – is this process of actualization" (Stenner, 2008, p. 99) or concrescence. Here the term 'concern' highlights the relativity of subject and object in the unity of an actual occasion. Whitehead borrows the Quaker meaning of concern as

divested of any suggestion of knowledge, [and] more fitted to suggest this fundamental structure. The occasion as subject has a "concern" for the object. And the "concern" at once places the object as a component in the experience of the subject, with an affective tone drawn from this object and directed towards it. With this interpretation, the subject-object relation is the fundamental structure of experience. (Whitehead, 1933/1967, p. 226)

'Concern', as the fundamental structure of experience, is central to the becoming of an actual occasion. The next section shall describe how Whitehead explains the process of the becoming and perishing of such actual occasions.

3.2.2.1 *Temporal Structure of Actual Occasions*

Whitehead defines actual occasions and their relations in terms of tensed time, or the asymmetrical relation of past, present and future (Rose, 2002; Whitehead, 1927-8/1978, 1933/1967). Within this framework everything stands in a determinate relation to everything else. The present cannot be understood in isolation from the past and the future, which in turn cannot be understood apart from their relations to the present. The character of each is determined by some conditional relation to the others:

> In the present, the future occasions, as individual realities with their measure of absolute completeness, are non-existent. Thus the future must be immanent in the present in some different sense to the objective immortality of the individual occasions of the past. In the present there are no individual occasions belonging to the future. The present contains the utmost verge of such realized individuality. The whole doctrine of the future is to be understood in terms of the Account of the process of self-completion of each individual actual occasion. (Whitehead, 1933/1967, p. 247)

Subjective time offers a framework of process or continuous flow with a 'specious present' (James, 1890) or floating 'now', which is structurally divided. The present can be thought of as a continuous flow or movement away from the past and towards the future. There is an ever-shifting 'now', the present, which is distinct from, yet continuous with, the past and the future; "a continuous process that is structurally divided into an ever-shifting chain of relations" (Rose, 2002, p. 33).

Within this temporal framework, "two descriptions are required for an actual entity: (a) one which is analytical of its potentiality for 'objectification' in the becoming of other actual entities, and (b) another which is analytical of the process which constitutes its own becoming" (Whitehead, 1927-8/1978, p. 23). Here, Whitehead presents us with two ways of thinking about actual occasions or actual entities: the macroscopic level, at which all actual occasions occur serially (matching the sequential structure of subjective time); and the microscopic level, at which the actual occasion itself is analysed in terms of its constituent parts. A human life, for example, can

be thought of in terms of the macroscopic level, and each moment of that life in terms of the microscopic level.

3.2.2.1.1 The Objectification of an Actual Occasion in the Becoming of Other Actual Occasions

At the objective or macroscopic level all actual occasions occur serially, within a framework following that of subjective time. An actual occasion always occurs within a field of actual occasions, which make up its general environment. This environment consists of three types of relations. Antecedent relations to the past; contemporary relations to occasions that are co-present; and consequent relations to the future:

| Antecedent Relations (Past) | Contemporary Relations (Present) | Consequent Relations (Future) |

The conditional relations between an actual occasion and its past and future are uni-directional and asymmetrical. Whitehead stated that this can be expressed objectively as a relation of causal efficacy. This is because an actual occasion is efficaciously conditioned by past (antecedent) occasions and, in turn, efficaciously conditions future (consequent) occasions. As mentioned above, Whitehead's system of thought is grounded in the aesthetic experience of value. Following from this, the efficacious nature of the relation of an actual occasion to its past and future is thought as primitive experience.

> In the phraseology of physics, this primitive experience is 'vector feeling,' that is to say, feeling from a beyond which is determinate and pointing to a beyond which is to be determined. But the feeling is subjectively rooted in the immediacy of the present occasion; it is what the occasion feels for itself, as derived from the past and as merging into future. In this vector transmission of primitive feeling the primitive provision of width for contrast is secured by pulses of emotion, which in the coordinate division of occasions […] appear as wave-lengths and vibrations. (Whitehead, 1927-8/1978, p. 163)

Furthermore, individual occasions can be said to have a beginning and an end. This is reflected in the sequence past (antecedent) occasion → present (contemporary) occasion → future (consequent) occasion. But, if there is to be any continuity of existence, there must also be a point of connection between successive occasions. Any gap between occasions would be non-existence (Rose, 2002). In Whitehead's scheme, the point of connection is the satisfaction of an occasion. This moment of satisfaction of one actual occasion is shared in the becoming of a new actual

occasion. In the moment of its satisfaction, the antecedent occasion is taken up as an object or datum by the present actual occasion. Similarly, the satisfaction or termination of the present occasion is simultaneously the beginning of the consequent occasion.

3.2.2.1.2 The Process of Becoming an Individual Actual Occasion

At the microscopic level, the 'life history' of an actual occasion (Rose, 2002) consists of a finite duration or process of self-construction or self-organisation. An individual actual occasion can be divided into its constituent parts, which are coincidental with a different phase in the becoming and perishing of the actual occasion. However, it is not possible for these divisions to exist independently from the actual occasion of which they are part. The internal structure of individual actual occasions exhibits a tripartite division in accord with the framework of subjective time:

Response → Supplementation → Satisfaction
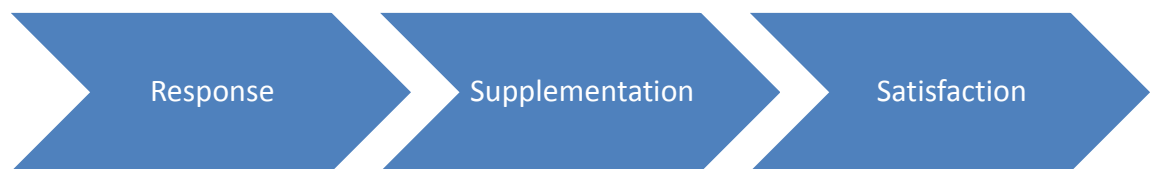
During the response phase an actual occasion is receptive to what is 'given'. It is at this moment that an actual occasion is in direct relation to its antecedent occasions. This initial phase is the present side of an antecedent (or past) occasion's moment of perishing, its 'satisfaction'. There is a transfer from the antecedent occasion to the present occasion in the shared moment of the antecedent perishing and the present becoming. As Rose puts it:

> Because the termination or end of one Occasion is identical with the beginning of the next, the two Occasions will share the same information or datum, the Present Occasion taking up or inheriting the antecedent Occasion's information as its *initial datum* […] The shared datum will be the same datum viewed from either side of the relation: final datum or 'satisfaction' from the side of the perishing antecedent; initial datum or 'origination' from the side of the Present Occasion. The responsive phase is thus defined as the moment whereby an occasion inherits or *prehends* the shared datum from its perished antecedents (where *prehension is defined as a form of "uncognitive apprehension"*). (Rose, 2002, p. 40; original emphasis)

The present occasion's self-organising activity occurs during the supplemental phase, in which it is also in direct relation with its contemporary occasions. The present occasion's own organisational power is added to, or manipulates, the data inherited from antecedent and

contemporary occasions. Whitehead posits two types of supplementation in living organisms. These are aesthetic and intellectual supplementation. In the former, the subjective form has as a constituent component "an emotional appreciation of the contrasts and rhythms inherent in the unification of the objective content in the concrescence of one actual occasion. In this phase, the perception is heightened by its assumption of pain and pleasure, beauty and distaste" (Whitehead, 1927-8/1978, p. 213). In the latter, a constitutive feature of the subjective form of the actual occasion is "the eliciting, into feeling, of the full contrast between mere propositional potentiality and realized fact" (p. 214). That is, consideration of potentiality or possibility (what might be) as well as concrete actuality (what is) is achieved. Aesthetic supplementation may occur in any living or animate thing. However, intellectual supplementation only occurs in conscious things – those things we think of as possessing minds.

The character of the present occasion, which Whitehead calls its 'subjective form' (see 1927-8/1978, p. 23), may be defined as follows:

It is the subjective form of an actual occasion that distinguishes it from its relatives. The subjective form is the 'taking up', and supplementation, of the inherited data by the present occasion. This in turn serves as "the condition for the possibility of any such inheritance" (Rose, 2002, p. 40). It is the subjective form as a product of an actual occasion's self-organisation of its inherited data that means that no actual occasion is ever reducible to its antecedents. Novelty is introduced by the creative act of self-organisation. Each actual occasion "will thereby be a novel addition to the general framework of relations that constitute the creative advance of nature" (Rose, 2002, p. 40).

The amount of supplementation in the self-organisation of an actual occasion varies considerably between occasions. In some actual occasions the supplementation might be insignificant. In such cases there is a large degree of determination of an actual occasion by its antecedents – the present occasion almost perfectly replicates past occasions. This type of deterministic actual occasion manifests itself in inorganic matter. By contrast, there are cases where supplementation is dominant in the self-organisation of an actual occasion. This means that

there is more freedom within the actual occasion – it is more self-determined – and the inherited data has less determination over the present occasion. This type of actual occasion most often manifests in living organisms.

The final stage in an actual occasion's process of concrescence is its point of satisfaction. This is the moment where an occasion becomes fully concrete – it is the completion of the process of an actual occasion's self-construction. An actual occasion attains a final, determinate unity at this point of satisfaction. This is a unity derived from the value-constituted instance of a particular set of experiences: the many data (antecedent occasions) are organised into the one (present) actual occasion. The satisfaction is simultaneously the termination of the present occasion and the beginning of that occasion's causal efficacy for future or consequent occasions. "The terminal operation, here called the 'satisfaction', embodies what the actual entity is beyond itself" (Whitehead, 1927-8/1978, p. 219) as it is objectified – that is, as it becomes an objective datum for future occasions.

When the macroscopic and microscopic descriptions described above are combined we see that there is a flow of actual occasions. This flow of actual occasions is summarised by Stengers as "a succession of experiences, each one of which takes the preceding one for an ingredient while conferring a meaning upon it" (Stengers, 2011, p. 72). This scheme allows Whitehead to account for both external conditioning and self-conditioning, structure and agency. The conferring of meaning upon the inherited data with increasing degrees of supplementation also provides an explanation for the emergence of life from matter, and intelligence from life. Taking process and becoming as central to all being brings creativity and change to the fore. However, this emphasis on process requires us to rethink endurance and stability. This issue will be considered in the next section.

3.2.3 Endurance & Stability: Societies of Actual Occasions

From a process-relational perspective, the apparent concrete actualities inherited from the past are not to be seen as simple foundations. According to Brown and Stenner, "[i]n the relay race of process, the baton of potentiality is passed on and on via quantum events of actuality" (2009, p. 36). But, as Cromby (2011b) points out, even if we wish to emphasise fluidity and process, we must also account for continuity, endurance and stability. Whitehead's philosophy allows us to rethink the relationship between occurrence and endurance. Whitehead (in Brennan, 1974) distinguishes two ways of looking at time. The first, what Whitehead calls an optimistic way of thinking, sees time as becoming, a perpetual flowing into newness, and emphasising the essential novelty of the future. The second way sees time as a falling away, a perpetual perishing, a hurrying

towards death. This Whitehead terms a pessimistic way of thinking. What Whitehead offers is somewhat a hybrid of the two:

> if you hold, as I do, that transition, passage, is in the nature of things, this means that time is not just a falling away from reality, a perpetual perishing. When you look at transition, you can see that the past is becoming the basis of the present. The past is perishing when its own immediacy turns into the efficacy of its basis of the present. The immediate past enters into the present. (Whitehead, in Brennan, 1974, p. 125)

Endurance and stability, then, are accounted for in terms of the determinate (or causally efficacious) relationship between an actual occasion and its antecedent and consequent occasions. Continuity is 'built into' the process or flow of actual occasions. Endurance derives from an unfolding sequence of actual occasions, each successively feeling or experiencing the experience of its immediate predecessor. As Stenner explains:

> Continuity is not given but is to be explained in terms of concepts like reproduction, repetition and iteration, and these concepts refer to the grouping of atomic occasions. (2008, p. 102)

Each successive occasion reproduces its predecessor in some form. But, at least in living organisms (and especially in higher life forms such as humans), there is always the potential or possibility for novelty to be added into the reproductive process. Thus Whitehead accounts for stability and change, continuity and discontinuity.

Furthermore, every actual occasion expresses the general character of relatedness. This relatedness goes beyond the serial flow of actual occasions (the temporal structure of occasions) to include the relations between contemporary occasions producing extension in space. Whitehead terms any collection of actual occasions as a 'nexus'. He defines nexus as

> a set of actual entities in the unity of the relatedness constituted by their prehensions of each other, or—what is the same thing conversely expressed— constituted by their objectifications in each other. (Whitehead, 1927-8/1978, p. 24)

There is not necessarily any specific order to a nexus (plural nexūs). However, where there is order, a

> 'society' is a nexus with social order, and an 'enduring object,' or 'enduring creature,' is a society whose social order has taken the special form of 'personal order'. (ibid., p. 34)

Whitehead (1927-8/1978, p. 34) defines 'social order' along three lines:

i. There must be a common element of form illustrated in the definiteness of each actual occasion included in the nexus.

ii. This common element of form arises in each member of the nexus by reason of the conditions imposed upon it by its prehensions of some other members of the nexus.

iii. These prehensions impose that condition of reproduction by reason of their inclusion of positive feelings of that common form.

If a nexus has such a social order it is called a 'society', and the common form is the 'defining characteristic' of the society.

In terms of the temporal sequence of occasions, Mays (1959, p. 193, n. 1) suggests we think of a 'nexus' as an historical route. 'Social order' would then be the reiteration of a specific pattern throughout the route; a 'common element of form' is a sensory or physical pattern; and prehension is the way in which each occasion inherits or feels its character from its antecedent occasions. Mays' simplification helps us better understand Whitehead's system. However, an addendum is necessary. Mays' simplification seems to suggest that a nexus is no more than a single historical route or series of occasions. This may be appropriate when thinking about a sub-atomic particle, but is not well-suited to an account of more complicated enduring objects or enduring creatures with spatial extension. Therefore, we need to accept that a nexus can equally be a collection of contemporary actual occasions or parallel historical routes without social order. For Whitehead, a nexus can only be considered to have social order if each member (actual occasion) of that nexus shares a defining characteristic such that they constitute an enduring object or creature. If actual occasion A prehends actual occasion B (and vice versa) they would form a nexus, but if they do not share a defining characteristic they would not form a society. In other words, the occasions that make up, say, a human being or a chair can be considered to be a society – they share the defining characteristic of being part of the human being or chair – but a human being sitting in a chair would be a nexus – since chair and human prehend, but do not define, each other. If we take this to be the case, a society is not only a reiteration of a specific pattern throughout an historical route, it involves parallel or contemporary reiteration too.

Since any historical route or collection of historical routes sharing a common defining characteristic (no matter how complex) is a society, Whitehead distinguishes those societies which have a simple self-identity from those which have a complex structure. As Mays (1959, p. 194) points out a "complex society is a patterned network of various strands of transition (routes of events)". An animal body made up of many cells, or a rock made up of a multiplicity of atoms, are two examples of complex societies. Each cell or atom can be thought of as a four-dimensional

thread (occasions reproducing the three dimensions of space enduring through time)[2]. A simple society (one with personal order), on the other hand, is uni-dimensional. That is, it is purely an historical route, continuous and temporal with no extension in space. An example of a society with personal order, which Whitehead gives, is that of the life of a human. While the human's body is a complex society, enduring in four dimensions, his stream of consciousness or flow of personal experience is purely temporal. This idea will be discussed in more depth in the next section.

3.3 IMPLICATIONS FOR THE UNDERSTANDING OF HUMAN SUBJECTIVITY

In order to avoid bifurcating nature into subject and object, Whitehead suggests that we think in terms of "grades of actual occasion operating at a variety of levels of complexity expressed through differing forms of assemblage or composition" (Brown & Stenner, 2009, p. 29). Brown and Stenner seize upon this to argue that psychology might find in this notion 'a genuine subject matter' neither divorced from reality nor reduced to pure materiality: human beings conceived as being composed of indefinitely many occasions of experience. Human beings, however, that are "always more than [a] particular personal society of actual occasions of experience, since any 'stream of consciousness' presides over, as it were, a broader matrix of living occasions from which it abstracts itself" (p. 31). As Stenner (2008) suggests, the personal experience or subjectivity of a human being can be thought of as a temporal society (i.e. a society with personal order) of presiding actual occasions.

3.3.1 Stenner on Whitehead and Subjectivity

For Whitehead, any coordinated stream of experiences should be thought of as an instance of a personal society of actual occasions:

> Societies of the general type, that their realized nexūs are purely temporal and continuous, will be termed 'personal'. Any society of this type may be termed a 'person'. Thus [...] a man is a person. (Whitehead, 1933/1967, p. 263)

Remember that each actual occasion is a self-realising event, which becomes and perishes; that each occasion also has "its direct 'inheritance' from its past and its anticipation of what it will become in the future" (Stenner, 2008, p. 105); that each occasion is "a concrescence of many data into the unity of the subjective form" (ibid.); and that personal order is distinct because it is purely temporal with no spatial extension. So, human subjectivity entails one occasion of experience followed by another, followed by another, and so on. Since the personal society (subjectivity or mind) of a human being is a coordinating centre of activity for the societies that make up that human as whole (e.g. the body and the various societies [organs and systems] constituting that

---

[2] Treating time as a dimension risks spatialising time, which Whitehead argued against (cf. Brennan, 1974). However, this phraseology is adequate for present purposes.

body), Stenner (2008) suggests that we think of the occasions making up the personal society as 'presiding' occasions.

It is important to realise, though, that a 'personal society' or 'person'

> can only exist in the context, as it were, of an embodied and spatial complex of broader 'living' societies. The personal society abstracts itself, as it were, from this broader complex, presupposing its inheritance but transforming it into a new purely temporal register. The human being as a whole thus exceeds its personal society. The personal society presupposes the unity of the wider nexus of living societies which constitute its living body. This set in turn presupposes a wider environment of living and non-living assemblages from which that body has abstracted itself. (Stenner, 2008, p. 106)

Thus, the subjectivity or mind of a human being is always embodied and that body is always in-the-world. As a result, the subjective form of a person will be shaped by that person being located within human societies and cultures, which include relations of power and organisations of material and symbolic capital aligned with those relations.

Stenner's (2008) account is valuable because it emphasises both the ongoing flow of experiences and the embodied, in-the-world character of that flow. However, there is an aspect of Whitehead's thought (the notion of the subject-superject) that is also important for the understanding of subjectivity, which Stenner places little emphasis on.

3.3.2   The Subject-Superject

Stenner (2008) summarises some of the features shared by Whitehead's actual occasions in a fourteen-point list. The last three points in this list deal with Whitehead's notion of the subject-superject pairing:

12. One must [...] distinguish the process of self-realization from its product. To do this, Whitehead distinguishes the subject from the superject. The subject is the process of self-realization considered in terms of its own novel internal constitution or in terms of the immediacy of its self enjoyment. It is the internal self-becoming of the actual occasion. The superject, by contrast, is the objective *product* of these experiences – the creature of its creative process. An actual occasion is thus always di-polar, involving the subjective process of feeling and its objective product (Whitehead, 1927–1928/1985, p. 29).
13. As subject, the actual occasion is the becoming unity of conjunctive synthesis. As superject it takes its place as one among the many in disjunctive diversity. In short, the experience of the subject is expressed by way of the superject as an object.
14. Finally, we return to process by way of the principle of relativity, which holds that "it belongs to the nature of every 'being' that it is a potential for every 'becoming'" (Whitehead, 1927–1928/1985, p. 45). Once an actual occasion becomes a determinate superject, then it can play the role of one of the many objects that are the concern of another actual occasion with its process of creative conjunctive synthesis. The subject becomes the superject, which in

31

turn becomes the object for a new subject. (2008, p. 100; emphasis and references in the original)

Here, Stenner recognises Whitehead's tripartite understanding of subjectivity, which is illustrated in the sequence:

Datum/Data Object(s) (Response)	Process of Self-Organisation Subject (Supplementation)	Product Superject (Satisfaction)

However, Stenner does not mention the superject again after this summary. As a consequence, Stenner's discussion of personal experience as a temporal society of presiding actual occasions (2008, pp. 105-106) appears to privilege the subject as process of self-organisation over the superject as objective product. In this reading, Stenner seems to have adopted the optimistic view of time mentioned above. If, however, we retain Whitehead's hybrid notion of time (cf. Brennan, 1974) and give equal weight to each stage of the tripartite process of the actual occasion (at the microscopic level), it becomes apparent that the superject also has an important role in the continuity of human subjectivity.

In the sequence Object(s) → Subject → Superject the subject has concern for its many objects as it takes the objects into itself. This coincides with the response phase of the actual occasion. The subjective process of self-organisation corresponds to the supplementation phase of the actual occasion, and the superject as product of the subjective process is coincident with the moment of satisfaction of the actual occasion, as it attains a final, determinate unity. There is never a subjective process without a product. Thus Whitehead spoke in terms of the subject-superject. Furthermore, when an actual occasion becomes a determinate superject it simultaneously becomes one of the many objective data for the subjective process of consequent actual occasions. Arguably, this is crucial to an understanding of the continuity and stability of human subjectivity. The human subject always takes past experiences into itself alongside the experience of the present moment. Past and present moments (actual occasions) of experience are 'organised' in the present moment, and feed into the next moment of experience.

By paying more attention to Whitehead's notion of the subject-superject, in addition to Stenner's (2008) view of subjectivity, we can account for continuity in experience (how past experiences relate to the present experience and how present experience relates to future

experiences) and how the human subject can become its own object (self-contemplation) – the subject becomes superject becomes object for the next subject in the ongoing flow of actual occasions of experience. Moreover, acknowledging the role of the superject (as determinate product) in this process also allows us to consider what Foucault termed 'technologies of the self'. These technologies

> permit individuals to affect by their own means, or with the help of others, a certain number of operations on their own bodies, souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality. (2000b, p. 225)

In objectifying their past (antecedent occasions), a person (present subject) may scrutinise themselves through such technologies of the self in a perpetual life project, "a working on oneself that defines a certain mode of existence" (Brown & Stenner, 2009, p. 162). If certain modes of existence are proscribed and others promoted (by dominant ideologies, for example), the subject will continually compare its antecedent superject to an ideal and work on itself to match such an ideal; organising itself in anticipation of the future. In this way, the becoming of the subject-superject is contingent upon the power relations in which it is embedded.

3.4 SUMMARISING

In this chapter Whitehead's process-relational ontology was discussed. This discussion of Whitehead's work began with considering creativity as the category of the ultimate. Whitehead takes 'construction' or 'creativity' (as a synthetic, self-organizing activity) to be a central philosophical principle (Rose, 2002). Whereas other forms of constructivism or constructionism define this principle epistemically (i.e. in the Kantian sense: how people order the world), a Whiteheadian constructivism redefines it ontologically. 'Construction' or 'creativity' is a constitutive feature of the world as *it* orders *itself*. A constructivism based on Whitehead's process-relational ontology builds on the constructivist insights associated with the turn to language, but does not reduce the world to either 'discourse' or 'materiality' (Stenner, 2008, 2009a, 2009b, 2011).

Whitehead's notion of actual occasions of experience was also discussed with an emphasis on their temporal structure. This led to a reconsideration of endurance in terms of nexūs and societies of actual occasions. In turn, this led to a discussion of the implication of these ideas for the understanding of human subjectivity. For the most part, Stenner's (2008) argument was followed: human subjectivity or mind is viewed as a temporal society of presiding actual occasions. However, it was suggested that Stenner downplays Whitehead's notion of the superject. It was argued that by placing the superject as objective product of the subjective process on a par with

the subject as process of experience we can better explain the experience of continuity and stability and be better equipped to analyse the effects of power. By taking up this view of subjectivity we have a starting point for building a concept of the person that has implications for understanding moral distress. But, it must be noted, this is only a 'bare-bones' starting point. Flesh can be begun to be put on these bones by considering the role of prehensions (feelings) in human subjectivity.

4 SENSE & SENSIBILITY:
FEELINGS & EMOTIONS
IN THE
FLOW OF EXPERIENCE

Every reality is there for feeling: it promotes feeling; and it is felt (Whitehead, 1927-8/1978, p. 309)

A highly developed mind grows up on the fine articulation of generally strong and ready feeling (Langer, 1967, p. 147)

The moment by moment flow of our experience consists, before it consists of anything else, of a flow of embodied sensations or *feelings* (Cromby, 2006, p. 13; original emphasis)

4.1 INTRODUCING

Feelings and emotions are important to nurses' experiences of moral distress (see Chapter 2). Any consideration of moral distress must, therefore, also consider human emotions and feelings. This chapter will argue that feelings not only function in terms of human *sensibility* – capacities for sensation and responsiveness or susceptibility to sensory stimuli and for emotionality – but also have an important role in making *sense* of the socio-natural world – the grasping of meaning and understanding. First, this chapter shall briefly discuss how 'feelings', 'emotions', and the related term 'affect' have been used in contemporary social sciences and humanities. It is suggested that none of these is compatible with the Whiteheadian approach adopted in this thesis. There shall then be brief, further exploration of the role of feelings in Whitehead's metaphysics and implications for understanding human subjectivity. Following this, human feelings shall be explored in more depth with a particular focus on feelings of knowing and emotional feelings and how these relate to morality and to moral distress.

4.1.1 Contemporary Terminology

Recently, there has been renewed interest within social sciences and humanities in phenomena usually referred to as 'affect', 'emotion' and 'feeling'. Many suggest this amounts to an 'affective turn' or 'turn to affect' (e.g. Athanasiou, Hantzaroula, & Yannakopoulos, 2008; Patricia T. Clough, 2008; Patricia Ticineto Clough & Halley, 2007; Greco & Stenner, 2008; Hemmings, 2005; Leys, 2011; Papoulias & Callard, 2010). This affective turn is not homogeneous since it cuts across many disciplines. As a result, no consensus has been reached with regard to the definition of terms.

Sometimes terms are used interchangeably. On the other hand, definitions are often tied to a particular perspective. For example, in some forms of psychoanalysis (e.g. British object relations), 'affect' refers to what in everyday parlance would be referred to as emotions; whereas in cultural studies, 'affect' is generally used to denote states of being, rather than manifestations of emotions (Greco & Stenner, 2008; Hemmings, 2005; Massumi, 2002). Relatedly, Greco and Stenner (2008, p. 11) identify how "the term 'affect' [has become] associated with all things sophisticated and good and the term 'emotion' with all things superficial and bad". For example, Massumi (2002), McCormack (2003), and Thrift (2008) all wish to separate their preferred 'affect' – which they associate with 'movement' 'unqualified intensity', and 'creative potential', and which cannot be reduced to the individual – from 'emotion' and 'feeling' – which they associate with 'fixity', 'qualified meaning', the individual person, and romanticism. However, it remains debateable as to whether a distinction between 'affect' and 'emotion' can be maintained (Greco & Stenner, 2008; for further critiques see Hemmings, 2005; Leys, 2011; Papoulias & Callard, 2010; Thien, 2005; Wetherell, 2012Ch. 3).

'Affect' and 'affective' are also sometimes used in psychology. For example, use of the terms 'positive affect' and 'negative affect' in cognitive, social, and positive psychology (e.g. Diener & Emmons, 1984; Parrott, 2001; Watson, 2002) – where 'affect' refers to "any psychological state that is felt and in some way is evaluative or valenced" (Parrott, 2001, p. 4). 'Affect' is also used, albeit with a different (often Spinozist and/or Deleuzian) meaning, in critical approaches (e.g. Brown & Stenner, 2001, 2009; Tucker, 2010, 2011). However, the terms 'feeling' and 'emotion' are more widely used in this discipline (e.g. Ekman, 1992; Franken, 2002; Haidt, 2001, 2003; Lazarus, 2006; Plutchik, 1994; Reeve, 2005; Scherer, 2009) and in sociology (e.g. Burkitt, 1997, 1999; Denzin, 1985; Turner, 1999; Turner & Stets, 2005, 2010; Williams, 2000, 2001), but their use is inconsistent since researchers either fail to provide any definition of the terms (cf. Burkitt, 1997; Ortony & Turner, 1990), or, when explicit definitions are used, they vary (Cromby, 2007b). Moreover, 'emotion' and 'feeling' are often used interchangeably by psychologists, "either because the definition of one is broadened to include the other, or because 'feelings' denote states which function precisely as emotions despite not being widely recognised as such" (Cromby, 2007b, p.

98). In such cases, feelings of 'helplessness', 'worthlessness', or 'threat', for example, function just like emotional states (such as fear), but do not, by and large, appear in taxonomies of emotion (Griffiths, 1998, cited in Cromby, 2007b, p. 99). Where a distinction is made between feelings and emotions,

> emotions are seen as patterned repertoires of body-brain responses (whether hard-wired and encapsulated, socialised and enculturated, or some mixture of these) which both motivate and organise activity. Feelings are then taken to be the hedonic or phenomenological aspect of these responses – whether as a distinct, additional cognitive component, in the form of bodily feedback derived from them, or both. (Cromby, 2007b, p. 99)

None of these definitions are suitable for the present study. Either they are wholly incompatible with Whitehead's process-relational philosophy, or they are not entirely consistent with the view of subjectivity arrived at in Chapter 3. As a result, a different approach – one that prioritises feelings – is necessary. This requires a return to Whitehead's philosophy.

4.2   FEELINGS IN WHITEHEAD'S METAPHYSICS

> An actual entity feels as it does feel in order to be the actual entity which it is
> (Whitehead, 1927-8/1978, p. 222)

In Chapter 3, processes of actual occasions of experience were discussed in terms of concrescence and value-relations. This chapter discusses these processes in terms of prehensions. Recall that the moment of satisfaction of an actual occasion is its attainment of a final, definite unity. This is achieved through a variety of determinate operations. These operations are 'prehensions'. Whitehead (1927-8/1978, p. 23) says,

> the first analysis of an actual entity, into its most concrete elements, discloses it to be a concrescence of prehensions, which have originated in its process of becoming. All further analysis is an analysis of prehensions.

Whitehead describes two types of prehension. The first he calls 'positive prehensions', also termed 'feelings'; the second he names 'negative prehensions', which have the purpose of 'eliminating from feeling'. Both species of prehensions are involved in the becoming of an actual entity.

The initial stage in the process of concrescence consists of many feelings. Subsequent phases are constituted by a succession of "more complex feelings integrating the earlier simpler feelings, up to the satisfaction which is one complex unity of feeling" (Whitehead, 1927-8/1978, p. 220). This complex is composed of five factors:

> (i) the 'subject' which feels, (ii) the 'initial data' which are to be felt, (iii) the 'elimination' in virtue of negative prehensions, (iv) the 'Objective datum' which is felt, (v) the 'subjective form' which is *how* that subject feels that objective datum. (Whitehead, 1927-8/1978, p. 220; original emphasis)

Thus the superject (the final unity of an actual occasion) is dependent upon definite feelings, a definite subject, definite initial data, definite negative prehensions, definite objective datum, and a definite subjective form. Data enter into an actual occasion through it feeling those data. How those data are felt constitute the subjective form of the actual occasion. Thus an actual occasion cannot be abstracted from its feelings. Neither can a feeling be abstracted from the actual occasion – the subject of the feeling and the superject it produces:

> The subject-superject is the purpose of the process originating the feelings. The feelings are inseparable from the end at which they aim; and this end is the feeler. The feelings aim at the feeler, as their final cause. The feelings are what they are in order that their subject may be what it is. Then transcendently, since the subject is what it is in virtue of its feelings, it is only by means of its feelings that the subject objectively conditions the creativity transcendent beyond itself. (Whitehead, 1927-8/1978, pp. 221-222)

Object and subject are interdependent. A subject is what it is because of the objects it feels. Simultaneously, the actual world enters into subjectivity (the superject), and is thus objectified, by way of being felt by the subject:

> All actual entities in the actual world, relatively to a given actual entity as 'subject,' are necessarily 'felt' by that subject, though in general vaguely. An actual entity as felt is said to be 'objectified' for that subject. (Whitehead, 1927-8/1978, p. 41)

Due to negative prehensions, only a select minority of the actual world is felt by the subject. And since every negative prehension has its own subjective form, they contribute (although not as objective data) to the complex unity of feeling which constitutes the subjective form of the final satisfaction.

Whitehead also distinguishes between 'physical feelings' and 'conceptual feelings'. 'Simple physical feelings' are those prehensions involved in the causal relations found in nature (studied by physical sciences). 'Complex physical feelings', on the other hand, constitute the purely instinctual and reflex actions (Whitehead, 1927) of biological organisms; the latter including human sense-perception. For (Whitehead, 1927-8/1978, p. 32), the "basic operations of mentality are 'conceptual prehensions.' These are the only operations of 'pure' mentality". However, most mental operations are 'impure' because they involve the integration of physical prehensions (sense-perceptions) with conceptual prehensions (conceptions).

In a rare instance of Whitehead using examples in *Process and Reality*, he suggests that

> the primary function of a proposition is to be relevant as a lure for feeling. For example, some propositions are the data of feelings with subjective forms such as to constitute those feelings to be the enjoyment of a joke. Other propositions are felt with feelings whose subjective forms are horror, disgust, or indignation. The 'subjective aim,' which controls the becoming of a subject, is that subject feeling a proposition with the subjective form of purpose to realize it in that process of self-creation. (Whitehead, 1927-8/1978, p. 24)

It is apparent from this quotation that Whitehead saw feeling, language, and thought as complexly intertwined and teleological in character (cf. Whitehead, 1927). The immediate complex of feeling is affected by the determination of the relevant future and anticipatory feelings, which provide its intensity.

In sum, Whitehead's (1927-8/1978) theory of prehensions is central to his metaphysical and cosmological system. From simple causal elements in physical nature ('simple physical feelings'), through the reactions of biological organisms to their environment and human sense-perception ('complex physical feelings'), to cognition and judgement ('conceptual feelings'), the theory of prehensions places great significance on feelings. As the quotation at the beginning of this section states, an actual occasion is constituted by its feelings. This has important ramifications for understanding human subjectivity. The individual human is continually in contact with – by way of prehending and feeling – itself and the socio-natural world. In other words, physical feelings – perceptual and sensory processes (seeing, hearing, smelling, tasting, touching, and so on) – and conceptual prehensions – social activities and practices (language, ideas, customs, conventions, and so forth) – co-constitute the subjective form of human experience. The particular textured and valenced character of an individual's subjectivity (or subjective form) derives from them. Drawing on recent work in sociology and psychology, the next section shall explore human feelings in more depth.

4.3   HUMAN FEELINGS

Feelings are principally phenomenal, functioning as the primary medium through which the dynamic body becomes an omnipresent constituent of subjectivity (Cromby, 2007a, 2007b). Feelings are bodily processes in the flow of being-in-the-world. They are both generated by the body in the world and constitutive of mind, so that:

> the human individual is one fact, body and mind. This claim to unity is the fundamental fact of human existence, always presupposed, rarely explicitly formulated: I am experiencing and my body is mine. (Whitehead, 1938/1966, p.159)

There can be no human experience without a human body. We see with our eyes, taste with our tongue, smell with our nose, touch with our skin, and so forth. When our body is functioning

healthily we are free to enjoy life relatively unhindered by it, although human being will always be constrained – as well as enabled – by our bodies. When it alerts us to some kind of need (hunger, a full bladder, etc.), a function breaks down or is disrupted (e.g. stomach-ache or eye-strain), or when it is the centre of especially pleasant or noxious sensations (perhaps sexual stimulation or pain), we 'notice' our body slightly more. But there is never a (waking) moment when we are not feeling our body and feeling with it. But, Whitehead says,

> our immediate experience also claims derivation from another source, and equally claims a unity founded upon this alternative source of derivation. This second source is our own state of mind directly preceding the immediate present of our conscious experience. A quarter of a second ago, we were entertaining such and such ideas, we were enjoying such and such emotions, and we were making such and such observations of external fact. In our present state of mind, we are continuing that previous state. (1938/1966, p. 160)

However, the word 'continuing' only half fits Whitehead's intention because "we do not quite continue in our preceding state of experience. New elements have intervened" (1938/1966, p. 160). Because we are continuously feeling our body and feeling with it, the body provides new elements in each successive moment of experience. In the present moment, the new elements of experience provided by our body are fused with those constituting our immediately prior experience (elements that include intuitions and symbols, as well as feelings). Our very being consists of a continuous flow of such moments, or actual occasions, of experience.

Feelings can be seen as the default mode of subjectivity, texturing it and constituting its character. They are not, however, merely internal events or private cognitions. Rather, "their body-relatedness may also give them a visible aspect such that how we feel can be a matter of public display" (Cromby, 2007b, p. 99). This does not mean that it is possible to simply or unproblematically 'read off' the complexities and subtleties of our experiential states from our bodies. This will always be a matter of interpretation, dependent on prior experience and knowledge. Though, when we look at another person it is often apparent that they are feeling something. This is frequently relevant to our interaction with them, even if neither of us can adequately name or describe that feeling.

Feelings have a ternary structure: "(1) a sense of feeling in terms of self-awareness; (2) a sense of the self feeling the feeling; and (3) a revealing of the moral, inner, interactional meaning of this feeling for the self and its on-going plan of action" (Denzin, 1985, p. 224). Again, this should not be taken to mean that feelings are simply 'inside' the feeling subject; they are relational. As Butt (1999, p. 137), following Merleau-Ponty (1962), notes:

> When we touch an object, the feeling is not inside us, nor is it 'in' the object; it is a component of the perception that occurs between us and the object. Similarly, emotions are between us and the world, a feeling that tells us something about our connection with it. They are vital clues about our intention that we might otherwise miss.

As a result, the subject has a tripartite relationship with her body: she *is* her body, she is *in* her body, and she is *outside* her body (Denzin, 1985). Through this three-fold relationship the subject is engaged with themselves, with other people, and with the world more widely. Such engagement is frequently ambiguous. Oftentimes, our feelings are ambivalent and cannot be reduced to simple accounts of 'what we really feel/want'.

The emphasis here is on embodied experience – the subject's felt connection to the current situation. But this is always a moving, unfolding process. The body is simultaneously the vehicle for such movement and "the structure that radiates and expresses the feelings" that are felt (Denzin, 1985, p. 227). Consequently, for Denzin (1985, p. 227), embodied experience is temporal, circular, situated, and dialectical "for it turns back upon itself, affirming, denying and elaborating what is and is not felt". From a Whiteheadian perspective, rather than thinking in terms of 'circularity', this affirmation and denial process can be thought in terms of the continual shifting balance between negative and positive prehensions. Since negative prehensions (what is eliminated from feeling) in the present occasion have their own subjective form, they can become positive prehensions (felt feelings) in later occasions of experience. Similarly, positive prehensions can be 'filtered out' by later negative prehensions.

Broadly speaking, feelings concern sense and sensibility and fall into one of three categories (Cromby, 2007b, 2011a, 2012b): (a) emotional feelings (or sensible feelings [Denzin, 1985]): the corporeal or somatic component of emotions; (b) feelings of the lived body (Denzin, 1985) such as those associated with sense perception, proprioception, interoception, equilibrioception, nociception, and so on; and (c) feelings of knowing, which are often vague, fleeting, and subtle, commonly referred to with the terms 'intuition' or 'gut feeling' in English (including intentional value-feelings, self-feelings, and moral feelings [Denzin, 1985]). The distinction between these categories is necessary for analytical purposes, but in real, everyday, lived experience all types of feeling will intertwine.

In line with the discussion of prehensions above, all three categories of feeling involve bodily feedback (the multiple sign systems of Ruthrof's analysis below), which is "constitutive of a body-relatedness by which feelings imbue subjectivity with a character reflective of our embodied, materially situated, intrinsically relational engagement with the world" (Cromby, 2007b, pp. 101-102). Feelings are not individualistic or asocial. Our bodies are penetrated by and infused with

41

social and relational influences (Bourdieu, 1977; Bourdieu & Wacquant, 1992; Burkitt, 1991, 1997, 1999; Connolly, 2002; Wolff, 2010). Feelings may be associated with an individual body location, but they are, at the same time, socialised, cultivated, modified and transformed by social practices; they are contingent upon, situated within, and occasioned by social relations; and they are imbued with cultural and subcultural norms (Cromby, 2007b, 2011a, 2012b).

While all feelings may be involved in experiences of moral distress, arguably, feelings of knowing and emotional feelings are most relevant to the current study: feelings of knowing because all decisions (moral or otherwise) have a felt component; emotional feelings because nurses consistently report strong emotions in experiences of moral distress (see Chapter 2). The rest of this chapter shall, therefore, be devoted to discussing these two types of feeling.

4.3.1   Sense: Feelings of Knowing & Felt-Thinking

In his work on feelings, Cromby (2007b, 2011a, 2012a, 2012b, 2012c) utilises Ruthrof's (1997) insight that, rather than being merely linguistic, meaning is heterosemiotic. Meaning is seen as constituted at the shifting and dynamic intersection of numerous sign systems. Ruthrof suggests that this intersection is the body and that linguistic expressions are given a definite meaning when they are associated with visual, olfactory, gustatory, haptic, corporeal, kinaesthetic, and other non-verbal signs. These various sign systems interact contingently in temporary, interpenetrative and corroborative relations.

Daniel Hutto's (2005, 2011, 2012a, 2012b) distinction between semiotic and semantic meaning is useful here. In his philosophy of enactivist cognition, Hutto argues that in order for a mental state to qualify as properly semantic and contentful, it must "have the function of saying or indicating that things stand thus and so, and being consumed by other systems because of what it says or indicates" (Hutto, 2012b, p. 179). Since many of the processes that enable basic mentality "are merely (a) reliably caused by (or nomically depend upon) the occurrence of certain external features, (b) disposed to produce certain effects (under specific conditions), and (c) have been selected because of their propensities for (a) and (b)" (ibid.), they are not truly semantic. Instead, their proper function is in guiding responses to specific kinds of worldly offerings. That is, processes that only possess properties (a)-(c) are perhaps better understood in terms of (feelingful) relations with the world. Rather than involving semantic content, many of these processes are, then, semiotic in character. If we apply this to the role of bodily feelings in meaning-making, we could say that feelings initially have semiotic meaning since they function to co-constitute the occasion of experience.

Because of their corporeal immediacy, embodied signs generate intensities, textures, and affordances that favour some meanings and resist others. As Cromby points out "whatever signs it

coincides with, a feeling of irritation is not a feeling of elation" (2012c, p. 91). It is only when feelings become bound up with symbol systems that there can be any semantic (that is, contentful) meaning. Thus semantic meaning involves embodied feelings, linguistic conventions, and social practices, but cannot be reduced to any one of these elements (Cromby, 2007b, 2012b; Gendlin, 1997; Langer, 1967; Merleau-Ponty, 1962; Ruthrof, 1997).

There are many fleeting, subtle and vague bodily feelings, which are often "difficult to convey except in terms of their relational and epistemic significance" (Cromby, 2011a, p. 89). Thus we often speak of feeling helpless, powerless, suspicious, uncomfortable, content, and so forth. Cromby notes that, in everyday interaction, English speakers use the terms 'gut feelings' and 'intuition' to refer to such feelings. John Shotter (1993a, 1993b) characterises these feelings as components of 'joint action', requisite to all relations and interactions. Human interaction, he says, should be viewed not as the deliberate realisation of (a priori) well-defined sequences of actions, but as spontaneous flows of sensuous inter-responding. We frequently act "on the basis of what we 'vaguely felt' was 'required by the situation' we were in at the time" (Shotter, 1993b, p. 4). It is possible that if we are prevented from acting in the way we feel is required by a situation – especially if that situation has a deep moral character (in terms of harm caused to another person, for example) – we may become distressed. It is easy to speculate that this may be a partial basis for moral distress.

If meaning is constituted by the intersection of multiple embodied sign systems, then so, too, is thinking. Moreover, the processes involved in thinking – the "sensory processes of seeing, hearing, smelling and tasting, and the complex processes of memory that help render experience coherent and sensible" (Cromby, 2012b, p. 8) – are bound up with socialised flows of feeling, which are always contingently associated with language. Thought is, according to Cromby, "continuously constituted from a flux of embodied valences, textures, affordances and intensities: an ongoing, corporeal sense of our own being and place in the world that shades thinking with value and desire" (2012b, p. 8). This supports and extends the point made above that human subjectivity (or experience) is coloured by the feelings and prehensions that constitute it. Feeling and language come together in thought as conversational fragments are utilised to 'complete' our embodied feelings; enabling us to 'fix' them within the flow of experience and to communicate them to others.

Thought is often described as internal conversation or inner speech, which has a social basis in the acquisition of spoken language (Archer, 2003; Billig, 1991; Crossley, 2011; Mead, 1934; Vygotsky, 1978, 1987/1934). Vygotsky highlighted the close relationship between inner speech and feelings:

> Thought is not begotten by thought; it is engendered by motivation, i.e., by our desires and needs, our interests and emotions. Behind every thought there is an affective-volitional tendency, which holds the answer to the last 'why' in the analysis of thinking. (1987/1934)

However, Vygotsky's analysis problematically separates the body, biology, and the 'inner' from speech, language, and the 'outer' (Cromby, 2007b). This de-emphasises the degree to which feelings themselves are socialised by limiting socialisation chiefly to language. The resultant biologistic character of Vygotsky's analysis "makes it difficult to adequately conceptualise the dynamics of subjectivity, and in particular the ways in which feelings and language are frequently thoroughly intertwined" (Cromby, 2007b, p. 107). For Merleau-Ponty (1962), the primordial lived unity of sensation and perception is the chief constituent of subjectivity, giving structure to our world through kinaesthetic feedback within habitual activity and acquired, socialised bodily techniques (cf. Burkitt, 1999, 2003). Meanings based in corporeal processes may become tied to fragments of dialogue. Similarly, linguistic tropes may become associated with bodily feelings. But the "relationship between language and the sensible [...] is a constant dialectic with no ending because language can never capture the mute world of the sensible" (Burkitt, 2003, p. 331). Furthermore, any attempt to separate sense and sensibility is mistaken because it would result in "sense without sensibility, sensibility without sense" (McAvoy, 2015, p. 30; cf. Wetherell, 2012). Cromby (2012b) uses the phrase 'felt thinking' to capture the intertwining of feeling and inner speech. Feelings of knowing have a role in aesthetic and moral judgement, but, arguably, all felt thinking is intrinsically axiological (i.e. value-laden) in character.

4.3.1.1 Feelings of Knowing & Morality

There are particular actions, judgements and thoughts which are usually viewed as specifically moral in character. For example, in Western culture, causing harm to another human being is usually deemed to be wrong (or bad), whereas taking care of another person is more often thought of as right (or good). These are issues facing nurses every day. In such cases judging the rightness or wrongness of a deed is frequently thought of as straightforward – it is *obviously* good or bad. Arguably, this obviousness is derived from beliefs, intuitions or dispositions, which have their origins in social relations. However, there are many more instances of moral conduct that are not so simple. Take the following scenario, for example:

> *Julie and Mark are brother and sister. They are traveling together in France on summer vacation from college. One night they are staying alone in a cabin near the beach. They decide that it would be interesting and fun if they tried making love. At very least it would be a new experience for each of them. Julie was already taking birth control pills, but Mark uses a condom too, just to be safe. They both enjoy making love, but they decide not to do it again. They keep that night as a special secret, which makes them feel even closer to each other.* (Haidt, 2001, p. 814)

In this case there was no chance that Julie would become pregnant (two forms of contraception were used) so 'inbreeding' is not an issue. It is also clear that both Mark and Julie were consenting adults and that no harm befell them. Despite this many people will say that it was wrong for Julie and Mark to make love; yet, when asked why, will often reply "I don't know, I can't explain it, I just know it's wrong" (Haidt, 2001; Haidt, Björklund, & Murphy, 2000). This is evidence that these judgements are based on intuitions (the socially derived 'gut feelings' or 'feelings of knowing' discussed by Cromby and Shotter), rather than reasoning or rational deliberation. Often, a (moral) judgement is made through processes of intuition. Such a (snap) decision is usually in simple dichotomous terms – good or bad, right or wrong. It is only when asked why they have made their decision that an individual engages in post-hoc reasoning to justify themselves and to persuade others to their 'way of thinking' (Haidt, 2001, 2007). Intuition and 'gut feelings' will, then, be components of nurses' moral decisions and any associated moral distress.

So, feelings of knowing are integral to moral decision making in cases where there seems to be a 'right' and a 'wrong' choice. This implies that some decisions and actions are moral, whereas other thoughts and activities are not. However, this may be a specious dichotomy. Shotter sees feelings of knowing as inherently moral. He argues that because

> one's "mind" is not just a general-purpose organ of general go-anywhere-anytime intelligence, but is 'at home' only in one's own times; one thinks both 'out of' and 'into' a certain cultural 'background'. (1993b, p. 5)

This Shotter calls 'knowing from within'. He contrasts this with 'knowing that' (the relationship between a person and a proposition; knowing that things stand thus and so) and 'knowing how' (the practical knowledge required to carry out a craft or skill). 'Knowing from within' is a form of practical knowledge, but "it is knowledge which only has its being in our relations to others" (Shotter, 1993b, p. 7). Accordingly, this knowledge is of a moral kind because its use as (ethically) proper or not depends on the judgement of others. This 'knowing of the third kind' – as Shotter alternatively names it – is a practical-moral knowledge, which has important implications for the current research. The context of moral distress is minimised in existing research, ignoring the fact that experiences of any kind are intrinsically situated and contextual. More particularly, the literature also fails to recognise that moral distress arises out of a nurse 'knowing from within' that specific situation. This thesis seeks to redress this.

4.3.2 Sensibility: Emotional Feelings

Emotional feelings are the experiential, subjective, embodied component of emotions (Cromby, 2007b, 2011a, 2012b): the racing or pounding heart of fear; the bodily heaviness and 'broken heart' of extreme sadness, the lightness of elation, and so on. However, emotions cannot

be reduced to such feelings. Ian Burkitt (1997, 1999, 2014) suggests that emotions are best conceptualised as complexes – multi-dimensional experiences involving physical, symbolic and relational elements. Rather than being the result of processes internal to the individual which are then expressed, emotion complexes are shaped by and help shape sociocultural interactions and relationships (Boiger & Mesquita, 2012; Burkitt, 1997, 1999, 2014). Emotions in social contexts are ongoing processes: the unfolding of feelings and (verbal and non-verbal) actions, contingent on actual developments in relations, which lend moment-to-moment texture and nuance to the situation. In contexts of relations people are both affected by their socio-natural surroundings and affect others around them.

Drawing on Burkitt's work, Wetherell (2012, 2014, 2015) suggests that emotions be thought as affective practices – emotions are to do with what people say and do and the habits they acquire within relations: they are enacted. But, affective practices are much more than enaction:

> body/brain landscapes, meaning making, feeling, communication, and social action entangle and become figured together in emotion episodes. The affective and the discursive intertwine. (Wetherell, 2015, p. 86)

Affective-discursive practices (such as patriotic lumps in throats at dawn services, the panic attacks of agoraphobia, righteous indignation in political discourse, victimhood, projects of authenticity, mindfulness meditation, shaming and being ashamed) carve deep ruts in the bodies, brains, mind, and subjectivities of individuals. But these are simultaneously ruts in the social and cultural resources patterning and justifying social action that social actors combine as their own and make personal. (Wetherell, 2015, p. 88). Thus, the concept of affective practices draws on other practice approaches and the insights of discursive psychology, but also takes seriously the extra-discursive and corporeal.

It may be true that emotion categories are incorporated into socio-cultural interpretative repertoires. It is also undeniable that they are rhetorically deployed to influence others – saying 'I am angry' can serve as an act of blaming. But analysing rhetorical uses of emotion terms in isolation from their embodiment removes them from other (phenomenal, relational, and communicative) aspects of emotions. An utterance is not just the words spoken to construct an emotion or to accomplish an action. A complete utterance is more than the words. It is the "expression of a person's embodied location in a relationship or context" (Burkitt, 1999, p. 115; cf. Whitehead, 1927, pp. 66-67). As such, it includes expressive intonation, contingent upon the relational context. It is also tied to the feelings experienced by the speaker as they relate in/to the situation.

4.3.2.1   The Moral Dimension of Emotions

Emotions such as contempt, anger, and disgust have been explored in relation to morality and ethics. Richard Shweder and his colleagues (1997) identified three types of ethic which are used across cultures to constitute and resolve moral issues:

i.   Ethics of community – stress the primacy of the group and where the person is situated within hierarchical structures. The rightness or wrongness of an action lies in its relation to or infringement of duty, loyalty, respect for authority, honour of the group, and so on.

ii.   Ethics of autonomy – stress the rights and freedoms of the individual. Wrongness or rightness of actions relates to violations of rights, issues of fairness and justice, and (dis)respect for individual freedom and choice, and so forth.

iii. Ethics of divinity – stress the recognition and respect of divinely ordained order, preservation of purity, guarding against contamination, sinfulness, etc.

Relatedly, Rozin, Lowery, Imada, and Haidt (1999) suggested that contempt has particular prominence in an ethic of community, anger in an ethic of autonomy, and disgust in an ethic of divinity. Broadly speaking, in Western culture, if a person embedded within social or community hierarchies transgresses the social norms of the group (the community ethic), they will find themselves on the receiving end of the contempt of fellow members of that group. In a context where the dominant ethic is one of autonomy, a person who infringes the rights of another will become the target of that other's anger. While a person who contravenes an ethic of divinity will suffer the disgust of those around them.

The transgressor, when subjected to contempt, anger, or disgust, in turn may experience emotions which specifically correspond to the violated ethic and the emotions of others (Benson, 2001, 2003). For example, Ciarán Benson (2003) suggests that if a person breaches a community ethic and is the target of others' contempt as a result, it may be appropriate for them to experience shame, guilt, embarrassment, and so on. If the transgressed ethic is one of autonomy and the offender is the focus of another's anger, they are apt to experience fear, anxiety, guilt, and so forth. If they infringe a divinity ethic and become an object of disgust, it may be felicitous for them to experience self-disgust, shame, etc. Benson proposes that the avoidance of such emotions is a strong motivation for not contravening ethical and social norms. Consequently, these ethical or moral emotions shape the emotional boundaries of a person's identity as it is constructed within one or other ethic; emotions become the 'unthinkable' boundaries of individual selves (Benson, 2001, 2003; see also Bourdieu, 1977, Ch. 4). (It should be noted that not only are the ethics themselves socially acquired, but so, too, are the corresponding sets of emotional responses [of

47

others and of the transgressors].) In terms of moral distress, these kinds of emotions might have a role in the kind of person nurses takes themselves to be and how others view them.

The research presented in the foregoing discussion is perhaps a little misleading, however. It essentially treats some emotions as moral and others as not. But, instead of singling out a privileged set of moral emotions; all emotions are potentially relevant to ethics and morality (de Sousa, 2001). Emotions are value-laden. There are appropriate ('right') and inappropriate ('wrong') times to experience or express any emotion. For example, in western culture it is generally thought inappropriate to feel or display happiness at a funeral, grief and sadness are more appropriate. In this way, all emotions are tied to power relations. As Burkitt (1999, p. 123) points out:

> The precepts and regulations of a class (or of any other social group) could be said to form the emotional habitus, while the bodily techniques form the dispositions for the production, or suppression, of emotional signals in particular circumstances. The emergence of the wrong emotion signs show, in the eyes of one's peers, a lack of social skill or, worse, some underlying psychological 'disorder' which has disabled the person in learning the required bodily techniques. Either way the person has failed to learn the expected levels of self-regulation and self-control, and because of this is judged inadequate by those who are more powerful, or whose class or gender upbringing has instilled in them a different set of controls and techniques which, because of their power, are seen as 'superior'.

Thus social control is achieved through regulatory and self-regulatory emotions and bodily techniques. Furthermore, as Paul Stenner (2005a, 2005b) notes, a person must also be deemed to have the right to a certain emotion at any given moment. For example, a person whose spouse is flirting with a third party might be considered to have the right to be jealous; if no such flirting has ever occurred, on the other hand, that person may be deemed to not have that right. These issues may be particularly relevant to nurses' experiences of moral distress. For instance, a nurse must not only have/enact the right feelings and emotions while on the ward (e.g. compassion, empathy, etc.), they must also have a right to the emotions and feelings they have/enact. Conversely, they must not enact feelings and emotions to which they do not have a right: a nurse may not be deemed to have the right to be upset by the death of a patient, whereas family members are likely to have that right.

4.4   SUMMARISING

To summarise, if subjectivity is understood in terms of a temporal society of presiding actual occasions (Stenner, 2008), which is always already embodied and in-the-world, this society gains its distinct character from its prehensions and feelings (of that body and world). The texture of a person's experience derives from what and how they feel. Broadly, human feelings can be seen to fit into three categories: sensible or emotional feelings; feelings of the lived body; and feelings of

knowing or of sense-making. All these feelings, while associated with an individual bodily location, are socially shaped. Emotion complexes are always tied to symbolic and relational practices and feelings of knowing are tied to sociocultural knowledge practices and local moral orders. Even feelings of the lived body, such as hunger, pain, tiredness, and sexual desire become entwined with discursive practices and habituses. In the ongoing flux of experience, feelings – of sense (meaning making) and of sensibility (emotionality) – and thought become inseparably intertwined. In this way, feeling is the default mode of subjectivity.

Each category of feeling is relevant to the research reported in this thesis, although sensible feelings and feelings of knowing perhaps more so. Emotional feelings are significant to experiences of moral distress since participants of the moral distress research reviewed in Chapter 2 frequently reported emotional experiences. Feelings of knowing are significant to moral judgements and, indeed, to all social relations. They are involved in the knowing of 'right and wrong', and in determining how we should proceed in a given situation. Thus it is easy to speculate that feelings of knowing will also be central to the moral experiences of nurses.

5 THE MANY BECOME ONE, THE ONE BECOMES MANY:
METHODOLOGY & METHODS

> The true method of discovery is like the flight of an aeroplane. It starts from the ground of particular observation; it makes a flight in the thin air of imaginative generalization; and it again lands for renewed observation rendered acute by rational interpretation. (Whitehead, 1978/1927-8, p. 4)

5.1 INTRODUCING

This chapter shall discuss methodological issues and describe the methods used in this study. The first section shall briefly discuss Paul Stenner's recent work on deep empiricism as an onto-epistemological starting point for the methodology developed in later sections. The concept of 'bricolage' shall then be discussed in the second section. It is suggested that bricolage constitutes the kind of plural methodology that deep empiricism requires. The third section shall then discuss the notion of 'diffractive methodology' as the specific way in which bricolage is implemented for this project. The fourth and final section shall describe the methods – the design, participants, data generation, and analytical tools – used within this diffractive methodology.

5.2 DEEP EMPIRICISM

Paul Stenner (2008, 2009, 2011a, 2011b) has recently been developing an epistemology for psychology and the social sciences, drawing on the philosophy of Whitehead, William James and others, which he calls 'deep empiricism'. Stenner starts from the assumption that:

> The comprehension of human life [...] *demands* an interpretive system which expresses the interconnection between different forms of knowledge since human life *is* an expression of the interconnection of what otherwise seem to be diverse aspects of being. As the history of psychology has surely proved, narrow-minded specialism in this context is a certain recipe for distortion, profound misunderstanding and consequent misrepresentation. It should not be forgotten that this will be distortion, misunderstanding and misrepresentation of *ourselves.* Our own 'being', and that means our own 'becoming', both collectively and personally is at stake. (2009b, p. 196; original emphases)

What is required, Stenner argues, is an articulation of the distinction between 'the psychological', 'the organic' and 'the physical' that simultaneously recognises and allows for inter-relations between these domains.

Rehearsing Stenner's arguments in full is beyond the scope of this chapter. What is important for present purposes, however, is that he notes that discourse presupposes or depends upon concepts, which in turn presuppose or depend upon percepts, which in turn presuppose or depend upon "a basic energetic form of shared connectivity by which physical things mutually affect one another" (Stenner, 2009a, pp. 120-121). In other words, 'the physical' is a more primordial grade of order of actual occasions than 'the psychical' and 'the psychical' society, therefore, is parasitical upon 'the physical' nexus. Without physical energetics there can be no perception and without perception there can be no conception, thus 'the psychical' cannot emerge unless 'the physical' also becomes. Importantly, discourse requires and "exploits conceptual mentality, abstracting from it a new economy of communicative connectivity" (Stenner, 2009a, p. 123). This means that we cannot reduce mind to language and discourse. As the last chapter noted, mind emerges from the body's feelings as they become intertwined with language.

So, returning to the quotation above, the comprehension of human life requires a recognition not only of "distinguishable grades of experience" (Stenner, 2009a, p. 124) – from the physical to the perceptual to the conceptual to the linguistic – but also of the interconnections between them. This is, in part, what Stenner means by 'deep empiricism', which is the guiding epistemology of this research project. The following two sections of this chapter shall outline the methodology adopted to 'operationalise' this epistemic position and the final section shall describe how the methodology was put into practice.

5.3 BRICOLAGE

As should be apparent by now, the view taken in this thesis is that the socio-natural world and human experience are complex and manifold. As such they cannot be adequately accounted for by any single research method. This is because all research methods seek to eliminate uncertainty and complexity and to reduce phenomena to parsimonious explanations – they reject

the so-called noise in search of a signal (Brown & Stenner, 2009; Serres, 1982/1980). Relatedly, 'off-the-shelf' research methods often produce monological knowledge that reduces human be(com)ing to a single factor. Arguably, a more creative form of research is required to produce new insights and concepts about the social and psychological world. It becomes necessary to move away from convergent forms of meaning-making to more divergent forms.

Bricolage offers this alternative. This term refers to the work of the bricoleur, a French word denoting a handyman who makes use of the tools available to complete a task; a "Jack of all trades, a kind of professional do-it-yourself" (Lévi-Strauss, 1966, p. 17). It has recently been used to conceptualise the many methodological practices of qualitative research. Some researchers employ a crystal metaphor (Ellingson, 2009; Kincheloe & Berry, 2004; L. Richardson, 2000; L. Richardson & Adams St. Pierre, 2005). For example, Kincheloe (2001, p. 693) states that the crystal "combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach". Ellingson (2009) uses the term 'crystallization' to develop a similar approach to research as that adopted here. However, the term carries connotations which are problematic if one is adopting a process ontology. In everyday use, 'crystallisation' means 'to form or cause to form crystals' or 'to give definite or concrete form to'. Both meanings imply something that is solid; the production of a static, unchanging object. In short, the 'crystallisation' metaphor may be diametrically opposed to the process-relational approach and suggests the production of definitive truth claims. As a result, it was felt that the term 'crystallisation' was unsuitable for this project.

With the embrace of the complexity of the world – and human experience thereof – comes the realisation that social reality is not a fixed entity. 'In its impermanence the lived world presents special problems for researchers that demand attention to the nature of its changes and the processes of its movements' (Kincheloe & Berry, 2004, p. 24). (Here, we can see an intersection between bricolage and the diffractive methodology discussed below.) Moreover, in the context of social science, complexity demands that the researcher develops a thick explanation; one that avoids the reductionism of merely describing the functional or structural role of an individual phenomenon. A 'literacy of complexity' that understands the intersection of the roles, social locations, and positions of all humans, with myriad layers of interpretations of self, contexts, and social actors goes some way towards establishing a new rigour for research (Kincheloe, 2005; Kincheloe & Berry, 2004).

Because bricolage utilises the 'tools at hand', the researcher is free to use techniques from multiple methods, combining them in novel ways with each research project. When viewed from different (e.g. sociocultural, theoretical, or methodological) perspectives the same phenomenon

can be interpreted and described in different ways. This enables the researcher to be open to diverse interpretations; thus producing less reductive 'findings'. Bricolage has at its core a struggle to "find and develop numerous strategies for getting beyond [the] one dimensionality" of single method research (Kincheloe & Berry, 2004, p. 23). This involves "abandoning the short-sightedness of pre-specified, correct patterns of analysis in favour of more holistic, inclusive, and eclectic models" (Kincheloe & Berry, 2004, p. 21). The view of research method becomes one of much more than procedure. Researchers take a step back from the process of learning research methods to obtain a conceptual distance (Alvesson & Sköldberg, 2009; Bourdieu & Wacquant, 1992; Kincheloe & Berry, 2004). This distance side-steps a passive acceptance of the received wisdom of research methods and offers the researcher a way to avoid what has been called 'methodolatry' (Chamberlain, 2000; Janesick, 1994) or method fetishism (Bourdieu & Wacquant, 1992) – the privileging of method over other considerations in research.

Often data or findings are offered as empirical proof of, or support for, a particular argument. However, the argument itself is equally often a matter of interpretation and/or perspective. Therefore, this strategy risks falling into the trap of the *Fallacy of Misplaced Concreteness* – that is, mistaking abstractions for concrete reality (Whitehead, 1920/2004). Reality (both natural and social) is always becoming (Barad, 2007; Brown & Stenner, 2009; Massumi, 2002; Whitehead, 1927-8/1978). Therefore, making definitive or totalising – that is, fixed – truth claims based on a relatively small data set (especially from a single study) is premature. Bricolage understands that data – whether qualitative or quantitative – are always co-constitutive of phenomena and research results or findings are always interpretations (Alvesson & Sköldberg, 2009; Parker & Burman, 2008; Valsiner, 2000). Multiple interpretations aid the researcher in avoiding narrow claims to a single absolute truth and, instead, offer something more fluid or transient, something more provisional. Moreover, looking at how multiple interpretations and the differences which emerge from the use of diverse analytical tools overlap and diffract – interfere constructively and destructively – can offer additional sights into the phenomena. But this approach also creates potential problems for the researcher. The remainder of this chapter discusses *how* bricolage has been adopted for *this* research project and how the problems raised by its adoption have been addressed.

5.4   DIFFRACTIVE METHODOLOGY

This section shall first explicate an understanding of reflexive methodology. A notion of diffractive methodology shall then be discussed and contrasted with that of reflexive methodology. It should become apparent that there are deep philosophical differences between the two approaches in terms of ontology, epistemology and axiology. Diffractive methodology, it is

suggested, is more compatible with the idea that reality is complex, relational and always becoming and is, therefore, appropriate for this research project.

Reflexivity and reflexive methodologies were developed as critical tools used to systematically reflect on and account for the investigator as co-constitutive of knowledge in any research endeavour. The aim is to acknowledge the three-way relationship between objects, representations and investigator in knowledge production (e.g. Alvesson & Sköldberg, 2009; Bourdieu & Wacquant, 1992; Kincheloe & Berry, 2004). This is held up against less-reflexive (positivist) research approaches, which tend to ignore the role of the knower, instead focusing solely on the relationship between objects and their representations. Reflexive methodologies have become increasingly promoted in the humanities and social sciences.

However, the use of such geometrical optic and 'reflection' metaphors has contributed to the belief that the mirror can be turned back on oneself. These notions are tied too closely to representationalism – "the belief that words, concepts, ideas, and the like accurately reflect or mirror the things to which they refer" (Barad, 2007, p. 86). An implicit assumption of reflexivity is the idea that representations reflect (natural and social) reality. This is bound up with notions "that we have a kind of access to representations that we don't have to the objects themselves" (Barad, 2007, p. 87). Although reflexive methodologies were developed in an attempt to bridge the gap between knower and known, they fail to do so because "for all the recent emphasis on reflexivity as a critical method of self-positioning it remains caught up in geometries of sameness" (Barad, 2007, p. 72) and "does nothing more than mirror mirroring" (p. 88). That is, reflexivity is tied to its central metaphor: geometrical optics of reflections. Essentially, reflexivity leaves intact a distance between object and subject, researcher and world.

By contrast, the metaphor of diffraction is not about self-referential reflection; nor, in fact, reflection at all. As such it may serve as a tool for developing non-representationalist methodologies. Barad explores some important aspects of diffraction, which she suggests make it "a particularly effective tool for thinking about socialnatural [sic] practices in a performative [or enactivist] rather than representationalist mode" (2007, p. 88). Diffraction is, according to Barad, a material-discursive phenomenon that makes evident the effects of different differences. Drawing on Foucault and Butler, Barad sees discourses as practices which form the objects of which they speak. Crucially, though, Barad sees discursive practices as intimately entangled with matter and material practices – discourse and matter are inseparable, hence material-discursive practices. Diffractions are attuned to the differences that material-discursive knowledge-making practices make and to the effects these differences may have on the world.

5.4.1. Diffraction

Diffraction is a concept of physical optics with fundamental importance to physics. Diffraction experiments are central to the debates about the 'wave versus particle' nature of light and matter. The "so-called two-slit experiment (which uses a diffraction grating with only two slits) has become emblematic of the mysteries of quantum physics" (Barad, 2007, p. 73). Diffraction is to do with the way that waves combine as they overlap and the way in which waves apparently bend and spread when they encounter an obstruction. Diffraction can happen with any type of wave. Under the right conditions, water, sound, and light waves all display diffraction. For example, if two pebbles are simultaneously dropped into a pond, two sets of circular ripples will spread out from the point at which the pebbles break the surface of the water. Where the two ripples meet and overlap, diffraction occurs. Similarly,

> Consider a situation in which ocean waves impinge on a breakwater or some very large barrier with a sizable hole or gap in it. As the waves push through the gap, the waveforms bend and spread out. In particular, the approaching parallel plane waves emerge from the gap in the shape of concentric half circles. The ocean waves are thus diffracted as they pass through the barrier; the barrier serves as a diffraction apparatus for ocean waves. (Barad, 2007, p. 74)

The diffraction that Barad illustrates in the above quotation is shown in Figure 5.1.A. A similar pattern can be observed when there are two openings in the breakwater (see Figure 5.1.B). The semi-circular waveforms that emerge from the two openings in the breakwater combine to form an interference or diffraction pattern. The diffraction pattern results from relative differences in amplitude and phase of the overlapping waveforms. Directly opposite the midpoint between the two openings (point A) the intensity of the combined waveform is large. This is because the waves from both openings are in phase (the crests of the wave meet up with one another, and similarly for the troughs) and so constructively interfere with one another. There would be relative calm at points C1 and C2, where the waves are out of phase with one another (the crests of the wave from one opening meet with the troughs of the wave from the other opening, thus destructively interfering with [or cancelling] each other). But, at points B1 and B2, where the waveforms come back into phase with one another (but at a lower amplitude or intensity), the overall amplitude picks up again.

The diffraction of water waves is analogous to that of light waves as demonstrated by the two-slit experiment. Figure 5.2 shows "a side view of a two-slit experiment using a coherent monochromatic light source. The screen exhibits a characteristic diffraction or interference pattern with alternating bands of bright (i.e., places where the light waves are in phase and constructively interfere with one another) and dark (i.e., places where the light waves are out of phase and destructively interfere with one another) areas" (Barad, 2007, p. 79). Surprisingly, the two-slit

A   B
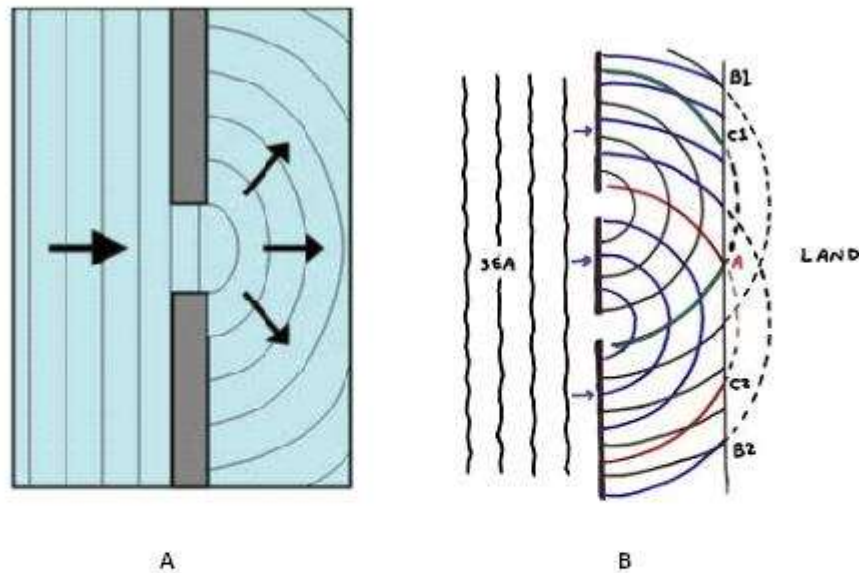
Figure 5.1. *Drawings depicting ocean breakwater diffraction patterns.* Image A shows the diffraction of ocean waves as they pass through an opening in a barrier. Image B shows the diffraction of waves as they pass through two similar-sized holes. The two holes act as a diffraction grating for incoming water waves. The parallel lines approaching the breakwater and the concentric circles emerging from the breakwater indicate the wave fronts or crests of the waves. The semi-circular waves that emerge from each hole in the breakwater combine to produce an interference or diffraction pattern.
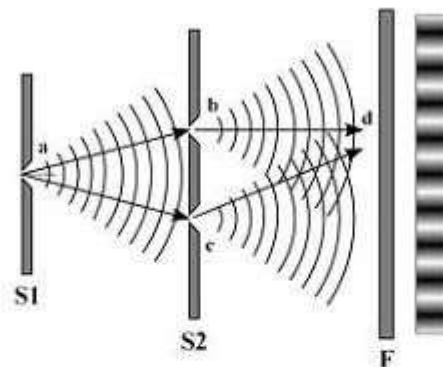
Figure 5.2. *The two-slit experiment.* This drawing shows 'a side view of a two-slit experiment using a coherent monochromatic light source. The screen exhibits a characteristic diffraction or interference pattern with alternating bands of bright (i.e., places where the light waves are in phase and constructively interfere with one another) and dark (i.e., places where the light waves are out of phase and destructively interfere with one another) areas' (Barad, 2007, p. 79).

experiment has also demonstrated that matter (previously thought to only exhibit the characteristics of particles) can, under the right conditions, also exhibit wave-like 'behaviour'. Two-slit experiments can produce diffraction patterns when matter (e.g. electrons) is used instead of light. The "alternating pattern of wave intensity is characteristic of interference or diffraction patterns" (Barad, 2007, p. 78). Interference is never simply destructive; it is also constructive. Diffraction also reveals the indefinite or indeterminate nature of nature. The indefiniteness of

56

boundaries is illustrated by diffraction patterns – displaying shadows in 'light' regions and bright spots in 'dark' regions.

5.4.2   Diffractive Methodology as Intra-Action

The adoption of the metaphor of diffraction acknowledges that the relation between researcher and researched, knower and known, is a relation of "exteriority within" (Barad, 2003). This is never a static relationality "but a doing—the enactment of boundaries—that always entails constitutive exclusions and therefore requisite questions of accountability" (Barad, 2003, p. 803). Subject and object are not fixed and do not pre-exist as separate entities as such, but emerge through intra-actions within and as part of processes and relations (see also Chapter 3 of this thesis). In contrast to "interaction", "intra-action" denotes the mutual constitution of entangled agencies, which do not precede but, rather, emerge within, their relations. Diffractive methodology is a commitment to understanding which differences matter, how they matter and for whom (Barad, 2003, 2007). There is also a focus on fine-grained detail and, ultimately, accounting for how practices matter. Here, diffractive methodology is entangled with the conceptualisation of emotions as affective practices (cf. Chapter 4).

A diffractive methodology is about engagement. It is not about reflecting from afar. All academic and cognitive activity (including, measuring, observing, theorising, knowing and thinking) are material practices of "intra-acting within and as part of the world in its becoming" (Barad, 2007, p. 396). When we engage in such activity, rather than discovering facts about things that exist independently from us, we learn about phenomena. That is, we are involved in constituting "specific material configurations of the world's becoming" (p. 91). It is not the case that knowledge practices merely have material effects. Barad argues that

> *practices of knowing are specific material engagements that participate in (re)configuring the world*. Which practices we enact matter—in both senses of the word. Making knowledge is not simply about making facts but about making worlds, or rather, it is about making specific worldly configurations—not in the sense of making them up ex nihilo, or out of language, beliefs, or ideas, but in the sense of materially engaging as part of the world in giving it specific material form. And yet the fact that we make knowledge not from outside but as part of the world does not mean that knowledge is necessarily subjective (a notion that already presumes the pre-existing distinction between object and subject that feeds representationalist thinking). At the same time, objectivity cannot be about producing undistorted representations from afar; rather, objectivity is about being accountable to the specific materializations of which we are a part. (Barad, 2007, p. 91; original emphasis)

Thus, differences are marked from within and as part of an entangled state. Relationalities become more important as differences are materialised.

Furthermore, adapting the arguments of the physicist Nils Bohr, Barad (2007) suggests that the apparatus used is always implicated in the research findings. For example, a particular apparatus is required to measure momentum (e.g. one with moveable parts), but different equipment is needed to measure position (e.g. one with fixed parts). The apparatus used to measure momentum cannot be used to measure position and the device used to measure position cannot be used to measure momentum – we can either know position or momentum but not both simultaneously – similarly, slight adjustments to the apparatus used in the two-slit experiment gives rise to different results. With the standard two-slit equipment, the image on the screen appears as a diffraction pattern. But with the addition of a detector at the slits (to decipher which slit an electron passes through), the image on the screen becomes one of individual marks made by the particles. Perhaps even more surprising, if the data of the detector at the slits is deleted afterwards the image on the screen returns to that of a diffraction pattern.

From this perspective:

> A *phenomenon is a specific intra-action of an "object" and the "measuring agencies"*; the object and the measuring agencies emerge from, rather than precede, the intra-action that produces them. Crucially, then, we should understand phenomena not as objects-in-themselves, or as perceived objects (in the Kantian or phenomenological sense), but as specific intra-actions. Because the basis of this ontology is fundamental inseparability, it cuts across any Kantian noumena-phenomena distinction: there are no determinately bounded or propertied entities existing "behind" or as the causes of phenomena. (Barad, 2007, p. 128; original emphasis)

Diffractive methodology and bricolage, then, are utilised to avoid taken-for-granted assumptions, over-simplification, reductionism and totalising truth claims. The notion of phenomena as intra-action of object, apparatus and researcher is important to the adoption of the bricolage as discussed above. Research findings will be more open to alternative perspectives. This raises at least two issues. The first is how to engage with bricolage without drifting back towards positivistic, monological notions of research and methodologies. The second issue, and flipside to the first, concerns the engagement with complexity. Focusing on entangled relationships, rather than things-in-themselves, allows more complex and sophisticated understandings of phenomena. Using multiple tools can lead researchers to multiple dimensions of a phenomenon (Kincheloe, 2005). However, there is then a danger of producing a complicated analysis of a complex phenomenon but without saying anything of consequence about it (N.J. Clarke, et al., 2014). Bricolage should be about offering fresh insight into a phenomenon and developing practical recommendations and solutions to problems. It is all very well engaging with dense theory and utilising elaborate methodologies and methods, but it is important to retain a pragmatic attitude if one wishes the end product of one's research to have a practical application.

5.5 METHODS

5.5.1 Data Generation

In this thesis, the term 'data generation' is preferred to 'data collection'. In accord with diffractive methodology, rather than seeing the researcher as a neutral observer or scientist who collects already existing information, the view is taken that researcher and participant co-create (a story or narrative about) the research topic through the research process (Stetler, 2010).

Aligned to bricolage, both quantitative and qualitative techniques were used in this study to get a sense of different dimensions of moral distress.

5.5.1.1 Quantitative Questionnaires

Four quantitative self-report questionnaires were used: Moral Distress Scale (MDS), Stress of Conscience Questionnaire (SCQ), Maslach Burnout Inventory – Human Services Survey (MBI), General Health Questionnaire (GHQ-12; all questionnaires are summarised in Table 5.1). Contrary to much quantitative research in psychology, these questionnaires are not seen as providing direct access to a person's inner psyche. Rather, they are seen as a form of restricted conversation between researcher and participant. As Rom Harré (1998, p. 133) points out,

> Questionnaires are not instruments in the sense that thermometers are. They do not measure a property. They are invitations to a conversation. The way the conversation goes is governed by discursive conventions, not by underlying causal processes.

The questionnaire stands in for the researcher's side of the conversation and the responses stand in for the participant's side. In answering the questionnaire, respondents are required to express something about themselves or their beliefs (Harré, 1998). However, their expression is restricted by the multiple-choice or forced response structure of the questionnaire.

5.5.1.2 Qualitative Interviews

In order to investigate the phenomenon of moral distress in more detail and to look at the meaning nurses attribute to their experiences, in-depth qualitative interviews were also used. The interviews produced a total of 21 hours 38 minutes of audio data (mean interview length = 50 mins; range = 24–93 mins). Questions and prompts were derived from the moral distress and qualitative interviewing literatures (see Table 5.2 for interview guide). The semi-structured nature of the interview allowed for additional appropriate questions to be asked alongside those in the interview guide.

It is recognised that all talk within the interview is situated within a specific context and that interviewer and interviewee may be orienting towards particular stakes and interests (J. Potter & Hepburn, 2005). Interviewees are not seen as 'a repository of opinions and reason' or as predefined

Table 5.1: Summary of Quantitative Questionnaires

Questionnaire	Topic	Description	No. of Items	No. of Scale Points	Scoring
Moral Distress Scale[3] (Corley et al., 2001)	Self-reported frequency and intensity of moral distress	Each item describes a situation in which a nurse might find themselves (e.g. Carry out a physician's order for unnecessary tests and treatment). Each item has two dimensions: Moral Distress and Frequency.	35	7 for Distress (0/None to 6/Great Extent) & 7 for Frequency (0/Never to 6/Very Frequently)	Moral Distress & Frequency score for each item. Overall Moral Distress & Frequency scores. The higher the score the more severe/ frequent the distress (min = 0, max = 245)
Stress of Conscience Questionnaire (Glasberg, et al., 2006)	Self-reported frequency and intensity of stress of conscience (or troubled conscience)	Each item is split into two parts. Part A asks about a particular situation in which a nurse might find themselves (e.g. Are you ever forced to provide care that feels wrong?). Part B asks 'Does this give you a troubled conscience?'	9	6 for Part A (0/Never to 5/Every day) & 6 for Part B (0/No, not at all to 5/ Yes, it gives me a very troubled conscience)	Part A (Frequency of situation) and Part B (Stress of Conscience) score for each item. Overall Frequency & Stress of Conscience scores. The higher the score the more severe/frequent the stress (min = 0, max = 54)
Maslach Burnout Inventory – Human Sciences Survey[4] (Maslach, Jackson, & Leiter, 1996)	Self-reported job-related burnout	Items gauge the frequency of job-related feelings (e.g. I feel emotionally drained from my work).	20	7 scale (0/never, 1/a few times a year, 2/once a month or less, 3/a few times a month, 4/once a week, 5/a few times a week, or 6/every day)	Items 4, 7, 9, 12, 16, 17, and 19 are reversed before scoring. The total score for the 20 items is the amount of burnout for the participant; the higher the score, the more severe the burnout (min = 0, max = 140)
General Health Questionnaire[5] (GHQ-12) (Goldberg, 1992)	Self-reported psychological health	The questionnaire asks 'Over the last few weeks have you' and each item finishes the question with a different health-related situation (e.g. 'Felt constantly under strain?'). Respondents are asked to indicate how they perceive each situation.	12	4 (4/Better than normal, 3/Same as normal, 2/Worse than normal, 1/Much worse than normal)	A mean health score is calculated; the lower the score the worse the psychological health is deemed to be (min = 12, max = 48)

[3] This questionnaire, developed in USA, was adapted for use in a UK context. Items referring to medical insurance or payment by patients and other items that are not applicable in the UK were removed and some items were re-worded using more appropriate terminology.

[4] This questionnaire has well-established population norms.

[5] This questionnaire has well-established population norms and is widely used for screening purposes.

Table 5.2: *Interview Guide*

Main Questions	Additional Prompts

1. I'm interested in what being a nurse is like for you. Can you tell me about your experiences of being a nurse?
 	
2.
   a. Can you tell me about any times when you have had to make ethical decisions concerning the care or treatment of patients?
 	
   b. Can you tell me about times when you have been involved in making decisions about what would be the right treatment or care for a patient?
 	
3.
   a. Can you tell me about any time you may have acted against your conscience in your job?
 	
   b. Have you ever done something in your job that you thought was not the right thing to do? Can you tell me about it?
 	
   c. Have you ever done something you your job that you thought was the wrong thing to do? Can you tell me about it?
 	
4.
   a. Did acting against your conscience affect your relationship with patients? How did it?
 	
   b. Did doing something that you didn't think was right affect your relationship with patients? How did it?
 	
   c. Did doing something you thought was wrong affect your relationship with patients? How did it?
 	
5. Has this sort of thing ever affected your relationship with colleagues? How?
6. Has this sort of thing ever affected your life outside of work? How?
7. How do you know the right thing to do?
	1. What was that like to experience?
	2. How did that make you feel?
	3. Can you remember any particular emotions?
	4. How did you experience the situation?
	5.
	   a. Do you have any words, phrases, metaphors, or pictures that could capture your experience(s)?
	   b. How well does this/do these fit your experience(s)?
	6. What did you sense in the situation?
	7. Did you notice anything in particular?
	8.
	   a. Did you take any kind of action?
	   b. What did you do?
	9. How would you describe it?

prior to the interview. To reiterate, the view taken is that the participants in the interview – interviewer and interviewee – are co-constituted within and in relation to "the ongoing communicative contingencies of the interview process" (Holstein & Gubrium, 1995, p. 14), which, in turn, occurs within and in relation to the research process as a whole, which is situated within

and in relation to wider socio-cultural and psychological processes. In short, the interview is an experience related to other experiences. Therefore, participants (re)produce versions of their experiences, understandings and meanings.

By using lay terminology as much as possible it is possible to minimise "flooding of the interview with social science agendas and categories" (J. Potter & Hepburn, 2005, p. 299). This is one of a number of problems that Potter and Hepburn (2005) argue reduce the usefulness of qualitative interviews in psychology, preferring instead the use of 'naturally occurring talk' or 'naturalistic records'. However, Potter and Hepburn's arguments are tied very much to a particular approach to research and language (conversation analysis) and privilege its methods over alternatives. For critical responses from various perspectives, which suggest (at least some of) Potter and Hepburn's arguments may only apply to that approach, see Griffin (2007) and Smith, Hollway, and Mishler (2005).

5.5.2 Language & Meaning

Meaning arises within the context of a given utterance, but it is also related to the wider world. As Bakhtin notes in his essay "Discourse in the Novel":

> The living utterance, having taken meaning and shape at a particular historical moment in a socially specific environment, cannot fail to brush up against thousands of living dialogic threads, woven by socio-ideological consciousness around the given object of an utterance; it cannot fail to become an active participant in social dialogue. (1981, p. 276)

The meaning of a word derives, in part, from a tripartite relationship: any given word has a relationship with itself, with other words, and with the (aspect of the) world it references. The meaning of a word arises not only from the context of its present usage, but also from other uses of that word, from the object of which it speaks, and from other words spoken about that object.

> Indeed, any concrete discourse (utterance) finds the object at which it was directed already as it were overlain with qualifications, open to dispute, charged with value, already enveloped in an obscuring mist – or, on the contrary, by the "light" of alien words that have already been spoken about it. It is entangled, shot through with shared thoughts, points of view, alien value judgments and accents. The word, directed towards its object, enters a dialogically agitated and tension-filled environment of alien words, value judgments and accents, weaves in and out of complex interrelationships, merges with some, recoils from others, intersects with yet a third group: and all this may crucially shape discourse, may leave a trace in all its semantic layers, may complicate its expression and influence its entire stylistic profile. (Bakhtin, 1981, p. 276)

Therefore, a multidimensional view of language is required. One that sees talk as referential/informational, constructed/constructive, and action-oriented/enacted/enactive, all at the same time. This view of language understands that reference is possible, yet also recognises

that reference is paradoxically made both opaque and more transparent by the dialogic character of words (Bakhtin, 1981).

What a person says may be used to perform a particular action (e.g. justify) and construct an event in a particular way for rhetorical means, but it can also be informational; that is, about something. Furthermore, meaning integrates past, present, and future: it emerges on the basis of earlier experiences that interlocutors integrate into the current occasion and it also emerges through the integration of an anticipated future into the current action (Stetler, 2010). Additionally, communication involves another aspect: understanding (Bakhtin, 1981; Brown & Stenner, 2009; Luhmann, 1995). That is, the final component of meaning is another person's understanding of an utterance and the information it conveys. What is more, every utterance anticipates a response – it is directed at an Other.

By adopting this view of meaning and language, I can BOTH take seriously what participants are telling me AND remain suspicious of how they come to tell me it in a particular way; all the while recognising that analysis entails my understanding and interpretation of a given utterance (see also Interpretation & Hermeneutics section below).

5.5.3 Bricoleur's Toolbox

This section shall describe the tools used in analysing the data in this study. It shall first briefly explain the hermeneutics of empathy and of suspicion used in interpreting the data. The notion of shifting the focus of analysis shall then be discussed. In line with the metaphor of diffraction, each analytic focus is considered as a wave. The researcher can then consider how these waves diffract. For this project, analysis involved four waves of interpretation: intra-action with empirical material, interpretation, critical interpretation, and self-critical and linguistic consideration. These waves shall each be discussed. Finally, abduction shall briefly be described.

5.5.3.1 Interpretation & Hermeneutics: Empathy & Suspicion

5.5.3.1.1 Hermeneutics of Empathy: Interpretation & Understanding

'Hermeneutics of empathy' is defined as meaning-recollection interpretations, which seek to understand talk and text from the speaker or writer's point of view (Langdridge, 2007; Ricoeur, 1981). This perspective takes seriously the intentional nature of talk and text.

5.5.3.1.2 Hermeneutics of Suspicion: Critical Interpretation

'Hermeneutics of suspicion' is defined as interpretations that do not assume talk and text have a one-to-one correspondence with the intentions of an individual speaker or author (Langdridge, 2007; Ricoeur, 1981). This critical perspective seeks to understand how it is something

comes to be said or written in a particular way, what processes and (power) relations might be at play.

5.5.3.2 *Shifting Focus/Diffracting Waves*

Social researchers often talk about different levels of analysis (e.g. Burck, 2005; Parker, 2013; Wodak & Meyer, 2009). Micro-analysis is concerned with looking at data in minute detail. It can be considered as intra-textual analysis. The aim is to discern the what (content, constructions) and how (action, process, relations, constructive nature) of the text. Meso-analysis can be considered to be inter-textual analysis because it examines the relationship between participants' accounts and how these narratives/discourses relate to other (possible) narratives/discourses. Macro-analysis is concerned with connecting participants' accounts to ideology and power. As such it can be considered as extra-textual analysis. The aim is to discern the why of the text. These levels identify proximal and distal characteristics and influences of talk and text. Savage argued that "using different analytical procedures may be helpful in teasing out different layers of understanding represented in the data, and allow the construction of different, and even contradictory, versions of the social world" (Savage, 2000, p. 1495; cf. Coffey & Atkinson, 1996). But talking of layers or levels in this way suggests a definite dividing line between them. Arguably, however, it is impossible to separate out these different influences in practice. Therefore, I shall use a metaphor of shifting focus. Using various analytic methods or techniques enables a shifting of focus to different aspects of the data and how participants' talk relates to the wider world. In this way, it is possible to focus on proximal and distal influences without implying any real separation in terms of layers or levels.

5.5.3.2.1 Four Waves of Interpretation

Each different focus or analytic technique shall be considered as a wave. Analysis proceeds as a matter of interpretation of four waves, each considering "questions and themes that are highlighted and sharpened by interfaces and confrontations between" the waves (Alvesson & Sköldberg, 2009, p. 278). Thus using the 'wave' metaphor allows the researcher to consider how the waves diffract. That is, how they constructively and destructively interfere with one another. Such an approach offers a way of avoiding taken-for-granted assumptions and naïve over-simplifications. The four waves are: intra-action with empirical material, theoretical interpretation, critical interpretation, and self-critical and linguistic consideration.

Ideally, all the four waves should play an equal role in analysis. In practice, however, the emphasis of each wave relates to the purpose of the research and the phenomenon being studied. Beginning with handling the empirical material "the researcher moves distinctly through the metatheoretical field, making explicit reconnections to the empirical material" (Alvesson &

Sköldberg, 2009, p. 278): there should be continual movement between the empirical material, interpretations, theory and meta-theory. The analyst interrogates the empirical material using all four waves, questioning the data to develop interpretations and understandings of the what, how and why of the text.

Wave 1: Intra-action with Empirical Material

The first interpretative wave involved three sub-waves or stages. First, a hermeneutic of empathy and understanding explored the accounts given in interviews. We can think in terms of 'raw interpretations' and 'low-abstract interpretations', which are essentially the researcher's common-sense impressions of the empirical material. The primary concern is the content of the text and what this can tell the analyst about the subjectivity of the individual participant; in this case, their experiences of moral distress. Secondly, hermeneutics of suspicion were used to explore the function of the participant's talk, the action(s) it performs, the processes involved, the relation between different parts of the interview transcript, and the constructive and constructed nature of what is said. Finally, relationships between cases were examined. Important differences and similarities between participants' accounts could then be examined. This also involved consideration of how interview texts might relate to other texts (e.g. policies and regulations).

Wave 2: Theoretical Interpretation

The second interpretative wave looked at underlying meanings of the empirical material. Analyses were guided by ideas related to academic theories and other frames of reference. It is argued that innovation is triggered by the fusion of seemingly disparate ideas or phenomena. The idea was to engage systematically with a few theoretical areas rather than attempting a superficial eclecticism; "[t]his is because every good theory is a systematic whole, and every application of such theories necessitates an understanding of their totality" (Alvesson & Sköldberg, 2009, p. 274). The aim was to open up alternative interpretations informed by theory and to "problematize the legitimacy of dominant interpretive patterns" (p. 276), rather than to provide as many different interpretations as possible.

Wave 3: Critical Interpretation

The third interpretative wave involved thinking about why certain interpretations dominated and consideration of 'winners and losers' as the result of a particular interpretation. The use of critical social theories to examine ideologies, power and social reproduction at work in the empirical material and, particularly, in the interpretations of that material was used. The intention was to avoid taken-for-granted assumptions (both disciplinary and sociocultural) in interpreting the empirical material. The purpose of this was to broaden and strengthen understanding by circumventing socially and culturally centric bias in interpretations.

Wave 4: Contextual, Self-Critical and Linguistic Consideration

As a multiplicity of interpretations was produced through the interplay of the empirical material and a number of different theories, meta-theory offered insights regarding ambiguity, the problematisation of dominant interpretations, and the stimulation of alternative views and interpretations. Consideration of text production and language use allowed a focus on the text being produced (as opposed to the text of empirical material). Claims to authority and the selection of the voices emphasised in the text were examined. The purpose here was to avoid a problematic narrowing of interpretations and, ultimately, to develop more sophisticated understandings. Alongside this, contemplation of theoretical and intellectual (i.e. disciplinary and institutional), cultural, and political contexts in which the research took place made more explicit how these contexts have affected my individual involvement and interaction with nurse moral distress.

5.5.3.3   Abduction

Abductive reasoning focuses on underlying patterns and develops useful explanations (R. Richardson & Kramer, 2006). Abduction begins with scrutinising the data; interpretations are then made in line with theory. As far as possible, all theoretical explanations for the data are considered. Theoretical conjectures and hypotheses are formed in this process, which are then checked empirically against the data and the most plausible explanations are then pursued (Charmaz, 2006).

There is, then, movement from one conception of a phenomenon to another (possibly deeper, more developed) conception of that phenomenon (Danermark, Ekström, Jakobsen, & Karlsson, 2002). Danermark and colleagues (2002, p. 91) suggest that we can think of this as a re-description or re-contextualisation of phenomena; that is, we can "observe, describe, interpret and explain something within the frame of a new context", such as in terms of a particular theoretical framework. There is continuous movement between the empirical material, interpretations, theory and meta-theory. This form of reasoning is superbly illustrated by Whitehead's aeroplane analogy in the epigraph to this chapter.

5.5.4   Design

All participants were asked to complete four quantitative questionnaires (described above). These questionnaires served a dual purpose. First, the scores were used for screening purposes. If a participant's score indicated high levels of stress or distress, then the study would be stopped and they would be advised to seek support (a list of useful support services was provided on the back of the study information sheet; see Appendix I). Fortunately, this never happened; none of the participants showed scores that indicated they were unsuitable for participation. Second, the scores from the questionnaires were used to generate descriptive statistics (see below). After completing the questionnaires, participants were then interviewed.

5.5.5 Participants

The sample total was 26 (see Table 5.3 for breakdown by role and Table 5.4 for nationality and ethnicity). The gender mix was 22 females and 4 males. The mean age of the sample was 34 years (range = 20–58). The mean length of nursing experience for the qualified, registered nurses at the time the interview took place was 11 years (range = 2.5–25 years). The mean length of training for the undergraduate students was 2.5 years (range = 1–3.5 years). One of the postgraduate students was a graduate entry nursing student with no prior nursing experience and had been training for 8 months. The other 2 postgraduate students had already qualified and been working as nurses before starting additional training; one had almost 5 years of experience, the other had just over 1 year of experience. All registered nurses were recruited via a single NHS Trust in a large city in the East Midlands of England, except 3 who were recruited via personal contacts of the researcher. All students were recruited via the associated School of Nursing.

Table 5.3: *Breakdown of sample by role*.

Role	Number of Participants
Staff Nurse (Adult)	6
Staff Nurse (Paediatrics)	2
Staff Nurse (Mental Health)	2
Deputy Sister (Adult)	4
Lead Nurse (Paediatrics)	1
Epilepsy Nurse Specialist	1
Community Psychiatric Nurse	1
Nurse Practitioner (GU Medicine)	1
Postgraduate nursing student	3
Undergraduate nursing student	6
Home Dialysis Trainer	1

Table 5.4: *Breakdown of sample by self-disclosed nationality and ethnicity*.

Nationality	Number of Participants
White British	14
White English	2
British, ethnicity not disclosed	4
English, ethnicity not disclosed	2
Mixed race British (white & black Caribbean)	1
White British/Australian	1
White Portuguese	1
Indian	1

Descriptive Statistics

The scores from the questionnaires varied widely. Table 5.5 shows the range and means of the scores for the MDS and Table 5.6 shows the number of participants who scored in each quartile range of scores on the MDS. All participants could be said to have low to moderate moral distress. It can be seen that experiences of moral distress occur rarely to moderately often. These figures indicate that, experiences of moral distress are infrequent, but when they do occur they

can be relatively intense. Table 5.7 shows the range and means of the scores for the SCQ and Table 5.8 shows the number of participants who scored in each quartile range of scores on the SCQ. These data suggest that, although relatively infrequently, nurses can experience moderate to high levels of stress of conscience. Table 5.9 shows the range and means of the scores for the MBI and the GHQ-12 and Table 5.10 shows the number of participants who scored in each quartile range of scores on these questionnaires.

Table 5.5: *Ranges and Means of MDS Scores*

Moral Distress		Frequency	
Range	Mean	Range	Mean
169 (min = 4, max = 173)	82.9	72 (min = 3, max = 75)	31.2

Table 5.6: *Number of Participants by Intensity and Frequency of Moral Distress*

	Low (61 or below)	Low to Moderate (62-122)	Moderate to High (123-184)	High (185 or above)
Moral Distress	10	7	9	0
Frequency	22	4	0	0

Table 5.7: *Ranges and Means of SCQ Scores*

Stress of Conscience		Frequency	
Range	Mean	Range	Mean
35 (min = 2, max = 37)	21.1	30 (min = 2, max = 32)	16.2

Table 5.8: *Number of Participants by Intensity and Frequency of Stress of Conscience*

	Low (13 or below)	Low to Moderate (14-27)	Moderate to High (28-41)	High (42 or above)
Stress of Conscience	7	11	8	0
Frequency	9	13	2	0

Table 5.9: *Ranges and Means of MBI and GHQ-12 Scores*

Maslach Burnout Inventory		General Health Questionnaire – 12	
Range	Mean	Range	Mean
68 (min = 5, max = 73)	35.3	12 (min = 20, max = 32)	26

Table 5.10: *Number of Participants by* Risk of *Burnout and Psychological Health*

	Low	Low to Moderate	Moderate to High	High
Risk of Burnout	(35 or below)	(36 -70)	(71-105)	(106 or above)
	13	12	1	0
Psychological Health	(19 or below)	(20-29)	(30-39)	(40 or above)
	0	23	3	0

The statistics presented in Tables 5.5 to 5.10 suggest that some of the participants in this study experience moral distress and/or stress of conscience and are adversely affected by their job. However, these data do not and, indeed, cannot show what participants' experiences mean to them and whether or not they feel they are being adversely affected by their job. As shall be seen in Chapters 6 to 10, though, the quantitative measures and analyses and the qualitative interview data and analyses are mutually supportive. That is, nurses do recognise that the ethical aspects of nursing can be distressing and/or stressful and that their job can affect them negatively.

5.6 SUMMARISING

In sum, this chapter explored the concepts of 'bricolage' and 'diffractive methodology' as alternatives to the use of a single method and as offering the kind of plural methodology required by the deep empiricism inspired by Whitehead's philosophy. These metaphors – bricolage and diffraction – informed the choice of methods and analytic tools used in this study, as described in this chapter. The adoption of diffractive methodology and bricolage are intended to aid the development of a complex understanding of moral distress and to avoid taken-for-granted assumptions, over-simplification, reductionism and totalising truth claims. It is a central tenet of deep empiricism, after all, that

> the inherited actualities of the past are no simple foundation. On the one hand, looking backwards, they are themselves the outcome of a creative process of concrescence that has resulted in one specific actualisation of potential. On the other hand, looking forwards, they are no 'finished product' but rather one of the many 'potential' ingredients that will play a role in the actualisations of the future. (Brown & Stenner, 2009, p. 33).

6 Nurses' Feelings of Knowing

6.1 Introducing

As noted in Chapter 4, feelings of knowing are likely to be components of nurses' decision making activities. Recall, these are the bodily sensations associated with meaning- and sense-making, which are often subtle, vague and fleeting – often called intuitions or gut feelings in English. As Shotter (1993b) points out, we act according to what we feel is most appropriate within the ongoing flow of the unfolding situation we find ourselves in. This chapter shall explore nurses' accounts of such feelings. The first section shall discuss gut feelings as they relate to knowing within the nursing profession and how these feelings relate to decision-making and other work activities. The second section shall then discuss feelings of discomfort as feelings of knowing and as seeds of distress. In line with the diffractive methodology discussed in Chapter 5, the third section of this chapter shall 'diffract' the key points from the previous two sections.

6.2 Nurses' Gut Feelings

Participants in this study frequently spoke in terms of 'intuition' and/or 'gut feelings', as exemplified by Jody, one of the student nurses who took part in this study. (For further biographical details of the participants in this study see Appendix II.) Jody talked about 'knowing in her stomach' whether something was right or wrong:

Extract 1: Jody

```
1   Jody:    In a situation when you know this is the right thing to do and you know this is how
2            things should go, it's kind of just the same way you feel when you know one and one
3            is two.  You know that's what it is, you know that's how things should go for your
4            patient and it's—  I'm not saying that happens all the time, because it's not always
5            that cut and dry, but when you know something is right, you kind of know almost
6            in your stomach.  I guess you kind of feel it, like, yeah, this is what you should do.
7            It's not a gut reaction because that sounds really flippant, and it's not a flippant
8            thing.  It's kind of just a deep, yeah, this is the right thing to do, I'm doing the right
9            thing.  And you kind of get feedback from that because your patient will appreciate
```

| 10 | it and then you'll think, oh yeah, I did a good thing. And that would kind of make |
| 11 | you feel happy about it and then you just know. |

There are at least three interesting issues raised by Jody's account. The first involves the phrase "it's kind of just the same way you feel when you know one and one is two" (E1L2–3). This phrase constructs the 'obviousness' of what is right. When a person knows that one added to one equals two, it is obviously so. One need not spend any time contemplating the answer of 1+1, it *just is* 2. This analogy suggests that, at least in some cases, people experience right and wrong as obviously so. That is, when one has learnt right from wrong, what is the right course of action is obvious; it *just is* right. Rhetorically, the analogy also works to suggest universality in two ways. First, one plus one will always equal two, so right will always be right and wrong will always be wrong. Secondly, 1+1=2 is not an idiosyncratic, subjective opinion. Everyone who adds one and one will end up with two. It is an objective fact. By using this analogy, then, Jody hints that anyone in this situation would feel the same way.

The second point of interest in Extract 1 centres on the phrase "that sounds really flippant, and it's not a flippant thing" (E1L7). According to the rhetorical perspective in psychology (e.g. Billig, 1991, 1996; Billig, Condor, Edwards, Gane, & Radley, 1988; J. Potter, 1996), when people are talking they anticipate potential objections to their accounts. Shotter's (1993a, 1993b) rhetorical-responsive constructionism suggests that this kind of anticipation is a form of sensuous inter-responding. The word 'flippant' denotes being frivolously disrespectful, shallow, or lacking in seriousness. Qualities perhaps deemed inappropriate in a nurse. Here Jody is managing or countering any possible accusation that she may not be suitable to become a nurse. Jody distinguishes her 'gut feelings' from 'gut reactions'. The latter carries negative connotations in this context. To act on a gut reaction would be to act spontaneously, before thinking things through – something that may also be considered inappropriate for a nurse. Whereas acting on a gut feeling is to act in accordance with what Jody has already spoken of as being obviously right. Jody's interest management (J. Potter, 1996), here, could be seen as an example of Shotter's (1993a, 1993b) spontaneous flows of sensuous inter-responding. She is anticipating, responding to, or sensing a potential response of the interviewer from within their interaction. Even in talking about her gut feelings, Jody was using her feelings of knowing within the interview context.

The third analytic priority revolves around the notion of getting 'feedback' from patients (E1L8). In one way, this relates to the interest management discussed above. As Jonathan Potter (1996) notes, descriptions become more credible when they accommodate the assent of others – including a detail of consensus in an account "provides *corroboration* of the factuality of a version" (p. 159; original emphasis). Here, Jody talks about the feedback from patients in support of her

feelings: It is not only Jody saying that her feelings were right and should be trusted; the positive feedback from patients provides corroboration. Additionally, the success of Jody's account fundamentally depends upon her ability to establish her direct experience of 'gut feelings'. Jody does this by localising her experience within a specific zone of personal relations (D. Middleton & Brown, 2005). According to Middleton and Brown (2005), such 'zones of personal relations' serve as an anchor and reference point for similar localisation by others. In other words, Jody's account works by localising her experience in a situation in which others could easily place themselves. These two features of Jody's account (consensus from others and the localisation of experience) establish the reality of her story.

When the analytic focus is shifted, however, the importance of 'feedback' from others highlights a degree of sociality of feelings of knowing. Jody's feelings co-constitute her relationship with her patients – feelings are a way of relating to other people. The show of appreciation on the part of a patient not only reassures Jody that she has made the right decision (based on her gut feelings), but also strengthens the relationship she has with that patient. As noted in Chapter 4, feelings of knowing are socio-cultural, in that, they co-constitute social experiences. Getting 'feedback' from a patient that one has 'done the right thing' may result in Jody trusting similar feelings in future.

Jody also emphasised the 'deepness' of her feelings (E1L7). Such comments are typical of the accounts given by other nurses in this study. For many of the participants, knowing when something is going well or going badly, what a patient needs, what a patient's prognosis might be is rarely a purely deliberative, 'in-the-head', thought. On the contrary, nurses often trust what they feel 'deep down'. But neither are these 'deep', 'gut feelings' entirely irrational or completely separate from ratiocination. For example, Millie (a Staff Nurse in the oncology department) also spoke of the 'deepness' of knowing:

Extract 2: Millie

1	Martin:	When you're having to make a spur of the moment decision in your job, how would
2		you know the right thing to do then, if you've not got time to think about all these
3		rules and...?
4	Millie:	A lot of the time it's just ingrained into you, it's experience, and I haven't got a lot of
5		experience, I've been qualified not even three years but that's still experience. So a
6		snap judgement of, 'Is that patient going to become unwell?' Their obs are saying
7		that they're okay, but they just don't look well. There's something about them today
8		that they do not look well and I know them. It's that nurses' gut feeling sometimes
9		and, 'They need to go down for x-ray now. Do I send them or do I not? No.' I make
10		that decision because I know one I've got a gut feeling and two I can back this up
11		with rationale. I think that's how I can make snap decisions. I've got rationale.

Use of the word 'ingrained' at line 4 is important here. It suggests deep-rootedness, with connotations that experience permeates one's whole body. There is a definite sense that making spur of the moment decisions involves the body as much as the mind. It appears that Millie is guided as much, if not more so, by her perceptions and gut feelings as by the medical data ("their obs" (E2L6): such as blood pressure, temperature, E.E.G. etc.). This is about knowing the patient, having a strong enough relationship with a person to realise when something is amiss. Feelings are relational – they connect people to one another and to the world around them. It is possible that the more nursing experience Millie gains, the more the job (nursing knowledge and skills) might pervade her body and, perhaps, the more her feelings will connect her to nursing and to her patients. However, depending on her experiences, the opposite may also be true: if she has many negative experiences, Millie could become distanced from nursing and her patients.

The relationship between 'gut feelings' and rational thought is also touched upon in extract 3. From an experiential point of view, the 'rationale' (E2L10–11) to back up one's 'gut feelings' is learnt through training to be a nurse and supplemented with on-the-job experience. Millie knows that she can trust her feelings because they are compatible with her knowledge base and skill set. From a theoretical viewpoint, acquisition of technical know-how, adequate physiological knowledge, and other nursing skills will combine with socio-cultural, relational, and interpersonal influences within a specific context at any given moment to produce a particular 'gut feeling'. Millie's use of the word 'rationale' is also interesting from a rhetorical perspective. 'Rationale' denotes having a fundamental reason or reasons to account for something, or having a reasoned exposition of principles. In this way, the ability to make "a snap judgement" (E2L5–6) based on 'gut feelings' is constructed in a manner that minimises the subjectivity of the feeler, implying that 'gut feelings' can be relied upon because of *a priori* reason(s).

The corporeal evidence of feelings of knowing and the relationship of this to more tangible evidence and 'objective' knowledge was further encapsulated by Millie at another point in the interview:

Extract 3: Millie

1 Millie: I think sometimes you just feel that you know someone's going to die. I can –
2   this sounds really weird, but it's true. I can smell death as well in someone who
3   is going to die any time. Sometimes it can be five days and they still haven't
4   died, but you know that they are dying. But you can smell it. Sometimes you
5   just know when they've gone even though they've still got a pulse. They're not
6   there. You can just feel it and that is part of a gut feeling and along with that
7   gut feeling goes your evidence, your evidence-based practice, your teaching,
8   your research, everything that forms a basis of why you practice and how you

| 9 | practice. But sometimes you just look at that person and you just think, 'No,' |
| 10 | there's something not right, but I don't know what it is. |

In Extract 3, again, knowing seems to be as much dependent on sensory impressions and other bodily signs (Ruthrof, 1997) as it is on rational thought and objective evidence. The quotation begins with Millie saying that she feels she knows when a patient is going to die, but she then goes on to say that this includes the sense of smell. Millie further emphasises feelings, and 'gut feelings' in particular, but is quick to point out that this is accompanied by an evidence base (E3L6–8). Millie's experience appears to be in terms of integrating her feelings with objective knowledge. This is an example of *felt* thinking. As Chapter 4 highlighted, Cromby (2012b) argues that all thinking is felt thinking. Thinking is simultaneously constituted from fragments of conversation and shared/shareable (objective) knowledge along with "a flux of embodied valences, textures, affordances and intensities: an ongoing, corporeal sense of our own being and place in the world that shades thinking with value and desire" (p. 950; cf. Whitehead, 1938/1966, pp. 159-164).

With a change of focus, it can be seen that Millie may be rhetorically managing any possible criticism. She begins by talking about feeling when someone is going to die (E3L1), which some may find dubious. She then moves on to talk about being able to smell when death is coming (E3L2-3). A potentially more controversial topic, which Millie herself recognises ("this sounds really weird" [E3L1–1]). To feel or smell death approaching could be dismissed as, at best, subjective misinterpretation or, at worst, superstitious nonsense or even delusion. By going on to say that feelings are always accompanied by evidence, Millie minimises the possibility that her account can be discounted in this way without completely negating the importance of her feelings in her experiences.

To briefly summarise, gut feelings are sometimes associated with an experienced or claimed obviousness and universality of right and wrong. In such cases, a feeling indicates to the feeler that something *just is* right (or wrong). This supposed obviousness may stem from the deep, ingrained, corporeal character of feelings of knowing. It must be stressed, however, that this is not merely an irrational, knee-jerk reaction. Rather, gut feelings or intuition, rational thought and consideration of objective knowledge co-constitute decision-making processes. Feelings of knowing are also relational. Nurses' feelings co-constitute their relationships with patients and colleagues. Additionally, feelings of knowing seemed to inform accounts given within research interviews. That is, interviewees may sensuously anticipate the interviewer's (possible) response to their accounts by offering counter-arguments to imagined appraisals of their narratives.

6.3 FEELINGS OF DISCOMFORT

Feelings of discomfort in relation to knowing when something is wrong were often spoken of by participants. Among several other situations, the nurses who participated in this study frequently talked about feeling uncomfortable when being asked to do something with which they disagreed; when witnessing a colleague do something that was inappropriate or that could be deemed bad practice; when information was withheld from patients; when inappropriate or unnecessary treatment, interventions or medications were administered; and when they were involved in making decisions about end-of-life care, such as withdrawing life support interventions. This section shall discuss some of these issues, beginning with Wendy's experiences of colleagues behaving inappropriately.

Wendy is a Staff Nurse in the Health Care of Older Persons department. In the extensive quotation in Extract 4, Wendy recounts two stories about situations when she had seen a colleague doing something that Wendy judged to be wrong. There are many interesting points that could be made with regards to this extract. However, the analysis that follows shall be restricted to commenting on four thematic priorities. First, 'feeling uncomfortable' will be discussed in terms of feelings of knowing. Secondly, some of the moral issues will be teased out. Thirdly, consideration will be given to the matter of competency in relation to identity concerns. Last but not least, issues of power shall be explored.

Earlier in the interview, Wendy had mentioned feeling uncomfortable when witnessing colleagues do things that she thought were not right. Extract 4 begins with her being asked to describe the feeling:

Extract 4: Wendy

1	Mart:	Are you able to describe what that feeling of discomfort was like?
2	Wend:	I felt sorry for the person. I thought they'd been – the lady that does the shouting
3		because they don't understand, I feel that she degrades people. She's just not
4		respecting them; it's quite degrading, it's... You feel uncomfortable for them, you
5		feel uncomfortable for others around as well. You're aware of the fact that there's
6		other – there can be relatives and other patients around and things, and you're
7		aware of how they are as well. The lady that I had a word with, earlier on in my
8		career, that made me feel angry. It was a very vulnerable person and she was being
9		treated in a way that there was no way that she could have stopped that from
10		happening. I was standing quite gobsmacked at the time in disbelief of what I was
11		seeing in front of me. It took a while for it to sink in. I was in quite dis', and I thought,
12		'No, I have not just seen her do that,' and then I thought, 'Yes, I did.' That made me
13		feel really angry because that person was so vulnerable. If you've got somebody
14		who can't quite hear and she's shouting at them, they can shout back, there's no
15		physical harm being done. But they could shout back at her and to a certain degree,
16		they're not as vulnerable. But the initial lady was. She was extremely vulnerable;
17		she was completely dependent on us for everything and she was being treated in a
18		completely unacceptable manner.

19	She moved her, this lady was so confused and unaware of what was happening, she
20	actually ended up sleeping in a – for want of a better word – a pen, a padded pen.
21	She wouldn't stay in the bed, she was constantly climbing out and crawling all over
22	the place. She used to crawl around the floor, she couldn't walk and she'd managed
23	to get out of the pen – actually it was before she had the pen. She managed to get
24	out of her bed space and she'd gone across the bay and thought, 'Well, she just wants
25	to go – she doesn't want to be cooped up in that corner.' So I allowed – she wasn't
26	causing any harm, there weren't relatives around and she was safe. I was watching
27	her and she was safe. So I was allowing her some freedom. Then this staff nurse
28	came in, saw her on the floor and just got her and just literally dragged her back
29	across the floor into her bed space again. Didn't ask me why she was there, saw that
30	I was there but didn't question why I hadn't moved her and she just physically
31	moved her back into the bed space again. So I felt really sorry for the little lady. As
32	I say, she was very vulnerable, it shouldn't have happened.

33	I think in a way as well, I felt a little – from a personal level, I wasn't comfortable
34	with the fact that she didn't deem me competent to deal with the situation. She
35	knew I was there and as I say, she didn't question why I hadn't done anything or
36	anything like that, she just over-rode my decision without even asking why I'd made
37	the decision. She hadn't asked anything. She just walked in, moved her and walked
38	out. I'm standing there thinking, 'Well, I am here, hello.' I've got a right to make
39	decisions about my patients and you've just come and completely over-ridden me
40	so she did make me feel quite inadequate, especially feeling quite vulnerable myself
41	as a new nurse. So that side of it was an effect on me as well, which is why I spoke
42	to her. I didn't go to management, I spoke to her personally. The other lady, I don't
43	feel that it's my place to say anything, as I say, they can shout back. She's not causing
44	them any physical harm and I have made management aware because something
45	needs to be done about it, but I don't feel that I need to approach her personally. If
46	she ever goes to the point where it's too much or if there's a very vulnerable person
47	or someone who can't defend themself, then I would step in and do something, but
48	I don't feel as compelled to do that with her. It's not a direct hard thing; it's just a
49	misunderstanding.

Before discussion begins, it may help the reader if the phrase 'the lady that does the shouting' (E4L2) is explained. Wendy is referring to a colleague she had previously mentioned, who speaks with a strong accent that many patients find difficult to understand. Wendy said that, rather than trying to speak more clearly, "the staff nurse is just shouting the same words louder". It is this that Wendy feels degrades people (E4L4).

Moving on, it is interesting to note that Wendy does not answer the question. She does not describe the feeling of discomfort. Instead, Wendy describes the situations and how they made her uncomfortable, which she first mentions at lines 4–5. This is immediately preceded by Wendy suggesting that her colleague disrespects and degrades patients by shouting at them. Here, it seems that feelings of discomfort are, experientially, feelings of knowing. Wendy's feelings of uncomfortableness and her knowing that her colleague's actions were wrong are co-constitutive. It is not that her feelings were induced by a prior recognition that what her colleague did was wrong, nor that her recognition followed her feelings. Rather, her feelings and her knowing were

simultaneous. Wendy felt uncomfortable on behalf of the patients (E4L4–6) – she had empathy for them. She also felt uncomfortable for the other people who witnessed her colleague shouting (E4L5). In a way, Wendy's words are ambiguous here. Did she feel uncomfortable for others in a similarly empathic way because witnessing a nurse shout at patients is not a nice experience? Or could it be that Wendy felt uncomfortable because she was embarrassed to know that these people had witnessed such poor behaviour from a fellow nurse? It is possible that these potential sources of Wendy's discomfort are not mutually exclusive; that her discomfort is a mixture of both. Either way, her feeling uncomfortable is still a form of feeling of knowing. It is not difficult to speculate what this 'knowing' might entail. In the first instance, Wendy knows that the people witnessing her colleague shout at a patient might also be feeling uncomfortable – in response to also believing that it is wrong – and so is empathetically feeling their discomfort. In the second case, Wendy knows that her colleague is bringing their profession into disrepute and that people might perceive Wendy as condoning the behaviour, especially given that she does not intervene. In the third scenario, of course, Wendy's knowing would be some form of integration of the first two.

Wendy's use of the second person pronoun when talking about feeling uncomfortable is also interesting: "You feel uncomfortable for them, you feel uncomfortable for others around as well" (E4L4–5). Wendy could have easily said 'I felt uncomfortable' and retained the general meaning of her account. But her use of the words 'you feel' implies that anybody would feel the same way if they found themselves in a similar situation. In effect, Wendy alludes to the normality and generality of her feelings of discomfort. Whereas 'I felt uncomfortable' would have connotations that the feelings were specific to Wendy at that particular moment, 'you feel uncomfortable' suggests that anyone would feel this way in this kind of situation (Goffman, 1959, 1979). If Wendy's feelings of discomfort are common to other people, rather than merely idiosyncratic, it suggests the belief, that a nurse shouting at patients is wrong, is also commonplace. In this way, Wendy's account constructs both her colleague's behaviour as an obvious transgression for all to see and minimises the subjectivity of Wendy's evaluation of, and reaction to, it.

Shifting the focus slightly, we can see that feelings of discomfort (as feelings of knowing), at least in part, constitute the embodiment of shared beliefs. Societies and cultures provide their members with a set of narratives (Frank, 2010; Hutto, 2008) or a discursive or interpretative repertoire (J. Potter & Wetherell, 1987; Wetherell, 1998, 2012) of norms, mores and moral beliefs, which permeate the bodies of individuals in the form of habits of feeling. As argued in Chapter 4, thinking (including in terms of these narratives or interpretative repertoires) always proceeds within flows of socialised feeling. As Cromby (2012b, p. 951) says, "[b]elief does not uniquely

combine discourse and feeling: it is a particular form of felt thinking, characterised by durability and personal significance". It is suggested here that Wendy's feelings of discomfort constitute this form of felt thinking. It seems that it is her belief that the sick, the frail, and the elderly should be cared for in ways that maintain their dignity – a common belief within our society. If a person acts in contravention of that belief, Wendy's embodied response is one of discomfort.

The second point of analysis revolves around the moral issues contained within Wendy's narrative. In Extract 4, Wendy emphasises the vulnerability of one patient and downplays the vulnerability of others. For example, when recounting the story about the elderly woman who had been dragged across the ward, Wendy repeatedly uses the word 'vulnerable' (E4L8, 13, 16, & 30) and explicitly says that "there was no way that she could have stopped that from happening" (E4L9). By contrast, when Wendy is talking about the patients who are shouted at by another nurse, she says "they're not as vulnerable" (E4L15) and implies that they are able to defend themselves because "they can shout back" (E4L14). In terms of Wendy's morality, the issue of patient vulnerability versus their capacity to defend themselves seems, in this context, to be about who needs to be defended – which patients Wendy needs to protect, or give more priority to protecting.

For Wendy this issue seems to be tied up with differentiating physical harm from verbal or mental harm. Wendy implies that physical harm is more serious than verbal harm. When a nurse is shouting at patients it may be degrading or disrespectful (E4L3–4), but "there's no physical harm being done" (E4L14). In contrast to this, although Wendy does not explicitly mention any physical harm befalling the other patient, she does hint at it. It is easy to infer that, if a nurse "just literally dragged her back across the floor" (E4L27) and "just physically moved her" (E4L29), a frail patient might have been hurt. By differentiating physical and verbal harm in this way, Wendy also makes a distinction between (un)acceptable harm, on the one hand, and completely unacceptable harm, on the other. (Un)acceptable harm is not entirely acceptable (Wendy feels uncomfortable when witnessing her colleague shout at patients) but it does seem tolerable (Wendy does not intervene). In this way, verbal harm does seem to be more acceptable than physical harm (in the case of the latter, Wendy "had a word with" [E4L7] the colleague who dragged a patient across the floor). On the one hand, Wendy speaks to her colleague about the wrongdoing. On the other hand, Wendy does not see it as her place to talk to her colleague (instead, opting to inform her managers in the hope they will deal with the problem) because no physical harm is being done. In the former scenario, Wendy risks causing tension at work by making an enemy of her colleague. In the second instance, Wendy avoids this by not confronting her colleague.

Thirdly, and related to some of the tensions highlighted above, Wendy's account draws attention to the diffraction (the intertwining) of competency and identity. Wendy's intervention seems to be

as much, if not more, about her perception that her own competency was being challenged or called into question as it is about the moral issues involved in the patient being moved (E4L32–41). Wendy explicitly says that she "wasn't comfortable with the fact that she didn't deem me competent to deal with the situation" (E4L32–33). It seems that the actions of Wendy's colleague were an affront to Wendy's positive identity of herself as competent nurse, leaving Wendy feeling inadequate (E4L38–39). She even suggests that this is partly the reason why she chose to speak to the other nurse rather than go to management (E4L40–41). Conversely, in the scenario where another colleague shouted at patients, Wendy did not personally intervene (E4L41–47). In this instance, there is no question of Wendy's competency and identity being challenged, so Wendy opted for reporting her colleague to management. This issue of identity management is entangled with the moral tensions discussed above, highlighting the multifaceted and complex nature of the decisions nurses have to make on a daily basis.

Last, but not least, the discussion turns to the issues of power that can be identified in Extract 4. Three points, in particular, will be highlighted. The first involves the physical coercion involved in dragging an elderly patient across the ward. This is perhaps the most obvious example of power relations in Extract 4. Wendy repeatedly emphasises the vulnerability (E4L8, 13, 16, 30) and helplessness (E4L9, 16, 18) of the patient. This contrasts quite starkly with the way Wendy describes the actions of her fellow nurse (E4L26–30). In particular, the phrases "just literally dragged her back across the floor" (E4L27) and "she just physically moved her" (E4L29) suggest both the ease with which the nurse moved the patient back to the bed space (there is not even a hint that she struggled) and a degree of callousness in doing so. The contradistinction between the description of the nurse and the patient serves to highlight not only the power disparity but also the 'wrongness' of the deed. Not only did the nurse physically 'manhandle' the patient, but the patient was too helpless to defend herself.

There is also a certain power disparity between Wendy, as newly qualified nurse, and her colleague, who is a Senior Staff Nurse. The power imbalance between Wendy and her colleague actualises, or is enacted, within institutional hierarchies. A Senior Staff Nurse is recognised as having more experience and knowledge, is positioned higher in the hospital hierarchy, and thus is 'officially' sanctioned with more power than a new nurse. In this regard Wendy's colleague could be deemed well with her rights – bestowed upon her by her position in the hierarchy – to 'over-ride' Wendy's decision (E4L49 & 54). While there is an institutional power disparity between Wendy and her colleague, the power relationship is more complex. Despite "feeling quite vulnerable […] as a new nurse" (E4L39), Wendy is not completely powerless. Rather, she feels she has "a right to make decisions about [her] patients" (E4L37) – a right bestowed upon her by being

a qualified, registered nurse, and that certain patients are *her* patients – and is able to confront her colleague.

Perhaps more subtle is the power relationship between Wendy and the patient. The way that Wendy talks about her patient reveals that she is the more powerful in the relationship. For example, Wendy says that she was "allowing her some freedom" (E4L26). This implies that, rather than the freedom belonging to the patient, to exercise at will, it is Wendy's choice whether or not to *give* or *allow* the patient some freedom. Wendy could well have made a different decision and withheld that freedom from the patient. There is a parental tone to Wendy's account, which infantilises the patient. Much like a baby, Wendy describes the patient as crawling about on the floor (E4L21) and as sleeping in a padded pen (E4L19). The infantilisation of the patient is further constructed by Wendy's emphasis on her vulnerability and helplessness and use, at line 30, of the phrase "little lady". All this serves to illustrate that in this situation, as the nurse, Wendy is more powerful than the patient. Linking this back to earlier analytic points, it is not only Wendy's positive self-image that is challenged by her colleague's actions; it is also her power over the patient that is brought into question. Wendy's own feelings of inadequacy and vulnerability (and of discomfort) could be as much related to the issue of power, as to the tangled matters of identity, competency and morality. Arguably, then, the intertwining of moral tensions with the issue of identity management is further enmeshed with these issues of power.

Bringing the discussion back to feelings of knowing and of discomfort, Extract 5 comes from a point in the interview in which Wendy had been asked how she knows the types of situations she recounts in Extract 4 are wrong:

Extract 5: Wendy

1	'Cause it feels wrong, it looks wrong. It sounds wrong, it is wrong. There are
2	some things that some people do that you think, 'Is that right?' and when you
3	question it and look into it and again, gather more information about it, then
4	you can make that decision later on. But there are some things, like the
5	incidences I was talking about, that they are wrong. I don't need to talk about,
6	I don't need any more information, I don't need an explanation. That was
7	wrong. That felt uncomfortable. That was not nice to see and that was wrong.
8	Sometimes it's just instinct maybe.

Here, we can see an association between feeling 'uncomfortable' and knowing that something is wrong or witnessing something that is "not nice to see" (E5L7). Much like the 'gut feelings' discussed above, Wendy associates this feeling of discomfort with instinct. This is an example of how feelings make some decisions quick and simple to make. Whereas, earlier, feelings

of discomfort were interpreted in terms of the feelings of knowing discussed in Chapter 4, here Wendy's feelings shall be interpreted using Whitehead's notion of 'propositions'.

Propositions were the topic of a quotation in Chapter 4 (cf. p. 37), in which Whitehead (1927-8/1978, p. 24) suggests that they are lures for feeling. How a given proposition develops and is judged depends as much upon the specific history of the prehending subject as upon the proposition itself. For Whitehead, propositions are "the tales that might perhaps be told of particular actualities" (1927/1978, p. 256). Thus propositions only exist as entertained in experience. It is suggested here that while Wendy's narratives may report on *actual* events, those events entered into Wendy's experience in the form of propositions[6]. That is, it is the propositions of the events that entered into Wendy's experience, not the actual events themselves. The actualities concerned were integrated with Wendy's previous experiences and understandings in her perception of those actual events (in the form of propositions). During this process, the propositions were judged in a particular way by Wendy. In the first instance, the propositions were a lure for particular judgements – Wendy *felt* the propositions in a particular way. However, one must bear in mind that Wendy's past experiences have a significant influence on how the said propositions entered into her experience and were judged – her past experiences are central to how the propositions are felt. This shall be illustrated using the specifics of Wendy's account in Extract 5.

The propositions we are concerned with are those of the 'wrong deeds of Wendy's colleagues'. Wendy says that, when she sees such behaviour, "it feels wrong, it looks wrong. It sounds wrong, it is wrong" (E5L1). To clarify, 'it' refers to the behaviour of Wendy's colleagues. According to the interpretation offered here, 'it' – the actions of Wendy's colleagues – is the proposition. As such, 'it' is a lure for particular feelings and judgements; that is, feeling, seeing, hearing, and judging the 'wrongness' of 'it'. The 'felt wrongness' of 'it', furthermore, then becomes a lure for Wendy to feel uncomfortable (E5L6). Such judgements and feelings are not based purely on the actualities of the actions of Wendy's colleagues. Rather, they have as much, if not more, to do with the values and beliefs (formed through experiences of socio-cultural norms and mores within past social interactions and relations) that Wendy brings to the present moment. Wendy's feelings of discomfort, then, constitute her embodiment of shared beliefs.

In Wendy's narrative, some things are constructed as obviously wrong and immediately recognisable as such. This is similar to Jody's account in Extract 1. Extract 5 is interesting in this

---

[6] Just as those events entered into the experience of this author in the form of Wendy's verbal propositions during the interview and subsequent transcription and analysis of that interview; and as those events are now entering into the experience of the reader through the written propositions on this page.

regard because such obviousness and recognisability is linked to multiple bodily senses – if something looks, sounds and feels wrong, then it must be wrong. For Wendy there is no doubt about it. As she says later in the extract, she requires no additional information or explanation. She just knows it is wrong. However, Wendy does contrast this with other, 'less obvious', cases when more information is required and time is needed to make a decision. In one sense, these are the verbal propositions Wendy uses to recount her experiences – they are the tales she tells of particular actualities.

In sum, it was suggested that feelings of discomfort are a specific form of feeling of knowing: a felt-thought that something is wrong. It was also noted that, as with feelings of knowing more generally, feelings of discomfort are sometimes associated with an obviousness and universality of right and wrong. As such, feelings of discomfort (as feelings of knowing), at least in part, constitute the embodiment of shared beliefs. Following Whitehead (1927-8/1978), it was also proposed that some actions and situations are lures for feelings of discomfort. Furthermore, the picture of morality (issues of right and wrong) that emerges from the above analyses is a complex one. Morality appears to be bound up – or diffracts – with issues of identity, power and social relations. In turn, nurse identity diffracts with issues of competency. This suggests that moral conduct is rarely a simple matter.

6.4   DIFFRACTING
This section of the chapter shall 'diffract' the key points of the preceding sections. A number of 'diffractions' emerge:

6.4.1   Feelings of Knowing as Relational
Relational aspects of feelings of knowing were highlighted in both of the preceding sections. For example, Jody's account in Extract 1 drew attention to how her gut feelings, in part, constitute her relationships with patients. It was also noted that, in talking about her gut feelings, Jody was using her feelings of knowing within the interview context. Her feelings co-constituted her relationship with the researcher with whom Jody sensuously inter-responded, anticipating possible accusations of flippancy and managing her interests.

It is also apparent from other examples discussed in this chapter that feelings of knowing are implicated in the ways people relate to the world more generally. For example, Millie (E2 & 3) talked about how her gut feelings helped her make decisions at work – her relationship to particular situations – and Wendy's (E4 & 5) account of feelings of discomfort is also about her relationships with patients, colleagues and the situations she has found herself in. These examples

emphasise how feelings come between the feeling subject and their world (including other people).

6.4.2   Feelings of Knowing as Rational

The deep, ingrained, corporeal character of feelings of knowing was emphasised in the discussion of nurses' gut feelings. Nevertheless, Millie's narrative (E2 & 3) also showed that feelings of knowing (i.e. gut feelings or intuition), rational thought and consideration of objective knowledge co-constitute decision-making processes. This implies that we should not separate thought and feelings too much when theorising them.

6.4.3   Feelings of Knowing as a Component of Shared Belief

The discussion of Wendy's experiences (E4 & 5) noted that feelings of knowing (Wendy's feelings of discomfort) are a component of her embodiment of shared beliefs. It was argued that Wendy's feelings are influenced as much by her socio-culturally derived beliefs as by the unfolding situation she might find herself in.

6.4.4   Morality, Identity, Power, Professional Competency, & Social Relations

It became apparent that morality is complex. It is not merely a matter of knowing or deciding what is right and what is wrong. In nursing, at least, the practicalities of ethical decision-making, on a day-to-day basis, are fraught with subtleties and tensions that diffract with power relations and issues of identity and competency, which complicate matters. Because of the nature of closed-question, forced-response Likert scale questionnaires, these nuances and complexities are likely to be completely missed by quantitative moral distress research (e.g. Corley et al., 2001; Elpern et al., 2005; A.-L. Glasberg et al., 2008; Juthberg et al., 2010; Lützén et al., 2010).

6.4.5   Feelings of Knowing in Moral Conduct

Feelings of knowing are implicated in moral conduct. Such feelings may be associated with the correctness, rightness, or appropriateness – or otherwise – of an action or situation. These feelings are sometimes also associated with the obviousness and/or universality of right and wrong. It was also suggested that some actions or scenarios are lures for feelings of discomfort.

6.4.6   Feelings of Discomfort as the Seeds of Distress

It is suggested that, in the context of nursing in the NHS, feelings of discomfort may be the seeds of moral distress. That is, these feelings of discomfort have the potential to develop, in some circumstances, into moral distress. Feelings of discomfort seem to suggest that action must be taken to address some wrongdoing. If, for whatever reason, action is not (or cannot be) taken these feelings may develop into moral distress.

6.5 SUMMARISING

Nurses' feelings of knowing seem to be central to their decision-making and the care they deliver. Far from being irrational, nurses' gut feelings appear to operate in conjunction with more formal and objective knowledge within decision-making processes. These feelings co-constitute the relations that nurses have with their world – with other people, with situations, and so on. Furthermore, the foregoing analyses also suggest that such feelings are also inherently social, being a component of the embodiment of shared beliefs. It was also suggested that feelings of discomfort, as feelings of knowing or of sense-making, may be the seeds of distress. Building on this idea, the next chapter shall first explore some of the antecedent situations from which moral distress emerges, before turning to consider some of the feelings and emotions that nurses associate with such distress.

7 BECOMING DISTRESSED I:

ANTECEDENT OCCASIONS & FEELINGS OF MORAL DISTRESS

7.1 INTRODUCING

This chapter shall concern some of the conditions that give rise to distress and the feelings that co-constitute distressing experiences. The chapter consists of four parts: The first part, *Occasions Antecedent to Distress* shall consider some of the situations in which nurses may become distressed. The second part, *Feeling Distressed*, shall then explore the feelings spoken of by nurses as being central to experiences of moral distress. The final part of the chapter shall 'diffract' the key analytic points of the earlier sections. Issues of embodiment, identity, social relations, and power and interest shall be highlighted.

7.2 OCCASIONS ANTECEDENT TO DISTRESS

Three inter-related or diffracting concerns, as occasions antecedent to distress, seem to be central to the experiences recounted by the nurses who participated in this study. The first of these revolves around clinical issues. Two specific clinical issues seem to be particularly important in nurses' distress: (i) nurses sometimes experience the treatment they are required to give as negative or unnecessary and may become distressed as a result; (ii) end-of-life care – unsurprisingly, given the magnitude of what is at stake – can be very distressing for nurses. The second issue concerns relationships with colleagues. Nurses reported becoming distressed due to, amongst other things, ethical disputes and disagreements and by what they sometimes felt was a lack of sufficient competency among certain colleagues. The third issue involves nurses' relationships with patients and their families. Nurses spoke of how these relationships could

sometimes be distressing, especially when patient and family member decisions and professional judgements were incongruent. There is a deliberate absence of direct quotes as these issues are described. The analytical points were derived from across participants' interviews and could, therefore, be better demonstrated via the use of creative non-fiction. Thus, this first part closes with two vignettes – based on multiple participant accounts – that illustrate how these matters are often bound up or diffract with one another.

7.2.1   Clinical Issues

7.2.1.1   Negative or Unnecessary Treatment

Unnecessary or negative treatments or interventions were frequently spoken of by the nurses in this study. For example, several nurses talked about becoming distressed when colleagues repeatedly attempted but failed to cannulise a patient. Additionally, some mental health nurses talked about medication being used as a way of managing the behaviour of patients rather than for any positive therapeutic benefits. These nurses said that although it was distressing to be involved in this kind of medication, it was often felt that there was no alternative on already stretched wards. One nurse also spoke about being asked by family members to insert a feeding tube for an elderly patient with acute dementia and who was clearly suffering and close to death. The nurse felt that inserting the feeding tube would lead to extending the life and thus the suffering of the patient, but that because it was the family's wishes that she had little choice in the matter. So she inserted the tube despite becoming distressed. These are just a few examples of how interventions and treatments are experienced as negative or unnecessary by nurses and how, in turn, they become distressed.

7.2.1.2   End-of-Life Care

End-of-life care can be very distressing for nurses purely due to the fact that death is involved. But moral and ethical issues can make that distress more complex. For example, nurses may believe that withdrawing life support is the best course of action for a particular patient, but still become distressed when they are the one required to switch off the machines. One nurse even spoke about a belief in euthanasia, but becoming distressed and struggling with turning off life support for a patient who she agreed had no chance of recovering. This difficultly may stem from the deep seated cultural belief that killing is wrong, for example. On the one hand, the nurse feels that it is in the patient's best interests for life support to be withdrawn; thus minimising their suffering. On the other, they believe that killing is wrong and so do not want to withdraw life support. These kinds of experience highlight how moral issues can be more complicated than a simple matter of knowing right from wrong.

7.2.2   Relationships with Colleagues

The nurses who participated in this study frequently talked about how some relationships with colleagues could be morally distressing. There were two significant relational factors spoken of. First, ethical disagreements or disputes can be distressing. If a nurse felt a particular treatment or intervention was wrong for a specific patient but a colleague – most often a doctor – advocated it, nurses might become distressed. This distress was often coupled to a feeling of powerlessness against a more senior, more powerful colleague. Nurses commonly reported feeling like their voice was ignored by doctors or more senior nurses in decision making processes. The distress experienced by these nurses was exacerbated when decisions seemed opaque to them – when no explanation of the choice of treatment or intervention was given. This underlines the toxic effects of power imbalances (cf. Smail, 2005). However, some of these nurses reported their distress being eased when colleagues took the time to adequately explain their decisions. This suggests that it is import to build working relationships that minimise or mediate the likelihood of distress.

Secondly, nurses recounted becoming distressed by what they felt was inadequate competency on the part of some colleagues. For example, if junior doctors attempted procedures in which they had little experience or if other nurses seemed to be insufficiently attentive or even neglectful. Some nurses also commented on how the long hours worked by junior doctors can be extremely tiring and how this, in turn, can affect the decisions they make. Sometimes the decisions made by these doctors were deemed by the nurses not to be in the best interests of patients. However, some nurses suggested that it takes a strong nurse to stand up to the doctors. This reflects the institutional hierarchy in which doctors (even the most junior ones) are placed higher than nurses. In such a situation, a nurse would need to be very confident to challenge a doctor's decision. It was suggested that ramifications of doing so were not insignificant if the nurse's opposition was not tactful enough or was taken to be a threat to the doctor's authority.

7.2.3   Illustrative Vignettes

The following two vignettes illustrate some of the issues highlighted above. They are based in participant accounts, but combine the experiences of several nurses. As a result the characters and scenarios used in these vignettes are fictional composites.

Vignette 1: The Crying Room

About a year ago, Donna, a paediatric staff nurse, was working a night shift. The shift was going smoothly when an eleven month old baby girl, named Scarlett, was admitted after having a febrile convulsion – a seizure that occurs when a child has a fever. It's a relatively common childhood condition and not serious in most cases. So, although the SHO, a junior doctor, was unable to find the cause of Scarlett's fever he was satisfied that it was nothing serious – she had no other symptoms and all other appearances suggested Scarlett was fine to go home. However, just as Donna was about to discharge her, Scarlett's temperature spiked and her appearance

began to worry Donna. In Donna's opinion Scarlett's peripheral perfusion had dropped, she felt cold and had a mottled complexion. The SHO agreed and decided to cannulise Scarlett to administer intravenous fluids, asking Donna to assist.

The SHO attempted to insert the cannula three times, but couldn't find a vein. Donna could see that Scarlett was becoming distressed from having the cannula repeatedly stuck into her arm. This made Donna feel uncomfortable and so she told the SHO she was not happy for him to continue. Donna suggested that he ask a senior colleague to do the procedure. He agreed and called the paediatric intensive care registrar. The PICU registrar also had several failed attempts at inserting the cannula. Donna said that she was not happy for this repeated failed cannulisation to continue. After a moment the registrar called the PICU consultant to come and cannulise Scarlett. Since there were now three doctors concentrating on Scarlett, Donna decided to check on her other patients.

A little while later Donna came back and popped her head around the door to check on Scarlett, expecting to see her cannulised with a fluid drip. But that wasn't the case. The consultant had obviously had several attempts at inserting the cannula, but had had no success. Donna felt that Scarlett had been used as a pin cushion because the doctors were too task-focused. 'Doctors seem to forget that their patients are people with feelings', she thought. It was her job to advocate for her patients and so said, 'oh, have we still not got the cannula in?' The consultant came out of the room and started shouting at Donna. 'What are you trying to say?' he asked, 'are you questioning my ability? How dare you question me, I'm a consultant?' Donna replied, 'look, I'm the patient advocate. It's my job.' 'But we're a team', the consultant snapped back, 'we should stick together and support each other's decisions'. Donna felt that the consultant was becoming more and more aggressive, rude and confrontational and she wasn't sure how to respond.

By this time Donna was also becoming distressed herself. She felt torn. On the one hand, she felt that Scarlett would benefit from intravenous fluids. On the other hand, Donna felt that continuing to try inserting the cannula, causing Scarlett more pain, was wrong. The consultant said, 'this child needs fluids'. 'Well, if Scarlett needs fluids', Donna responded, 'we're going to have to think of another way to give them to her. Because currently you can't get a cannula in and I'm not happy for you to carry on any more'. 'Well, how else are we supposed to do it?' the consultant asked aggressively. Donna thought for a moment before answering. 'If the child needs fluids that badly, you're going to have to put an interosseous needle in', she said. But both Donna and the consultant knew that Scarlett was not unwell enough for them to resort to that procedure. So, they agreed to monitor Scarlett closely and decide what to do if she deteriorated.

After her confrontation with the consultant, Donna went into the clean utility and closed the door. Once inside she burst into tears and cried for several minutes. It was unprofessional, she felt, to become emotional in front of patients and their families, so she needed to shut herself away in her crying room.

Later, Scarlett's mother thanked Donna for standing up for her daughter. She also told Donna that she had witnessed every failed cannulisation attempt and estimated it to be fourteen or fifteen times. Luckily, Scarlett's condition improved without the intravenous fluids so she was not put through the pain of another cannulisation again.

Vignette 2: The Misuse of Power?

Mick used to work in a medium secure forensic psychiatric hospital, but recently switched jobs to become a community psychiatric nurse. There were two main reasons Mick made the change. First of all, he was unhappy with the way that medication was repeatedly used in a non-therapeutic way. Psychiatric medications were frequently used to manage service users' behaviour, rather than to treat their symptoms. Mick's colleagues rationalised this by saying, 'we need to shut them up for everyone else's sanity'. But Mick felt that this overuse of medication was morally wrong. It made him feel uncomfortable and he often tried to persuade his colleagues that it was wrong, but nobody listened. Mick realised that this use of medication stemmed from the fact that units are often understaffed, that staff resorted to this kind of service user management because they didn't have time for anything better. But he still became more and more distressed as drugs continued to be used as a form of control rather than as a form of treatment or therapy.

Mick also felt that too many of his colleagues regularly overstepped boundaries with service users. He felt that ethical practice includes the maintenance of proper personal and relational boundaries with all service users. For Mick, it was particularly important to maintain these boundaries with those diagnosed with personality disorders. Mick had read the research about the development of PD. This research suggested PD is a result of attachment issues that may have arisen because of inconsistent parenting and not learning appropriate boundaries as a child. However, Mick often saw many of his colleagues hugging service users or greeting them with a kiss on the forehead or cheek. This made Mick uncomfortable. He felt that this was probably confusing for some service users because some of the care team maintained stricter boundaries in the belief that this would help the service users to learn appropriate behaviour.

Mick felt that the inconsistency was morally wrong. He tried to talk to his colleagues, to reason with them and persuade them to his point of view. However, none of the nurses who Mick talked to could see things from his perspective. At first, this annoyed Mick. After a while his annoyance developed into anger, which, in turn, developed into a deep seated frustration. He began to lose sleep over his concern for the service users and his own inability to change things. Before long, Mick became disillusioned with his work, feeling that his understanding of mental health nursing was completely different to everybody else's. He began to feel apathetic towards his job and decided he needed to leave.

7.3   FEELING DISTRESSED

As the previous section shows, there are several antecedents to nurses becoming distressed. At first nurses seem to feel uncomfortable in certain situations (as discussed in Chapter 6). This discomfort becomes more intense the longer the situation continues. This intensification is accompanied by numerous other feelings and emotions. These feelings and emotions are the focus of this section, which is split into two parts. The first focuses on the use of the general term 'emotional', exploring some of the ways this term is used by participants. The second part looks at specific feelings and emotions nurses spoke of as being part of their distress. Particular attention is paid to 'frustration', 'worry', 'dread', and 'upset'.

7.3.1 Emotional Talk

Several nurses spoke generally, using the term 'emotional' – or variants thereof (i.e. emotion(s), emotionally, emotive). In many cases this involved talking about becoming emotional or that the situation was emotional. Use of the term 'emotional' seems to be more about trying either (i) to express a combination of emotions, (ii) to refer to a general negative feeling state (and used interchangeably with 'upset' and 'distress', or (iii) to express feelings that are not easily captured by specific emotion categories. In the first instance, some nurses talked about feeling angry, frustrated, sad, sorrowful, and guilty all at the same time. Here, the term 'emotional' is used as a kind of short hand for these multiple emotions.

In the second instance, it seems as though 'emotional' is used to capture a generally unpleasant experience. In such cases, 'emotional' was used as a synonym for 'upset' or 'distress' (i.e. becoming emotional = becoming upset = becoming distressed; an emotional occasion = an upsetting occasion = a distressing occasion). At times, each of these terms ('emotional', 'upset' and 'distress') seemed to have a similar specific meaning – something like sadness.

Thirdly, elsewhere in the data, use of the term 'emotional' seems to imply a more general unpleasant or negative experience or, in some cases, even a disturbance or affliction. In such instances, it seems that specific emotion categories may not readily capture these experiences. That is, it appears that these nurses experienced emotional or sensible feelings which do not necessarily map directly on to the English emotion lexicon. With this in mind, we must treat the vocabulary of specific emotions tentatively – it is unlikely that words and experiences have a one-to-one relationship; language may not adequately represent life as lived. As a result, the analyses in the next section are somewhat contingent.

7.3.2 Specific Emotions & Feelings

Several specific emotions and feelings were frequently spoken of by participants, which were often associated with distress. In keeping with Chapter 4, emotions are conceptualised as complex phenomena. They are multi-dimensional experiences involving physical, symbolic, relational and felt elements. Furthermore, feelings need not be emotional. Rather, feelings are equally likely to be feelings of knowing (the focus of Chapter 6 of this thesis) or feelings of the lived body (cf. Chapter 9). Some of the feelings and emotions that were more commonly mentioned in interviews will now be explored. The multidimensional view of talk (described in Chapter 5) – as simultaneously referential/informational, constructed/constructive, and enacted/enactive – is key to the analyses presented here.

'Frustration', 'frustrated' and 'frustrating' were all frequently mentioned by a significant number of interviewees. There was a definite sense that these nurses repeatedly feel dissatisfied

or disappointed by certain aspects of their job. Some even spoke as though they feel that, at least at times, their attempts to be a good nurse, to do the 'right thing', and act in their patients' best interests is being thwarted. (This notion, that nurses experience barriers to delivering high quality care, shall be explored in depth in Chapter 8.) There was also a palpable sense, in some interviews, that nurses' frustration is sometimes accompanied by a feeling of helplessness or powerlessness. This is particularly the case when their input into decision-making processes is limited or they are excluded from the process altogether, when they feel they have inadequate material or human resources (e.g. funds, time, and staffing levels) for good quality care, or when they witness colleagues acting inappropriately or incompetently.

In Extract 6, Suzana (a staff nurse in an Acute Medicine Unit) attempts to describe her feeling of frustration:

Extract 6: Suzana

1　　　　It's like imagining that you're seeing, you're watching a situation but you have
2　　　　something blocking you and you cannot reach it. So you want to help that person
3　　　　but something is pulling you back saying "if you don't do this rather than going to
4　　　　help them, you will be in trouble because you didn't do that". So, in a way you end
5　　　　up feeling "I want to go there, but I can't". It's not that I can't. I can choose to ignore
6　　　　that thing that's pulling me back, but then I'm in trouble because of that. So, it's just
7　　　　[laughs] it's difficult to explain it. That's how I can explain it. It's like imagining that
8　　　　you're looking at something that you really want to help, but you're inside a box
9　　　　that says "don't go outside and don't do it".

There is a definite sense of being constrained in Suzana's account. She mentions feeling like she is being 'pulled back' (E6L2 & 5), 'blocked' (E6L1) and "inside a box" (E6L7). These words convey a feeling of being trapped and restrained. Suzana also implies that there are other (organisational) priorities that are more important than her desire to help (E6L2–3); if these demands are not met then she will be 'in trouble' (E6L3 & 5). Suzana gives the impression of feeling ambivalent, of being pulled in different directions. She talks of 'wanting to help' (E6L2 & 7) and 'wanting to go there' (E6L4), but also of a reluctance to act on that instinct – feeling that 'she can't' (E6L4) – in order to avoid getting into trouble.

This seems to speak to the intersection or diffraction of power and interest. As David Smail (2005, p. 34) notes, "while it may be the case that ultimately naked compulsion is what underwrites any form of power, the path to advantage and security is most often smoothed through the exploitation of interest". Rather than power requiring the use of brute force to coerce people to work in its favour, people may comply with power to protect their own interests. This notion of power and interest diffracting with one another, as Smail goes on to suggest, turns "traditional psychology *inside out*, […] rather than seeing individuals as *pushed from within* by various urges

and desires for which, ultimately, they are personally responsible, they are *pulled from without* by the social manipulation of, in the last analysis, inescapable biological features of being human" (2005, p. 35; original emphasis). It is in Suzana's interest to *not* get in trouble with her employer – to avoid punishment and retain her job – and so she is compliant with institutional power and acts against her own conscience. In effect, Suzana's account is about how she is *pulled from without* – how her feelings are lured – in different directions. One lure for feeling or social pull – to act in the interests of the sick – is **frustrated** or **hindered** by another lure for feeling or social pull – to act in accordance with the interests of the institution. Ultimately, the latter wins out because acting in accordance with institutional interests is in Suzana's own best interests because it also means she can keep her job. Rather than being the passive recipient or object of power (as subject *to* power), Suzana actively participates (as subject *of* power) in a network of power relations (Foucault, 1977, 1980; Hook, 2007). This illustrates how emotions cannot be understood outside of the specific social and power relations in which they arise (Burkitt, 1997, 1999, 2014): Suzana's frustration is constituted by, and is partly constitutive of, a specific set of relations.

Another emotion term frequently used by participants (in relation to the moral distress they experience) is 'worry', and its variants 'worried' and 'worrying'. Use of these terms tends to give the general impression of continuous and ongoing rumination accompanied by a feeling of unease. Nurses often mentioned that they are sometimes unable to fully concentrate on anything else due to worrying about certain issues. This not only affects a nurse's work but also impacts on their life away from the job. The latter is illustrated by Abigail's description of her worry in Extract 7:

Extract 7: Abigail

1	Not being able to switch off. Not being able to concentrate. Yeah, there are times
2	when it has made it harder to do things outside of work, such as reading a book or
3	watching a film because you've got worries in the back of your mind, in the
4	background. Yeah, there are times probably when I maybe drink a bit too much
5	alcohol, more than I should have, to kind of block out the worries.

The continuous and ongoing rumination mentioned above is implied by Abigail in line 1: "Not being able to switch off". The insinuation here is that worrying makes it difficult to relax. This is made explicit as Abigail continues; not only does she find it harder to concentrate, she finds simple pastimes, such as reading, more difficult "because you've got worries in the back of your mind, in the background". It is interesting that Abigail switches to second person pronouns ('you' and 'your') here. She could have easily said "because I've got worries in the back of my mind" and retained the meaning of the sentence. Indeed, she is clearly talking about herself at this point so first person pronouns are apt. Abigail's use of the second person seems 'designed' (but not necessarily intentionally so; J. Potter, 1996) to engender a degree of empathy: she is implying "*you know what*

it is like when you've got worries in the back of your head". Any listener who has had similar experiences of worry can identify with Abigail finding it difficult to concentrate whilst watching a film, for example.

In lines 3 and 4 she talks about how she uses alcohol to "block out the worries". Using alcohol as a strategy to cope with work stress and distress is seemingly not uncommon among nurses; a significant minority of nurses spoke about alcohol in this way. This issue shall therefore be discussed in Chapter 9, which explores some of the common coping strategies reported by nurses. It is noted here, however, that Abigail's worries are apparently problematic for her to the extent that she feels the need to 'block them out'. It is not difficult to imagine how the feelings of ill ease and continuous and ongoing rumination associated with worry could become bothersome and that one might desire to break from them, however temporarily. As Chapter 9 shall discuss in more depth, alcohol intoxication entails a complete bodily change – a change in feelings as well as in mentality – that enables such a break.

Other aspects of worry are highlighted by Amy who mentioned 'dreading going back to work' after particularly distressing experiences (one of which is discussed in Chapter 10):

Extract 8: Amy
1   Just the heart racing and the stomach churning and just worrying about what
2   you're going to encounter when you come into work. And not knowing.

'Dread' is a term shared by a significant minority of participants (e.g. Jody in Extract 9, below) and could be considered as extreme worry. This is borne out somewhat by Amy's description of her dread as "the heart racing and the stomach churning and just worrying" (E8L1). To say one is dreading something (e.g. going to work), is to indicate that one is extremely apprehensive about or reluctant to have an anticipated experience. This in turn implies that this experience is anticipated to be an unfavourable one. It is suggested here, therefore, that the bodily sensations Amy talks about are perhaps feelings of knowing associated with the anticipation of adversity or misfortune. This has implications for the theoretical framework outlined in Chapter 4; it highlights how the distinction between sensible feelings, feelings of the lived body, and feelings of sense-making is an analytical distinction. In day-to-day, moment-to-moment lived experience the distinction is more difficult to maintain. Amy's racing heart and churning stomach seem to be both emotional feelings (of dread) and feelings of knowing (of anticipation or expectation).

This interpretation is supported by Amy saying that she worries about what she will be faced with when she goes into work. Amy says she does not know what she will encounter, but worrying about it implies that she has some kind of negative expectation. Amy's anticipation or expectation

of an unpleasant experience is bound up with previous experiences of distress. It is a wholly embodied anticipation of – and a desire to avoid – a new distressing experience. If Amy returns to work and encounters a similar situation to the one that distressed her before, Amy is likely to become distressed, which she most likely would prefer not to go through again. From the accounts of other participants, this is a relatively common experience for nurses. For example, in Extract 9, Jody talks about dreading going back to work because she felt unsupported:

Extract 9: Jody

1	When I was on that dementia ward, I would just come home and feel really upset
2	and then just dread going back there because I didn't feel supported. It didn't feel
3	like I had enough support there. And because it was kind of difficulties from several
4	areas – it wasn't just difficulties with the patients, because then you can get support
5	from the staff – because there was also difficulties with the staff, you couldn't get
6	support from anywhere.

The dread that Jody mentions in Line 2 seems to be associated with a number of inter-related issues: difficulties with patients; difficulties with staff; feeling unsupported. Jody's account here is about a time when she was a student mental health nurse and so difficulties with patients could be due to her relative inexperience and/or lack of knowledge or due to the challenging behaviour exhibited by some service users. Jody's dread and feeling unsupported, then, might be associated with these aspects of the job – her inexperience or demanding service users. However, Jody talks about "difficulties with the staff" (E9L4). This is in reference to a problem of understaffing (an issue discussed at some length in Chapter 8) she had mentioned earlier in the interview. When Jody says "you couldn't get support from anywhere" her phraseology may be less metaphoric than it might at first seem. On a busy ward with too few nurses, the nurses may be too busy to provide support to Jody. It is hardly surprising, then, that Jody felt unsupported. It is easy to see how a relatively inexperienced nurse faced with little support and challenging service users might become distressed. As shall be discussed in Chapter 9, support is vital to a person's ability to cope with distress. A lack of such support may contribute to Jody feeling "really upset" (E9L1) and 'dreading going back there'.

7.4 DIFFRACTING

In sum, the foregoing has explored some of the antecedents of nurses' moral distress and some of the emotions and feelings involved in that distress. Specifically, attention was paid to clinical issues, such as end-of-life care and negative or unnecessary treatments, and unfavourable relationships with colleagues as contexts within which nurses become morally distressed. The term 'emotional' was also discussed. It was noted that there are at least three ways in which nurses used this term: (i) to express a combination of emotions, (ii) to refer a general negative feeling state

(used interchangeably with 'upset' and 'distress', and (iii) to express feelings that are not easily captured by specific emotion categories. This discussion was used to draw attention to the contingent character of the subsequent discussion of specific emotions ('frustration', 'worry', 'dread', and 'upset').

This final section diffracts the key analytic points from above. A number of issues emerge:

7.4.1   Embodiment

The question of embodiment recurs throughout the analyses presented in this chapter. From the physical presence and bodily acts of caring for patients, delivering interventions and treatments, involvement in decisions, and relations with patients, their families and with colleagues to the feelings and emotions of distress, embodiment is fundamental to nurses becoming distressed. It is nurses' embodied engagement with the antecedent occasions that seems to lead to distress. For example, *being* the nurse responsible for switching off the machines after the decision to withdraw care has been made, rather than merely *thinking* that it is the best or right thing to do. The former can be more distressing for nurses than the latter. It is this embodied engagement with the world that means that becoming distressed must also be embodied (e.g. the churning stomach and racing heart of dread; the feeling of restraint in frustration) and that embodied solutions, such as alcohol intoxication, are sought (see discussion of coping strategies in Chapter 9).

7.4.2   Relations

Relations with specific people and with contexts (institutions, situations, antecedent occasions, etc.) are also significant aspects of nurses become distressed. That is, the feelings and emotions that co-constitute distress are particular ways of relating to clinical issues, colleagues, and patients and their family members. In other words, distress is a specific enacting of specific relations. It must be stressed that these ways of relating to the world are not necessarily chosen or deliberate. Rather, they are affective practices (Wetherell, 2012), emotion complexes (Burkitt, 1997, 1999, 2014), dispositions (Bourdieu, 1977), emotional enactments (Hutto, 2012b), subjectifications (Foucault, 1977; Hook, 2007), or subjective forms (Whitehead, 1927-8/1978, 1933/1967), which have their incipience in the actual occasions of a person's past experiences. As such, numerous social, cultural, historical, biographical, and ideological influences shape them. These relations, then, include not only present circumstances, but also antecedent experiences and anticipations of the future (see Chapter 10 for discussion of past and future experiences in relation to present subjectivity).

7.4.3   Power & Interest

As Foucault (e.g. 1977, 1978, 1980, 2000a, 2008) consistently insisted, power is at work everywhere. Power relations were central features of both of the illustrative vignettes that closed the first half of this chapter. Donna's confrontation with the PICU consultant in the first vignette highlights some of the tensions involved in healthcare hierarchies. On the one hand, nurses are explicitly encouraged to act as advocates for their patients and to challenge doctors' decisions that they feel are not right for individual patients. On the other hand, consultants assume a higher position within institutional hierarchies and some react aggressively to any challenge to their authority. This structural contrariety places nurses and (senior) doctors in contraposition to one another and can lead to the kind of confrontation seen in Vignette 1.

The topic of the second vignette concerned Mick's feelings that power is misused/abused in mental health care. Not only do mental health professionals have the power to detain people against their will – a power accorded them under the Mental Health Act – but, as a result of staffing issues, also may misuse/abuse their power to medicate service users for non-therapeutic reasons. Mental health professionals, and nurses in particular, may medicate service users to control their behaviour because they do not have the time to do anything else. In short, this misuse/abuse of medical power may be a product of an under-resourced NHS.

Power and interest were also implicated in the discussion of emotions in the second part of the chapter. For example, an account of frustration was offered that explicitly linked it to the operation of power and interest. Indeed, this rendering of frustration – specifically the way in which Suzana (E6) acts in her own best interests and, more importantly, simultaneously in the interests of her employer – can be seen as an example of *subjectivization* (Hook, 2007): not only is Suzana accorded a subject-position (obedient nurse), she also actively takes on or assumes this position by resisting the lure to help patients to a greater extent than her she is permitted by the subject-position. For Foucault, subjectification and subjectivization are affect-effects of the functioning of modern disciplinary power (Foucault, 1977; Hook, 2007).

7.5   SUMMARISING

This chapter explored some of the occasions antecedent to moral distress and feelings nurses associate with such experiences. Additionally, a distinction was made between generic 'emotion talk' and talk about specific feelings and emotions. The former, it was noted, tended to take one of three forms: to express a combination of emotions; to refer a general negative feeling state (and used interchangeably with 'upset' and 'distress'; or to express feelings that are not easily captured by specific emotion categories. The discussion of specific feelings and emotions covered 'frustration', which was re-thought as one external lure for feeling hindering another lure for

feeling, 'worry' and 'dread', which were re-cast as including both sensible and sense-making feelings. The inclusion of feelings in experiences of moral distress means that it is wholly embodied, which may be one form of bodily engagement with antecedent occasions and with ongoing and unfolding situations. As such, bodily solutions or coping strategies are often sought to deal with the 'problem'. Furthermore, since moral distress appears to be about bodily engagement, it follows that it must also be relational – it is to do with relations with specific people and with contexts. It was suggested, therefore, that moral distress might be thought of as affective practices born out of actual occasions of a person's past experiences. Moreover, because moral distress is relational, it was pointed out, it also concerns power and interest and is implicated in processes of subjectivization.

There appear to be many situations and contexts in which nurses experience distress with some form of ethical or moral element. For example, participants often spoke about situations involving colleagues. Primarily, stories involved negative comments about a colleague: ranging from narratives about disagreements over the best or most appropriate treatment or intervention for a patient – what was the 'right' thing to do – to accounts of witnessing a colleague engage in out and out bad practice. The nurses in this study also frequently spoke of clinical related issues that caused them distress. Respondents' narratives included situations in which they had been involved that required them to give treatment or an invention that they felt was unnecessary or inappropriate, especially during end-of-life care. Some of the other contextual issues often neglected by the moral distress literature shall be explored in the next chapter.

8 BECOMING DISTRESSED II:
EXPERIENCING SYSTEMIC BARRIERS TO CARE

I just think it's interesting that it's not the work itself but very possibly the organisations that are responsible for moral distress. [If] not moral distress, [then] certainly sort of job distress. (Kathryn; Undergraduate Student, BSc Adult Nursing)

8.1 INTRODUCING

Because the existing literature places little emphasis upon them, this chapter shall focus on how nurses experience some aspects of their jobs as systemic barriers to excellent care. These systemic barriers to quality care include a number of inter-related issues: (i) bureaucracy (a reported excess in the amount of paperwork, audits, and so on that nurses are required to undertake); (ii) inadequate staffing levels and (sometimes) high staff turnover; (iii) financial constraints, either at a ward, hospital, Trust, or national level; (iv) lack of time to carry out care to a high standard, usually resulting from large workloads; (v) politics and policies at a local and national level; and, as one nurse reported, (vi) an unhealthy ward culture.

Nurses frequently talked about experiencing daily, low level distress stemming from these systemic barriers. Such barriers are well beyond the control of individual nurses, yet participants reported feeling worried, anxious, or guilty that they were not able to care for patients to the standard which they felt they should. The rest of this chapter shall highlight some of these barriers; specifically, staffing levels, bureaucracy, and politics and policies. It should become clear that what may appear to be quite proximal influences, in fact, often have distal origins. The following sections

shall also discuss a paradox that emerges: nurses seem to experience some aspects of their job as externally imposed barriers preventing them from delivering excellent care; yet, some nurses also feel personally responsible, guilty and/or that they are a bad nurse when they are unable to achieve the standards they believe they should. The final section of this chapter shall then 'diffract' and summarise the points made in the preceding sections.

8.2   NOT ENOUGH NURSES …

Staffing levels (including the rate of staff turnover) and workload are a major concern for nurses, with half the participants mentioning these issues at least once. Relatedly, ten (out of 26) participants also described time constraints as a cause for concern. These three inter-dependent problems – staffing levels, workload, and time constraints – mean that patients sometimes (frequently, even) are not receiving the standard of care that they need and that participants in this study believe they should be giving. The following three quotations are illustrative:

Extract 10: Rachel
> Because you do feel, you know, it's you with twelve patients, you feel there's not enough of you to go.

Extract 11: Rajesh
> We feel sorry for the patients because of the poor staffing sometimes. Because of sickness, absentism, or increased patient admissions, or the severity of the patients admitted.

Extract 12: Bernadette
> Sometimes feel it's so busy that you can't give the patient care that you would like to give.

These three short extracts emphasise that patient care may suffer due to low numbers of nurses. Indeed, Rachel (E10) mentions a patient-nurse ratio of 12:1, which made her feel like there was not enough of her to go round. Elsewhere in the interview Rachel cited this as one of the reasons she had decided to become an intensive care nurse: in the intensive care unit there is one-to-one care. If nurses already feel stretched looking after such numbers of patients, and indicate patient care might not be at its best as a result, it will certainly be exacerbated if a member of the nursing team is absent due to illness or some other reason. Poor staffing, as Rajesh (E11) hints, will inevitably impact patients. High patient numbers, especially if at least some of those patients have particularly acute conditions or severe illnesses, combined with a relatively low number of nursing staff results in an incredibly busy shift for nurses. As Bernadette (E12) describes, this in turn results in lower standards of patient care.

At first sight, this is a very proximal problem: there are not enough nurses on the ward to provide a sufficient level of care to patients. The origins of this problem, however, are much more

distal: decisions made by the United Kingdom government regarding the budget allocated to the National Health Service. If there is not enough money allocated (at a national level) to employ a sufficient number of nurses, then there will inevitably be too few nurses on wards (at a local level). When the present coalition government took office in 2010, the NHS "had received a decade of record investment, allowing it to meet ambitious targets to cut waiting times and improve care, and was achieving record levels of public satisfaction" (Lister, 2013, p. 17); an approval rating of over 90% (Tallis, 2013). Between May 2010 and June 2012 there was a reduction of around 5,780 nursing staff in England (whole time equivalent = 3,700; Buchan & Seccombe, 2012). Moreover, by 2012 patient satisfaction had fallen to 58% (Ramesh, 2012b). It is very unlikely that this reduction in satisfaction is entirely down to fewer nurses, but nursing numbers are likely to have some effect on patient care, and thus on patient satisfaction.

Staffing levels do not only affect patients, however. In the Extract 13, Amelia agrees that staffing issues have a big impact on patient care, but adds that there is also an impact on the nurses themselves. As a Deputy Sister, Amelia seemed to have more of an overview of the issues and was also particularly articulate. While few participants were as unabashed and/or articulate in telling how staffing issues affect them, this excerpt illustrates an experience common to many nurses.

Extract 13: Amelia

1	Staffing issues, and that was the main thing, because that has such a big impact on
2	everything we do; whether it's patient care; whether it's care to staff. You know, we
3	all go on about patient care all the time, which obviously is at the forefront, but what
4	about care to a staff? If I'm running a shift on the ward and I can't give my staff
5	breaks, that's not appropriate. They're then functioning for twelve and a half hours,
6	half the time without a glass of water, without nipping to the toilet, just because we
7	physically can't. And I feel guilty, both for the patients because I'm then making
8	nurses who may not be fit for the job, not having anything to eat for twelve and a
9	half hours, look after them; but I also feel guilty for the nurses that I physically can't
10	get to to relieve for a break and it's a fine line isn't it?

Amelia describes one way in which patient care suffers. It is not just that there are a lot of patients and not many nurses. Added to this is the fact that nurses may not get adequate breaks, which means that those nurses "may not be fit for the job" (E13L7). Even though it is a matter largely beyond her control, as a senior nurse on the ward where she works, Amelia feels guilty both for the nurses and the patients. Amelia feels guilty that she does not get time to relieve other nurses so they can have a meal or toilet break; and she feels guilty that patients may be receiving sub-standard care as a result. Note how Amelia's account is localised within a specific zone of personal relations (D. Middleton & Brown, 2005). Her guilt is not some kind of free-standing, physiologically-based, individual response. Rather, Amelia's guilt and her social relations (with her colleagues and the patients), at least partially, constitute one another. The guilt Amelia feels

cannot be understood separately from the relationships in which it occurs (Burkitt, 1997, 1999, 2014).

Similarly, in the extensive extract that follows, Millie describes how time constraints affect her relationships and how this makes her feel. Millie's account highlights how some nurses feel personal responsibility for situations often beyond their control.

Extract 14: Millie

1	Mill:	There was one of the questions in the questionnaire that said, 'Do you ever avoid
2		people, patients and relatives? But I thought that the questions was really getting
3		at the fact that because it was a hard situation, so you just go away from it, but I
4		ticked 'yes', I have avoided people, but actually it's not because it's a hard situation
5		and I don't want to go there, it's because I haven't got the time. That's very difficult
6		to wrestle with because it should not be like that. Everybody should deserve and
7		have the right to having as much time as they need, but I know that if I go in there
8		they'll ask for something and they'll ask me really in-depth complex questions
9		which will take hours to sort out and needs to take out; but I haven't got hours so
10		yes, I will send someone else to go and give something or go and take the obs, 'cause
11		I know if I go in my uniform it takes a responsibility with it and people will ask me
12		questions and I haven't got the time. That makes me feel awful too 'cause I know
13		that I haven't fully given the care to that family that I should do, but I can't because
14		of time restraints.
15	Mart:	Okay. You say it feels awful, can you actually describe that feeling?
16	Mill:	Sinking feeling inside, feel like I'm a bad nurse, feel like I'm doing injustice to the
17		ward, the uniform and to that patient.

In lines 1–13, Millie tells of her experiences of avoiding patients and their families because she does not have enough time to devote to them and their concerns. Millie states that she finds this difficult "because it should not be like that. Everybody should deserve and have the right to having as much time as they need" (E14L5–7). Working as a nurse on an oncology ward, Millie does not have enough time to answer questions that patients might have. In effect, Millie is saying that, due to time constraints, she is not able to give patients the care they deserve and have a right to. Millie recognises that her nurse's uniform, her identity as a nurse, "takes a responsibility with it" (E14L10). Yet she delegates to someone else (most likely, a health care assistant [HCA]) when it comes to taking a patient's obs. Millie does not have time to spend an hour or so answering a patient's questions, so she abdicates that responsibility.

The nursing profession emphasises personal responsibility. The Nursing and Midwifery Council's code of conduct (NMC, 2008), which was mentioned by several participants, repeatedly informs nurses and midwives of their obligations as individuals. *The Code* lists nurses' and midwives' responsibilities and obligations, divided into four themes. The first stresses that the care of people should be the primary concern of nurses and midwives, that these people should be treated as individuals with dignity, and this dignity should be respected. The second concerns the

protection and promotion of the health and well-being of those in the care of the nurse or midwife, their families and carers, and also the wider community. Thirdly, nurses and midwives should 'provide a high standard of practice and care at all times' (NMC, 2008, p. 1). Finally, *The Code* asserts the importance of being open and honest, acting with integrity, and upholding the reputation of the profession. Before going on to explicate these points, the code makes explicit the fact that nurses and midwives are personally accountable for their actions and omissions in their practice, and must be able to justify their decisions at all times. This is not to imply that nurses would not experience distress if *The Code* did not exist or if it were different. Nurses are likely to experience distress simply because they want to be good nurses and because, by and large, they are decent people. As things stand, however, *The Code* contributes to the complexity of nurses' distress.

The themes of *The* Code (and the 6Cs discussed in Chapter 1) are reflected in/reflect certain public expectations (in the UK) that nurses ought to be caring public servants. Many patients expect nurses not only to be compassionate, professional, and knowledgeable, but also to be attentive to the patient's needs and wants. However, patients might also defer to the authority of nurses as healthcare professionals. So, the professional identity of nurses – as signified by the nurse's uniform – has a whole set of expectations, values, rights and responsibilities attached to it.

There are complex power relations at work here. One aspect of which is that, as healthcare professionals, nurses are endowed with a certain authority, which is signified by the uniform. Nurses, then, are afforded a certain amount of power (e.g. over patients[7] and HCAs) within the healthcare system. However, there is a significant hierarchy in most hospitals in the NHS. For example, at a ward level, consultants and registrars carry the most power. Indeed, many participants in this study spoke about how such senior doctors consider nurses to be inferior. So, in this case, the nurse uniform designates a relative lack of power. Furthermore, the uniform also signifies individual responsibility – another aspect of the complex power relations mentioned above. Rather than the healthcare system being organised to accept institutional liability, accountability is placed on the individual nurse.

One could then see Millie's act of delegation as a form of resistance in this power relation. There is also some compliance here, however. Despite the act of resistance, Millie stills feels personally responsible for the care of her patients. She says that she feels awful "'cause I know that I haven't fully given the care to that family that I should do" (E14L12).Even though Millie acknowledges that the problem arises due to time constraints (E14L13) – something beyond her

---

[7] An extreme example of which is the kind of abuse carried out within the North Staffordshire Foundation Trust that came to public attention just before this study commenced (cf. Chapter 1).

control – she still shoulders the burden of responsibility herself. So, within this specific power relation, Millie simultaneously complies and resists. The time constraints exist because there are not enough nurses on the ward to get everything done and deliver a high standard of care (E14L23-27). Yet, paradoxically, individual nurses are left blaming themselves.

Indeed, Millie is left with a sinking feeling, feeling like she's a bad nurse and doing injustice to her patients, her employer, and her profession (E14L15-16). This complex of feelings is significant because of the metaphorical connection between them. Millie says she has a "sinking feeling inside". In talking about her feeling in this way, Millie is not only describing the physical sensation she has – which is recognisable to others who have had similar feelings – she is also metaphorically, and thus indirectly, signalling that she may have felt unhappy or depressed. Lakoff & Johnson (1980/2003) show how sadness or depression are commonly spoken about using a 'down' metaphor, which has a physical basis in the drooping posture associated with being unhappy. We could add that this 'down' metaphor also has its basis in sinking feelings such as Millie's.

The 'down' metaphor is also significant in relation to the other feelings Millie mentioned. Metaphorically, bad is also 'down' (Lakoff & Johnson, 1980/2003). Perhaps Millie also associates the sinking feeling with becoming a bad nurse – sinking from good to bad. Care is a central value of the nursing profession (cf. Chapter 1). If a nurse is prevented from maintaining this central value, not only might it be upsetting, but that nurse might also perceive themselves as not being able to 'live up to the high standards' of their profession (note the 'up' metaphors) and, therefore, also perceive themselves as bad. Arguably, this is the case for Millie, especially when we consider that she also felt like she was doing her profession an injustice. As Lakoff and Johnson demonstrate, virtue is metaphorically 'up' "because virtuous actions correlate with social well-being" (1980/2003, p. 17). As a virtue, justice is also 'up'. Conversely, then, injustice is 'down'. So, all of the feelings Millie states she felt – sinking inside, being a bad nurse, doing an injustice – are connected by the 'down' metaphor. A metaphor also associated with low status and unpleasantness, which sinking feelings, badness and injustice connote.

According to a recent Unison poll of almost 3000 nurses (as reported in The Nursing Standard; 'Nurses stretched', 2014), 65% reported not having enough time because of understaffing, with 54% suggesting that that care is being left undone, even though many are doing unpaid overtime and working through their breaks. Forty-five per cent of respondents reported caring for eight or more patients on ward settings. This rises to 51% for night shift staff. Perhaps most worrying, though, is that 48% of respondents are concerned that their workplace is at risk of a Mid Staffs-style situation, or that it is already happening in some parts of their organisation.

8.3 ... AND TOO MUCH BUREAUCRACY

Another reason that nurses in this study suggested as a cause of time constraints was the bureaucracy involved in nursing. Several participants made reference to the amount of paperwork and auditing that nurses are required to undertake. Paperwork, audits, and targets are intended to both improve communication between healthcare professionals, support delivery and continuity of patient care, demonstrate clinical judgements and decision making, and identify risk for patients; they also have a function in improving accountability and, in so doing, have a legal purpose in providing evidence of practitioners' involvement or interventions in relation to patients or clients (NHS Scotland, n.d.; NMC, 2009). It should be noted at this point that it is not record-keeping *per se* that nurses reported as burdensome. Patient records and notes seen as directly (and immediately) relevant to care were often spoken of positively. However, participants felt that some paperwork was not of any immediate benefit to patients and took up too much valuable time, which could be better spent on face-to-face contact with patients. The following two extracts are typical of the comments participants made in this regard:

Extract 15: Bernadette
> It's paperwork and targets; it's got in the way of looking after patients.

Extract 16: Abigail
> I find a lot more time is now spent on paperwork and filling in risk assessment things for audit purposes to make the hospital look good, rather than spending time with patients, which is actually what they want because they don't care about the paperwork

Both Bernadette (E15) and Abigail (E16) flatly state that the paperwork and targets detract from patient care. Abigail goes further and suggests that the bureaucracy only exists to make the hospital look good rather than being of any tangible benefit to patients. Abigail suggests that her patients would prefer it if she had more time to spend with them.

When tasks, such as paperwork, become routine aspects of everyday life, feelings towards those tasks often go unnoticed. As might be expected, then, there are no strong feelings overtly spoken about by either Bernadette or Abigail. However, this does not mean they have no feelings about the bureaucracy at all. It is just that these feelings operate more in the background. As Darren Langdridge argues, "[t]he tone of a narrative also provides important insights into the meanings being expressed [...] The tone may reveal information about the stories being told that is not apparent in the content" (2007, p. 137). Here, there seems to be a degree of exasperation and more than a touch of resentment in Abigail's and Bernadette's narrative tones. It is as if they are saying 'this is not what I signed up for'. Indeed, at another point in the interview, Bernadette

told of how she had loved nursing when she first entered the profession almost twenty years ago; but how, in recent times, she had become disillusioned by her job and was just counting down the months until she could retire. Bernadette stated that the way paperwork had reduced how much time she could spend with patients was a major factor in her disillusionment.

As with the problem of too few nurses on hospital wards, nurses experience bureaucracy as a systemic barrier to high standards of care. The point is not whether or not the nurses are correct. Rather, it is that nurses sometimes feel like they cannot do a good job due to experiencing paperwork as a barrier. Extract 17 is illustrative of this:

Extract 17: Amelia
> I go home some days and I just think I've made no difference today. I haven't done
> anything. I feel like I've left more work than I have achieved, just because they bring
> in another form that you've got to tick off and another form you've got to tick off.
> And you think, well I don't feel some days I've done a good job. And that's really sad,
> you know, for my patients; and for the staff as well. It's really sad.

Amelia talks about thinking and feeling like she's made no difference and even of having left more work than she has done. She says that this leads to her feeling like she hasn't done a good job, which in turn leads to sadness for both the patients and staff. What is significant here is that Amelia distances herself from the sadness somewhat. She does not say that she is sad or that feeling like she has not done a good job (because of the amount of paperwork she has to complete) makes her sad. Instead, Amelia says *that's* – this is taken to mean not doing a good job – sad for the patients and the staff alike. This is another example of how emotions are tied to specific social and power relations (Burkitt, 1997, 1999, 2014). Amelia's sadness should not be understood in the abstract, as an instance of a universal emotion. The entirety of the situation, which Amelia describes, defines her sadness. This set of social and power relations – with patients, colleagues, institution, and so on – co-constitute Amelia's sadness and vice versa – Amelia's sadness co-constitutes her relations.

If, following Burkitt (1997, 1999, 2014; cf. Chapter 4, this thesis), we view emotions as complexes then identity can be seen to be another component of Amelia's sadness. Feeling like she has not made a difference, that she has left more work than she has done, and that she has not done a good job are contrary to the values of nursing. All of these feelings, then, are Amelia's lived experience of not meeting the standards and professional values of her profession. This implies that, at times, she may view herself as a bad nurse. Thus these identity issues also co-constitute the sadness that Amelia speaks of: experiencing oneself as being bad is likely to contribute to one experiencing such a negative emotion.

It is important to note that there seems to be an air of resignation in Extracts 15, 16, and 17. Despite Abigail, Bernadette, and Amelia recognising that the bureaucratic aspects of their job are a barrier to the high standard of care they believe they should give, they all seem to be resigned to the fact. If someone experiences something as bad or wrong, one might expect them to resist it. Yet, despite the tone of resentment in these nurses' accounts, there is no sign of resistance.

This section and the preceding one explored two specific aspects of their job that nurses experience as systemic barriers to high quality care: lack of nurses and excessive bureaucracy. This suggests that politics and policies at various levels (from the NHS Trust right up to national government) are sometimes antagonistic to an excellent standard of care for patients. The next section shall explore this idea in a little more depth.

8.4 ANTAGONISTIC POLITICS & POLICIES?

The systemic barriers discussed above stem from policies and politics from national government right down to the hospital (and sometimes even at an individual ward level). So far, the focus has been on two specific barriers – the problem of too few nurses and that of too much bureaucracy. In this section, however, the focus shall be wider.

Christine talks about how government policies are putting more pressure on staff. She immediately qualifies this by stating that the decreases in funding means there will not be enough members of staff to properly cover service provision and that this will result in errors being made due to added time constraints. In this respect, Christine's account is similar to those discussed above. The major difference here is that Christine explicitly links these problems to governmental strategies:

Extract 18: Christine

1	The rolling effect of government strategies and cutbacks is adding a lot more
2	pressure. And the worry is that damage will be done. 'Cause we won't have staffing
3	and errors will be made, because there's a lot of pressure on time. And that you can't
4	offer the kind of quality of care. Even though I tend to still give that quality of care,
5	I just have to catch up later. But that's an added pressure in itself, which can become
6	quite tiring.

The UK's National Health Service was once viewed as the world's most equitable and efficient healthcare system (NHS Confederation, 2014; Davis & Tallis, 2013; Ingleby, McKee, Mladovsky, & Rechel, 2012). Yet, the current coalition government has pressed on with transforming it into "an increasingly dysfunctional, market-based programme" (Midlands Psychology Group, 2014, p. 232). Pollock (2005) suggests that this political strategy seriously threatens the quality of the NHS in a number of ways. For example, a market-based health service

shifts the focus away from serving patient needs and towards cutting costs and creating surpluses (i.e. profits for shareholders). Furthermore, Pollock contends, large portions of the NHS budget are diverted away from frontline services, ring-fenced for independent sector contracts. Christine experiences the consequences as a felt pressure.

A noticeable difference between Christine's account of her experiences and the accounts of the nurses quoted above is that, whereas above, participants talked mainly about emotional feelings and feelings of knowing, Christine speaks of feelings of the lived body: her tiredness. Several other participants also spoke about feeling drained or exhausted after a shift, particularly – and perhaps unsurprisingly – if their ward was understaffed. It seems that nurses are sometimes overworked. It is argued here that the values of nursing have a significant role in this. Caring as a core value of nursing means that practitioners are "committed to the act of caring as central to nursing practice and the relationship with patients" (Burkitt, 2014, p. 201). Because nurses are committed to caring for their patients they are more likely to do all they can for those patients; even when the nurses themselves are stretched to uncomfortable limits by the kinds of systemic barriers to care that are the focus of this chapter. The healthcare system, then, is exploiting the values of nursing so that individual nurses continue to aim for the same standard of care they could achieve if more resources were available. To paraphrase Christine (E18L3–4), the quality of care cannot be achieved, but nurses still strive for it and, in so doing, fall behind in other aspects of their work (which they have to catch up on later). It is not that the bureaucracy replaces other aspects of the nurse's job. All the existing components of the role continue to be fulfilled, but there are now additional requirements that need to be met on top of all the others. In a similar way to that discussed above, we can see that responsibility is put on the individual to accomplish everything.

Christine's repeated use of the pressure metaphor in Extract 18 is significant here. It suggests that she experiences the "rolling effect of government strategies and cutbacks" (E18L1) as an overpowering force to which she must conform. The accumulation of different policy initiatives and budgetary reductions by successive governments get lived out moment-to-moment by nurses as a felt pressure that rarely gets articulated. This goes some way towards accounting for the resignation found in the previous section: the all-pervasive character of political endeavours may make it seem futile to resist. Furthermore, the workload of nurses may result in them simply not having the energy to resist policies they experience as antagonistic to excellent care, even when they feel policies are anathemas that transform healthcare into an industrial-like process such as described by Amelia in Extract 19:

Extract 19: Amelia

1   I used to work in the emergency department, which I think is one of the most target
2   driven places. It has to be because of the sheer number people you get. But
3   sometimes you would have to really not give the best patient care because you had
4   to meet that deadline. And I hate that. I hate that as a nurse you feel like you've
5   failed the patients. And you feel like it's a bit of a cattle market, shall we say, or a
6   production line. And I would hate my relatives coming into the hospital to feel like
7   that. And sometimes that's how they felt because it's literally so short staffed a lot
8   of the time, there's not the money there anymore, that we can't give the care that I
9   would love to give

In Extract 19, Amelia talks about patient care suffering as a result of having to meet government-set targets. Accident and emergency departments across England have a target that no more than five per cent[8] of patients should wait more than four hours (NHS England, n.d.). Failure to meet this target may result in the hospital being fined. However, rather than improving the care patients receive, sometimes the result is that accident and emergency departments can feel like a cattle market or production line for both patients and staff (E19L5). Data for the Trust for which participants worked suggest that this target is not being met – in January 2014, for example, only 91.8% of A & E attendees waited less than 4 hours.

It is significant that Amelia mentions a lack of staff as a result of funding cuts in a similar way to Christine in Extract 18. Once again, it shows that politics and policies are experienced as antagonistic to high standards of care, which has led to Amelia feeling "that we can't give the care that I would love to give". Amelia's account was given at a time when, according to the College of Emergency Medicine, UK accident and emergency departments are "facing a crisis" and have been described as "like working in a war zone" (Ahsan, 2014) because A & E attendances in England have increased from around 14 million in 2002/3 to over 20 million in 2010/1 (Nuffield Trust, 2014).

The participants in this study seem to be suggesting that care is suffering due to antagonistic politics and policies and there is some evidence to support this view. For example, the chief executive of NHS England, Sir David Nicholson recently warned that the NHS faces 'managed decline' unless it is properly funded (Johnston, 2014). This seems to be what these and other nurses are experiencing. As mentioned above, a recent poll found that some nurses are concerned that services are so stretched as to be dangerous ('Nurses stretched', 2014). According to the King's Fund *Quarterly Monitoring Report* for the first quarter of 2014 (Appleby, Thompson, & Jabbal, 2014), the number of people on hospital waiting lists for elective procedures is at a six year high

---

[8] Prior to 2010 the target was 2 %.

(at almost 3 million). There is also evidence that hospital attendances and GP referrals are increasing (NHS England, 2014).

8.5 DIFFRACTING

The above analyses begin to make apparent a number of intersecting, entangled, or diffracting issues involved in the day-to-day life of nurses:

8.5.1 Identity

Amelia (E13) talks about her role and status as a Deputy Sister – a position within the institution that is identified by her job title. However, the issue of identity is clearest in Millie's account (E14) of what it means to wear a nurse's uniform. The uniform is a visible symbol of the nursing profession, marking out any wearer as a nurse. This is true of Amelia's situation, too. What is not apparent in the extract is that her status as Deputy Sister is also signified by her wearing a different uniform to more junior nurses.

The issue of identity is also significant in terms of being a good nurse or a bad nurse; each of which can be seen as a separate identity. Millie sometimes feels like she has the latter identity (i.e. bad nurse) and several other participants said they do too. For example, we saw how this issue was a component of Amelia's sadness in Extract 17.

8.5.2 Responsibility

This issue was first discussed in relation to accountability being signified by the nursing uniform (E14) and how nurses seem to sometimes feel personally responsible for situations beyond their control. As David Smail astutely observes, this presents a challenge to psychological understanding because:

> The conscience, after all, does not lie: it reports (commentates) faithfully enough on how it feels to be the instrument of wrongdoing. But […] the conscience can be *mistaken*. What it is mistaken about is not the *feeling* of responsibility, but the *origins* (or possibly the definition) of the 'wrongdoing'.
>
> It is the *feeling* of responsibility (conscience) that the powerful seek to exploit in others in order to divert attention from the actual (distal) *causes* of their discomfort.
> (2005, p. 77; original emphasis)

In line with this observation, the above analyses pointed out that the nursing profession emphasises individual responsibility with the obligations of nurses and midwives clearly spelt out in the NMC's (2008) code of conduct. It was noted that, with regards to nursing, identity matters diffract with a complex of expectations, values, rights and responsibilities. In some ways this complex remains constant for all nurses, but in other ways it changes with pay grade. For example, all nurses are obligated to adhere to the rules set out in *The Code* (NMC, 2008), but more senior nurses, such as Amelia also feel a responsibility to the nurses in their charge (E13). Added to this is

a tension in which nurses find themselves both obligated to their patients and to the bureaucracy imposed by management and politicians. It is this tension – a component of what has been called 'working the in-betweens': working in-between competing values and interests (Varcoe et al., 2004) – that seems to co-constitute the distress of some nurses.

8.5.3   Morality

Relatedly, and unsurprisingly (given the focus on ethical experiences in the interview), this analysis underscores the moral concerns of nurses. Accounts noticeably focused on notions of right and wrong, what is appropriate or inappropriate. For example, Amelia (E13) suggested that it is not appropriate that nurses are missing breaks because it means that they might not be fit for the job. Extracts 15, 16 and 17 also hint at the wrongness or inappropriateness of some forms of paperwork, which detract from patient care. Connected to this is the matter of being a good or bad nurse. In particular, Millie (E14) and Amelia (E17) expressed feeling like they were bad nurses at times. Millie linked this to a feeling of doing injustice to her profession and her patients. As the analyses above pointed out, even though there appears to be constraints beyond the control of individual nurses they seem to take personal responsibility and blame themselves – they feel that they are bad nurses – when they cannot maintain a high standard of care.

8.5.4   Feelings

Feelings intersect or diffract with all of these issues. Whether it is the feelings of knowing associated with feeling that something is wrong, feeling like one cannot achieve sufficient standards of care (E10 & E12), feeling like a bad nurse (E14 & E17), or the felt pressure imposed by politics and policies (E18); emotional feelings, such as sorrow (E11), guilt (E13) or sadness (E17); or feelings of the lived body, such as tiredness (E18), feelings co-constitute all of the experiences reported by the nurses quoted in this chapter. This suggests that it is pertinent for future research to explore how feelings are co-constitutive of other experiences.

8.6   Summarising

This chapter explored some of the aspects of the job that nurses sometimes experience as barriers to high standards of care. Specific attention was paid to issues around staffing levels, particularly low numbers of nursing staff and the subsequent heavy workload of nurses; high levels of paperwork and auditing, felt not to be of any direct benefit to patients; and the politics and policies, both locally and nationally, experienced as antagonistic to care. Four overarching concerns emerged from the analyses: issues of identity, responsibility, morality, and feelings. In their accounts, nurses reported feeling that the impact of understaffing, bureaucracy, and certain political decisions meant that they had less time to spend with patients. It must be noted here that,

if nurses are spending less time with patients, it is in direct contravention of the Trust's pledge to patients, which states that:

> At [this Trust] we are here for you. We pledge to you that all day, everyday [sic], we will all do our very best to ensure:
> - You are cared for, politely and respectfully by kind and helpful staff, *who have the time* to listen to you and keep you informed at every step. (emphasis added)

If the experiences of the nurses quoted in this chapter are to be believed, staff do not have the time to listen to their patients and to keep them informed. If the Trust wishes to keep its promise to patients, the issues discussed in this chapter need to be addressed.

9 CONSEQUENCES OF

&

COPING WITH DISTRESS

9.1 INTRODUCING

This chapter shall explore some of the consequences of moral distress and some of the strategies nurses have found useful in coping with workplace distress. In the first instance, the focus shall be upon three common consequences: how relationships are sometimes affected by nurses experiences of moral distress; how nurses might become fatigued by distress and the effect this has on their lives; and ways in which nurses' mental health can be affected by moral distress. The notion of frustration developed in Chapter 7 shall be important to this discussion. It shall be suggested that experiencing this kind of frustration can have an impact on nurses' relationships outside work. Other concepts important to the following analyses include Foucault's notions of 'disciplinarity' and 'subjectification', which are implicated in the production of nurse-subjects, which in turn are involved in the emergence of moral distress and, necessarily, the consequences of that distress.

In the second instance, coping strategies such as engaging in sport and exercise or arts and crafts, consuming alcohol and trying to ignore their distress, and gaining support from significant others (e.g. colleagues, friends, and family) shall be discussed. An argument shall be developed that these coping strategies involve changing one's feelings through changing one's environment and/or one's practices. Thus, feelings of distress are replaced (however temporarily) by other feelings through engaging in such coping strategies.

9.2 Some Consequences

This section shall focus on some of the consequences of moral distress. Particular attention shall be paid to the impact of distress on nurses' home life in terms of (i) how relationships may be affected, (ii) effects of fatigue, and (iii) how nurses' mental health may be affected. These issues will be explored in relation to the experiences of four nurses: Phoebe, an Undergraduate Student, paediatrics branch; Abigail, a Staff Nurse in an acute mental health inpatient admission ward; Howard, a Staff Nurse in a forensic mental health unit; and Wendy, a Staff Nurse in a health care of older persons department. The examples used here were chosen as illustrative of the kinds of issues participants reported as resultant from their moral distress.

In Extract 20, Phoebe talks about how she has been affected by distress:

Extract 20: Phoebe

1	Mart:	Okay and what is it like to experience cases where, like you mentioned a child had
2		been severely beaten by her father, what's it like for you to experience?
3	Phoe:	It's horrible. I always- like I've just been, I've started mentoring first years and I
4		always say to them "the first- in nursing I found, the first time you see everything,
5		it's so hard hitting". The first time I del- I, like, realised her case, like, we've had- we
6		had another little boy who came into resus. And we took his shoes off, he had dirty
7		feet. He had poo up his bum. He had poo up his back. And we found that he didn't
8		have, like, toothbrushes and things. It's frustrating because, I'm quite sort of- in my
9		head I just want to go over to them "oh what are you doing to your child?" Like, "sort
10		it out". But obviously, I really struggle sometimes. Like, getting my head around it
11		can really affect me. And it can affect me, like, in my home life. Like, I'll go back to
12		my house and someone's moaning because the washing up's not done and I'm
13		getting frustrated because I'm, like, "I've just seen, like, horrific things and heard
14		horrific things and you're worried about that?" It can be- sometimes you feel quite
15		isolated in society with your views. And it can be, I find personally, it can be quite
16		lonely because a lot of people aren't willing to discuss things like this. And, not that
17		it's a nice topic over dinner, but I'm one of those people, I wanna talk about things
18		like this and look at people's opinions and discuss it and debate it and move forward
19		with, like, "what can you do next?" and how you can support people. I cry a lot. I go
20		home and I have a good- some days I'll get off a shift and you will just walk away
21		just like "what is going on in the world? Why is this happening? How can people do
22		this?" And it does, it really gets you. And, yeah, I cry. I drink a lot of wine sometimes.
23		And just as I said, sort of, when I used to smoke and have that little time to think
24		about it. Because if you don't try and use a coping mechanism to cut something off
25		it's gunna just eat you up, I think. Especially, like, I came into nursing when I was
26		eighteen and it's not exactly an old age to be faced with death, dying, people beating
27		their children. And it is hard. And it is a struggle. And I think if you don't have
28		support then you can- it can go to bad things ((laughs))

Earlier in the interview Phoebe had talked about a young patient's injuries and particularly how they had come about. The child had been admitted after being severely beaten by her father (E20L1–2). Phoebe is asked at the beginning of Extract 20 what it is like for her to experience such things. She describes her experiences as "horrible" (E20L3), "so hard hitting" (E20L3) and "horrific"

(E20L12–13). These words capture the extremely unpleasant, deplorable character of Phoebe's experiences and the impact they have on her. She also mentions becoming frustrated. This frustration seems less to do with the way parents treat their children – Phoebe's response to that is one of horror – and more to do with wanting to confront them over what they have done, wanting to tell them to "sort it out" (E20L8–9), but feeling unable to do so. There are several factors that must be considered here. First, there will be institutional rules against confronting family members in this way. Secondly, as a student nurse Phoebe is relatively inexperienced and so may not have the confidence to speak to parents about these issues. Thirdly, Phoebe may be intimidated by some parents – several participants spoke about being afraid of patients' family members and/or of being assaulted. Taking these issues into consideration, we can see how this interpretation of Phoebe's frustration (as a result of wanting to confront parents, but not feeling able) is in line with the account of frustration developed in Chapter 7. There, it was suggested that frustration is the result of being *pulled from without* (Smail, 2005) in different directions by various *lures for feeling*, where one (or more) significant pull or lure hinders others. According to the argument being developed here, Phoebe is pulled or lured in at least four directions: (i) the socially shared belief or norm that people should not abuse or neglect their children; (ii) the institutional rules that parents should not be confronted; (iii) a relative lack of experience or training in dealing with these issues; and (iv) a need to avoid verbal abuse or physical assault. For Phoebe lure (i) seems to be frustrated by one or more of lures (ii) – (iv). This can be seen as an example of how nurses *work the in-betweens* (Varcoe et al., 2004) – they work *in-between* several competing lures for feeling.

It is significant that Phoebe does not describe her experiences much beyond "horrific" or "frustrating", but instead focuses on how her home life is affected (E20L10). She indicates that she can be frustrated by day-to-day chores (such as washing up) or, more specifically, by her housemates' nagging if the chores are not done (E20L11). The way that Phoebe talks suggests, unsurprisingly given how she describes her experiences, that she sees these chores as trivial in comparison: "I've just seen, like, horrific things and heard horrific things and you're worried about that?" (E20L12–13). In this way, Phoebe is also hinting that her housemates do not understand what she has been through. She goes on to say that as a result of her nursing experiences "sometimes you feel quite isolated in society" (E20L13). Even though Phoebe lives with a number of other people, she still feels separated from them. As a result, this feeling of isolation (even when around others) is accompanied by a feeling of loneliness for Phoebe "because a lot of people aren't willing to discuss things like this" E20L14–15). And so Phoebe cries a lot (E20L18 & 20): in short, Phoebe is distressed by her feelings of isolation and loneliness, which she attributes to not being able to discuss her experiences with other people. So Phoebe searches for other coping strategies.

Phoebe's coping strategies include trying to make sense of her experiences, which is limited to thinking things through on her own – an internal conversation in the absence of conversing with others – having to deal with her problems by herself rather than getting support from her friends and family. This may contribute toward Phoebe's feeling of loneliness. (The importance of social support in coping with distress is discussed below.) Phoebe also talks about drinking "a lot of wine sometimes" (E20L20–21). A coping strategy not uncommon among nurses (also discussed below).

Phoebe's use of the phrase "Because if you don't try and use a coping mechanism to cut something off it's gunna just eat you up" (E20L22–23) is significant. It suggests that one must remove oneself from a distressing experience, or remove that experience from oneself – "to cut something off" – otherwise one will be consumed by the distress – "it's gunna just eat you up". This metaphor indicates that distress may destroy, decompose or expend a person unless they can find a "coping mechanism" to prevent that from happening. So, distress consumes the self unless a 'coping mechanism' is used.

The term 'coping mechanism', derived from the discipline of psychology, is often defined along the lines of cognitive adaptations to environmental stress that are based on conscious or unconscious choice and that enhance control over behaviour or give psychological comfort (e.g. Aldwin, 2007; Carver, Scheier, & Fulford, 2008; Folkman & Lazarus, 1980). Phoebe's language, then, psychologises both the experience of distress (as a consumer of the self) and strategies used to cope with such experiences (as cognitive adaptations). This overtly psychological discourse may be tied to the way that, within the NHS, there is a heavy emphasis upon individual responsibility. More widely, this psy-discourse and concern for individual accountability is bound up with the individualising power-knowledge nexus and technologies of discipline and of self that are definitive of neo-liberalism (Brown & Stenner, 2009; Foucault, 1977, 2000b, 2008; Hook, 2007).

Turning to another emotion frequently spoken of by participants, in Extract 21, Howard explains the effect lack of sleep due to worrying (as discussed in Chapter 7) has on him:

Extract 21: Howard

1   Knackering [laughs] And then- yeah, knackering. Then you've got less patience and
2   stuff when you go into work the next day. Or you sometimes haven't got the energy
3   to do the things you want to do in your own time, I guess.

Howard's repetition of "knackering" in line 1 accentuates the exhaustion he feels from losing sleep through worry. Indeed, feeling 'drained' was a dominant theme of his interview. Howard highlights two important consequences of his fatigue: the impact on his work and the impact on his personal life. For Howard, 'being knackered' means he has less patience at work (E21L1–2). In saying this, Howard indicates that he may be less able to tolerate provocation or annoyance, or is

less able to remain calm, than he otherwise might. This could potentially have a serious impact on the quality of care Howard is able to deliver. Worry and the resultant lack of sleep could, therefore, be considered as another barrier to high quality care.

Equally important, though, is the impact that fatigue has on Howard's personal life. He says that it can sometimes mean that he hasn't got the energy to do the things he wants to do in his spare time (E21L2–3). For some nurses, then, their job can take over their entire lives. These people cannot simply go home and leave their work at work. Nursing issues infiltrate every aspect of some nurses' lives, which is experienced by them as problematic – there is never a time when they are not a nurse, when they can relax and not think about their job. The issues involved in such cases may not be the personal responsibility of the nurse concerned, yet the nurse still feels that they are individually accountable (see also Chapter 8 for discussion of this issue). This can be seen as an example of the disciplinarity and subjectification/subjectivization processes that Foucault (e.g. 1977; 1980, 2000a, 2008; cf. Hook, 2007) asserted as central features of modern personhood: for Foucault, the individual subject does not precede, or 'come before', the network of power relations in which it is enmeshed; rather, the subject is constituted "within the framework of current power relations" (Foucault, 1980, p. 117). The point here is that the healthcare system has inculcated the nurse subject-position upon (at least some of) the people who work as nurses to the point that they feel personally responsible for what goes on within their workplace even when they are not there and, sometimes, find it difficult to not *be* the nurse-subject. This results in the kind of fatigue that Howard spoke about in Extract 21, which he felt prevented him from becoming a non-nurse-subject – to do the things he wants to do in his own time. Abigail talks about similar experiences in Extract 22:

Extract 22: Abigail

1 Fatigue. Sometimes, yeah, anxiety. I would say, during shifts on the ward, I mean,
2 in the last two weeks I've seen at least three nurses in tears for different reasons.
3 So it is affecting people, people's mental health, the staff's mental health as well,
4 definitely. It's just exhaustion sometimes. Sometimes you get hungry because you
5 don't have time to eat, and then you can get headaches. I suppose these physical
6 things, yeah. And then also, I guess it will affect your sleep. I've had my sleep
7 affected because after a very busy shift, you go home worrying about things and you
8 can't sort of relax and get off to sleep. You've got lots of things going round in your
9 head.

Three diffracting analytic priorities concerning Abigail's account in Extract 22 shall be discussed: (i) the importance of "physical things" that Abigail mentions, such as hunger and headaches; (ii) the centrality of fatigue, exhaustion, and affected sleep; and (iii) the notion of distress affecting people's mental health. As discussed in Chapter 8, nurses often do not get

adequate rest breaks and sometimes work long shifts (12 hours or more) without having enough time to eat properly. In Extract 22, Abigail talks about sometimes going "hungry because you don't have time to eat" (E22L4), which can then lead to headaches (E22L4–5). This is an indication that the job can be detrimental to nurses' physical wellbeing, which may result in their not being fully fit to provide high quality care. As also discussed in Chapter 8, this can lead to further moral distress if the nurse recognises that the care they are able to provide is suffering because they are hungry and tired.

In much the same way as Howard in Extract 21, Abigail's emphasis on loss of sleep (E22L5–7), exhaustion (E22L3) and fatigue (E22L1) further highlights how worry can impact on nurses' lives. If a person is continually ruminating on moral dilemmas and mentally replaying previous events, "you can't sort of relax and get off to sleep" (E22L7). It is hardly surprising, then, that reduced sleep results in exhaustion and fatigue. It is important to note that elsewhere in the interview Abigail spoke about being diagnosed with chronic fatigue syndrome. According to the NHS Choices website (NHS, 2013), "Chronic fatigue syndrome (CFS) causes persistent fatigue (exhaustion) that affects everyday life and doesn't go away with sleep or rest". Several causes of CFS are listed on the website, but the most important for the present discussion is "psychiatric problems, such as stress and emotional trauma". Many of the experiences that are the focus of this thesis could be categorised in this way. Indeed, Abigail suggests that "it is affecting people, people's mental health, the staff's mental health as well" (E22L2–3). So, the moral distress and stress regularly experienced by nurses may, in some instances, seriously hinder their physical and mental wellbeing. The latter is certainly the case for Wendy:

Extract 23: Wendy

1   I have worked quite a few shifts, and there's going to be quite a few more, when we
2   work on a 23-bedded ward and there's only two trained staff nurses. So I've had 11
3   patients or 12 patients to look after on my own. That's providing medications and
4   doing all the medical procedures; there's nobody else to help out apart from nursing
5   auxiliaries who can't do the medical things. That puts a massive strain on my times
6   and does play with my conscience. I recently went through a very serious bout of
7   depression; I was off for three months due to these problems at work. It was purely
8   down to problems at work. Just going home feeling inadequate, I'd not done my job.

Wendy's experience of having to look after 11 or 12 patients on her own (E23L2–3) echoes the problem of understaffing discussed in Chapter 8. Wendy feels that this situation "puts a massive strain on my times and does play with my conscience" (E23L5). The phrase "massive strain" connotes a large burden; being drawn tight or taut, especially to the utmost tension; or being stretched to the full. Again, this parallels the discussion in Chapter 8 – in relation to Christine's repeated use of the 'pressure' metaphor in Extract 18, for example. Although this is

significant in itself, the fact Wendy states that it engages her sense of what is right or wrong ("and does play with my conscience") is perhaps more important to the present discussion.

Wendy implies that her time is so stretched that she feels it is wrong; that she does not have enough time to properly care for a dozen patients on her own. Her conscience is troubled to the extent that she goes home "feeling inadequate" and that she had not done her job (E23L7–8), a feeling shared by other nurses (cf. Chapter 8). Wendy's account shows that these feelings can seriously damage a person's mental wellbeing: they contributed to her experiencing "a very serious bout of depression", which meant she was off work for three months (E23L6). This suggests that moral distress can potentially morph into other forms of psychological distress. Feelings of inadequacy are common to the form of distress frequently categorised as depression (APA, 2013; Beck & Alford, 2009; Cassano & Fava, 2002; WHO, 1992). Recall that, as noted in Chapter 8, some nurses frequently feel that they are not meeting the expectations of their profession. There is a risk that these nurses may also become severely (clinically) psychologically distressed.

9.3 COPING STRATEGIES

This section shall focus on some of the coping strategies – the activities that were found useful in dealing with the stress and distress experienced at work – that participants talked about. The four most common strategies – sports and exercise, arts and crafts, alcohol use, and social support – shall be discussed, emphasising two significant aspects of these activities: (i) their embodied character and (ii) their social embeddedness.

9.3.1 Sports & Exercise

One of the common coping strategies that nurses talked about concerned their participation in sports or exercise. In some cases, such as Amelia's story in Extract 25, talk of sport and exercise was about escaping from, or getting away from, stresses and worries and not having to think about work. In other instances, such as Lora's account in Extract 24, these activities were spoken of as an 'outlet':

Extract 24: Lora
1   I can tell the difference from... I started this sport in the summer and before then I
2   was always grumpy and probably not a particularly – not a nice person to be
3   around. Just I think not just as happy and I think work did probably affect me more
4   then. Whereas now I feel like this is really the outlet for me. So I feel like I'm a much
5   happier person and I can deal with work a lot more and I do come into work much,
6   much more energised.

Here, Lora talks about having recently taken up a sport (E24L1), which she finds useful "the outlet for me" (E24L4) because it makes her "a much happier person" (E24L4) and, by implication, less grumpy. Lora also feels more energised and better able to deal with work (E24L4–5). When asked, a little later in the interview, to speak more about the sport, Lora revealed that what she was talking about here was martial arts and that she found it to be a useful outlet for her frustration

and any aggression that she may feel in relation to that frustration. This 'outlet' metaphor implies a corresponding 'container' metaphor: the body is a container of frustration and aggression, which accumulate within Lora, making her "always grumpy" and "not a nice person to be around" (E24L1– 2), and so must be released or 'let out' so that she can become happier. This suggests that frustration and aggression are experienced as being inside one's body even though, as argued above and in Chapter 7, frustration derives from outside the individual. But there is a reason for this apparent paradox: although frustration arises when one pull from without or lure for feeling precludes another pull or lure (i.e. one pull or lure hinders another), all experience is *of* the body and is felt; so frustration, too, is experienced this way. That is, being pulled from without involves one's feelings being lured, and so, when one pull hinders another, frustration is felt *by*, *through* and *with* one's body.

Despite the 'outlet' metaphor, it is the embodied nature of sport and exercise that is important here. It may be that rather than Lora's frustration and aggression 'really' being let out or released, the usefulness of sport and exercise as a strategy of coping with distress and stress lies in the changes in feeling that these activities entail (e.g. frustration and aggression are replaced with/by other feelings). Indeed, this argument can be further supported through an examination of Amelia's experiences of swimming as "a very good coping mechanism" (E25L4):

Extract 25: Amelia

1	I go swimming every day and although that sounds ridiculous, but that helps me
2	relieve stress. I love swimming. When I'm in the water, I don't think of anything else.
3	I don't think of work. I don't think of anything. I sort of just- As soon as I get in the
4	pool, I just let it go. And I think that's become a very good coping mechanism. And I
5	like doing that because it does allow me just to, sort of, for a brief minute, just lift
6	the weight off and just just relax; just smile and be happy and pretend life isn't as
7	horrible as this job makes me think it is. You know, this job has seriously altered my
8	perception on life. Not in a good way. Not in a good way, at all. Which is why I
9	understand so many nurses are leaving the profession. And they are, y'know,
10	because they don't wanna do it anymore. But yeah, so swimming. I swim to relieve
11	stress.

The first thing to note in relation to Extract 25 is that Amelia associates swimming with not having to think: "When I'm in the water, I don't think of anything else. I don't think of work. I don't think of anything" (E25L2–3). As briefly mentioned above, this seems to be about escaping the worries, distress and stress of work (and life in general: E25L6). Much like the martial arts that Lora talks about in Extract 24, swimming is a wholly embodied activity. As such, it is not simply a matter of swimming being a distraction – in the sense of taking cognitive attention away – from these negative thoughts. Rather, swimming (and other sports and exercise activities) as a coping strategy seems to be about becoming completely, bodily immersed in an activity. This bodily immersion in

an activity – to become actively and practically engaged in *doing* something – entails changes in feeling that are consonant with that activity. That is, worry, stress and distress are practices involving particular feelings and becoming immersed in a different practical endeavour involves different particular feelings. At the risk of over simplifying matters, getting away from, or escaping, distress and other negative feelings requires changing ones feelings through changing (a) one's practices and/or (b) one's environment. The problem is that, for nurses to change their feelings completely, this may necessitate leaving the profession all together (E25L8). There is evidence that this is a relatively common response to moral distress (Corley, 2002; Fogel, 2007; Hart, 2005; Pendry, 2007; Wilkinson, 1987/88). Sport and exercise (and the other activities discussed below) seem to provide nurses with a way of changing their feelings through temporary changes in practices and environment, such that they can continue in the profession.

9.3.2   Arts & Crafts

Embodied leisure activities that allow one to (temporarily) change one's feelings are not restricted to sport and exercise. Some nurses in this study reported arts and crafts as activities they find useful in coping with stress and distress. Such activities range from performing arts (e.g. music or drama), through drawing and painting, to crafts like knitting and sewing. This section shall briefly explore these creative activities, focusing on Monica's sewing and cushion-making (Extract 27) and Rachel's participation in amateur dramatics:

Extract 26: Rachel

1	I do a lot of theatre in my in my spare time. And I've got a lot of good friends there
2	and it's a good atmosphere there. And sometimes I'll go to rehearsal straight after
3	work, if it just falls on that day. And I've had really bad days and I've gone there and
4	it's really made me feel a lot better. So that definitely is a stress reliever. It just takes
5	my mind off everything. I don't think about anything other than rehearsing or
6	singing or (things) like that while I'm there. And it's a good laugh, lifts your spirits
7	up. And if you're having a down everyone tries their best to cheer you up. So you
8	ten- the two hours that you have at rehearsal I haven't thought about work once,
9	which is quite nice [laughs].

Rachel appears to find participating in theatre in her spare time useful in at least two ways. First, there is the social aspect: "I've got a lot of good friends there and it's a good atmosphere there" (E26L1–2); "And if you're having a down everyone tries their best to cheer you up" (E26L6–7). Secondly, there is the bodily participation in performing: "I don't think about anything other than rehearsing or singing or (things) like that while I'm there. And it's a good laugh, lifts your spirits up" (E26L4–5). Arguably, both of these aspects of amateur dramatics enable a change in feelings similar to those noted in the *Sport and Exercise* section. Performing arts entail a change in one's practices or activities (and environment) much like in the physical activities discussed above. A change in feelings corresponds to the change in practice – from nursing to performing and from

(di)stressed to happier. Belonging to a theatre group also brings the benefit of social support (which might also be found in other groups, such as sports teams, choirs, friends and family, and so on).

Other creative activities are found to be useful strategies to cope with distress and stress by nurses in this study. For example, Monica sews and makes cushions and other items. She finds this helps her to relax. According to the argument developed above this is another activity that allows one to alter one's feelings through an engagement with that activity at a bodily (not purely mental) level:

Extract 27: Monica
> I like to erm, I do a lot of sewing and (might) make, y'know, cushions and stuff like
> that. It helps me relax.

9.3.3 Alcohol & Trying to Ignore the Problem

So far, the discussion has focused on activities used to alter feelings. But this is not the only way one might bring about such bodily changes. Substance use can also engender these kinds of modifications of feelings. Indeed, nurses in this study also talked about using alcohol as a strategy to cope with the distress and stress they experienced as part of their work. In Extract 28, Amelia jokes about "having a nice vodka" (E28L16) to help her cope with her distress:

Extract 28: Amelia

1	Amel:	I'll just bottle it and take it home and [laughs] dump it there and come back here for
2		another day
3	Mart:	Okay
4	Amel:	mm
5	Mart:	And what is it like for you to actually have to do that?
6	Amel:	uhm
7	Mart:	Or feel that you have to do it?
8	Amel:	[exasperated out breath] I don't- I think it's just part of the job now. It's something
9		that's so normal for me, not having to share my worries or my anxiousness or my
10		guilt with them because I don't want it to affect them. I'm so used to sort of bottling
11		it up and then taking it home. But saying that, you could- I could get home after like
12		a run of five shifts in a row and just burst out crying. And that does happen. Because
13		you come home and you think I've achieved nothing, you know. And because I don't
14		show it at work and because I try and stay focused and as upbeat as I can to support
15		others at work, you do bottle it up. And then it's gotta come out at some point, hasn't
16		it? [Laughs] And so I'll end up probably blubbing in a corner or something, having
17		a nice vodka [laughs]. That works equally as well. Very nice.

It is striking that, although Amelia says that she goes swimming every day to relieve her stress (E25), she still experiences times when her distress becomes intensified and she ends up in tears (E28L11–12) and has to find some other coping strategy, such as drinking vodka (E28L16).

While Amelia enacted her telling of this as a joke (marked by her laughter; for discussion of the complex roles performed by laughter see Billig, 2005) as though it might not be accurate, in the context of the accounts of other participants (for example, Extracts 29 & 30), it may relate to Amelia's actual experiences more than this jokiness might make it seem. For example, embarrassing incidents are often transformed into humorous narrations (Billig, 2001). So Amelia's joking may be more about her embarrassment from admitting that she'll "end up probably blubbing in a corner or something, having a nice vodka" (E28L15–16) than the (un)truthfulness or (in)accuracy of her account

The truth or falsity of whether or not Amelia actually uses alcohol is somewhat irrelevant, though. What is more significant is that Amelia talks about "bottling up" her worries, anxiousness and guilt until it 'spills out' at home: "And then it's gotta come out at some point, hasn't it?" (E28L14–15). At which point – in her narration, at least – she turns to alcohol to help her cope with her distress. Here we have a similar 'container' metaphor to that discussed in relation to Extract 24. Amelia *feels* worried, anxious, and guilty but also feels that, as a more senior nurse (a Deputy Sister), she should not talk to her colleague about her feelings because she doesn't want it "to affect them" (E28L10). That is, Amelia has bodily feelings that she also feels she should not express or enact. So Amelia keeps her feelings to herself and takes them home, where she is freer to express or enact her feelings of distress: "I could get home after like a run of five shifts in a row and just burst out crying" (E28L11–12). Amelia then uses alcohol to change her feelings – alcohol intoxication affects the phenomenal experience of one's whole body.

If the accounts of participants in this study are typical of nurses' experiences, in general, alcohol use seems to be a relatively common coping strategy. (Other research has consistently found alcohol use and substance abuse to be relatively common among nurses; e.g. Dunn, 2005; Plant, Plant, & Foster, 1991; Trinkoff, Eaton, & Anthony, 1991; Trinkoff & Storr, 1998.) In Extract 29, Abigail explains her alcohol use:

Extract 29: Abigail
1   Yeah, it is difficult because it affects your life outside work and it means you can feel
2   constantly drained, even when you're not in work. It's difficult to switch off. I
3   suppose different people, and myself in different ways over the years, will use
4   different strategies to cope with that. I mean, probably over all the years I've done
5   all these things, maybe sometimes I drink a bit too much, sometimes I've just
6   stopped going out at all to try and keep myself in a state where I can cope with the
7   work. I suppose that's two extremes of coping mechanisms.

Abigail begins by talking about how the stress and distress she experiences in her job affects her life outside work (E29L1–2). Notice how Abigail uses second person pronouns here. This seems to be about generalising her experience to other people. It is not a specific other to which Abigail

refs, but a generalised other (Mead, 1934), which also includes herself. That is, Abigail's talk reduces the idiosyncratic character of the experiences she is reporting – anybody would be affected in the same way in such a situation, everybody would "feel constantly drained, even when you're not in work" (E29L1–2).

It is interesting that Abigail talks about trying "different strategies to cope" (E29L3), implying that drinking "a bit too much" (E29L4–5) or not "going out at all" (E29L5) are the coping strategies she has settled on (and perhaps favours) as ones that keep her in state in which she can cope with work (E29L5–6). Lines 4 to 6 are interpreted as having a double meaning: First, Abigail's alcohol use temporarily alters her feelings so that she feels better able to continue working. Secondly, there appears to be some recognition that excessive alcohol consumption could impact on her work, so she avoids going out and thus the temptation to drink. The former is about changing ones feelings through alcohol consumption – to feel better, or at least not as bad. The latter entails avoiding alcohol (and thus not experiencing any change in feelings), and could also potentially lead to isolation if staying in also means staying away from friends. Both of which might exacerbate work stress and distress, especially taking into account Abigail's suggestion that people's mental health is being affected by distress and stress at work (E22L2–3). There is considerable evidence, for example, that social support may buffer the effects of stress and that social isolation can intensify distress (e.g. Cornwell & Waite, 2009; Kawachi & Berkman, 2001).

Extract 30 comes from a point in Millie's interview at which she had been asked how she tends to cope with the distress she experiences at work. Millie begins by saying that she tries avoiding the issue before then talking about "ward nights out" where everyone will "just go and get drunk" (E30L2):

Extract 30: Millie

1	To be honest, it's not to face it. I know it's not a good way, but I was thinking about
2	this the other day. We tend to have ward nights out and what will happen is, we'll
3	just go and get drunk [laughs] and I think that's the way we cope with it. It's not
4	good, it's not healthy, but I think that is the way. Just forget about it, have a bit of a
5	blow out and then move on. We don't talk about our feelings really, as nurses. I don't
6	know what other people feel; I feel that if you can't deal with it you shouldn't be a
7	nurse. I know that's not rational and if anyone else said that I'd be like, 'Oh, that's
8	not true at all'. But I feel, and in my personal life too, that if things affect me they
9	shouldn't, 'cause I need to be strong for other people. I need to be strong for my
10	patients; you cannot cry and that's very old school, where you weren't allowed to
11	cry on the wards. You had to go out and you would actually get told off by your
12	matron if you were seen crying. It's not like that anymore, at all, and if someone
13	does cry at work, you're given a lot of support and you are almost sent home
14	because, obviously, it's a very upsetting career to be in. But I think most people feel
15	that they have to be strong and so they just shut it away.

Despite 'knowing' that 'not facing the problem' is not a good coping strategy, this is Millie's first response to her distress and stress. Millie's next strategy to cope with her distress – to go out with colleagues and get drunk – is also one she feels is neither good nor healthy (E30L3). Yet Millie says "that is the way" (E30L3–4). Much like Amelia and Abigail, Millie seems to use alcohol to change her feelings: to "Just forget about it, have a bit of a blow out and then move on" (E30L4). The "blow out" metaphor bears some resemblance to the container metaphor discussed above and to the 'felt pressure' discussed in Chapter 8 in relation to Extract 18. If there is a *felt* build-up of stress and distress – experienced as contained within one's body and as a feeling of pressure – then a 'blow out' is necessary to release the build-up or pressure. That is, as this chapter has been arguing, something (an embodied activity, such as sport or exercise, arts and crafts, or the ingestion of alcohol [or some other substance]) is required to help alter one's feelings.

It is interesting that Millie says that "We don't talk about our feelings really, as nurses" (E30L4–5). Several of the other nurses in this study said the exact opposite: that talking to colleagues was a great help in coping with work stress and distress (see Extract 32 below, for example) – many nurses feel that they should support one another because they all have similar experiences of stress and distress. This apparent paradox seems, in part, to be to do with Millie's first line of defence as trying to ignore the problem. Especially considering the support she later mentions (E30L11). But there is more to not talking about one's feelings with other nurses. The last line of Extract 30 is also revealing: "I think most people feel that they have to be strong and so they just shut it away". Much like Amelia (E28), Millie does not want her distress or her stress to affect her colleagues so she has to be strong and "just shut it away". Some nurses apparently feel they must bear the burden by themselves, that they must not burden others with their problems. This is somewhat ironic considering many of the burdens that nurses must bear are shared (as other chapters in this thesis make apparent; see Chapter 8, in particular). Perhaps a suitable solution to this problem would be to provide an open forum at the end of each shift in which nurses can share and reflect upon their experiences together. Indeed, the Director of the National Nursing Research Unit, Jill Maben, has suggested this may be one of the most important requirements for maintaining good quality care (Maben, 2014). Such forums would offer (protected) space and time for nurses to provide social support for one another. This may also afford nurses the opportunity to realise that the burden of stress and distress is already a shared burden and that working through the issues together may be a better strategy than keeping one's worries and distress to oneself. Discussion now turns to the importance of social support.

9.3.4   Social Support

Some participants spoke about talking through their problems with others (either colleagues, friends or family members) as a particularly useful way of coping with their distress. This section shall discuss the importance of social support in terms of (i) support affording the opportunity for enacting feelings and (ii) support providing (a) *clarification*, (b) *comfort*, and (c) *encouragement* (Smail, 2005).

In Extract 31, Lora emphasises the support she receives from her boyfriend and that she is able to talk to him about the distress she experiences at work:

Extract 31: Lora

1	Mart:	Has this sort of thing ever affected your life outside of work?
2	Lora:	No, I think, like, my boyfriend's very supportive. He knows that I get upset at things
3		that happen at work and I'm able to talk to him. Obviously without [laughs] saying
4		anything confidential to him. Like I said, he's really supportive. So if I need to talk
5		about something I know I can. And I think I'm the sort of person that, when I talk
6		about – I try not to bottle it up because I think then it would affect my relationships
7		outside of work. Whereas I think if I'm able to talk about things, yes, I get upset and
8		I get a bit teary-eyed and things, but I think it's the best way for me to deal with
9		things so I wouldn't say that if affects my relationships because I have a way, an
10		outlet. I have somebody that I can talk to and that would be sympathetic and listen
11		to me.

In contrast to Amelia (E28) and some of the other participants in this study, Lora explicitly states that "I try not to bottle it up" (E31L5–6). Lora implies that talking about her problems – the distress and stress she experiences at work – with someone who is "sympathetic and [will] listen to me" (E31L10) amounts to sharing the burden. Rather than 'bottling it up' – keeping her distressing feelings to herself – and thus experiencing a 'build up' or pressure (as discussed above), Lora talks to her boyfriend and expresses or enacts her feelings: "I get upset and I get a bit teary-eyed and things" (E31L7). This expression or enacting of feelings is "an outlet" (E31L9) for those feelings. Using a Whiteheadian term, one might say that enacting feelings enables the *satisfaction* of those feelings. In congruence with the proposition above that a change in activity can change one's feelings, it is suggested that the satisfaction of feelings comes about through the practice of enacting them.

Lora returned to the notion of talking as a strategy to cope with her distress later in the interview:

Extract 32: Lora

1	Mart:	How do you deal with stress and distress at work?
2	Lora:	I think talking about it is one thing and I have a lot of my colleagues that I see outside
3		of work and stuff, so sometimes it's just about going and venting about situations

| 4 | and discussing what's happened and how we feel about what's happened and things |
| 5 | like that. |

In a similar way to Extract 31, Lora talks in terms of 'letting out' ("venting"; E32L3) her feelings, distress and stress. Superficially, Lora's account of talking to her boyfriend seemed to be about having his support in terms of him listening to her. However, it is easy to extrapolate from her account of the support she receives from her colleagues that she sees outside of work – as reciprocal, dialectical or dialogical – that his support might also be about discussion. Lora is explicit in saying that talking to her colleagues is about "discussing what's happened and how *we* feel about what's happened". That is, these discussions are as much about the feelings of her colleagues as they are about Lora's own feelings. Perhaps, then, Lora's boyfriend is not merely a passive listener, but also actively talks things through with her.

If a suitable forum is made available to nurses, the kind of dialogue discussed in the previous paragraph could provide them with the opportunity for mutual support, in which they can offer each other *clarification* – the organisation of the past in the present (see Chapter 10) – *comfort*, and *encouragement* (what David Smail calls 'the three planks of therapy'; Smail, 2005). Indeed, this is precisely what some nurses apparently find useful in group clinical supervision. In Extracts 33 and 34 – which are taken from different points in the interview – Jody talks about her experiences of group supervision:

Extract 33: Jody

1	We have group supervision, so we can always talk about these kinds of issues,
2	talk about, "Oh, this happened. What do you guys think of it?" and get
3	somebody else's perspective. I think that's a really important thing to do, and
4	that's why I kind of like to be aware or involved in those kinds of events and
5	those kinds of discussions because it's nice to see how people work through it
6	and how people talk through it.

Extract 34: Jody

1	That's why I like group supervision because you can talk about the bad things, but
2	then you can also say, "Oh, but this was done really well," or, "Oh, well, you do it like
3	that, but in this case we do it like this," and that's really good. So I think it's quite
4	important to have a network so you can kind of, on the one hand, vent about all the
5	shit that happens because I think that's quite important to just let it all out, and on
6	the other hand, to kind of get some positive feedback from it as well.

It is apparent from Jody's statements that, at least in her experience, group supervision is a forum for *clarification* ("talk about, "Oh, this happened. What do you guys think of it?" and get somebody else's perspective" [E33L1–2]; "it's nice to see how people work through it and how people talk through it" [E33L4–5]) and *encouragement* ("to kind of get some positive feedback from it" [E34L5–6]). The positive regard with which Jody speaks of group supervision suggests that

she also finds *comfort* in these sessions: she *likes* to be involved in group supervision (E33L3–4; E34L1); "it's *nice*" (E33L4); "that's really *good*" (E34L3).

Significantly, Jody also indicates that group supervision is a forum for changing one's feelings: "so you can kind of, on the one hand, vent about all the shit that happens because I think that's quite important to just let it all out, and on the other hand, to kind of get some positive feedback from it as well" (E34L4–6). So, Jody uses the 'outlet' metaphor discussed above. Supervision provides her with the opportunity to "vent about all the shit that happens", to rid herself of the feelings of distress and stress from work and replace them with more positive feelings from the "positive feedback" she receives. It is a time and place in which the expression or enacting of (negative) feelings is appropriate (and endorsed) and an opportunity to feel differently, to feel more positive feelings. Arguably, then, group supervision allows nurses to change their feelings through changing both their environment and their practices (at least temporarily) through mutual clarification, encouragement and comfort. Despite these benefits, however, some nurses claimed that group supervision is being eroded by recent budget cutbacks (cf. Chapter 10, Extract 37).

9.4 DIFFRACTING

A number of 'diffractions', which emerge from the above analyses, shall now be briefly explored:

9.4.1 Working the In-Betweens & Frustration

The phrase 'working the in-betweens' has been appropriated from Varcoe and colleagues (2004). This phrase was coined to illustrate how "[e]nacting moral agency [involves] working in a shifting moral context, and working in-between their own values and those of the organizations in which [nurses work], in-between their own values and those of others, and in-between competing values and interests" (Varcoe et al., 2004, p. 317). The account of frustration developed in this thesis (this chapter and Chapter 7) maps onto this notion. If a person finds themselves in-between their own values, other people's values, the values of organisations and institutions, and other competing values and interests, then that person is likely to be *pulled from without* (their feelings are lured) in different directions. In such situations, it is probable that one (or more) of these sets of values will frustrate or hinder the others.

9.4.2 Health

Health emerged as an issue in at least two ways. First, as was seen in Extracts 22 and 23, there can be significant health consequences stemming from moral distress. Secondly, some of the coping strategies adopted by nurses may entail health benefits: sports and exercise have long been

espoused as components of a healthy lifestyle. It is also possible that the adoption of sport or exercise could be doubly beneficial for nurses: sport and exercise can potentially counter the ill health experienced by some nurses, as well as being useful as a strategy to cope with stress and distress. However, when it comes to the efficacy of exercise as a way of overcoming psychological distress (such as the depression experienced by Wendy [E23]), the research evidence is mixed – some studies have found positive outcomes (cf. Ströhle, 2009), whereas a recent randomised controlled trial found no substantial benefits (Chalder et al., 2012); and a recent prospective cohort study suggested that the relationship between activity and depressive symptoms is bidirectional – activity may alleviate depressive symptoms in the general population and, in turn, depressive symptoms in early adulthood may be a barrier to activity (Pinto Pereira, Geoffroy, & Power, 2014). This indicates that distress can actually become a barrier to strategies which might otherwise be useful in coping with that distress.

9.4.3   Work–Non-Work Imbalance

In discussing consequences of moral distress and other work stress (as well as in Chapter 7, for example), it became apparent that some nurses experience an imbalance between work and non-work. For example, some nurses find it difficult to concentrate on simple pastimes such as watching a film or reading (E7, Ch. 7) or may lack the energy to use their spare time as they wish (E21). This goes beyond work–life balance as usually conceived in the literature (e.g. Crompton & Lyonette, 2006; Lewis & Cooper, 1999): a balance between time spent engaged in explicit work activities and time spent engaging in other interests. The analyses of this chapter suggest that work can infringe upon those non-work activities – in the form of worry and so on – even when attempting to balance work with other interests. That is, some nurses' positively prehend their (past) nurse-feelings in (present) non-nurse occasions. Put differently, the nurse-subject-position seems to become so saturated (through subjectivization processes) that it is difficult for some to re-position themselves (Davies & Harré, 1990) as non-nurse-subjects outside of work.

9.4.4   Changing Feelings

During the discussion of coping strategies, an argument was put forward that these strategies entail changing one's feelings through changing one's environment and/or activities. It is suggested that, to some degree, all of the coping strategies discussed above are useful because they enable this kind of change in feelings – they are activities or practices that bring about (lure) certain feelings and ward off (eliminate) others.

9.5   SUMMARISING

To summarise, this chapter first explored some of the consequences of the distress experienced by nurses in relation to the morally-laden decisions and dilemmas they encounter at

work. It then looked at some of the strategies nurses reported as being useful in coping with such distress and other workplace stress. In terms of consequences, the discussion focused on (i) how relationships may be affected, (ii) effects of fatigue, and (iii) how nurses' mental health may be affected. It was argued that the nurse-subject, as personally responsible and accountable, is produced via disciplinarity and subjectification/subjectivization processes. In this regard, moral distress might be considered to be a by-product of a technology of the self; in that, moral distress is produced when nurses feel personally responsible for something beyond their control. It also means that some nurses find it difficult to become non-nurse-subjects even when they are not at work. This potentially tips the balance towards work in the relationship between work and non-work.

In the second part of the chapter attention was turned to activities such as sport and exercise, arts and crafts as useful coping strategies. A discussion of the use of alcohol and the importance of social support then followed. It was argued that bodily immersion in an activity, becoming actively and practically engaged in doing something, entails changes in feeling that are consonant with that activity. As such, sports and exercise, arts and crafts, and alcohol intoxication are useful coping strategies *because* they involve such changes in feelings. It was also suggested that social support is valuable in coping with moral distress because it both affords an opportunity for enacting feelings and nurses can potentially receive clarification, comfort, and encouragement from significant others.

10 BECOMING DISTRESSED III: (RE)ENACTING DISTRESS

10.1 INTRODUCING

A significant minority of participants became markedly distressed as they talked about previous experiences of distress within the interview. This chapter shall explore how past distress may remain a dormant part of a person's subjectivity and re-emerge or become (re)enacted in the narrations of those past distressing experiences (this can be related to what Hardingham [2004] called 'moral residue'). The term (re)enacting is used, firstly, in line with the position taken in Chapter 4 that all emotions and affects are enacted. That is, emotions are seen as affective practices (Wetherell, 2012; cf. Burkitt, 1997, 1999, 2014). Since the enacting of distress emerged in these interviews as individuals spoke of previous experiences of distress, it is suggested that it constitutes a re-enacting of that past distress. Participants were *both* enacting present distress *and* re-enacting past distress. Hence the term (re)enacting. Secondly, the present participle is preferred to the past tense because it implies an ongoing process of (re)enaction within the flow of both subjectivity and social relations.

To explore this (re)enacting of distress, a recent repositioning of discursive psychology, called Affective Textual Analysis (ATA), is used. This approach uses conversation analytic (CA) and discursive psychological (DP) techniques to explore how feelings are enacted in talk (Cromby, Brown, Gross, Locke, & Patterson, 2010). However, ATA adopts a process ontology rather than the linguistic ontology adhered to in CA and DP. In consonance with the position adopted in this thesis (cf. Chapter 4), ATA starts from the assumption that embodied responses are often bound up with spoken interaction and can be analysed using discursive techniques. For example, shifts in pitch, volume and speed, or speaking with a tremulous or croaky voice are discursive traces or markers of affective force and embodied emotionality, interpretable within the action sequences in which they occur. This chapter shall utilise these techniques to explore how participants (re)enact distress

when narrating previous experiences during a research interview. For this to be possible, a different transcription method to that used so far is required. Since CA and DP adopt what is often called the "Jefferson system" – after its developer, the late Gail Jefferson (e.g. Jefferson, 1985) – ATA also uses this system. (A guide to Jefferson transcription notation, as used in this chapter, can be found in Appendix III.)

There is a second purpose to this chapter, however. Thinking with Whitehead (Stengers, 2011) – in particular, concepts drawn from his late philosophy (e.g. Whitehead, 1927-8/1978; see also Chapters 3 & 4 of this thesis) – this chapter shall also consider how present experience (subjectivity) is connected to past experience and anticipates future experiences. That is, it shall be argued that subjectivity entails an organisation of past experiences in the present, for present purposes and in anticipation of the future. The argument shall proceed along these lines as each subsequent section builds upon the previous one.

10.2 IT WASN'T RIGHT FOR HIM

Lora is a paediatric staff nurse. In Extract 35 she talks about an experience involving a patient's personal resuscitation plan (PRP). The PRP had been agreed by the thirteen year old patient's parents. However, when he began deteriorating and the care team began to follow the PRP, his mother changed her mind and asked for additional interventions that were not in the PRP. Lora says she found this morally distressing (E35L1) because "it wasn't right for him" (E35L25). In telling this story Lora became markedly distressed:

Extract 35: Lora

```
 1  Lora:     .hh uhm (0.2) tpt I'd say probably my other experiences of moral distress would be
 2            around children that do have personal resuscitation plans .HHhH ehm one one
 3            patient in particular he:: uhm (0.1) tpt h- ~he's died now~ .Hhh but uhm (0.1) tpt
 4            h- ~his:~  h- he came intuh he had a >sorry< (.) >.SHHhh< Hh erm (0.2) >he had a
 5            ~persnal resuscitation plan< anderm .HHhh he:: had come intuh hospital (.) tpt
 6            ander:m~ (0.1) hi- >his resuscitation plan basicly jst< said do ~oral antibiotics .Hh
 7            anderm (.) his his erm~ tpt he had seizures and things, >he wuz a patient with<
 8            special needs. .Hhh erm ~he had seizures n things like th↑at so~ .HHh <~~it wuz
 9            erm just> oral antib↑i↓otics and erm~~ ~either (.) tpt rectal diazepa:m: or Bicor
10            Midazolam  as  erm seizure treatment~ .Hhh erm  ~~>sorry< I think it ↑just ↓(h)er
11            ↑upset ↓me because ↑I've ↓not thought about him for a while. .Hhh erm~~ .Hhh
12            ~but yeah, um his I don- (.) even though his um resuscitation plan had been agree:d
13            erm by his mum, (.) tpt I think erm I >↑don't think she was qu↑ite ready tuh let him
14            go yet< ↓he wuz erm (.) I ↑think he was ~thir↑teen ↓when he died .Hhh erm~ (0.1)
15            tpt ~~and er:m: basicly he had a <↓neuro-degenerative con↑dition>~~ .SHh hh
16            ~erm so >basic↑ly when he came in tuh hospital:< his mum said that she wanted
17            him tuh have .Shh er intravenous antibiotics~ a:nd basicly any seizure treatment
18            so: .Shh already we were going off what had been agreed <through his>
19            resuscit↑ation plan. .Hhh erm (.) tpt but obviously: parents wishes at that particular
20            time ↓do over↓ride >the resuscitation plan< i- like I said, its not its not similar tuh
```

21	erm the <u>D</u>NR orders in in adults. .Hhh erm .SHh s:o:: (0.1) yeah so w- we were
22	↑go↓ing ↑a↓long with what mum wanted (.) we were doing <u>in</u>travenous antibi<u>ot</u>ics
23	we we <u>esc</u>al<u>at</u>ed when <u>he</u>: wuz having <u>sei</u>zures .SHhh so that we went down th- the
24	in<u>trave</u>nous erm:: er sort of an<u>ti</u> anti-<u>sei</u>zure medicines .Hh as well, .SHh and er:m:
25	(0.2) tpt ~it got to the point that~ (.) <u>he</u>'d been in fer quite a <u>while</u> and we <u>still</u> were
26	<u>escalat</u>ing (.) we were <u>still</u> ~<u>doin the</u> the <u>IV</u> erm <u>anti-seizure</u> <u>me</u>dicines as well
27	whenever <u>he</u> was having <u>pro</u>longed <u>fits</u> .SHh .Hh anderm <u>I</u> I <u>felt</u> like yih know it
28	<u>wasn't</u> right for <u>him</u>

Lora's pauses and emphasised in-breaths can be heard as signs that this experience is difficult for her to talk about. It is as though she is struggling to get the words – the story – out. Lora is clearly still affected by what happened on that day. Her voice becomes wobbly (E35L3) and she begins to cry, for which she apologises (E35L4 & 9). Lora also says that it has upset her and that this may be because she has not thought about this person for a while (E35L9–10). The recollection – the recalled memory – does not come prior to the telling of the story; rather, it *is* the telling (D. Middleton & Brown, 2005). Lora's thinking about this person does not take place in her head and is then communicated by her talk. Her talk constitutes the thought. Although only partially because Lora's talk and her feelings of sadness together co-constitute her memory or thought. Her becoming upset does not simply follow her thought or recollection, as cognitive appraisal theory posits (e.g. Lazarus, 2006; Moors, Ellsworth, Scherer, & Frijda, 2013). Neither do Lora's feelings precede her thoughts as the James-Lange theory suggests (e.g. Shiota & Kalat, 2011, p. 14). Instead, Lora's feelings of upset are part of her thought or recollection. The thought or recollection *is* the combination of words and feelings.

If we trace the process of Lora becoming upset – her (re)enacting the distress she felt at the time of her original experience – it seems to begin right from the start of Line 1: an in breath, "uhm" and relatively lengthy pause are the first signs that what she is saying troubles her in some way. This is soon followed by a prolonged in breath and "ehm" just after she first mentions personal resuscitation plans (E35L2). Lora may associate these plans with distressing experiences in general, but almost certainly with this occasion in particular. As Lora begins to talk about this specific patient her talk becomes more affectively laden. There is an elongated vowel sound on the word 'he' followed by an 'uhm', then a pause, a tut, and a self-repair before Lora's voice becomes tremulous as she says "he's died now" (E35L3). There is then an accentuated in breath, another 'uhm', pause, tut and self-repair, more tremulous voice and another self-repair (E35L3). All of this is hearable as signs of Lora's developing distress and occurs just before she begins to cry – her "sorry" (E35L4) is an apology for her tears and is punctuated with a loud sniff. Lora signals in her talk and in her tears – what McAvoy (2015, p. 30) calls "the semiotics of affect" – that there is disturbance here.

These signs of Lora (re)enacting her previous distress continue for the next few lines (E35L4–7) and at the beginning of Line 8 her voice becomes even shakier as she talks about the medications the patient was prescribed. It could be that these drugs are particularly upsetting for Lora, but it seems more plausible that her intensified distress at this point is more to do with an accumulation or build up from the preceding lines. Lora has been telling the story for a while and her felt thinking reaches this crescendo at this point. As Lora carries on recounting her experience, she continues (re)enacting her distress (albeit at a somewhat lower intensity). From Line 7 onwards there is increased variation in intonation; Lora's voice continues to be tremulous to varying degrees; her breathing remains pronounced; her tears and sniffing continue; and there are multiple pauses, self-repairs and elongations of syllables.

Lora includes details about the patient's condition (E35L14) and the treatment his mother asked for (E35L15–16) in her narrative. She then points out how the request for additional treatment contradicted the PRP (E35L16–17), which she had already explained (E35L8–9). This illustrates how paediatric PRPs are flexible and can be disregarded if the child's parents change their minds. One might imagine that this is an ethical and commendable element of PRPs: Rather than the medical care team deciding what is best and disregarding the views of the patient's family, parents are free to override the PRP and choose alternative treatments. However, this is not how Lora experienced the PRP in this case. The moral character of this experience for Lora only becomes apparent at the end of the extract (E35L25). Perhaps Lora's experience was so distressing for her not just because a child was dying, but because she felt that the treatment chosen by his mother "wasn't right for him". She felt that *this* change in treatment wasn't right for *this* patient.

The way Lora's distress emerges as she tells her story is interesting. In Whiteheadian terms we could say that Lora's thoughts and feelings have, prior to this moment, been held outside her awareness by negative prehensions – they are eliminated from feeling (see Chapters 3 & 4 for discussion of prehensions). Until she begins telling this narrative, which brings her thoughts and feelings back into her awareness – they become positive prehensions and are felt. In speaking *these* words and feeling *these* feelings about *this* experience, Lora's negative prehensions become positive prehensions. But this process is gradual. As mentioned above, Lora's distress seems to build to a crescendo and then recedes. By the end of the interview Lora's distress had faded into the background. Her feelings (positive prehensions) had become negative prehensions once more.

10.3 OUT OF MY DEPTH
Amy was a postgraduate student at the time of her interview. She is American, so had initially trained as nurse in the US and worked there for a year before coming to the UK for further

study. Amy had worked the night shift in a small hospital. Her ward had general medical patients at one end and telemetry patients at the other. Telemetry is used for patients who are at risk of abnormal heart activity. Such patients are outfitted with measuring, recording and transmitting devices, which can alert nurses if the patient is suffering from an acute (or dangerous) condition. Working in this environment meant that Amy was used to working with patients with serious healthcare needs. However, one night when she was on standby Amy received a call asking her to come and work in the intensive care unit (ICU) because they needed extra help there. When Amy arrived, she was allocated one patient who was on a Cardisan drip to lower her blood pressure and manage her irregular heart rhythm. Amy had not had any training or experience in using this drug. Extract 36 begins with Amy talking about the explanation she was given for being allocated this patient.

Extract 36: Amy

```
1   Amy:     they gave er tuh me because they're like well she's a DNR. she has a hospice consult
2            in the morning (.) yih know (.) you can't do any- yih know if she dies th(h)en .hh it's
3            yih know and that kind uhv wuz like. .hHh I don't know what I'm doing with this
4            patient yih know I don't know how tuh manage thes:e (.) heart medications an- #an
5            then they're like# w:ell: yih know it's: it's not too ba:d yih know #we'll show yah
6            how tuh do it and# (1.2) ~>just from the start it was lihke<~ <°ohh gohhd°> ahih
7            heh hh if I can't manage  (.) yih know (2.0) t- tuh have that (.) a patient that (0.4) is
8            beyond (.)~>what you know how tuh care for< (.) .hh and then~ tuh have them like
9            er:: (0.6) ~s::ay: (.) well: >yih know<~ (.) >you can't do anything worse to her<
10           #she's got a hospital consult in the morning# .hh yih know (.) a:nd (0.1) s::o: #it
11           wuz:# (.) s:ee I- w- ~I should have probably said~ (0.2) #more forcefully# ~I
12           shouldn't do~ °thahht° and it was yeah a very stressful situation (.) so (..) yeah I (.)
13           and then~ (.) ↑I ↓probably because when ↑I ↑got ↓there the previous nurse hadn't
14           re↑ally (.) .hh sh- her her heart had continu- her heart rate had been continu↑ously
15           climbing and her ~oxy(h)gen saturation had been continu↑ous↓ly going <down ↓all
16           day.> .HHhh and then ↑I ↓got there (.) and it ↓wuz ↑to the point ↓where~ ↑well I
17           need to ↑↑call ↓the ↑doc(h)tor ↓an- and ~I come in nd I've got a patient who's going
18           down hill (0.1) with::~ (0.2) #↓yih know.# (0.2) ~stuff that I don't know how to
19           do~ .HH HHh #(h)it ↓wuz ↓juhst like.# (0.2) ~I should have called the ↑doc↓tor and
20           I should uhv told the nurses~ ~~when I got there ↑well (.) .HHhH I ↑can't do that
21           patient ei↓ther~~ because they ↑ha- (.) ↓they had patients there who ~we↓ren't on
22           any heart medica↓tions~ and #who were# ~kind uhv ↑like~ (.) .HhH ↓the patients
23           I had up on my floor (0.1) tpt ~because they were waiting to go ↑up ↓the next
24           morning so .hh what I should've done wuz said~ .hhhh (.) ↑I can't take this patient
25           I really should ta:ke (0.4) >pa:tients that I know how to handle< but (0.2) °yih know
26           being° ↑well o↑kay all right #I'll do that# huh huh hih and er: (0.2) >being out of my
27           depth:.< so I guess that's: (.) one s:pecific I can think uhv
```

It appears that Amy's relative lack of nursing experience wasn't considered when allocating a patient to her. It seems that Amy was given a patient who was on medication she had no experience with because the patient didn't really 'matter' to the ICU staff; being so close to death already and having a 'do not resuscitate' (DNR) order and hospice consultation the following

morning (E36L4–5, 8–9). Amy's relative lack of experience might account for her not having the confidence to say no to being allotted a patient she felt she was not capable of adequately caring for (E36L7). Even though accepting this patient led to Amy becoming distressed (E36L11) and feeling "out of her depth" (E36L24).

This occasion seems to have had a significant impact on Amy. First, the event is memorable enough (or she appears to view it as important enough) for her to talk about it some considerable time afterwards when being asked about her experiences of moral distress. Secondly, there are signs that it still affects her as she recounts the experience. This begins to be noticeable at Line 2 of Extract 36, marked by the plosive sound in "then" followed by an in breath after Amy says "if she dies". There is then a more emphasised in breath at Line 3 immediately preceding Amy saying "I don't know what I'm doing with this patient" and "I don't know how to manage these medications". Amy's voice then becomes croaky as she continues her story (E36L4). These are all hearable as signs of Amy's (re)enacted distress.

Amy's distress becomes more marked from Line 5 onward. Her voice is first croaky then, after a relatively long pause, tremulous. The changes in speed, breathiness and volume are also significant indicators of Amy (re)enacting her previous distress: ">~just from the start it was lihke~< <°ohh gohhd°>". As Amy's voice becomes tremulous she also talks faster than before. As Amy gets to the word "like" her voice becomes breathy. This continues into the words "oh god", which are also spoken a lot quieter than surrounding talk. This can all be heard as Amy enacting a sense of rapidly onset despair: Amy has already stated that she didn't know how to care for this patient and she then re-enacts her sense of helplessness in her delivery of this line. It is as though she is saying "what am I going to do if this patient deteriorates?" Amy's sense of being out of her depth is then reinforced as she says "a patient that (0.4) is beyond (.) >~what you know how tuh care for< (.)" (E36L7). Thus, Amy talks about this patient as being outside (beyond the limits) of her capability.

There is an apparent tone of regret in Amy's narrative. At Line 10, she begins to talk about how she could have acted differently. Instead of accepting the patient, Amy suggests that she should have been more forceful and said no. But even now, in saying this all confidence leaves her voice. Amy's voice is tremulous, then there is a relatively lengthy pause before her voice becomes croaky, then tremulous again, before falling to a breathy whisper: "~I should have probably said~ (0.2) #more forcefully# ~I shouldn't do~ °thahht°" (E36L10–11). Thus, while there is an air of regret and recognition of how things might have been different, Amy still seems a little unsure of herself. However, a few lines later Amy's repeated use of and emphasis on the word "should" (E36L17–18) in talking about how things could have gone differently make her retrospective moralising more convincing. Indeed, even though there are still signs of distress in her talk – tremulous or croaky

voice, protracted breaths, pauses, changes in intonation, self-repairs and whisper – throughout the rest of Extract 36, Amy's talk about what she 'should have done' is more forcible than at Lines 10–11 (e.g. the emphasis on "either" in Line 19 and on "should've done" in Line 22).

Amy's narrative is, of course, a re-interpretation of her earlier experience. For example, Ricoeur (1991) suggests that narrative makes sense of an experience that didn't make sense to her at the time and Freeman (2009) argues that the lag between past and present, experience and hindsight, may alter the significance of an experience as a result of intervening experiences transfiguring the earlier one. In a more Whiteheadian vein, however, it is suggested here that Amy's narrative is an organisation of the past, in the present, for present purposes. That is, her earlier experience did have meaning at the time, and subsequent experiences may also have granted it new significance, but her narrative organises those past experiences for the purposes of the research interview and, in particular, to answer the question she had been asked by the interviewer (i.e. have you ever done something that you thought was the wrong thing to do?). As mentioned above, Amy has selected an experience that she deems both relevant and significant to the present occasion. She then tells her story to show how she had done something that she felt was not right – meeting the requirements of the interview and the specific question. However, the present purposes involve more than the demands of the research project. If Amy is not to be taken to be a bad person or a bad nurse she must also manage her interests (J. Potter, 1996) or present herself in a certain way (Goffman, 1959). Admitting that she had done something she thought was wrong might also be to admit she is bad. In talking about what she should have done, however, Amy not only shows she is a reflexive person and a reflective practitioner – the latter being an important aspect of professional nursing (Bulman & Schutz, 2008; Johns & Freshwater, 1998) – she also suggests that she would have preferred to have acted otherwise. Thus presenting herself as a good person/nurse. Thus Amy organises her past for these present purposes.

10.4 IT WAS JUST HORRENDOUS

Christine is a Nurse Practitioner with 20 years nursing experience. At the time of the interview she was working in genitourinary medicine, but had previously worked both in general medical and mental health settings. As the title of this section announces, Extract 37 is a section of her interview in which she talks about an experience that she found horrendous: treating a female patient who had been sexually assaulted. It becomes clear that this incident had a profound effect on Christine:

Extract 37: Christine
```
1 Chris:    tpt ↑er::m tpt .h h. in↑ish↓uhly I found it really difficult and there wuz one ti:me
2           whe:re (.) .h hh. there wuz a young woman who ud been sexually assaulted (0.1)
3           a:nd it wuz jst horrendous (.) .h hh. and I jst felt (.) there must be a better way: of
```

4		dealing with this (.) .h hh. (0.3) and erm hh. (0.4) .Hhh so ↑I deci↓ded that I would
5		go nd get <u>train</u>ed nd I <u>train</u>ed <to <u>do</u> erm> ><u>sex</u>ual assault <u>coun</u>selling< tpt (0.2) but
6		it's sti(h)ll (0.2) yah know (whilst) it was <u>it was very distress</u>ing (0.3) tpt but erm
7		.Hhhh b- so <u>I</u> um (0.2) bcame a <u>vol</u>un<u>teer</u> for rape counselling feh <u>five</u> years (.) and
8		<u>that</u> wuz my <u>way</u> (.) of dealing with it really. .Hhhh but it wuz jst the <u>whole</u> (0.1)
9		sur<u>round</u>ing (0.3) ↓of <u>why that</u> young woman <u>ca</u>me tuh the clinic (0.3) tpt so um
10		.HHhhh (0.2) ↑yeah o- ↑w- we ↓used tuh have ↑super<u>vis</u>ion but (.) <u>that's</u> been <u>pulled</u>
11		<u>now</u> (.) ↑erm (.) we had er (0.1) a ↑psycho↓therapist attached ↓tuh the ↑<u>unit</u>. (.) and
12		<u>that</u> wuz very <u>good</u> (.) nd when ↑<u>I</u> worked at <u>men</u>tal health we <u>had</u> we <u>always</u> had
13		supervision. (0.1) ((Christine pulls tissues from a box on her desk while continuing
14		to talk)) ↑s↑o:: (0.1) so <u>it's</u>: (0.1) ↑those kindah <u>situations</u> <u>really</u>
15	Mart:	okay
16		(0.2)
17	Chris:	that you cn <u>take</u> home sometimes. (.) ↑an ↑I think <u>supervision</u> would be a <u>useful</u> erm
18		(0.1) forum for ↑<u>that</u> (0.1) tpt I ↓<u>do</u> ↓get ↑supervision around .Hhh ↑the H↑<u>IV</u> cli↓ent
19		group <u>because</u> I <u>do</u> (.) er: a lot of <u>psy</u>chological re<u>fer</u>ral tuh fuh <u>psychothe</u>rapy fuh
20		newly diag↑nosed .Hhhh er ↑men who've erm a ne- er an H<u>IV</u> (.) diagnosis or s- men
21		who're <u>strug</u>gling tuh come tuh terms with their diagnosis but .hhh (0.2) ↑er:m (.)
22		yeah <u>sex</u>ual ↓assault and abuse can be quite <u>tough</u> at times. but yih know it's .Hhh
23		it's something that I do. li- I decided that I <u>would</u> .hhh get the tr↑ain↓ing tuh ↑get s-
24		um (0.1) get some kind of idea of how ↑tuh to ↓work with ↑<u>that</u> .hhh um >and
25		↑dur↓ing< the course of: doing the rape counselling training we did we l- we did a
26		lot of ↓work around vic↓arious trauma (.) tpt yih know? about? teking on the trauma
27		of the <u>client</u>. (.) .hh I jst <u>think</u> (.) <u>that</u> young woman h- who led ↓me ↑down that ↑path
28		(.) yih know what she'd been through wuz jst hor<u>rend</u>ous? so (0.2) so yeah that's
29		(0.2) that's that really?

Christine describes her encounter with this patient as "horrendous" (E37L3) and "very distressing" (E37L6), stressing these words as she says them. She was so profoundly affected by this experience that she decided to become a rape counsellor, which involved a considerable commitment in terms of paying for and devoting her spare time to training and then volunteering as a counsellor for five years. And, despite this taking place over five years ago, Christine is still clearly affected by it. During this part of the interview Christine became very upset and began crying – she re-lived or re-enacted her distress. Her tears are the reason for her pulling the tissues from the box at Line 13.

It is interesting that in some ways there are fewer signs of distress in Christine's talk than either of the previous two examples. Whereas Lora's and Amy's voices became tremulous and/or croaky when they were distressed, Christine's voice remains steady even when she is crying. But this is unsurprising when we consider Christine's wealth of experience. She has had a long and varied career from which she has accumulated a lot of training and practice in dealing with difficult incidents. It is almost inevitable, then, that Christine has learned to regulate her voice when talking about sensitive and affectively charged issues. And there are other signs of her (re)enacted distress. Besides the afore-mentioned tears, there is Christine's increasingly protracted breathing

(E37L1–9) and many lengthy pauses that can be heard as indicating this experience is difficult for Christine to talk about.

Returning to thinking with Whitehead, we can see that, much like Amy above, Christine organises her past in the present for present purposes. However, it is also possible to see that in organising the past in the present, Christine also anticipates the future. This organising and anticipating occurs at two levels. The first level at which this organising occurs is within Christine's narrative. Christine became distressed by her encounter with a patient who had been sexually assaulted. She organised this past experience in the present (at the time it happened) deciding to undertake training as a rape counsellor in anticipation that she could offer support to rape victims in the future. Secondly, Christine organises her past experiences in the research interview to tell her story (for the purposes of the research project). At this level her anticipation of the future takes the form of using the interview as an opportunity to suggest that clinical supervision would help her (and other nurses) cope with distress experienced at work (E37L16–17). Clinical supervision is defined as "a process that promotes personal and professional development within a supportive relationship that is formed between equals" (McSherry, 2002, p. 20). Its purpose is to prevent problems in busy, stressful practice settings. Christine hints that clinical supervision has been stopped for some aspects of her job, but that it should be reinstated – she anticipates that a possible outcome of the research project is to recommend the provision of clinical supervision for nurses. This is not to suggest that Christine consciously or deliberately organises her past – in either instance. Rather, the organisation takes place in the flow of her talk. Her talk is the mechanism (in the critical realist sense; e.g. Archer, Bhaskar, Collier, Lawson, & Norrie, 1998) through which the organisation of her past takes place.

10.5 DIFFRACTING

Several significant diffractions emerge from the above analysis. These include the idea that the past is organised in the present in anticipation of the future; an apparent relationship between power and personal liability; and the possibility of change.

10.5.1 The Past is Organised in the Present in Anticipation of the Future

All three nurses quoted in this chapter are connected to their pasts – that is, their pasts remain a part of their subjectivity. An argument was developed – as subsequent analyses built upon previous sections – that the past is organised for present purposes, anticipating the future. Beginning with Lora's narrative in the first section, it was suggested that, while the majority of time past experiences are held outside of awareness (eliminated from feeling) by negative prehensions, the possibility remains for these experiences to re-enter awareness (to become positive prehensions) and be felt once more. In relation to Amy's story, the second section then proposed

that as the negatively prehended past becomes positively prehended once more it is organised for present purposes. Finally, with regards to Christine's account, section three argued that this organisation of the past in the present anticipates the future. This argument was enabled by (and referred to) Whitehead's metaphysics as discussed in Chapter 3.

10.5.2   Power & Liability

All three narratives present the central character (the storyteller) as relatively powerless. This is significant in (at least) two ways. First, it suggests that the initial distress experienced by these nurses – as opposed to their distress in the interview – is co-constituted by the power relations in which it occurred. In some ways, this is similar to the cases explored in Chapter 8 in which nurses felt personally responsible for situations beyond their control. There it was argued, following Smail (2005), that it is this feeling of responsibility that is exploited by the powerful in order to divert attention from the actual causes of distress. On the surface, this seems more applicable to Amy's story than those of Lora and Christine. Amy's distress seems to have resulted from a feeling of being coerced into accepting a patient she did not feel prepared to care for adequately; whereas Lora's and Christine's distress seems to originate more from their compassion or empathy for their respective patient. However, their distress is as much a product of the context in which they find themselves – including distal power relations, which shape that context – as Amy's distress. In Lora's case this context includes working in a system in which (she feels) she is unable to voice her concerns (that the intervention is not right for the patient, for instance). In Christine's case the context includes living in society – perpetuated by the interests of the powerful – in which some people sexually assault others. For example, it has been suggested that sexual assault is part of a cultural configuration that includes interpersonal violence, male dominance, and sexual separation (e.g. Jewkes, Penn-Kekana, & Rose-Junius, 2005; Sanday, 1981; Stermac, Segal, & Gillis, 1990). Nevertheless, individuals may still become distressed because they are not able to prevent such abuse. The second way in which the centrality of powerlessness in these narratives is significant concerns the rhetorical deployment of the notion. By presenting themselves as powerless, Lora and Amy also limit their liability in any wrongdoing. In this way, they are managing their interests (J. Potter, 1996). It is not they who are to blame for the wrongdoing, but more powerful others.

We must be careful, however, not to see the two aspects of power in these narratives – the contextual power relations and the rhetorical deployment of the notion of powerlessness – as oppositional in a simple either/or way. It is not that *either* power relations shape the contexts of nurses' experiences *or* these individuals used the idea of powerlessness as a rhetorical device to limit their own liability in any wrongdoing. Rather, *both* can be and, indeed, are simultaneously credible.

10.5.3   The Possibility of Change

The narratives presented in the extracts of this chapter also point to the possibility of change. In Lora's narrative actual change comes in the form of parents requesting alternative interventions for their son after having previously agreeing a personal resuscitation plan with the medical team. Lora experiences this change negatively. It is the immediate antecedent of her distress. However, Amy's story allows for the possibility of positive change. Amy posits what she 'should have done' – what she might do differently if she found herself in a similar situation in future. This suggests that Amy regrets what she feels was a mistake on her part (i.e. accepting a patient beyond her capabilities; not standing up for herself) and would prefer not to make this mistake again. Thus acting in accordance with what she 'should have done' would be a positive change for Amy.

Christine's narrative also contains positive change – both actual and possible. The actual change comes when Christine is spurred to change herself through encountering a young woman who had been sexually assaulted, undertaking training as a rape counsellor. Christine seems to have experienced this as a positive change. The possible change in Christine's story comes as she hints that clinical supervision – a valuable support forum for nurses – should be reinstated for all aspects of her job. Christine anticipates that she might be better supported in her job, that her future may be better.

10.6 SUMMARISING

This chapter has involved two parallel analytic priorities. First, it explored the (re)enacting of distress in the research interview. Through the use of affective textual analysis, features of participants' speech (such as a tremulous or croaky voice or protracted breathing) were viewed as discursive traces or markers of affective force and embodied emotionality enacted within the action sequences of interviews (i.e. the flow of interaction between interviewer and interviewee). It was argued that, because this enacting of emotionality occurred during the narration of past experiences of distress, in this context it constituted a re-enacting of past emotionality and feelings (i.e. past distress). This might be considered another consequence of moral distress – the distress may remain part of a person's subjectivity, hidden from awareness or eliminated from feeling by negative prehensions, to re-emerge at a later time when triggered or lured by circumstances (in this case, by talking about past experiences in a research interview).

Secondly, and relatedly, this chapter looked at how present experience is connected to past experience and anticipates future experiences. Following Whitehead, it was argued that subjectivity entails an organisation of past experiences in the present, for present purposes and in anticipation of the future. While for the majority of time past experiences are eliminated from

feeling by negative prehensions, the possibility remains that these experiences become positive prehensions and be felt once more. As the negatively prehended past becomes positively prehended once more it is organised for present purposes and in anticipation of the future.

11   Discussing

11.1 Introducing

The nurses who participated in this project shared their experiences of stress and distress at work. Many of these experiences can be considered to have a moral or ethical character, involving, as they do, consideration of doing what is right and avoiding doing wrong, concerns over what it means to be a good nurse, and desires to deliver high quality care. While distress may be relatively infrequent, when it does occur it can be rather intense, adversely affecting the health of nurses and other aspects of their lives, such as relationships with friends and family.

The bulk of the project now exists as past occasions in the becoming of this thesis. In this regard, this chapter shall involve an organising of the past, in the present. This organisation of the past takes two primary forms. First, by diffracting the diffractions of Chapter 6 to 10, a rethinking of moral distress in enabled. Secondly, the past is also organised through considering the limitations of the project and contextual and linguistic factors that may have impacted upon it, and by being self-critical. Additionally, in considering implications for theory and practice, making recommendations for practice and offering potentials for future research, this chapter shall also involve an anticipation of the future.

11.2 Organising the Past I: Diffracting Diffractions

This section shall discuss the diffracting sections of Chapters 6 to 10, diffracting those diffractions. Six motifs emerge from this process: (i) the centrality of feelings in participants' experiences; (ii) the relationality of these experiences; (iii) the complexity of morality, moral conduct, and moral distress; (iv) the prominence of power and interest in these matters; (v) a sense of nurses' lives being afflicted by moral distress and other workplace stress; and (vi) life-as-process. These six dominant thematic patternings recurred throughout the analyses and so deserve further consideration here.

11.2.1 The Centrality of Feelings

Whether it is the feelings of knowing associated with feeling that something is wrong, feeling like one cannot achieve sufficient standards of care, feeling like a bad nurse, or the felt pressure imposed by politics and policies; emotional feelings, such as sorrow, guilt, sadness, worry, or frustration; or feelings of the lived body, such as tiredness; feelings appear to co-constitute all of the experiences that nurses talked about. Feelings, then, seem to be central components of the majority, if not all, moral decisions and experiences of moral distress. A logical extension of this would be to say that all subjectivity is co-constituted by feelings.

Nursing – as with life in general – involves a bodily engagement with the world (cf. Chapter 7). It is because of this that the deep, ingrained, corporeal character of feelings of knowing became so apparent in Chapter 6. The feelings of discomfort – frequently spoken of by nurses – are a specific subset of feelings of knowing, which are key features of moral knowing and moral conduct (see below). Furthermore, these feelings of discomfort may be the seeds of moral distress – discomfort may intensify and combine with numerous other feelings and emotions to become distress (cf. Chapters 6 & 7). This has significant implications both for practice and moral distress research, which shall be discussed below.

Feelings of knowing, it has been argued, are a component of the embodiment of shared beliefs (cf. Chapter 6). As such, they are influenced as much by socio-culturally derived beliefs as by the unfolding situation a person finds themselves in. This is because feeling and thought (including belief, knowing, etc.) thoroughly permeate one another. Furthermore, alongside the deeply corporeal character of feelings of knowing, these feelings can also be rational in the sense that such feelings, rational thought and consideration of objective knowledge combine to co-constitute decision-making processes (cf. Chapter 6); that is, all thinking is 'felt thinking' (Cromby, 2012b) because subjectivity is always co-constituted by feelings. The analyses of Chapters 6 to 10, then, lend empirical support to the theoretical framework discussed in Chapter 4.

11.2.2 The Relationality of Felt Experiences

Numerous social, cultural, historical, biographical, and ideological influences shape feelings, which in turn co-constitute subjectivity. In Whiteheadian terms, there are multiple lures for feeling and these lured feelings are organised in the self-creation of the subject-superject. It is possible that the various lures for feeling be incongruent or incompatible. This suggests that the self-organisation of the subject could inherently involve tension or disequilibrium and, therefore, psychological equilibrium would be rare.

A person may seek out lures for particular feelings (e.g. enjoyment, amusement, etc.) and avoid others (e.g. sadness, boredom, etc.) and/or attempt to reduce the amount of incompatible

lures they encounter by changing their environment and/or practices; in effect, by changing their relations (cg. Chapter 9). Changing practices or environments or moving to another environment will likely involve encountering different lures for feeling (i.e. changing some relations with contexts, people and/or oneself), which inevitably will entail a change in feelings and, thus, a change in subjective form. As seen in Chapter 9, many nurses adopted coping strategies that include these kinds of changing. It was also seen that such changes need not be permanent to be beneficial – even temporary changes might relieve distress and stress to some extent. In relation to nurse moral distress, this has a number of implications for practice, which are discussed below.

11.2.3   The Complexity of Morality, Moral Conduct, & Moral Distress

The analyses of Chapters 6 to 10 underscore the moral concerns of nurses. Feelings of knowing and emotional feelings were seen to be implicated in moral conduct. Such feelings may be associated with the correctness, rightness, or appropriateness – or otherwise – of an action or situation (i.e. moral beliefs). These feelings are sometimes also associated with the obviousness and/or universality of right and wrong (cf. Chapter 6). Similarly, as Paul Stenner (2005a, 2005b) points out, morality not only involves having the right feelings and emotions within a given occasion, but also regulates who has a right to which feelings and emotions within that occasion. In this regard specific occasions are lures for particular feelings and emotions (Whitehead, 1927-8/1978). Vignette 1 in Chapter 7 illustrated how tensions can arise through conflicting lures: Donna's confrontation with the consultant was a lure for her becoming upset, yet her sense of professionalism (a social norm) was a lure for her feeling she had no right to be upset (at least in the public arena of the ward). In this regard, Donna was *pulled from without* (Smail, 2005) by inconsonant lures for feeling.

It appears that, even though there are constraints beyond their control, nurses may take personal responsibility and blame themselves – they feel guilty and/or that they are bad nurses – when they cannot maintain a high standard of care (cf. Chapter 8). This is hardly surprising given the fact that the nursing profession itself emphasises individual responsibility with the obligations of nurses and midwives clearly spelt out in the Nursing and Midwifery Council's (NMC, 2008) code of conduct. Nursing involves a complex of expectations (of the nursing profession, of various layers of the institution [ward, department, hospital, Trust, NHS, government departments], of patients and their families, of the medical profession [i.e. doctors] and other allied health professions, of individual colleagues, etc.), values, rights and responsibilities, which coincide with the nurse identity as symbolised by the uniform. A tension arises as nurses find themselves simultaneously pulled from without (Smail, 2005) in various directions as they are concurrently obligated to the often competing demands of their patients, their colleagues, the organisation in which they work, the general public, and other social institutions. Consequently, the practicalities of ethical decision-

making, on a day-to-day basis, are fraught with subtleties and tensions that diffract with power relations and issues of identity and competency. As suggested above, immanent tensions that occur as a subject self-organises itself while being pulled from without by inconsonant lures for feeling seems to be an inherent feature of subjectivity, yet in some cases these tensions become distressing. Distress might result when at least two lures for feeling are particularly compelling. Moral distress, therefore, might be an inevitable consequence of experiencing such a multifarious ethical environment.

Ethical or moral conduct and experiences of moral distress are, it would seem, never a simple matter. The complexity of moral distress is seldom, if ever, taken into account in the existing moral distress literature. The analyses in earlier chapters imply that moral distress does not simply arise from a nurse being prevented from doing what s/he believes is right as the literature proposes. Rather, moral distress appears to stem from a person being pulled from without by inconsonant lures for feeling. That is, moral distress appears to arise because there is rarely a simple right or wrong since ethical issues and moral conduct are always bound up with other social issues, such as relationships, identity, competency, power and interest.

11.2.4 The Prominence of Power & Interest

From discussion of power relations in Wendy's narrative (cf. Chapter 6), through the power relations presented by the illustrative vignettes (cf. Chapter 7), the notion that the powerful seek to exploit the feeling of responsibility in others (cf. Chapter 8), and the imbalance between work and non-work, which implies a level of exploitation (cf. Chapter 9), to the consideration of powerlessness (cf. Chapter 10), power and interest were key concerns throughout the analyses. As noted by David Smail (2005), the impress of social power works on the individual embodied subject to bring about distress. It is apparent from the analyses presented in earlier chapters that power operates both distally (e.g. economics, politics, culture and ideology) and proximally (e.g. workplaces, interpersonal relations, etc.) to produce these subject-effects. Thus, if being pulled from without by incongruent lures for feeling is the key mechanism that produces moral distress, then power and interest are implicated in its operation. This has important implications not only for our understanding of moral distress, but also for nursing practice and the organisation of NHS hospitals.

11.2.5 Afflicted Lives

It is not difficult to infer from the foregoing analyses that nurses' lives may be afflicted by experiences of moral distress. The feelings – of knowing, of the lived body, and of emotions – that were central to nurses' accounts of their experiences are often far from pleasant and, in many cases, spoken of as impeding life. For example, some nurses find it difficult to concentrate on

simple pastimes such as watching a film or reading (cf. Chapter 7) or may lack the energy to use their spare time as they wish (cf. Chapter 9). There was a definite sense of an imbalance between work and non-work for many nurses.

Some nurses' positively prehend their (past) nurse-feelings in (present) non-nurse occasions. That is, the self-creative process of these nurses' becoming in the present is grounded in the facticity of the concrete inheritance of their pasts (cf. Stenner, 2008). As a result, they continue to become nurse-subjects – as opposed to becoming non-nurse-subjects – outside of work. Besides some nurses not being able to enjoy their time away from work, this can have significant health implications for them: Some nurses suffer ill-health or severe psychological/emotional distress as a consequence of experiencing moral distress. For this reason alone nurse moral distress should be taken seriously by healthcare institutions and steps taken to minimise the risk of such experiences.

11.2.6 Life-as-Process

In accordance with Whitehead's philosophy (e.g. 1927-8/1978, 1933/1967, 1938/1966), as discussed in Chapter 3, we can clearly see that life as it is lived is *life-as-process*. Thus, as Paul Stenner (2008) notes, the personal experience of a human being can be thought of as a temporal society of presiding actual occasions. Within this temporal society, the flow from one actual occasion to the next involves each present actual occasion organising its concrete past (the antecedent occasions) in anticipation of its future (consequent occasions): The subject organises its objective data to produce a superject, which in turn becomes a datum for the next subject (actual occasion). This process was discussed most explicitly in Chapter 10, in terms of the way the pasts of the nurses quoted in that chapter remain a part of their subjectivity. In narrating their experiences, people organise the past in the present, for present purposes and in anticipation of the future. This notion of process was also touched upon in Chapter 7 in terms of affective practices (Wetherell, 2012) having their incipience in the actual occasions of a person's past experiences, and how relations include antecedent experiences and anticipations of the future as well as present circumstances. These ideas, though, remain implicit in all analyses.

How the subject-superject becomes – how the subject-superject self-realises and is constituted – depends upon the history of the specific and situated encounters of antecedent occasions (Stenner, 2008). More, precisely, the subject-superject is constituted by its feelings of that history and

> The feelings are what they are in order that their subject may be what it is. Then transcendently, since the subject is what it is in virtue of its feelings, it is only by means of its feelings that the subject objectively conditions the creativity transcendent beyond itself. (Whitehead, 1927-8/1978, pp. 221-222)

146

That is, the feelings of the subject condition the superject, which becomes an objective datum for the next actual occasion of experience. The subject is conditioned by its feelings of or relations to antecedent and contemporary occasions. Thus, how a nurse (or any person) becomes distressed – morally or otherwise – is relationally grounded (see 11.2.2 above).

To reiterate, all encounters are lures for particular feelings and, as discussed earlier, it is possible that these lures are incongruent. As a result, the subject-superject, which is the creature of the organisation of these lured feelings, may be inherently fractal. When at least two of the divergent lures for feeling are especially potent then the fractal subjective form might be one of distress. If they also have a particularly moral tone the resultant subjective form may be moral distress. As Chapter 3 noted, in objectifying their past, a person may scrutinise themselves through technologies of the self in a perpetual life project, "a working on oneself that defines a certain mode of existence" (Brown & Stenner, 2009, p. 162). If certain modes of existence are proscribed and others promoted (by dominant ideologies, for example), it is in the interests of the subject-superject to continually compare itself to an ideal and work on itself to match such an ideal. Thus the impress of power is omnipresent in life-as-process and, therefore, in becoming distressed.

Lest the reader form the impression that a pessimistic and/or deterministic perspective has been adopted, however, the discussion will now turn to the possibility of change enabled by life-as-process. Recall that self-realisation is also self-creation (cf. Chapter 3) – while this self-creation is grounded in the facticity of a concrete inheritance it involves the novel organisation of that inheritance. Stability is the achievement of particular ways of actualizing potential and of patterning occasions. Therefore, change can arise from breaking those patterns. The possibility of change was particularly evident in Chapters 9 and 10.

An argument was put forward, in Chapter 9, that the coping strategies adopted by nurses entail changing one's feelings through altering one's environment, moving to a different environment, and/or changing one's activities. It was suggested that, to some degree, all of the coping strategies discussed are useful because they enable this kind of change in feelings – they are activities or practices that are lures for particular feelings; that is, they bring about certain feelings and ward off others. Moreover, the narratives presented in Chapter 10 also point to the possibility of change. Christine's story (E37), in particular, contains positive change – both actual and possible.

11.2.7 Rethinking Moral Distress

Towards the end of Chapter 2 five criticisms of moral distress research were highlighted: (1) a lack of conceptual clarity; (2) the notion of "psychological disequilibrium" prevalent in the literature as problematic; (3) moral distress research has been accused of perpetuating hegemonic

meta-narratives about nurses' professional identity; (4) it has been suggested that moral distress stems from "nurses' discomfort with moral subjectivity", rather than an inability to act on moral decisions; (5) moral distress research reproduces a taken-for-granted notion of the bounded, self-contained individual. In light of these criticisms and the analyses and discussions in this thesis, a rethinking of moral distress is required.

In their article 'Moral Distress Reconsidered', McCarthy and Deady (2008) asked, 'Is moral distress a situation? A set of beliefs or attitudes? A range of emotions? A group of symptoms?' This line of questioning implies these possibilities are mutually exclusive. If the preceding analyses and discussions are taken seriously, however, we can see that this is mistaken. It seems that moral distress is not either a situation or a set of beliefs or a range of emotions or group of symptoms. Rather, the foregoing indicates that moral distress includes all of these things (and others: for example, social relations, identity, competency issues, the operation and impress of power) together. For example:

I.   The analyses in earlier chapters highlight that moral distress is constituted by affective practices (Wetherell, 2012) that are inherently feelingful. From its incipience in feelings of discomfort and the felt thinking of morality to the intensification, multiplication and entanglement of feelings in emotion complexes (Burkitt, 1997, 1999, 2014), moral distress includes *felt* experiences. In this way, moral distress does appear to involve a range of emotions as suggested by some of the previous literature (Cameron, 1986, 1997; Corley, 2002; A. L. Glasberg et al., 2007; Kopala & Burkhart, 2005; Pendry, 2007; Sundin-Huard & Fahy, 1999; Wilkinson, 1987/88). But, as earlier chapters indicate, it involves feelings of knowing and feelings of the lived body as well – the latter includes fatigue and bodily tension amongst others. These other types of feeling have received less attention – to varying degrees[9] – than emotions in previous research in this area.

II.   The relationality of felt experience draws attention to the contingent character of moral distress: it cannot be fully understood in isolation from the context(s) in which it emerges. Antecedent situations, institutional factors, and relationships with colleagues, patients and their family members all play a part in the development (or otherwise) of moral distress, each of which is a lure for particular feelings. Indeed, it was suggested above that a key mechanism of distress is being pulled from without by compelling incongruent lures for feeling. Hence moral distress does emerge within particular unfolding situations (Corley, 2002; Jameton, 1984; Kopala & Burkhart, 2005), but it is also contingent upon wider social,

---

[9] Some research has acknowledged some feelings of the lived body, for example.

political, economic and historical contexts (cf. Chapter 8, especially). These wider contexts have arguably been neglected by previous moral distress researchers.

III. The complexity of morality and moral conduct, and, consequently, moral distress highlighted above points to the involvement of moral beliefs in moral distress. Subsequently, this study goes some way towards supporting previous research, which also makes this claim (e.g. A.-L. Glasberg et al., 2008; Hamric & Blackhall, 2007; Hefferman & Heilig, 1999; Meltzer & Huckabay, 2004). However, this previous research seems to be based on the assumption that a person's moral beliefs are purely personal, individual and idiosyncratic. In contrast to this view, Chapters 4 and 6 suggested that feelings of knowing – and hence moral beliefs constituted by them – are often, if not always, derived from socially shared belief systems (e.g. narratives and discourses, which circulate within particular social assemblages) and are, therefore, never wholly idiosyncratic. It was also noted that moral decisions and moral conduct are rarely a simple choice of right versus wrong, but often also involve issues of identity (i.e. wearing the nurse uniform, being a good nurse, being a senior or junior nurse, etc.), social relations and the impress of power. As a result, actual conduct depends on far more than the nurse's (socially constructed) beliefs. This in turn means that moral distress cannot arise solely from a nurse's failure to act on her or his beliefs because they are always pulled from without by other, inconsonant lures for feeling.

In sum, moral distress can be thought of as involving felt experiences, affective practices and emotion complexes, as being contingent upon contexts, as involving nurses' beliefs, as being influenced by issues of identity and concerns over competency, and may result in physical ill health and psychological distress. Furthermore, it has been suggested that distress arises from being pulled from without by strong incongruent lures for feeling and when (some of) those lures are morally-laden that distress can be called 'moral distress'.

Thus, experiences of moral distress cannot be removed from the context in which they occur, nor from the beliefs that individual nurses bring to the situation, nor from the feelings and emotions that emerge in the unfolding situation, nor from the physical symptoms (e.g. headaches, fatigue, etc.), nor from judgements of competency, nor from the nurse identity, nor from concerns for being a good nurse, and so on. It appears that the inexactness of the concept of moral distress could be a consequence of the complexity of such experiences. The existence of competing definitions of moral distress and lack of conceptual clarity highlighted by McCarthy and Deady (2008) might, then, be due to the analytical focus of particular researchers and, perhaps, the manner in which they have wielded Occam's razor in the name of parsimony. Moral distress

researchers are beholden to do justice to the complexity of the experiences that they study. To do so involves taking into account as much of that complexity as possible when describing the concept.

11.3 ORGANISING THE PAST II: CONSIDERING THE PROJECT
This section involves, firstly, considering the limitations of this study and then considering the language used in this thesis. As far as possible – given the limits of reflexivity noted in Chapter 5 – the second part of this section shall also involve self-critical consideration.

11.3.1 Limitations
Several factors might be considered as potential limitations of this research. First, there are characteristics of the sample that may have a specific impact on the issues arising in the interviews. Two characteristics, in particular, are significant here: (i) the vast majority of the participants were working for or training within a single NHS Trust, which means that their experiences may be specific to this context (as opposed to being common to other NHS Trusts); (ii) the participant sample was somewhat self-selecting – individuals chose whether or not to respond to the recruitment email and volunteer to take part. Secondly, some might argue that a focus on interview data amounts to a reduction to language, which limits what can be known about feelings and, therefore, what can be known about moral distress. These issues shall now be considered in turn.

While it is true that the majority of participants came from the same NHS Trust this does not reduce the significance of their experiences for at least two reasons. The first of these is that, even if their experiences are unique to this NHS Trust, these nurses are still becoming distressed in certain situations and for particular reasons. It is, therefore, important that this research is taken seriously, if only by the specific Trust involved. Secondly, there is also reason to believe that the issues and experiences related in the interviews of this project are not specific to this one NHS Trust. That reason is that five of the participants' accounts related to experiences at other NHS Trusts or, in two instances, in other countries. These two points, taken together, suggest that the fact that most participants were affiliated to the same Trust might not be as much of a limitation as, at first, it might seem.

The second characteristic of the sample, however, is potentially more problematic. As self-selecting participants, it is possible that these particular nurses share something that makes them more likely to volunteer to participate in research. Indeed, several participants said that they know from their own experience how difficult it can be to recruit participants for research and this was a factor in them volunteering. In itself, this is not especially problematic, but it could potentially

result in some people volunteering to participate who had not experienced moral distress. This appears to be the case for a very small minority (maybe 3 of the 26 participants). It is also possible, given the fact that the recruitment email was sent to over 5000 nurses and nursing students, that those who responded were the select minority of nurses who had experienced the kind of distress this research is concerned with. On the other hand, however, this could point to a problem with the recruitment method: invitation to participate by email. Nurses are inherently busy people and may not have much time to either check their email or respond to research recruitment and, relatedly, may feel reluctant (due to such restrictions on their time) to volunteer to spend an hour or so of their time being interviewed. Future research focusing on nurses' experience should, therefore, consider other recruitment methods if a more inclusive sample is required.

There are also some limitations imposed by the data generation method. Some scholars have argued that interview research amounts to a disembodied focus on language, which neglects the material world and thus corporeality (e.g. Sandelowski, 2002). Since the research reported herein adopted interviewing as a data generation method it, too, could be accused of such neglect. Even though the interview was considered as an embodied (re)enacting of distress (cf. Chapter 10) and that, as well as being constructive and performative, language is simultaneously referential – it can still refer to (be about) the material world, including corporeality – it remains the case that corporeality was still, to some degree, marginalised. But this was considered to be a necessary compromise.

While there are other data generation techniques that may be more inclusive of the body and embodiment. For example, video ethnography (e.g. Hindmarsh & Pilnick, 2007), arts-based methods (e.g. Boden & Eatough, 2014), or those that utilise measurements of bodily processes (such as galvanic skin response [GSR], blood pressure, or heart rate, for example) alongside linguistic data (e.g. Ellis, 2007; Lyons & Cromby, 2010), these methods tend to be more intrusive; either in terms of the time required of participants or in terms of how much of the participants' life is revealed to the researcher. In the former case, GSR measurements, for example, would have required equipment to be set up and time taken for sensors to acclimatise to participants' skin before the interview could begin. This would have added a considerable amount of time to the session. In the latter case, using video ethnography, for instance, would intrude more on nurses' lives – not only upon the nurses themselves, but also upon colleagues, patients and patients' family members, which would have involved significantly more ethical consideration/approval, which in turn would have slowed down the research process. On balance, then, interviewing was considered appropriate.

Perhaps more importantly, though, is that interviewing relies upon people being able to articulate their experiences and their feelings. There were a number of occasions when participants found this difficult, however. When asked how they felt in a certain situation or what it was like for them to experience, some participants struggled to answer. Such questions were often met with silence and, even after a significant pause, some nurses were unable to fully verbalise their experiences and their feelings, sometimes responding with "I don't know". Stetler (2010) suggests that, in focusing on the situation – by asking questions such as 'can you describe a specific situation or experience?' or 'did you notice anything in particular at that time?' – and bodily experience, thoughts, or feelings – with questions such as 'how did you experience the situation?', 'what did you sense in the situation?', and 'do you have any words, phrases, metaphors, or pictures that could capture your experience?' – it is possible to help interviewees overcome the problem of putting their feelings and experiences into words. These kinds of prompts were used in interviews for this study but, despite this, several participants still had difficulties in articulating some of their feelings. This may stem from the way some feelings are fleeting, subtle and vague and are not symbolised or 'put into words' at the time they are experienced; that is, we do not always know how we feel. As a result, when a person is asked about such feelings at a later time – in a research interview, for example – they are unable to verbalise them. Additionally, as discussed in Chapter 7, some experiences involve many different feelings and emotions that, due to their complexity, can be difficult to differentiate or articulate beyond using a 'catch-all' term like 'emotional'. These issues point to a general limitation in using interview-based research to explore feelings and emotions, which scholars need to be aware of when designing studies.

11.3.2 Contextual, Self-Critical & Linguistic Consideration

This part shall briefly explore some of the ways the context, in which the research took place, has affected my individual involvement and interaction with nurse moral distress. It shall also discuss considerations of text production and language (with a focus on the text being produced as opposed to the text of empirical material).

In terms of the theoretical and intellectual context of this research, the recent turn to affect and renewed interest in the philosophy of Alfred North Whitehead have been extremely influential. Similarly, contemporary developments in pluralist qualitative methodology have also had a big impact on the study. Without exposure to these current trends, the project would have taken a very different form: both the theoretico-philosophical framework and the methodological approach affect what can be known about any topic. Furthermore, having a background in psychology has also been significant in how the research has been approached; even though mainstream psychological theories and methods have been largely rejected in favour of a more

critical psychology. That is, adhering to 'critical social psychology' – as opposed to, say, sociology or anthropology – still has implications for how one thinks or how research is done.

With that said, however, the methodology adopted encouraged me to think about the role of methods in the construction of knowledge, especially when it came to writing the analysis chapters. When combining methods with disparate ontological, epistemological and theoretical assumptions the issue of commensurability can arise (Lincoln, Lynham, & Guba, 2011). I was, therefore, particularly concerned that what I was saying was coherent, that I adequately accounted for the differences between the various techniques used and also presented a cogent analysis that did not seem to be self-contradictory. The 'shifting focus' metaphor allowed me to concentrate on different features of the data and to think about how each of the analytic techniques might be considered as different perspectives on the data. From this position, any differences produced by different analytic waves are not contradictory or incommensurable. Rather, they are different points of view that 'see' different aspects of the data.

Additionally, being a research student in the School of Sports, Exercise and Health Sciences has also had significant influence on the research; simultaneously restricting and liberating. Restricting, because my research had to have some connection to sport, exercise, or health to be accepted by the School, which led to the interest in nurse moral distress in the first place. Liberating, because I was relatively free to take any perspective I chose and conduct the research how I wanted to – had I been located in the Social Psychology department in the School of Social Sciences, for example, I would have most likely been expected to have used a purely discursive psychology or conversation analysis approach. In these ways, disciplinary and institutional contexts have shaped the research.

At various points during writing the analysis chapters I struggled to find the most appropriate words or slipped into old habits of language use. Western culture tends to dichotomise mind and body, feeling and cognition, emotion and rationality, with associated ways of speaking/writing. This kind of either/or thinking, which may have its roots in Aristotle's law of the excluded middle, seems to be deeply ingrained in our culture. Even though my theoretical framework explicitly rejects these bifurcations, I was still sometimes lured by language and, thus, carelessly reproduced the dualisms I am trying to overcome. We must exercise caution in the language we use if we want to think in both/and terms and speak/write in ways that do not reproduce such bifurcations.

11.4 Anticipating the Future: Implications & Potentials

This section anticipates the future in terms of (a) the implications this research has for nursing practice; (b) the implications this research has for theory; and (c) the potential it offers for future research directions.

11.4.1 Implications & Recommendations for Practice

This research has plausible implications for nursing practice:

There is evidence that distress can affect the accuracy with which people enter numbers on healthcare devices, such as infusion pumps. More errors tend to be made by distressed people than those experiencing more positive feelings (Cairns, Pandab, & Power, 2014). It is easy to speculate that if number entry errors are made on healthcare devices, these errors could also be made when carrying out drugs calculations. Any number error could potentially have serious consequences for patients, in terms of them receiving the wrong dose of medication or at the incorrect rate, and so on. This means that, not only can experiencing moral distress be detrimental to nurses' own health (cf. Chapter 9), there is also a chance that patients could be put at risk. Nurses' feelings of discomfort (as discussed in Chapter 6) should, therefore, be taken seriously and every endeavour made to address the issues surrounding these feelings to reduce the risk that they develop into distress. This is not merely nor solely the responsibility of individual nurses. Rather, responsibility lies with ward teams, hospital and Trust management (and the NHS as a whole) to protect staff from harm. A nursing staff free from distress is less likely to make errors and become more able to provide high standards of care.

In terms of the potential to change feelings through changing environments and/or practices, there are a number of implications. First, as employers of nurses, NHS bodies (e.g. hospitals, NHS Trusts, NHS England and, ultimately, the Department for Health) should strive to create environments for their staff which minimise the risk of feelings of discomfort and distress. A significant contribution towards this could come from addressing the kinds of barriers to care discussed in Chapter 8 (i.e. staffing and workload issues, bureaucracy, funding levels and resourcing, and other policies and political initiatives experienced as antithetical to high standards of care). The NHS is beholden to its staff as much as it is to patients; a cared for and healthy staff is more likely to be efficient and able to deliver higher standards of care.

Secondly, employers of nurses should consider providing them with the time and space to share and reflect upon their experiences together (Maben, 2014; Tate et al., 2014). NHS Lothian, Scotland's second-largest health board, offers confidential counselling to its 24,000 staff to help them deal with issues they may be facing at work or in their private lives (Sanderson, 2014). However, it is struggling to meet the costs of this service. The kind of joint reflection being

proposed here is perhaps more cost effective, in that, this type of forum would provide an opportunity for mutual support in which nurses could offer one another the clarification, comfort and encouragement – Smail's (2005) three planks of therapy – that has significant potential to alter their feelings and thus reduce distress. This could potentially reduce the need for formal counselling.

Thirdly, employers could provide staff with opportunities for undertaking the kinds of activities discussed in Chapter 9 – sports, exercise, arts and crafts – that afford a changing of feelings. To be effective and encourage wide participation, the scheduling of these activities should take account of the shift patterns that nurses (and other staff) work. These recommendations could be incorporated into existing healthy workplace/workforce initiatives, such as NHS Health at Work (NHS, 2014), and advice for NHS employers and employees (e.g. NHS Employers, n.d.; NHS, n.d.).

11.4.2 Implications for Theory & Potential Research Directions

This research also has implications for theoretical and empirical research. The following discussion is divided into two parts, each coinciding with a different research focus: (i) nurse moral distress, (ii) feelings and emotions.

11.4.2.1 Nurse Moral Distress

Many of the issues identified and discussed in this thesis are, at best, downplayed or, at worst, not considered at all by the existing research. It would, therefore, be beneficial for future moral distress research to explore the contexts of distress, paying specific attention to how moral conduct and experiences of moral distress intertwine or diffract with issues of identity, social relations, and power and interest within micro-, meso- and macro-contexts. If being pulled from without by potent inconsonant lures for feeling results in distress, then nurse moral distress is not merely a consequence of an individual being unable to act – or being prevented from acting – according to her or his beliefs, as much of the literature claims (e.g. Corley, 2002). Future research in this area should, then, pay more attention to potential and actual, proximal and distal, lures for feeling in the nursing context and to what extent these lures are (in)congruent. A fuller understanding of such lures for feeling would highlight which lures might most easily be removed or circumnavigated. A more detailed exploration of aspects of the job that nurses experience as barriers to care would be particularly beneficial in this regard.

11.4.2.2 Feelings, Emotions, Affect

At various points during analyses, a clear separation of feelings into the three categories outlined in Chapter 4 – feelings of emotion, of the lived body, and of knowing – was difficult to maintain. That is, it is far from easy to decide which of these types some feelings belong to: some

feelings appear to be simultaneously a component of sensibility and of sense-making, for example. This should come as no surprise given that it was stressed that the distinction was an analytical or theoretical one. The fuzziness of some feelings implies that the theoretical framework set out in Chapter 4 (cf. Cromby, 2007b; Denzin, 1985) should be applied with caution in empirical work. It seems that sense and sensibility are intimately intertwined; that is, there is not a definitive distinction between the two (cf. McAvoy, 2015; Wetherell, 2012, 2015).

With that said, however, the concept of 'feelings of knowing' (Cromby, 2007b; Shotter, 1993a, 1993b) does offer an opportunity for empirical investigation of an aspect of experience that has, heretofore, been largely neglected. This thesis, for example, would have been very different without it. A full understanding of these kinds of feelings, though, must conceptualise knowing in a wide sense: as having knowledge or information in terms of an acquaintance with facts, truths, principles, beliefs, judgements, sense-making and so on. As a result, the term 'feelings of tendency' (James, 1890; Shotter, 2010) or 'felt thinking' (Cromby, 2012b) might be more applicable in the empirical exploration of these kinds of feelings.

Additionally, while the approaches developed by Ian Burkitt (1997, 1999, 2014) and Margaret Wetherell (2012) position "affect as a dynamical process, emergent from a polyphony of intersections and feedbacks, working across body states, registrations and categorizations, entangled with cultural meaning-making, and integrated with material and natural processes, social situations and social relationships" (Wetherell, 2014, p. 1), both relatively downplay the role of feelings and, as a consequence, minimise experiential or phenomenal aspects of affect. Furthermore, in marginalising feelings in this way, Burkitt's and Wetherell's accounts also de-emphasize how emotions and affects intersect or diffract with other feelings (i.e. of the lived body and of tendency). This thesis has suggested that such entanglements are central to experiences of moral distress and, therefore, are likely to be central to other affective practices (Wetherell, 2012, 2014, 2015) and emotion complexes (Burkitt, 2014). A proposal is put forward that the approach to feelings (cf. Cromby, 2007b, 2012b; Whitehead, 1927-8/1978, 1933/1967, 1938/1966) and emotions (cf. Burkitt, 2014; Wetherell, 2012, 2014, 2015) adopted herein is further synthesised and developed in such a way that it allows us to analyse the "moments of recruitment, articulation or enlistment" in which "many complicated flows across bodies, subjectivities, relations, histories and contexts entangle and intertwine together to form [*that* particular] affective moment, episode or atmosphere with its particular possible classifications" (Wetherell, 2014, p. 22), which neither approach makes possible individually.

11.5 THE SATISFACTION: CONCLUDING REMARKS

This thesis has resulted in a rethinking of nurse moral distress. Whereas previous research in this area has arguably been too quick to simplify and individualise such experiences, it has been suggested herein that, due to the complexity of moral conduct in general, moral distress involves complex experiences – involving feelings, affective practices and emotion complexes, and nurses' beliefs; seemingly influenced by issues of identity and concerns over competency; sometimes resulting in physical ill health and psychological distress – which are social and relational in character. Moral distress, therefore, should not be considered in isolation from the contexts in which it emerges. This rethinking of moral distress led to an alternative conceptualisation of distress: it was suggested that distress arises from being pulled from without by strong incongruent lures for feeling and when (some of) those lures are morally-laden that distress might be called 'moral distress'.

This thesis now exists as data for consequent occasions of experience.

12 APPENDICES

12.1 Appendix I: Study Information Sheet

Study Information Sheet

You have been selected as a potential participant because you have experience of working as a nurse or are training to be a nurse.

Nursing has been described as being a moral endeavour. It is often argued in the nursing literature that the moral decisions nurses are required to make can sometimes lead to stress or distress. Moral distress involves situations in which the nurse knows the right thing to do, but feels unable to do it due to some kind of constraint. Research has consistently found that moral distress (sometimes called stress of conscience) can result in psychological disequilibrium, emotional distress and physical stress, with feelings of frustration, anger and guilt commonly reported. These responses may lead to avoiding patients, reduced patient care, decreased job satisfaction, 'burnout', and nurses moving jobs or leaving nursing altogether. A better understanding of nurse moral distress could lead to improved nurse training and better occupational management of moral distress; this could reduce sick leave, improve nurse retention, and lead to improved patient care. However, very little research investigating moral distress has so far been carried out in the UK.

You are under no obligation to take part in this study. If you do agree to take part you will be interviewed about your nursing experiences. The interview will last no more than 1 hour, and will particularly focus on ethical decisions and any associated distress you may have experienced. You will also be asked to complete 4 questionnaires (Moral Distress Scale; Stress of Conscience Questionnaire; General Health Questionnaire [GHQ-12]; Copenhagen Burnout Inventory) before the interview takes place. Findings will form the basis of a PhD thesis, and will be presented at conferences and published in academic journals. The interview will be audio recorded and transcribed for analysis.

Any information you give will be treated in strict confidence and will be kept anonymous and confidential to the researcher and supervisor unless (under the statutory obligations of the agencies which the researchers are working with), it is judged that confidentiality will have to be breached for the safety of yourself or others. For example, if it is found that you are having psychological effects from your work, the researcher will inform your employer or university in order that they may provide you with the necessary support.

You are under no obligation to take part in this study; you do not have to take part. You should only agree to take part if you are comfortable to do so. If you do take part, you retain the right to withdraw from this study at any stage for any reason; you will not be required to explain your reasons for withdrawing and any data you have provided will be destroyed and will not be included in the study.

If you have any questions about the study or about your taking part, please feel free to ask Martin (the researcher).

If you feel that you are in 'distress' and would like support with this you can find a list of support services and contact details on the back of this information sheet.

Researcher	**Supervisor**
Martin Willis	Dr. John Cromby
School of Sport, Exercise & Health Sciences	School of Sport, Exercise & Health Sciences
Loughborough University	Loughborough University
Leicestershire, UK	Leicestershire, UK
LE11 3TU	LE11 3TU
07720174364	01509 223000
m.e.h.willis@lboro.ac.uk	j.cromby@lboro.ac.uk

This study has been approved by the Ethical Advisory Committee of Loughborough University.
If you are unhappy with the conduct of the study or have any complaints about it, please contact Dr John Cromby (contact details above).

Support Services

If you find that you are stressed or distressed, you might find it helpful to discuss it in clinical supervision. However, if you would like additional support, there are several confidential services that you can contact, many of which are free:

Nottingham Mental Health Helpline – for people experiencing mental distress; service operates from 5pm - 9am Monday to Friday, and 24 hours a day at weekends and bank holidays:

0800 561 0072

Breathing Space – free and confidential phone line service for any individual, who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to:

0800 83 85 87

Samaritans – provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair:

08457 90 90 90

Rethink – mental health resources for people under stress or worried about their thoughts and feelings. Includes useful links and a range of information and advice on mental health issues:

http://www.rethink.org

0300 5000 927

University of Nottingham Counselling Service

Room A75, Trent Building, University of Nottingham, University Park, NG7 2RD

0115 951 3695

counselling.service@nottingham.ac.uk

The International Stress Management Association – exists to promote sound knowledge and best practice in the prevention and reduction of human stress:

www.isma.org.uk/

NHS plus – has advice for individuals about workplace stress:

www.nhsplus.nhs.uk/

12.2 Appendix II: Biographical Details of Participants (self-disclosed at time of interview)

Name[1]	Job Title	Department/ Course	Experience[2]	Age	Gender	Nationality
Abigail	Staff Nurse (RMN[3])	Acute inpatient admission ward	10 years 6 months	37	Female	British
Amelia	Deputy Sister	Major Trauma Unit	4 years	31	Female	British/ Australian
Amy	Postgraduate Student	MSc Advanced Nursing	1 year 3 months[4]	23	Female	American
Bernadette	Deputy Sister	Rehabilitation	18 years 3 months	58	Female	British
Christine	Nurse Practitioner	Genitourinary Medicine	20 years	49	Female	British
Emma	Epilepsy Nurse Specialist	Family Health	24 years 10 months	47	Female	British
Howard	Staff Nurse (RMN)	Forensic Mental Health	4 years 10 months	31	Male	British
Jody	Undergraduate Student	Masters of Nursing Science	4th year of 4 year course	20	Female	British
Joey	Staff Nurse (RGN[4])	Health Care of Older Persons	2 years	23	Male	British
Joy	Lead Nurse	Paediatric Nephrology	25 years	47	Female	British
Kathryn	Undergraduate Student	BSc Adult Nursing	2nd year of 3 year course	43	Female	British
Lora	Staff Nurse (RGN)	Paediatrics	3 years 7 months	25	Female	British
Millie	Staff Nurse (RGN)	Nursing Development/ Oncology	2 years 10 months	26	Female	British
Monica	Staff Nurse (RGN)	Adult Intensive Care Unit	2 years 6 months	23	Female	British
Penny	Postgraduate Student	Graduate Entry Nursing (Child Branch)	7 months	23	Female	British
Phoebe	Undergraduate Student	Masters of Nursing Science	4th year of 4 year course	21	Female	English
Rachel	Staff Nurse (RGN)	Adult Intensive Care Unit	4 years 8 months	27	Female	British
Rajesh	Postgraduate Student	MSc Advanced Nursing	3 years[4]	25	Male	Indian
Ross	Home Haemo-Dialysis Trainer	Renal	27 years	46	Male	British
Sophie	Deputy Sister	Stroke Unit	10 years	54	Female	British
Suzana	Staff Nurse (RGN)	Acute Medicine Unit	2 years 6 months	25	Female	Portuguese
Trish	Community Psychiatric Nurse (CPN)	Community Mental Health Service	26 years	45	Female	British
Veronica	Deputy Sister	Elective Orthopaedics	7 years	49	Female	British
Vicky	Undergraduate Student	BSc Adult Nursing	3rd year of 3 year course	22	Female	English
Wendy	Staff Nurse (RGN)	Health Care of Older Persons	4 years 6 months	45	Female	British
Zara	Undergraduate Student	Masters of Nursing Science	3rd year of 4 year course	22	Female	English

1. All participants have been given pseudonyms to protect their anonymity.
2. For registered nursing staff this is how long they have been working since qualification. For nursing students this is how long they have been training.
3. RMN = Registered Mental Health Nurse.
4. Prior to beginning postgraduate degree.
5. RGN = Registered General Nurse.

12.3 Appendix III: Jefferson Transcription Notation

Brief explanation of transcription notation used in Chapter 10:

(.)	Noticeable pause less than 0.1 second long
(0.3) (2.5)	Timed pauses in seconds
wor-	A dash shows a sharp cut-off
wo:rd wo::rd	Colons show that the speaker has stretched the preceding sound (relative length indicated by more or fewer colons)
Word word	Underlining indicates emphasised word or sound
WORD .HHh .SHh	Capitalisation indicates sound that is noticeably louder than surrounding talk
ºwordº	Degree signs indicate speech that is noticeably quieter than surrounding talk – usually whispering
(words)	A guess at what might have been said if unclear
>word word<	Inward arrows (greater than and lesser than symbols) indicate speech that is noticeably faster than surrounding talk
<word word>	Outward arrows indicate speech that is noticeably slower than surrounding talk
↑word ↓word	Onset of noticeable pitch rise or fall
word.	Full stop at end of word indicates falling intonation, as though coming to a stop
.hh .hhh .hhhh	In breath (relative length indicated by more or fewer aitches)
Hh hhh hhhh	Out breath (relative length indicated by more or fewer aitches)
.sh .shh .shhh	Sniff (relative length indicated by more or fewer aitches)
#word# ##word##	Indicates croaky voice – when doubled indicates more croaky
~word~ ~~word~~	Indicates tremulous or wobbly voice – when doubled indicates more wobbly
ahih heh huh huh hih	Laughter
tpt	Tut sound
wohrd	Word said with a breathy voice
wo(h)rd	Word said with a plosive breath sound

13 REFERENCES

Ahsan, S. (2014, 5 March). On the NHS frontline: 'Being a doctor in A&E is like being a medic in a war zone'. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/mar/04/nhs-frontline-medic-film-doctor-and-and-e

Aldwin, C. M. (2007). *Stress, coping, and development: An integrative perspective*. London: Guilford Press.

Alvesson, M., & Sköldberg, K. (2009). *Reflexive methodology: New vistas for qualitative research* (2nd ed.). London: SAGE.

APA. (2013). *DSM 5*. Arlington, VA: American Psychiatric Association.

Appleby, J., Thompson, J., & Jabbal, J. (2014). How is the NHS performing? *The King's Fund Quarterly Monitoring Report* (Vol. April 2014). London: The King's Fund.

Archer, M. (2003). *Structure, agency and the internal conversation*. Cambridge: Cambridge University Press.

Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (1998). *Critical realism: Essential readings*: Routledge.

Athanasiou, A., Hantzaroula, P., & Yannakopoulos, K. (2008). Towards a new epistemology: The "affective turn". *Historein, 8*, 5-16.

Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science, 30*(1), 81-88.

Bakhtin, M. (1981). Discourse in the novel. In M. Holquist (Ed.), *The dialogic imagination: Four essays* (pp. 259-422). Autin, TX: University of Texas Press.

Barad, K. (2003). Posthumanist performativity: Toward an understanding of how matter comes to matter. *Signs: Journal of Women in Culture and Society, 28*(3), 801-831.

Barad, K. (2007). *Meeting the universe halfway*. Durham, NC & London: Duke University Press.

BBC. (2006, 4 October). NHS safe in my hands says Cameron. *BBC News.* Retrieved 4 November, 2014, from http://news.bbc.co.uk/1/hi/uk_politics/5403798.stm

Beck, A. T., & Alford, B. A. (2009). *Depression: Causes and treatment*: University of Pennsylvania Press.

Bennett, A. (2014, 16 January). Nick Clegg blames labour for 'single-handedly' causing banking crash. *Huffington Post*. Retrieved from http://www.huffingtonpost.co.uk/2014/01/16/nick-clegg-labour-banking_n_4608403.html

Benson, C. (2001). *The cultural psychology of self: Place, morality and art in human worlds*. London: Routledge.

Benson, C. (2003). The unthinkable boundaries of self: The role of negative emotional boundaries for the formation, maintence, and transformation of identities. In R. Harré & F. M. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 61-84). Westport, CT: Praeger.

Billig, M. (1991). *Ideology and opinions: Studies in rhetorical psychology*. London: SAGE.

Billig, M. (1996). *Arguing and thinking: A rhetorical approach to social psychology*. Cambridge: Cambridge University Press.

Billig, M. (2001). Humour and embarrassment: Limits of `nice-guy' theories of social life. *Theory, Culture & Society, 18*(5), 23-43. doi: 10.1177/02632760122051959

Billig, M. (2005). Laughter and ridicule: Towards a social critique of humour. London: SAGE.

Billig, M., Condor, S., Edwards, D., Gane, M., & Radley, A. (1988). *Ideological dilemmas: A social psychology of everyday thinking*. London: SAGE.

Boden, Z., & Eatough, V. (2014). Understanding more fully: A multimodal hermeneutic-phenomenological approach. *Qualitative Research in Psychology, 11*(2), 160-177. doi: 10.1080/14780887.2013.853854

Boiger, M., & Mesquita, B. (2012). The construction of emotion in interactions, relationships, and cultures. *Emotion Review, 4*(3), 221-229. doi: 10.1177/1754073912439765

Bourdieu, P. (1977). *Outline of a theory of practice* (R. Nice, Trans.). Cambridge: Cambridge University Press.

Bourdieu, P., & Wacquant, L. (1992). *An invitation to reflexive sociology*. Cambridge: Polity Press.

Brennan, J. G. (1974). Whitehead on time and endurance. *The Southern Journal of Philosophy, 12*(1), 117-126.

Brown, S. D., & Stenner, P. (2001). Being affected: Spinoza and the psychology of emotion. *International Journal of Group Tensions, 30*(1), 81-105. doi: 10.1023/A:1026658201222

Brown, S. D., & Stenner, P. (2009). *Psychology without foundations: History, philosophy and psychosocial theory*. London: SAGE.

Buchan, J., & Seccombe, I. (2012). Overstretched. Under-resourced: The UK nursing labour market review 2012. London: Royal College of Nursing.

Bulman, C., & Schutz, S. (2008). *Reflective practice in nursing* (4th ed.). Oxford: Blackwell Publishing.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy, 27*(3), 237-262. doi: 10.1111/j.1467-6427.2005.00314.x

Burkitt, I. (1991). *Social selves: Theories of the social formation of personality*. London: SAGE.

Burkitt, I. (1997). Social relationships and emotions. *Sociology, 31*(1), 37-55. doi: 10.1177/0038038597031001004

Burkitt, I. (1999). *Bodies of thought: Embodiment, identity and modernity*. London: SAGE.

Burkitt, I. (2003). Psychology in the field of being: Merleau-Ponty, Ontology and social constructionism. *Theory & Psychology, 13*(3), 319-338. doi: 10.1177/0959354303013003002

Burkitt, I. (2014). *Emotions and social relations*. London: SAGE.

Butt, T. (1999). Realism, constructionism and phenomenology. In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 127-140). Buckingham: Open University Press.

Cairns, P., Pandab, P., & Power, C. (2014). *The influence of emotion on number entry errors.* Paper presented at the 32nd Annual ACM Conference on Human Factors in Computing Systems.

Cameron, M. E. (1986). The moral and ethical component of nurse-burnout. *Nursing Management, 17*(4), 42B-42E.

Cameron, M. E. (1997). Ethical distress in nursing. *Journal of Professional Nursing, 13*(5), 280. doi: 10.1016/S8755-7223(97)80104-4

Campbell, D. (2013, 31 December). 7,000 key NHS clinical staff made redundant amid enforced cuts. *The Guardian*. Retrieved from http://www.theguardian.com/society/2013/dec/31/nhs-staff-laid-off-amid-savings-drive

Campbell, D. (2014a, 10 October). Advances in NHS care 'going into reverse'. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/oct/10/advances-nhs-care-reverse

Campbell, D. (2014b, 23 October). The NHS calls for an extra £8bn by 2020 in order to safeguard its services. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/oct/23/nhs-radical-overhaul-hospitals-8bn-services

Campbell, D. (2014c, 17 October). NHS staff shortages pose risk to patients, warns watchdog. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/oct/17/nhs-staff-shortages-risk-patients-cqc-report

Campbell, D. (2014d, 22 July). Rise in bailouts as more hospitals overspend on budgets. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/jul/22/hospital-trusts-overspend-budgets-bailouts?CMP=twt_gu

Carver, C. S., Scheier, M. F., & Fulford, D. (2008). Stress, coping, and self-regulatory processes. In O. P. John, R. W. Robins, & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 725-769). New York, NY: The Guilford Press.

Cassano, P., & Fava, M. (2002). Depression and public health: An overview. *Journal of Psychosomatic Research, 53*(4), 849-857. doi: S0022399902003045 [pii]

Chalder, M., Wiles, N. J., Campbell, J., Hollinghurst, S. P., Haase, A. M., Taylor, A. H. (2012). Facilitated physical activity as a treatment for depressed adults: Randomised controlled trial. *British Medical Journal, 344*(e2758). doi: 10.1136/bmj.e2758

Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of Health Psychology, 5*(3), 285-296. doi: 10.1177/135910530000500306

Chambliss, D. F. (1996). *Beyond caring: Hospitals, nurses, and the social organization of ethics*. Chicago, IL: The University of Chicago Press.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. London: SAGE.

Clarke, J., & Newman, J. (2012). The alchemy of austerity. *Critical Social Policy, 32*(3), 299-319. doi: 10.1177/0261018312444405

Clarke, N. J., Willis, M. E. H., Barnes, J. S., Caddick, N., Cromby, J., McDermott, H. (2014). Analytical pluralism in qualitative research: A meta-study. *Qualitative Research in Psychology*. doi: 10.1080/14780887.2014.948980

Clough, P. T. (2008). The affective turn: Political economy, biomedia and bodies. *Theory, Culture & Society, 25*(1), 1-22. doi: 10.1177/0263276407085156

Clough, P. T., & Halley, J. (Eds.). (2007). *The affective turn: Theorising the social*. Durham, NC: Duke University Press.

CNA. (2003). *Ethical distress in health care environments*. Ottawa, ON: Regulatory Policy Division of the Canadian Nurses Association.

Coffey, A. J., & Atkinson, P. A. (1996). *Making sense of qualitative data: Complementary research strategies*. London: SAGE.

Connolly, W. E. (2002). *Neuropolitics: Thinking, culture, speed*. London: University of Minnesota Press.

Cooper, C. (2014, 24 October). NHS spends £2.5bn on agency staff to meet rising demand. *The Independent*. Retrieved from http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-spends-25bn-on-agency-staff-to-meet-rising-demand-9816894.html

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics, 9*(6), 636-650. doi: 10.1191/0969733002ne557oa

Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33*(2), 250-256. doi: 10.1111/j.1365-2648.2001.01658.x

Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of health and social behavior, 50*(1), 31-48. doi: 10.1177/002214650905000103

CQC. (2014). The state of health care and adult social care in England 2013/14. London: Care Quality Commission.

Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy, 12*(2), 119-127. doi: 10.1111/j.1466-769X.2011.00484.x

Cromby, J. (2004). Between constructionism and neuroscience: The societal co-constitution of embodied subjectivity. *Theory & Psychology, 14*(6), 797-821. doi: 10.1177/0959354304048107

Cromby, J. (2005). Theorizing embodied subjectivity. *International Journal of Critical Psychology, 15*, 133-150.

Cromby, J. (2006). Reconstructing the person. *Clinical Psychology Forum, 162*, 13-16.

Cromby, J. (2007a). *Feelings and embodied subjectivity.* Paper presented at the Eleventh Biennial Conference of the International Society for Theoretical Psychology, Cape Town, South Africa.

Cromby, J. (2007b). Toward a psychology of feeling. *International Journal of Critical Psychology, 21*, 94-118.

Cromby, J. (2011a). Affecting qualitative health psychology. *Health Psychology Review, 5*(1), 79-96. doi: 10.1080/17437199.2010.544637

Cromby, J. (2011b). Scullery's question: Multiplicity, felt experience and continuity. In P. Stenner, J. Cromby, J. Motzkau, J. Yen, & Y. Haosheng (Eds.), *Theoretical psychology: Global transformations and challenges* (pp. 138-148). Toronto, ON: Captus Press.

Cromby, J. (2012a). The affective turn and qualitative health research. *International Journal of Organisation, Work & Emotion, 5*(2), 145-158. doi: 10.1504/IJWOE.2012.049518

Cromby, J. (2012b). Beyond belief. *Journal of Health Psychology, 17*(7), 943-957. doi: 1177/1359105312448866

Cromby, J. (2012c). Feeling the way: Qualitative clinical research and the affective turn. *Qualitative Research in Psychology, 9*(1), 88-98. doi: 10.1080/14780887.2012.630831

Cromby, J., Brown, S. D., Gross, H., Locke, A., & Patterson, A. E. (2010). Constructing crime, enacting morality: Emotion, crime and anti-social behaviour in an inner-city community. *British Journal of Criminology, 50*(5), 873-895. doi: 10.1093/bjc/azq029

Crompton, R., & Lyonette, C. (2006). Work-Life 'Balance' in Europe. *Acta Sociologica, 49*(4), 379-393. doi: 10.1177/0001699306071680

Crossley, N. (2011). *Towards relational sociology*. Abingdon: Routledge.

Cummings, J., & Bennett, V. (2012). *Compassion in practice: Nursing, midwifery and care staff: Our vision and strategy*. Leeds: NHS Commissioning Board.

Curtis, P. (2011, 12 September). Reality check: How much did the banking crisis cost taxpayers? *The Guardian*. Retrieved from http://www.theguardian.com/politics/reality-check-with-polly-curtis/2011/sep/12/reality-check-banking-bailout

Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. C. (2002). *Explaining society: Critical realism in the social sciences*. London: Routledge.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour, 20*(1), 43-63.

Davis, J., & Tallis, R. (Eds.). (2013). *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld Publications.

de Sousa, R. (2001). Moral emotions. *Ethical Theory & Moral Practice, 4*(2), 109-126. doi: 10.1023/A:1011434921610

Denzin, N. K. (1985). Emotion as lived experience. *Symbolic Interaction, 8*(2), 223-240. doi: 10.1525/si.1985.8.2.223

Dictionary.com. (n.d.). Compassion. *Dictionary.com unabridged.* Retrieved 10 November, 2014, from http://dictionary.reference.com/browse/compassion

Diener, E., & Emmons, R. A. (1984). The independence of positive and negative affect. *Journal of Personality & Social Psychology, 47*(5), 1105-1117.

Dunn, D. (2005). Substance abuse among nurses – defining the issue. *AORN Journal, 82*(4), 572-596.

Edgar, A., & Pattison, S. (2011). Integrity and the moral complexity of professional practice. *Nursing Philosophy, 12*(2), 94-106.

Ekeberg, V. (2011). Mature care and the virtue of integrity. *Nursing Philosophy, 12*(2), 128-138. doi: 10.1111/j.1466-769X.2010.00474.x

Ekman, P. (1992). An argument for basic emotions. *Cognition and Emotion, 6*, 169-200. doi: 10.1080/02699939208411068

Ellingson, L. L. (2009). *Engaging crystallization in qualitative research: An introduction*. London: SAGE.

Elliott, L., & Wintour, P. (2010, 22 June). Budget 2010: Pain now, more pain later in austerity plan. *The Guardian*. Retrieved from http://www.theguardian.com/uk/2010/jun/22/budget-2010-vat-austerity-plan

Ellis, D. (2007). *Narrative, disclosure and psychophysiology: A mixed methods exploration of emotion.* (Unpublished PhD Thesis), Loughborough University, Loughborough.

Elpern, E. H., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care, 14*(6), 523-530.

Eshleman, A. (2009). Moral responsibility. *The Stanford Encyclopedia of Philosophy.* Winter 2009. Retrieved 5 November, 2014, from http://plato.stanford.edu/archives/win2009/entries/moral-responsibility/

Fogel, K. M. (2007). *The relationships of moral distress, ethical climate, and intent to turnover among critical care nurses.* (Unpublished PhD Thesis), Loyola University Chicago, Chicago, IL. Retrieved from http://gradworks.umi.com/32/80/3280688.html

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health & Social Behavior, 21*(3), 219-239.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. London: Allen Lane.

Foucault, M. (1978). *The will to knowledge: The history of sexuality, volume I*. London: Penguin Books.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings by Michel Foucault*. New York, NY: Pantheon Books.

Foucault, M. (2000a). *Ethics: Subjectivity and truth*. London: Penguin.

Foucault, M. (2000b). Technologies of the self. In P. Rabinow & R. Hurley (Eds.), *Ethics: Subjectivity and truth*. Harmondsworth: Penguin.

Foucault, M. (2008). *The birth of biopolitics: Lectures at the Collège de France, 1978-1979*. Basingstoke: Palgrave Macmillan.

Fox, R. M. (1981). Situations creating ethical stress. *The Medical Journal of Australia, 1*(4), 162-163.

Francis, R. (2013a). Analysis of evidence and lessons learned (part 1). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Vol. 1). London: Her Majesty's Stationery Office.

Francis, R. (2013b). Analysis of evidence and lessons learned (part 2). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Vol. 2). London: Her Majesty's Stationery Office.

Francis, R. (2013c). Present and future/Annexes. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Vol. 3). London: Her Majesty's Stationery Office.

Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago, IL: University of Chicago Press.

Franken, R. E. (2002). *Human motivation* (5th ed.). Belmont, CA: Wadsworth.

Freeman, M. (2009). *Hindsight: The promise and peril of looking backward*: Oxford University Press.

Full Fact. (2013, 4 March). Is NHS spending rising or falling? *fullfact.org.* Retrieved 6 November, 2014, from https://fullfact.org/articles/NHS_budget_health_spending_statistics-28697

Gallagher, A. (2010). Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing, 16*(2). doi: 10.3912/OJIN.Vol16No02PPT03

Gaudine, A., LeFort, S. M., Lamb, M., & Thorne, L. (2011a). Clinical ethical conflicts of nurses and physicians. *Nursing Ethics, 18*(1), 9-19. doi: 10.1177/0969733010385532

Gaudine, A., LeFort, S. M., Lamb, M., & Thorne, L. (2011b). Ethical conflicts with hospitals: The perspective of nurses and physicians. *Nursing Ethics, 18*(6), 756-766. doi: 10.1177/0969733011401121

Gendlin, E. (1997). *Experiencing and the creation of meaning: A philosophical and psychological approach to the subjective*. Evanston, IL: Northwestern University Press.

Georges, J., & Grypdonck, M. (2002). Moral problems experienced by nurses when caring for terminally ill people: A literature review. *Nursing Ethics, 9*(2), 155-178.

Gergen, K. J. (2009). *Relational being: Beyond self and community*. Oxford: Oxford University Press.

Glasberg, A.-L., Eriksson, S., Dahlqvist, V., Lindahl, E., Strandberg, G., Söderberg, A. (2006). Development and initial validation of the Stress of Conscience Questionnaire. *Nursing Ethics, 13*(6), 633-648. doi: 10.1177/0969733006069698

Glasberg, A.-L., Eriksson, S., & Norberg, A. (2008). Factors associated with 'stress of conscience' in healthcare. *Scandinavian Journal of Caring Sciences, 22*(2), 249-258. doi: 10.1111/j.1471-6712.2007.00522.x

Glasberg, A. L., Eriksson, S., & Norberg, A. (2007). Burnout and 'stress of conscience' among healthcare personnel. *Journal of Advanced Nursing, 57*(4), 392-403. doi: 10.1111/j.1365-2648.2007.04111.x

Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Double Day.

Goffman, E. (1979). Footing. *Semiotica, 25*(1-2), 1-30.

Greco, M., & Stenner, P. (2008). Introduction: Emotion and social science. In M. Greco & P. Stenner (Eds.), *Emotions: A social science reader* (pp. 1-21). London: Routledge.

Griffin, C. (2007). Being dead and being there: Research interviews, sharing hand cream and the preference for analysing 'naturally occurring data'. *Discourse Studies, 9*(2), 246-269. doi: 10.1177/1461445607075340

Guajardo J, Leigh D, and Pescatori A (2011) *Expansionary austerity: New international evidence*. IMF Working Paper No. 11/158. International Monetary Fund.

Gutierrez, K. M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing, 24*(5), 229-241.

Haidt, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review, 108*(4), 814-834. doi: 10.1037/0033-295X.108.4.814

Haidt, J. (2003). The moral emotions. In R. J. Davidson, K. Scherer, & H. Goldsmith (Eds.), *Handbook of affective sciences* (pp. 852-870). Oxford: Oxford University Press.

Haidt, J. (2007). The new synthesis in moral psychology. *Science, 316*(5827), 998-1002. doi: 10.1126/science.1137651

Haidt, J., Björklund, F., & Murphy, S. (2000). *Moral dumbfounding: When intuition finds no reason*. Unpublished Manuscript. University of Virginia. Charlottesville, VA. Retrieved from http://faculty.virginia.edu/haidtlab/articles/manuscripts/haidt.bjorklund.working-paper.when%20intuition%20finds%20no%20reason.pub603.doc

Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook, 48*(5), 199-201. doi: 10.1067/mno.2000.110564

Hamric, A. B., & Blackhall, L. J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine, 35*(2), 422-429. doi: 10.1097/01.CCM.0000254722.50608.2D

Hanna, D. R. (2004). Moral distress: The State of the science. *Research and Theory for Nursing Practice, 18*(1), 73-93. doi: 10.1891/rtnp.18.1.73.28054

Hardingham, L. B. (2004). Integrity and moral residue: Nurses as participants in a moral community. *Nursing Philosophy, 5*(2), 127-134. doi: 10.1111/j.1466-769X.2004.00160.x

Harré, R. (1993). *Social being* (2nd ed.). Oxford: Blackwell.

Harré, R. (1998). *The singular self: An introduction to the psychology of personhood*. London: SAGE.

Hart, S. E. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship, 37*(2), 173-177. doi: 10.1111/j.1547-5069.2005.00030.x

Hefferman, P., & Heilig, S. (1999). Giving 'moral distress' a voice: Ethical concerns among neonatal intensive care unit personnel. *Cambridge Quarterly of Healthcare Ethics, 8*(2), 173-178.

Hemmings, C. (2005). Invoking affect: Cultural theory and the ontological turn. *Cultural Studies, 19*(5), 548-567. doi: 10.1080/09502380500365473

Hindmarsh, J., & Pilnick, A. (2007). Knowing Bodies at Work: Embodiment and Ephemeral Teamwork in Anaesthesia. *Organization Studies, 28*(9), 1395-1416. doi: 10.1177/0170840607068258

HM Treasury. (2012a). *Public Spending Statistics July 2012*. London: HM Treasury.

HM Treasury. (2012b). *Public spending statistics October 2012*. London: HM Treasury.

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. London: SAGE.

Hook, D. (2007). *Foucault, psychology and the analytics of power*. Basingstoke: Palgrave Macmillan.

Hutto, D. D. (2005). Knowing what? Radical versus conservative enactivism. *Phenomenology & the Cognitive Sciences, 4*(4), 389-405. doi: 10.1007/s11097-005-9001-z

Hutto, D. D. (2008). *Folk psychological narratives: The sociocultural basis of understanding reasons*. Cambridge, MA: The MIT Press.

Hutto, D. D. (2011). Philosophy of mind's new lease on life: Autopoietic enactivism meets teleosemiotics. *Journal of Consciousness Studies, 18*(5-6), 44-64.

Hutto, D. D. (2012a). Exposing the background: Deep and local. In Z. Radman (Ed.), *Knowing without thinking: The background in philosophy of mind* (pp. 37-56). Basinstoke: Palgrave Macmillan.

Hutto, D. D. (2012b). Truly enactive emotion. *Emotion Review, 4*(2), 176-181. doi: 10.1177/1754073911430134

Ingleby, D., McKee, M., Mladovsky, P., & Rechel, B. (2012). How the NHS measures up to other health systems. *British Medical Journal, 344*, e1079. doi: 10.1136/bmj.e1079

James, W. (1890). *The principles of psychology* (Vol. I). New York, NY: Henry Holt and Company.

Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice-Hall.

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*(4), 542-551.

Janesick, V. (1994). The dance of qualitative research design: Metaphor, methodolatry, and meaning. In N. K. Denzin & Y. S. Lincoln (Eds.), (pp. 209). London: SAGE.

Jefferson, G. (1985). An exercise in the transcription and analysis of laughter. In T. A. van Dijk (Ed.), *Handbook of discourse analysis* (Vol. 3, pp. 25-34). London: Academic Press.

Jewkes, R., Penn-Kekana, L., & Rose-Junius, H. (2005). "If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science & Medicine, 61*(8), 1809-1820. doi: 10.1016/j.socscimed.2005.03.022

Johns, C., & Freshwater, D. (Eds.). (1998). *Transforming nursing through reflective practice*. Oxford: Blackwell Science.

Johnston, I. (2014, 12 March). NHS faces 'managed decline' unless it is properly funded, says health chief. *The Independent*. Retrieved from http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-faces-managed-decline-unless-it-is-properly-funded-says-health-chief-9188282.html

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. (2007). Perceptions of conscience in relation to stress of conscience. *Nursing Ethics, 14*(3), 329-343. doi: 10.1177/0969733007075868

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. (2008). Stress of conscience and perceptions of conscience in relation to burnout among care-providers in older people. *Journal of Clinical Nursing, 17*(14), 1897-1906. doi: 10.1111/j.1365-2702.2007.02184.x

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. (2010). Perceptions of conscience, stress of conscience and burnout among nursing staff in residential elder care. *Journal of Advanced Nursing, 66*(8), 1708-1718. doi: 10.1111/j.1365-2648.2010.05288.x

Kawachi, I., & Berkman, L. (2001). Social ties and mental health. *Journal of Urban Health, 78*(3), 458-467. doi: 10.1093/jurban/78.3.458

Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing, 28*(5), 1134-1145. doi: 10.1046/j.1365-2648.1998.00810.x

Kincheloe, J. L. (2001). Describing the bricolage: Conceptualizing a new rigor in qualitative research. *Qualitative Inquiry, 7*(6), 679-692. doi: 10.1177/107780040100700601

Kincheloe, J. L. (2005). On to the next level: Continuing the conceptualization of the bricolage. *Qualitative Inquiry, 11*(3), 323-350. doi: 10.1177/1077800405275056

Kincheloe, J. L., & Berry, K. S. (2004). *Rigour and complexity in educational research: Conceptualizing the bricolage*. Maidenhead: Open University Press/McGraw-Hill Education.

Kirkup, J. (2013, 8 March). David Cameron rebuked over austerity claims. *The Telegraph*. Retrieved from http://www.telegraph.co.uk/finance/budget/9918107/David-Cameron-rebuked-over-austerity-claims.html

Kopala, B., & Burkhart, L. (2005). Ethical dilemma and moral distress: Proposed new NANDA diagnoses. *International Journal of Nursing Terminologies and Classifications, 16*(1), 3-13. doi: 10.1111/j.1744-618X.2005.00001.x

Laabs, C. A. (2007). Primary care nurse practitioners' integrity when faced with moral conflict. *Nursing Ethics, 14*(6), 795-809. doi: 10.1177/0969733007082120

Laabs, C. A. (2011). Perceptions of moral integrity: Contradictions in need of explanation. *Nursing Ethics, 18*(3), 431-440. doi: 10.1177/0969733011398101

Lakoff, G., & Johnson, M. (1980/2003). *Metaphors we live by*. London: The University of Chicago Press.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow: Prentice Hall.

Langer, S. K. (1967). *Mind: An essay on human feeling* (Vol. I). Baltimore, MD: The Johns Hopkins Press.

Lazarus, R. S. (2006). *Stress and emotion: A new synthesis*. New York, NY: Springer Publishing Company.

Lévi-Strauss, C. (1966). *The savage mind*. Chicago: University of Chicago Press.

Lewis, S. & Cooper, C. 1999. The Work–Family Research Agenda in Changing Contexts. *Journal of Occupational Health Psychology, 4*(4): 382–93.

Leys, R. (2011). The turn to affect: A critique. *Critical Inquiry, 37*(3), 434-472. doi: 10.1086/659353

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 97-128). London: SAGE.

Lintern, S. (2011, 7 December). Mid Staffordshire was a total system failure. *The Guardian*. Retrieved from http://www.theguardian.com/healthcare-network/2011/dec/07/mid-staffordshire-total-system-failure

Lister, J. (2013). Breaking the public trust. In J. Davis & R. Tallis (Eds.), *NHS SOS: How the NHS was betrayed – and how we can save it* (pp. 17-37). London: Oneworld Publications.

Ludwick, R., & Cipriano Silva, M. (2003). Errors, the nursing shortage and ethics: Survey results. *OJIN: The Online Journal of Issues in Nursing, 8*(3). http://198.65.150.241/ojin/ethicol/ethics_12.htm

Luhmann, N. (1995). *Social systems* (J. Bednarz Jr & D. Baecker, Trans.). Stanford University Press: Stanford CA.

Lützén, K., Blom, T., Ewalds-Kvist, B., & Winch, S. (2010). Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nursing Ethics, 17*(2), 213-224. doi: 10.1177/0969733009351951

Lützén, K., Cronqvist, A., Magnusson, A., & Andersson, L. (2003). Moral stress: Synthesis of a concept. *Nursing Ethics, 10*(3), 312-322. doi: 10.1191/0969733003ne608oa

Lützén, K., Dahlqvist, V., Eriksson, S., & Norberg, A. (2006). Developing the concept of moral sensitivity in health care practice. *Nursing Ethics, 13*(2), 187-196. doi: 10.1191/0969733006ne837oa

Lyons, A. C., & Cromby, J. (2010). Social psychology and the empirical body: Rethinking the relationship. *Social and Personality Psychology Compass, 4*(1), 1-13. doi: 10.1111/j.1751-9004.2009.00219.x

Maben, J. (2014). *Keynote address*. Paper presented at the Nottingham University Hospitals Annual Research Festival, "Engage, Enthuse, Empower", Nottingham.

MacDonald, H. (2007). Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing, 57*(2), 119-126. doi: 10.1111/j.1365-2648.2006.04063.x

Markus, H. R., & Kitayama, S. (1991). Culture and self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224-253.

Massumi, B. (2002). *Parables for the virtual: Movement, affect, sensation*. Durham, NC/London: Duke University Press.

Mays, W. (1959). *The philosophy of Whitehead*. London: George Allen & Unwin Ltd.

McAvoy, J. (2015). From ideology to feeling: Discourse, emotion, and an analytic synthesis. *Qualitative Research in Psychology, 12*(1), 22-33. doi: 10.1080/14780887.2014.958357

McCarthy, J., & Deady, R. (2008). Moral distress reconsidered. *Nursing Ethics, 15*(2), 254-262. doi: 10.1177/0969733007086023

McCormack, D. P. (2003). An event of geographical ethics in spaces of affect. *Transactions of the Institute of British Geographers, 28*(4), 488-507. doi: 10.1111/j.0020-2754.2003.00106.x

McDaniel, R. R. J., & Driebe, J. (2001). Complexity science and health care management. In J. J. Blair, M. Fottler, & G. Savage (Eds.), *Advances in health care management* (pp. 11-36). Amsterdam: Elsevier.

McSherry, R. (2002). Clinical supervision and clinical governance. *Nursing Times, 98*(23), 20.

Mead, G. H. (1934). *Mind, self and society: From the standpoint of a social behaviorist*. Chicago: The University of Chicago Press.

Meltzer, L. S., & Huckabay, L. M. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13*(3), 202-208.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London: Routledge & Kegan Paul.

Merrick, J. (2012, 9 December). NHS spending has been cut, Tories forced to admit. *The Independent*. Retrieved from http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-spending-has-been-cut-tories-forced-to-admit-8395976.html

Mesle, C. R. (2008). *Process-relational philosophy: An introduction to Alfred North Whitehead*. West Conshohocken, PA: Templeton Press.

Middleton, D., & Brown, S. D. (2005). *The social psychology of experience: Studies in remembering and forgetting*. London: SAGE.

Middleton, J. (2014, 7 May). 'The NHS needs more nurses to make it safe'. *Nursing Times*. Retrieved from http://www.nursingtimes.net/5070561.article

Midlands Psychology Group. (2014). Charting 'the mind and body economic'. *The Psychologist, 27*(4), 232-235.

Moors, A., Ellsworth, P. C., Scherer, K. R., & Frijda, N. H. (2013). Appraisal theories of emotion: State of the art and future development. *Emotion Review, 5*(2), 119-124. doi: 10.1177/1754073912468165

NHAP. (2014, 1 August). Why NHS privatisation is bad for your health. *nhap.org.* Retrieved 7 November, 2014, from http://nhap.org/whats-wrong-privatising-nhs/

NHS. (2013, 20 March). Chronic fatigue syndrome.   Retrieved 11 September, 2014, from http://www.nhs.uk/conditions/Chronic-fatigue-syndrome/Pages/Introduction.aspx

NHS. (2014). Introducing NHS Health at Work.   Retrieved 20 October, 2014, from http://www.nhshealthatwork.co.uk/

NHS. (n.d.). Workplace health.   Retrieved 20 October, 2014, from http://www.nhs.uk/Livewell/workplacehealth/Pages/workplacehome.aspx

NHS Confederation. (2014). Key statistics on the NHS *nhsconfed.org.* Retrieved 17 April, 2014, from http://www.nhsconfed.org/priorities/political-engagement/Pages/NHS-statistics.aspx

NHS Employers. (n.d.). Health and wellbeing.   *NHSEmployers.org*. Retrieved 20 October, 2014, from http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing.

NHS England. (2014). *Statistical press notice: NHS inpatient and outpatient events: February 2014*. Redditch: NHS England Retrieved from http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/MAR-February-14-SPN-77425.pdf.

NHS England. (n.d.). *NHS England: Improving A&E Performance: Gateway ref: 00062* Retrieved 17 November, 2014, from http://www.england.nhs.uk/wp-content/uploads/2013/05/ae-imp-plan.pdf.

NHS Scotland. (n.d.). Documentation and record keeping. *Advanced Nursing Toolkit*. Retrieved 17 November, 2014, from http://www.advancedpractice.scot.nhs.uk/legal-and-ethics-guidance/documentation-and-record-keeping.aspx.

NMC. (2008). *The code: Standards of conduct, performance and ethics for nurses and midwives*. London: Nursing & Midwifery Council.

NMC. (2009). *Record keeping: Guidance for nurses and midwives*. London: Nursing & Midwifery Council.

Nuffield Trust. (2014). A&E attendances in England. *nuffieldtrust.org.uk.* Retrieved 17 April, 2014, from http://www.nuffieldtrust.org.uk/data-and-charts/ae-attendances-england

'Nurses stretched'. (2014). Nurses stretched to breaking point, Unison survey warns. *Nursing Standard, 28*(32), 0-0. doi: 10.7748/ns2014.04.28.32.0.2832990

O'Donnell, P., Farrar, A., Brintzenhofeszoc, K., Conrad, A. P., Danis, M., Grady, C. (2008). Predictors of ethical stress, moral action and job satisfaction in health care social workers. *Social Work in Health Care, 46*(3), 29-51. doi: 10.1300/J010v46n03_02; 09

Ortony, A., & Turner, T. J. (1990). What's basic about basic emotions? *Psychological Review, 97*(3), 315-331. doi: 10.1037/0033-295X.97.3.315

Paley, J. (2004). Commentary: The discourse of moral suffering. *Journal of Advanced Nursing, 47*(4), 364-365. doi: 10.1111/j.1365-2648.2004.03113_2.x

Paley, J., & Eva, G. (2011). Complexity theory as an approach to explanation in healthcare: A critical discussion. *International Journal of Nursing Studies, 48*(2), 269-279. doi: 10.1016/j.ijnurstu.2010.09.012

Papoulias, C., & Callard, F. (2010). Biology's gift: Interrogating the turn to affect. *Body & Society, 16*(1), 29-56. doi: 10.1177/1357034x09355231

Parker, I. (2013). Discourse analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology, 10*(3), 223-239. doi: 10.1080/14780887.2012.741509; 19

Parker, I., & Burman, E. (2008). Critical psychology: Four theses and seven misconceptions. *Hellenic Journal of Psychology, 5*(1), 99-115.

Parrott, W. G. (2001). Emotions in social psychology: Volume overview. In W. G. Parrott (Ed.), *Emotions in social psychology: Essential readings* (pp. 1-19). Hove: Psychology Press.

Party, C. (2010). Invitation to join the government of Britain: The Conservative manifesto 2010. London: The Conservative Party.

Pendery, D. (2009, 27 February). Three top economists agree 2009 worst financial crisis since Great Depression; risks increase if right steps are not taken. *Reuters*. Retrieved from http://www.reuters.com/article/2009/02/27/idUS193520+27-Feb-2009+BW20090227

Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economics, 25*(4), 217-221.

Pinto Pereira, S. M., Geoffroy, M. C., & Power, C. (2014). Depressive symptoms and physical activity during 3 decades in adult life: Bidirectional associations in a prospective cohort study. *JAMA Psychiatry*. doi: 10.1001/jamapsychiatry.2014.1240

Plant, M. L., Plant, M. A., & Foster, J. (1991). Alcohol, tobacco and illicit drug use amongst nurses: A Scottish study. *Drug & Alcohol Dependence, 28*(2), 195-202.

Plsek, P. E., & Greenhalgh, T. (2001). The challenge of complexity in health care. *British Medical Journal, 323*(7313), 625-628. doi: 10.1136/bmj.323.7313.625

Plutchik, R. (1994). *The psychology and biology of emotion*. New York, NY: HarperCollins College Publishers.

Pollock, A. M. (2005). *NHS plc* (New Updated ed.). London: Verso.

Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: SAGE.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology, 2*(4), 281-307. doi: 10.1191/1478088705qp045oa

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: SAGE.

Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L. (2010). Compassion fatigue and burnout. *Clinical Journal of Oncology Nursing, 14*(5), E56-62. doi: 10.1188/10.CJON.E56-E62

Ramesh, R. (2012a, 21 August). NHS figures reveal 5,000 fewer nurses since 2010. *The Guardian*. Retrieved from http://www.theguardian.com/society/2012/aug/21/nhs-figures-reveal-fewer-nurses

Ramesh, R. (2012b, 12 June). Public satisfaction with NHS slumped during reforms debate, thinktank finds. *The Guardian*. Retrieved from http://www.theguardian.com/society/2012/jun/12/public-satisfaction-nhs-thinktank

Redman, B., & Fry, S. T. (2000). Nurses' ethical conflicts: What is really known about them? *Nursing Ethics, 7*(4), 360-366. doi: 10.1177/096973300000700409

Reed, J. (2012, 4 December). Is nursing lacking in compassion? *The Guardian*. Retrieved from http://www.theguardian.com/commentisfree/2012/dec/04/is-nursing-lacking-in-compassion

Reeve, J. (2005). *Understanding motivation and emotion* (4th ed.). Hoboken, NJ: Wiley.

Repenshek, M. (2009). Moral distress: Inability to act or discomfort with moral subjectivity? *Nursing Ethics, 16*(6), 734-742. doi: 10.1177/0969733009342138

Reporter, D. M. (2010, 5 January). NHS is only safe with us, declares Cameron in opening salvo of pre-election campaign as parties clash over spending. *Mail Online*. Retrieved from http://www.dailymail.co.uk/news/article-1240061/Cameron-fires-starting-gun-election-launches-Tory-Year-Change-campaign.html

Richardson, L. (2000). New writing practices in qualitative research. *Sociology of Sport, 17*(1), 5-20.

Richardson, L., & Adams St. Pierre, E. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 959-978). London: SAGE.

Richardson, R., & Kramer, E. H. (2006). Abduction as the type of inference that characterizes the development of a grounded theory. *Qualitative Research, 6*(4), 497-513. doi: 10.1177/1468794106068019

Ricoeur, P. (1981). *Hermeneutics and the human sciences : Essays on language, action and interpretation*. Cambridge: Cambridge University Press.

Ricoeur, P. (1991). Life in quest of narrative. In D. Wood (Ed.), *On Paul Ricoeur: Narrative and interpretation* (pp. 20-33). London: Routledge.

Robinson Wolf, Z., & Zuzelo, P. R. (2006). "Never again" stories of nurses: Dilemmas in nursing practice. *Qualitative Health Research, 16*(9), 1191-1206. doi: 10.1177/1049732306292544

Rose, P. (2002). *On Whitehead*. Belmont, CA: Wadsworth.

Rozin, P., Lowery, L., Imada, S., & Haidt, J. (1999). The CAD triad hypothesis: A mapping between three moral emotions (contempt, anger, disgust) and three moral codes (community, autonomy, divinity). *Journal of Personality and Social Psychology, 76*(4), 574-586. doi: 10.1037/0022-3514.76.4.574

Ruthrof, H. (1997). *Semantics and the body: Meaning from Frege to the postmodern*. London: University of Toronto Press.

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online Journal of Issues in Nursing, 16*(1), Manuscript 1.

Sampson, E. E. (1993). *Celebrating the other: A dialogic account of human nature*. Hemel Hempstead: Harvester Wheatsheaf.

Sanday, P. R. (1981). The socio-cultural context of rape: A cross-cultural study. *Journal of Social Issues, 37*(4), 5-27. doi: 10.1111/j.1540-4560.1981.tb01068.x

Sandelowski, M. (2002). Reembodying Qualitative Inquiry. *Qualitative Health Research, 12*(1), 104-115. doi: 10.1177/1049732302012001008

Sanderson, D. (2014, 3 November). Cash plea for counselling as demand for NHS staff soars. *The Herald*. Retrieved from http://www.heraldscotland.com/news/home-news/cash-plea-for-counselling-as-demand-for-nhs-staff-soars.25756458

Savage, J. (2000). One voice, different tunes: issues raised by dual analysis of a segment of qualitative data. *Journal of Advanced Nursing, 31*(6), 1493-1500. doi: 10.1046/j.1365-2648.2000.01432.x

Scherer, K. R. (2009). The dynamic architecture of emotion: Evidence for the component process model. *Cognition & Emotion, 23*(7), 1307-1351. doi: 10.1080/02699930902928969

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics, 15*(3), 304-321. doi: 10.1177/0969733007088357

Serres, M. (1982/1980). *The parasite* (L. R. Schehr, Trans.). Baltimore, MD & London: Johns Hopkins University Press.

Severinsson, E. (2003). Moral stress and burnout: Qualitative content analysis. *Nursing & Health Sciences, 5*(1), 59-66. doi: 10.1046/j.1442-2018.2003.00135.x

Severinsson, E. I., & Kamaker, D. (1999). Clinical nursing supervision in the workplace -- effects on moral stress and job satisfaction. *Journal of Nursing Management, 7*(2), 81-90. doi: 10.1046/j.1365-2834.1999.00106.x

Shiota, M. N., & Kalat, J. W. (2011). *Emotion* (2nd ed.). Belmont, CA: Wadsworth, Cengage Learning.

Shotter, J. (1993a). *Conversational realities: Constructing life through language*. London: SAGE.

Shotter, J. (1993b). *Cultural politics of everyday life: Social constructionism, rhetoric and knowing of the third kind*. Buckingham: Open University Press.

Shotter, J. (2010). Movements of feeling and moments of judgement: Towards an ontological social constructionism. *International Journal of Action Research, 6*(1), 16-42.

Shweder, R. A., Much, N. C., Mahapatra, M., & Park, L. (1997). The "big three" of morality (autonomy, community, divinity) and the "big three" explanation of suffering. In A. M. Brandt & P. Rozin (Eds.), *Morality and health* (pp. 119). London: Routledge.

Smail, D. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. Ross-on-Wye: PCCS Books.

Smith, J. A., Hollway, W., & Mishler, E. G. (2005). Commentaries on Potter and Hepburn, 'Qualitative interviews in psychology: problems and possibilities'. *Qualitative Research in Psychology, 2*(4), 309-325. doi: 10.1191/1478088705qp046cm

Speck, B. W. (1993). Defining stress as ethical conflict. *Bulletin of the Association for Business Communication, 56*(1), 34-37.

Stebnicki, M. A. (2000). Stress and grief reactions among rehabilitation professionals: Dealing effectively with empathy fatigue. *Journal of Rehabilitation, 66*(1), 23-29.

Stebnicki, M. A. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation, 10*(4), 317. doi: 10.1080/15487760701680570

Stengers, I. (2011). *Thinking with Whitehead: A free and wild creation of concepts*. Cambridge, MA: Harvard University Press.

Stenner, P. (2005a). Emotions and rights: On the interpenetration of the psychic and the social. In A. Gülerce, A. Hofmeister, I. Staeuble, G. Saunders, & J. Kaye (Eds.), *Contemporary theorizing in psychology: Global perspectives.* Concord, Ontario: Captus Press Inc.

Stenner, P. (2005b). Rights and emotions, or: on the importance of having the right emotions. *History & Philosophy of Psychology, 7*(1), 1-11.

Stenner, P. (2008). A.N. Whitehead and subjectivity. *Subjectivity, 22*(1), 90-109. doi: 10.1057/sub.2008.4

Stenner, P. (2009). On the actualities and possibilities of constructionism: Towards deep empiricism. *Human Affairs, 19*(2), 194-210. doi: 10.2478/v10023-009-0033-9

Stenner, P. (2011a). James and Whitehead: Assemblage and systematization of a deeply empiricist mosaic philosophy. *European Journal of Pragmatism and American Philosophy, 3*(1), 101-130.

Stenner, P. (2011b). Psychology in the key of life: deep empiricism and process ontology. In P. Stenner, J. Cromby, J. Motzkau, & J. Yen (Eds.), *Theoretical psychology: Global transformations and challenges* (pp. 48-58). Concord, ON: Captus.

Stermac, L. E., Segal, Z. V., & Gillis, R. (1990). Social and cultural factors in sexual assault. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault* (pp. 143-159). New York: Springer.

Stetler, R. (2010). Experience-based, body-anchored qualitative research interviewing. *Qualitative Health Research, 20*(6), 859-867. doi: 10.1177/1049732310364624

Ströhle, A. (2009). Physical activity, exercise, depression and anxiety disorders. *Journal of Neural Transmission, 116*(6), 777-784. doi: 10.1007/s00702-008-0092-x

Sundin-Huard, D., & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorising the relationships. *International Journal of Nursing Practice, 5*(1), 8-13. doi: 10.1046/j.1440-172x.1999.00143.x

Tallis, R. (2013). Introduction. In J. Davis & R. Tallis (Eds.), *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld Publications.

Tate, L., Donaldson-Feilder, E., Teoh, K., Hug, B., & Everest, G. (Eds.). (2014). *Implementing culture change within the NHS: Contributions from occupational psychology*. Leicester: The British Psychological Society.

Thien, D. (2005). After or beyond feeling? A consideration of affect and emotion in geography. *Area, 37*(4), 450-454. doi: 10.1111/j.1475-4762.2005.00643a.x

Thrift, N. (2008). *Non-representational theory: Space, politics, affect*. Abingdon: Routledge.

Trinkoff, A. M., Eaton, W. W., & Anthony, J. C. (1991). The prevalence of substance abuse among registered nurses. *Nursing Research, 40*(3), 172-174.

Trinkoff, A. M., & Storr, C. L. (1998). Work schedule characteristics and substance use in nurses. *American Journal of Industrial Medicine, 34*(3), 266-271.

Tucker, I. (2010). The potentiality of bodies. *Theory & Psychology, 20*(4), 511-527. doi: 10.1177/0959354309360947

Tucker, I. (2011). Somatic concerns of mental health service users: A specific tale of affect. *Distinktion: Scandinavian Journal of Social Theory, 12*(1), 23 - 35. doi: 10.1080/1600910X.2011.549335

Turner, J. H. (1999). Toward a general sociological theory of emotions. *Journal for the Theory of Social Behaviour, 29*(2), 133-161. doi: 10.1111/1468-5914.00095

Turner, J. H., & Stets, J. E. (2005). *The sociology of emotion*. Cambridge: Cambridge University Press.

Turner, J. H., & Stets, J. E. (2010). *The sociology of emotions*. Cambridge: Cambridge University Press.

Tyreman, S. (2011). Integrity: Is it still relevant to modern healthcare? *Nursing Philosophy, 12*(2), 107-118. doi: 10.1111/j.1466-769X.2011.00486.x

Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science & Medicine, 65*(8), 1708-1719. doi: 10.1016/j.socscimed.2007.05.050

Unsworth Webb, J. (2008). The application of ethical reasoning in mental health nursing. In J. Dooher (Ed.), *Fundamental aspects of mental health nursing* (pp. 117-130). London: Quay Books.

Vaartio, H., & Leino-Kilpi, H. (2005). Nursing advocacy—a review of the empirical research 1990-2003. *International Journal of Nursing Studies, 42*(6), 705-714. doi: 10.1016/j.ijnurstu.2004.10.005

Vaismoradi, M., Salsali, M., & Ahmadi, F. (2011). Nurses' experiences of uncertainty in clinical practice: A descriptive study. *Journal of Advanced Nursing, 67*(5), 991-999. doi: 10.1111/j.1365-2648.2010.05547.x

Valsiner, J. (2000). Data as representations: Contextualizing qualitative and quantitative research strategies. *Social Science Information, 39*(1), 99-113.

Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing, 45*(3), 316-325. doi: 10.1046/j.1365-2648.2003.02892.x

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Vygotsky, L. S. (1987/1934). *Thought and language*. Cambridge, MA: Harvard University Press.

Walker, S. K. (2012, 23 May). The myth of the 'inherited mess'. *Skwawkbox.* Retrieved 4 November, 2014, from http://skwalker1964.wordpress.com/2012/05/23/the-myth-of-the-inherited-mess-52/

Watson, D. (2002). Positive affectivity: The disposition to experience pleasurable emotional states. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 106-119). Oxford: Oxford University Press.

West, J. (2007). Ethical issues and new nurses: Preventing ethical distress in the work environment. *Kansas Nurse, 82*(4), 5-8.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse & Society, 9*(3), 387-412. doi: 10.1177/0957926598009003005

Wetherell, M. (2012). *Affect and emotion: A new social science understanding*. London: SAGE.

Wetherell, M. (2014). Trends in the turn to affect A social psychological critique. *Body & Society*, 1-28. doi: 10.11777/1357034X14539020

Wetherell, M. (2015). Tears, bubbles and disappointment–new approaches for the analysis of affective-discursive practices: A commentary on "researching the psychosocial". *Qualitative Research in Psychology, 12*(1), 83-90. doi: 10.1080/14780887.2014.958399

Whitehead, A. N. (1920/2004). *The concept of nature*. Amherst, NY: Prometheus Books.

Whitehead, A. N. (1927). *Symbolism: Its meaning and effect*. New York: Fordham University Press.

Whitehead, A. N. (1927-8/1978). *Process and reality* (Corrected ed.). New York: The Free Press.

Whitehead, A. N. (1933/1967). *Adventures of ideas*. New York: The Macmillan Company.

Whitehead, A. N. (1938/1966). *Modes of thought*. New York, NY: The Free Press.

WHO. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World health Organization.

Wilkinson, J. M. (1987/88). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29. doi: 10.1111/j.1744-6198.1987.tb00794.x

Williams, A., & Sibbald, B. (1999). Changing roles and identities in primary health care: Exploring a culture of uncertainty. *Journal of Advanced Nursing, 29*(3), 737-745. doi: 10.1046/j.1365-2648.1999.00946.x

Williams, S. (2000). Reason, emotion and embodiment: Is 'mental' health a contradiction in terms? *Sociology of Health & Illness, 22*(5), 559-581. doi: 10.1111/1467-9566.00220

Williams, S. J. (2001). *Emotion and social theory: Corporeal reflections on the (ir)rational*. London: SAGE.

Wodak, R., & Meyer, M. (Eds.). (2009). *Methods for critical discourse analysis* (2nd ed.). London: SAGE.

Wolff, E. (2010). Technicity of the body as part of the socio-technical system: the contributions of Mauss and Bourdieu. *Theoria, 76*(4), 333-354. doi: 10.1111/j.1755-2567.2010.01081.x