Tehran University of Medical Sciences

Nursing Practice Today

2025; Volume 12, No 3, pp. 304-315

Original Article

Barriers experienced by nurses working in psychiatric wards in caring for patients with mental disorders: A qualitative study

Roghaieh Keykha[1], Naima Seyedfatemi[2], Seyedeh Narjes Mousavizadeh[1], Parvaneh Vasli[3]*

[1]Department of Psychiatric Nursing and Management, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

[2]Geriatric Mental Health Research Center, Nursing and Midwifery Care Research Center, School of Nursing and Midwifery, Iran University of Medical Sciences, Tehran, Iran

[3]Department of Community Health Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

ARTICLE INFO

Received 26 February 2025
Accepted 09 April 2025

Available online at:
http://npt.tums.ac.ir

Keywords:
nurses;
care;
psychiatric nurses;
barriers to care;
qualitative research

Corresponding Author:
Parvaneh Vasli, Department of Community Health Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran. E-mail: p-vasli@sbmu.ac.ir

DOI: 10.18502/npt.v12i3.18979

ABSTRACT

Background & Aim: Providing quality care to hospitalized psychiatric patients is vital, but many barriers hinder it. This study aimed to identify the barriers faced by nurses working in psychiatric wards in providing care for inpatients with mental disorders.

Methods & Materials: This qualitative study used a conventional content analysis approach and was conducted from July 2023 to September 2024 in three hospitals in Iran. Twenty psychiatric nurses with at least six months of experience were selected through purposive sampling. Data were collected through 20 semi-structured interviews (about 45 minutes each) and analyzed using conventional content analysis with MAXQDA software (Version 10).

Results: The findings revealed two main categories of barriers that psychiatric nurses face. The first, individual-social-professional factors, include nurses' inappropriate perceptions and actions, societal and family misconceptions about psychiatric care, and mental fatigue. The second, organizational-managerial factors, include staff shortages in both quantity and quality, excessive workload, management misunderstandings about psychiatric care, lack of organizational support, lack of effective guidelines, unfavourable physical environment, inadequate healthcare and recreational facilities, and lack of financial support for nurses. In particular, lack of knowledge about mental disorders and perceived institutional neglect emerged as major barriers that significantly reduced nurses' motivation and compromised the overall quality of psychiatric care.

Conclusion: This study highlights the complex barriers to optimal psychiatric care. Overcoming these challenges through targeted interventions, such as enhancing professional support systems and organizational reforms, is essential to fostering a more conducive care environment. These measures can improve psychiatric care quality.

Introduction

A mental disorder (MD), or mental illness, refers to behavioral or psychological patterns causing significant distress or impairing daily functioning. These disorders may be persistent, recurrent, or episodic (1). Examples include schizophrenia, bipolar disorder, major depressive disorder with psychotic features, delusional disorder, and organic-related conditions (2). High-quality nursing care—defined as effective, safe, patient-centered care emphasizing timely interventions and communication—is critical for recovery and relapse prevention in psychiatric settings (3–4). Psychiatric nurses enhance patient well-being through ethical, human rights-based care and trust-building communication (5). However, dissatisfaction with hospital services and strained staff-patient relationships persist (6).

Barriers such as staff shortages, long wait times (7), treatment costs, and stigma limit care access and worsen outcomes (8). Stigma and traditional beliefs about MDs often delay care-seeking due to fear of judgment (9). Societal perceptions of psychiatric nursing also reduce workforce motivation (3). Despite efforts to improve care, systemic gaps in policies and structures hinder progress (10). This study defines "barriers" as factors impeding care access and complicating nursing practice in psychiatric wards. Addressing these challenges

Please cite this article as: Keykha R, Seyedfatemi N, Mousavizadeh S.N, Vasli P. Barriers experienced by nurses working in psychiatric wards in caring for patients with mental disorders: A qualitative study. Nursing Practice Today. 2025; 12(3):304-15.

is vital for effective treatment, complication prevention, and improved outcomes (11).

Prior studies highlight nurses' challenges in psychiatric care. In Iran, psycho-social difficulties and stressors were reported in acute wards (12). Ghanaian research emphasized resource limitations and cultural influences on schizophrenia management (13), while Saudi Arabian studies proposed strategies to improve care quality (14). Nurses caring for violent patients faced emotional stress and burnout (15). However, cultural and social barriers in Iran—such as traditional beliefs, stigma, and family dynamics—remain understudied.

Cultural and social factors significantly shape psychiatric care in Iran. Traditional beliefs about MDs perpetuate misconceptions, discouraging care-seeking (16). Family support can aid or hinder treatment (17), yet systemic issues like nurse shortages, funding gaps, resource inequities, and policy failures persist (18). Iran's mental health policy, influenced by historical and social factors, prioritizes public interventions and insurance but struggles with poor agency coordination, limited community-based care, and unsustainable funding (19).

This study addresses gaps in understanding Iran-specific cultural and social barriers faced by psychiatric nurses. By exploring these challenges, it aims to inform strategies for improving care quality and policy implementation in complex psychiatric settings.

Understanding the barriers faced by psychiatric nurses is critical to improving the quality of mental health care and ensuring better patient outcomes. This study addresses the pressing need to identify and analyze challenges in psychiatric nursing, which have been historically overlooked in healthcare systems. Shedding light on these barriers it provides a foundation for developing targeted interventions to enhance both nursing practices and organizational support structures.

Methods

Study design and setting

This research was conducted using a qualitative content analysis approach. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were followed to ensure a systematic and transparent reporting of the study findings (20).

The study was conducted across three hospitals in Iran between July 2023 and September 2024. Two of these hospitals, Taleghani Hospital and Imam Hossein Hospital, are located in Tehran and affiliated with Shahid Beheshti University of Medical Sciences. Taleghani Hospital has a psychiatric ward with separate male and female sections, each containing 12 beds and staffed by 12 nurses and 2 nursing assistants. Imam Hossein Hospital, a general hospital, houses four psychiatric units: a pediatric unit (20 beds), a women's unit (30 beds), and a men's unit (30 beds). Participants for this study were selected from the adult psychiatric units (male and female wards), each staffed by 10 nurses and one nursing assistant.

The third study site, Baharan Hospital, is a specialized psychiatric referral hospital affiliated with Zahedan University of Medical Sciences, located in southeastern Iran. It has three male psychiatric wards with a total of 64 beds, staffed by 31 nurses (male and female) and four male nursing assistants. Additionally, the hospital has a 30-bed female psychiatric unit, with 12 nurses and one nursing assistant. All nurses employed at these hospitals hold a bachelor's degree in nursing, and patients are admitted to gender-segregated wards.

Study participants

The study participants were psychiatric nurses working in psychiatric wards. A total of 20 nurses who met the inclusion criteria were selected through purposive sampling. Specifically, four participants were recruited from Taleghani Hospital, six from Imam Hossein Hospital, and ten from Baharan Hospital. The selection of the three hospitals was guided by their ability to represent diverse aspects of Iran's psychiatric care landscape, including variations in geographic location (urban vs. rural). This deliberate choice aimed to capture a wide range of barriers faced by psychiatric nurses across different contexts within the Iranian healthcare system, ensuring

the findings are more generalizable and reflective of the broader care environment.

The inclusion criteria required participants to have at least six months of psychiatric nursing experience, hold a bachelor's degree in nursing and be willing to participate and share their experiences. To ensure maximum variation and enrich the data, the study included nurses from different age groups, job positions, genders, professional experiences, and educational backgrounds, ranging from bachelor's to master's degrees. Eligible participants were identified through head nurses in the selected hospitals. Nurses who met the inclusion criteria were invited to participate voluntarily.

In total, 20 participants were selected, consisting of 16 nurses, 2 head nurses, and 2 supervisors from psychiatric wards. The sampling process continued until theoretical saturation was reached.

Although efforts were made to include both male and female participants, the majority of the sample (75%) consisted of female nurses. This gender imbalance may have influenced the diversity of perspectives, as psychiatric nursing experiences may be shaped by gender-specific factors. However, given the higher proportion of female nurses in psychiatric units, this distribution reflects the typical composition of the workforce.

Data collection

Data collection involved 20 in-depth, semi-structured interviews conducted by the first researcher, a master's degree holder in psychiatric nursing and a PhD candidate. To address potential bias arising from the first author's dual role as both a PhD candidate in psychiatric nursing and the sole interviewer, reflexivity measures were incorporated into the study. These included maintaining a reflexive journal to document personal insights and assumptions throughout the research process, as well as engaging an external reviewer to audit selected interviews for objectivity and consistency. These steps aimed to minimize the risk of social desirability bias and enhance the trustworthiness of the findings.

After obtaining informed consent, interviews were scheduled at a convenient time and location, often during work shifts in psychiatric wards. To mitigate concerns about privacy and candor during interviews conducted in psychiatric wards, additional measures were implemented to ensure confidentiality. Interviews were scheduled in private, quiet spaces within the ward whenever possible, and participants were assured that their responses would remain anonymous and inaccessible to colleagues or supervisors. These steps aimed to create a safe environment that encouraged open and honest communication.

Demographic data (age, gender, education, work experience, etc.) were collected before each interview. Open-ended questions like "How does a typical shift unfold?" and "What challenges do you encounter when providing care to patients with mental disorders?" were asked, followed by probing and clarifying questions to deepen understanding. At the end, participants were asked if anything important had been missed. As the interviews progressed, questions became more refined to explore emerging themes.

Interviews lasted 30 to 60 minutes, with an average of 45 minutes. All sessions were audio-recorded and transcribed verbatim, ensuring accuracy through repeated listening. Participants were invited to clarify any ambiguities or participate in follow-up interviews if needed.

Data analysis

In this study, data were analyzed using an inductive content analysis approach, which is one of the most common methods for systematically describing textual features and phenomena in qualitative research. This approach enables researchers to comprehensively examine the text and its contextual background to achieve a structured and scientific understanding of social phenomena (21).

As a first step, recorded interviews were meticulously listened to multiple times after each session, ensuring an in-depth familiarity with the data. Subsequently, verbatim transcriptions were created using Word13 software. After transcription, the interview texts were read

repeatedly to develop a holistic understanding of the content. Meaning units were then identified, and the initial coding process was performed by the first author. Extracted codes were compared based on their similarities and differences, with similar codes grouped into subcategories. The decision to merge or separate codes and subcategories was guided by conceptual similarities, recurrence of patterns across interviews, and theoretical relevance. Codes that conveyed overlapping meanings or described aspects of a broader phenomenon were merged into higher-order subcategories, while distinct themes that emerged as independent concepts were retained as separate subcategories. These subcategories were then compared and merged to form the main categories. External reviewers participated in bi-weekly sessions to review coded data, and any disagreements were documented and addressed through structured iterative discussions. In cases where conflicts persisted, a third independent reviewer with expertise in qualitative research was consulted to provide an objective resolution. This systematic approach ensured transparency and consistency in the coding process.

Data analysis was conducted through continuous engagement and discussion among research team members. The extracted codes and final categories were reviewed and refined through collaborative deliberations. The process of data collection and analysis proceeded simultaneously, continuing until theoretical saturation was reached—meaning no new codes emerged, and categories became recurrently stable (22). To substantiate the claim of theoretical saturation, additional metrics were incorporated into the analysis process. Code repetition rates and redundancy logs were systematically documented during data collection and analysis, with saturation determined when no new themes or significant variations emerged in the final three interviews. These measures provide a transparent and systematic basis for asserting that data saturation was achieved within the 20 interviews conducted. To efficiently manage and organize the substantial volume of data, MAXQDA10 software was utilized.

Ethical considerations

This study was approved by the Ethics Committee of Shahid Beheshti University of Medical Sciences under the ethical code IR.SBMU.PHARMACY.REC.1401.201. Additionally, all necessary permissions were obtained from relevant authorities before entering the research setting. The researcher introduced herself to the participants and explained the study's objectives before initiating the informed consent process. Those who agreed to participate provided both written and verbal consent and explicitly approved the audio recording of their interviews.

To uphold ethical principles, participants were assured that all their information would remain confidential and anonymized. Furthermore, they were informed that their participation was entirely voluntary, and they could withdraw from the study at any stage without facing any consequences or disadvantages.

Rigour

Credibility, dependability, confirmability and confirmability criteria were used to ensure the validity and reliability of the findings. Credibility was achieved through prolonged engagement with participants over multiple interactions, building trust, and triangulation using multiple sources of data, including interviews and field notes. In addition, member checking was conducted by sharing preliminary findings with six participants to validate the accuracy of the interpretations and ensure alignment with their experiences. To enhance credibility and reduce researcher bias, reflexivity was maintained through reflective journaling and ongoing discussions within the research team to critically examine assumptions and interpretations.

Dependability was ensured by checking for consistency between quotations, codes, and subcategories, and the coding process was assessed by two external reviewers (qualitative research experts with experience in psychiatric nursing studies). In addition, data were continuously reviewed by multiple researchers to ensure consistency in coding

decisions and category development. Collaborative analysis sessions were held to resolve discrepancies and refine themes. A detailed audit trail, including coding frameworks and thematic matrices, was maintained to document analytic decisions.

Confirmability was maintained by using verbatim quotes from participants to maintain authenticity and minimize researcher bias. A reflective journal was also kept to document the researcher's thoughts, decisions, and potential biases throughout the study. Transferability was enhanced by providing a clear description of the research process, participant characteristics, and study setting, with participant quotes linked to specific statements for transparency. Thorough descriptions of the context, including details about the hospitals, nursing roles, and cultural influences, were provided to allow readers to assess the applicability of the findings to others.

Results

The average age of participants in this study was 33.75 years, while their mean work experience in psychiatric wards was 6.05 years. Of the participants, 25% were male and 75% were female. Additional demographic details of the participants are presented in Table 1.

Through the data analysis process, two primary categories of barriers were identified: (1) individual-professional-social factors and (2) organizational-managerial factors (Table 2). Each category, along with its corresponding subcategories, is elaborated in detail below.

Table 1. Demographic characteristics of the participants

Code	Age	Gender	Education	Marital status	Total work experience (Year)	Psychiatric work experience (Year)	Shift type	Position	Employment status	Interview location
1	25	Female	Bachelor's	Single	3	3	Rotating	Nurse	2-year contract	Psychiatry ward/ Interview room
2	35	Female	Master's	Married	10	6	Rotating	Supervisor	Permanent	Nursing office
3	28	Male	Bachelor's	Single	5	2	Rotating	Nurse	Contractual	Psychiatry ward/ Interview room
4	38	Female	Bachelor's	Married	12	10	Rotating	Nurse	Permanent	Psychiatry ward/ Interview room
5	24	Female	Bachelor's	Single	2	2	Rotating	Nurse	2-year contract	Psychiatry ward/ Interview room
6	32	Male	Master's	Single	6	2	Morning	Head nurse	Permanent	Psychiatry ward/ Interview room
7	31	Female	Master's	Single	4.5	2	Rotating	Nurse	2-year contract	Psychiatry ward/ Interview room
8	28	Female	Bachelor's	Married	6	5	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
9	32	Female	Bachelor's	Married	9	9	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
10	35	Female	Bachelor's	Married	12	6	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
11	34	Male	Bachelor's	Married	7	4	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
12	32	Female	Master's student	Single	9	6	Rotating	Nurse	Temporary	Faculty of nursing and midwifery
13	29	Female	Bachelor's	Married	4	4	Rotating	Nurse	2-year contract	Psychiatry ward/ Interview room
14	44	Female	Bachelor's	Married	20	2	Morning	Nurse	Permanent	Psychiatry ward/ Interview room
15	44	Female	Bachelor's	Married	20	16	Morning	Head nurse	Permanent	Psychiatry ward/ Interview room
16	28	Male	Bachelor's	Single	5	5	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
17	31	Female	Bachelor's	Single	7	6	Rotating	Nurse	Permanent	Psychiatry ward/ Interview room
18	48	Female	Bachelor's	Married	18	10	Morning	Nurse	Permanent	Psychiatry ward/ Interview room
19	36	Female	Bachelor's	Married	6	2	Rotating	Nurse	Temporary	Psychiatry ward/ Interview room
20	47	Male	Bachelor's	Married	23	14	Morning	Supervisor	Permanent	Nursing office

Table 2. Categories, sub-categories, and example codes extracted from the data

Categories	Sub-categories
Individual-social-professional factors	• Inappropriate perceptions and actions of nurses • Misconceptions of families and society about psychiatric care • Mental fatigue
Organizational-managerial factors	• Quantitative and qualitative deficiencies in nursing staff • Misunderstanding of psychiatric care by managers • Lack of organizational support • lack of effective guidelines • Unfavorable physical environment • Inadequate healthcare and recreational facilities • Lack of financial support for nurses • Unnecessary workload

Individual-social-professional factors

Based on the analysis of participants' statements, the first major barrier to delivering high-quality care for patients with MDs stems from individual-social-professional factors. This category encompasses a combination of nurses' attributes, social influences, and professional challenges that may negatively impact care provision for hospitalized psychiatric patients. The subcategories derived from this analysis include: inappropriate perceptions and behaviours of nurses, misconceptions of families and society about MDs, and psychological fatigue. Each of these subcategories is elaborated on below.

Inappropriate perceptions and actions of nurses

The first subcategory, inappropriate perceptions and behaviours of nurses involves psychiatric nurses' misconceptions about the causes, nature, and treatment of MDs. These misunderstandings often lead to unprofessional conduct, such as disrespect, neglect of patient needs, or negative judgments toward those with mental illnesses. Such behaviours undermine the creation of a supportive environment and reduce the quality of care for psychiatric patients.

According to the participants, the primary reason behind these flawed perceptions and behaviours is insufficient knowledge and competency among nurses. One participant highlighted this issue regarding nurses' misconceptions about mental illness, stating:

"Many of my colleagues believe that these patients will never recover, so they subconsciously pay less attention to them. Naturally, when you think that way, you won't provide high-quality care. I used to have the same mindset when I first started working here." (Participant 5)

In terms of inappropriate behaviours toward psychiatric inpatients, another participant shared the following observation:

"Because of their condition, these patients sometimes act out in strange ways. For instance, it's not uncommon for them to insult their nurse. Unfortunately, some nurses believe they should respond in the same manner—so instead of de-escalating the situation, they start yelling back and insulting the patient." (Participant 3)

Misconceptions of families and society about psychiatric care

As expressed by the participants, nurses often work in an environment where both their families and society hold negative attitudes toward psychiatric care. A nurse's family's disapproval of their decision to work in psychiatric wards, coupled with societal stigma toward mental illness and psychiatric nurses, can significantly impact their motivation, job satisfaction, and ultimately, the quality of care they provide. One participant described the reluctance of their family to accept their work in psychiatric care:

"When I started working in the psychiatric ward, my entire family became anxious. They have such a negative perception of this field and absolutely no understanding of what we do here. My father even started calling people, trying to prevent me from being assigned to a psychiatric ward." (Participant 17)

Mental fatigue

According to the participants, one of the major professional challenges in caring for patients with MDs is the mental fatigue experienced by psychiatric nurses. This exhaustion stems from the intense emotional and cognitive demands associated with managing the complexities of psychiatric care. As highlighted by the participants, due to the patient's inability to articulate their issues, nurses are compelled to actively identify behavioural and symptomatic cues. This emotional strain, coupled with ineffective communication, can lead to psychological exhaustion and professional burnout, ultimately compromising the quality of care provided. Participant 12 described this challenge as follows:

"Taking care of these patients may not be physically exhausting, but it presents

significant mental and emotional challenges. These patients cannot express their problems, nor do they have family members accompanying them. It is entirely up to the nurse to understand what is wrong."

Organizational and managerial factors

The second category of findings pertains to organizational and managerial factors, which encompass several barriers: "Quantitative and qualitative deficiencies in nursing staff," "Managers' misconceptions about psychiatric patients," "Lack of organizational support," "lack of effective guidelines," "Inadequate physical environment," "Deficiencies in healthcare and recreational facilities" and "unnecessary workload." Each of these subcategories is elaborated below.

Quantitative and qualitative deficiencies in nursing staff

Participants indicated that both quantitative issues, such as a shortage of nursing and non-nursing staff, and qualitative shortcomings, such as the employment of inexperienced or unqualified nurses in psychiatric wards, disrupt the delivery of high-quality care to hospitalized psychiatric patients. Addressing the issue of inexperienced nurses, one participant stated:

"These patients require highly specialized and meticulous care, yet unfortunately, newly graduated nurses with no experience beyond their university internships are assigned to these wards. These inexperienced staff members become confused and overwhelmed, while patients receive suboptimal care." (Participant 7)

Misunderstanding of psychiatric care by managers

The second subcategory of organizational and managerial factors is the lack of understanding among managers regarding psychiatric care. Several participants pointed out that managerial misconceptions about the needs and care of psychiatric patients often lead to inappropriate interventions and misguided decisions, ultimately reducing the quality of care. In this regard, participant 14 provided an example of such a misunderstanding by describing an incident involving a hospital supervisor:

"Our supervisors don't understand our patients. I remember once, a supervisor came to inspect the unit while a severely ill patient was crying and asking to have the door opened. She told me to 'explain the situation and calm him down.' I had to tell her, 'He's psychotic and just admitted yesterday—how can I reason with him? This is a psychiatric ward, not a regular medical unit'"!

Lack of organizational support

Lack of organizational support, identified as the second subcategory of individual-social-professional factors, refers to the feeling of not being backed by the hospital and management in legal matters, physical and mental well-being, and job burnout. One participant elaborated on this issue:

" I was almost due when a mentally ill patient tried to escape as I was entering the ward. I had to choose between stopping them or protecting myself, so I just held the door shut. Luckily, my coworker stepped in and pulled the patient back. It was a close call—if something had happened to me, there's no financial or legal support for us in this ward." (Participant 19)

Lack of effective guidelines

The third subcategory of organizational-managerial factors was the lack of effective guidelines. Several participants emphasized the need for structured protocols to improve clinical care, but they felt that existing guidelines were neither effective nor practical in psychiatric wards. They reported that many of these protocols do not take into account the complexities of psychiatric care, particularly in crises that require immediate decision-making. According to participants, national accreditation standards and hospital guidelines were developed by individuals with little to no first-hand experience in psychiatric settings,

leading to unrealistic and impractical expectations. In addition, the rigid nature of these guidelines often prevents nurses from making clinical decisions tailored to the unique needs of psychiatric patients. As Participant 16 expressed:

"The whole mindset needs to change from the top, starting with the Ministry. If you look at the accreditation standards used for evaluation, you'd think the people who wrote them have never even stepped into a psych ward. Some of these standards just don't match our patients at all. For example, they expect us to provide certain educational sessions that are completely unrealistic for patients with severe mental disorders. These strict guidelines tie our hands and take away our ability to make real-time decisions. We need a flexible care model that lets nurses decide what's best for the patient at the moment."

In addition, some participants pointed out that the current protocols are overly idealistic and cannot be fully implemented in practice given the lack of staff and resources. As participant 13 explained:

"We try to follow the protocols we do. But psych wards, seriously need a complete overhaul. The people who designed them have no clinical experience. These guidelines are just too textbook, too abstract, and honestly, a lot of them simply don't work with severely mentally ill patients."

Unfavorable physical environment

The fourth organizational and managerial factor identified was an inadequate physical environment. Participants stressed that the layout and infrastructure of psychiatric wards play a critical role in delivering quality care. However, they pointed out that the current ward structures are substandard and serve as a major obstacle to effective patient care. The following statement illustrates this concern:

"When the ward layout is bad, nurses lose control. No matter how hard we try, it's almost impossible to provide good care. Our ward isn't just unsuitable—it's unsafe. We had a patient who was depressed and hanged himself with a bedsheet in the isolation room." (Participant 15)

Inadequate healthcare and recreational facilities

Participants highlighted that psychiatric patient, due to prolonged hospitalization, require adequate healthcare and recreational amenities to maintain physical well-being, expend energy, and alleviate feelings of stagnation. However, these resources are insufficiently provided in psychiatric wards. Below are two statements addressing the lack of healthcare and recreational facilities:

"We're short on basic supplies, like proper clothes. Some patients are young and strong, but we don't have bigger sizes. They have to wear whatever fits, and I know it must be uncomfortable, but there's nothing I can do." (Participant 6)

Lack of financial support for nurses

One of the subcategories of organizational managerial factors was the lack of financial support for nurses. Many participants expressed that inadequate salaries and benefits, given the difficulty of their work, have led to decreased motivation and job dissatisfaction. Compared to their colleagues in general hospitals, psychiatric nurses receive lower wages, even though their working conditions are often more challenging. Participants emphasized that the lack of understanding from managers regarding the difficulties of psychiatric nursing, combined with the lack of financial support and compensatory benefits, has negatively impacted their job security and mental well-being. One nurse explained this issue as follows:

"The financial situation has always been a problem. We get paid way less than nurses in other hospitals, and that's because even the hospital managers don't get how tough our job is." (Participant 12)

Another nurse highlighted the connection between financial support and psychological security:

"Financial security is a big deal for psych nurses. Compared to those in general hospitals, our salaries are way lower, even

though our job is tough. This lack of financial support affects our mental well-being too, and unfortunately, no one seems to care." (Participant 4)

Unnecessary workload

The last subcategory pertains to the unnecessary workload that nurses in psychiatric wards experience. This issue arises due to the unnecessary admission of patients by psychiatrists, which in turn places an excessive and avoidable burden on nurses, consuming valuable time that could otherwise be spent on critical patient care. Consequently, this practice reduces the overall quality of care delivered to psychiatric inpatients.

One participant emphasized how certain psychiatrists contribute to this problem by admitting patients who do not require hospitalization, stating:

"Some psychiatrists admit patients who don't even need to be there, just to fill beds and make money. These patients leave within a day, but nurses end up wasting time on all the paperwork. Instead of focusing on the sick patients, we're stuck dealing with admissions and discharges because the psychiatrists don't think about the mess it creates." (Participant 13)

Discussion

The findings of this study revealed that psychiatric nurses face two broad categories of barriers when caring for patients with MDs: individual-social-professional factors and organizational-managerial factors. Each of these categories and their respective subcategories independently, and sometimes in interaction with one another, negatively impact the quality of care provided to hospitalized psychiatric patients.

The first subcategory, nurses' misconceptions and inappropriate actions, stems from inadequate knowledge about mental illnesses, treatment, and recovery. These misconceptions lead to unprofessional behaviors, such as neglect or negative judgments, undermining care quality. A study by Hurley et al. (23) in Greece similarly found that nurses lacked adequate psychiatric care knowledge, though contrasting evidence highlights positive attitudes toward recovery-based approaches (24). The current study emphasizes that these misconceptions arise from insufficient training and experience.

The second subcategory, psychological fatigue, reflects the emotional and cognitive strain of managing complex patient needs. This aligns with Cisneros' (25) findings, where staff reported burnout due to safety concerns and multitasking demands. Psychological fatigue, exacerbated by inadequate facilities and organizational barriers, risks long-term burnout, further compromising care.

The third subcategory, misconceptions of families and society, highlights stigma surrounding psychiatric care. Societal and familial disapproval of nurses' roles, as noted in Saudi Arabia (14) and Ghana (26), reduces motivation and reinforces stigma. In Iran, these factors may be more pronounced due to stronger cultural stigma, necessitating public awareness campaigns and improved education to address professional identity challenges.

The first subcategory, quantitative and qualitative staffing deficiencies, includes shortages of skilled nurses and reliance on inexperienced staff. Sun et al. (27) identified similar gaps in training programs, while Australian studies highlighted graduates' lack of psychiatric competencies (23). These systemic deficiencies directly impair care quality.

The second subcategory, managerial misunderstandings of psychiatric care, reflects poor awareness among administrators. For example, rigid protocols and unrealistic guidelines, as noted by participants, mirror findings from Amiri et al. (29) and Sierra Leone's mental health challenges (30). Managers' lack of insight leads to ineffective decisions, such as unsafe ward layouts (Participant 15) or impractical accreditation standards (Participant 16).

Lack of organizational support further exacerbates challenges. Nurses cite minimal legal/financial backing (Participant 19) and inadequate physical environments (e.g., unsafe wards), aligning with studies on resource shortages (28, 29). Insufficient healthcare/recreational facilities (Participant 6)

and low financial incentives (Participants 12, 4) compound these issues, reducing job satisfaction and care quality.

Unnecessary workload, driven by avoidable patient admissions, diverts time from critical care (Participant 13). This systemic inefficiency, combined with staffing shortages, highlights the need for policy reforms to streamline admissions and reduce administrative burdens.

In Iran, organizational-managerial challenges may be more pronounced due to systemic resource limitations and cultural stigma. Compared to countries with robust mental health infrastructures, Iran's reliance on inexperienced staff, inadequate facilities, and ineffective policies (19) underscores the urgency for targeted investments and structural reforms.

Limitations and future research

A key limitation is the potential influence of the primary researcher's dual role (a doctoral student in psychiatric nursing) on data interpretation, despite reflexivity measures. Future studies should involve multidisciplinary teams to minimize bias. Additionally, the small number of male participants and nurses without specialized training limits generalizability.

Future research should employ ethnographic or grounded theory approaches to explore care dynamics more deeply. Including perspectives of psychiatrists, psychologists, and family caregivers could provide a holistic understanding of barriers to quality care.

Conclusion

This study is valuable and unique in two main ways. First, it is the first to explore nurses' experiences regarding barriers to providing quality care for patients with MDs in Iran. Second, its qualitative approach offers deeper insights into the interplay of individual-social-professional and organizational-managerial challenges in psychiatric nursing care.

A critical barrier identified is inadequate knowledge and skills among psychiatric nurses, rooted in insufficient training and misconceptions about MDs. Addressing this requires structured educational programs focusing on evidence-based psychiatric care, practical skill development, and ongoing workshops to update nurses' competencies. Integrating specialized courses into nursing curricula and fostering clinical mentorship could bridge this gap.

Organizational-managerial barriers, including staff shortages, poor physical environments, and managerial misunderstandings, significantly hinder care quality. For instance, unnecessary patient admissions by psychiatrists create avoidable workloads, diverting nurses from critical tasks. To mitigate these issues, healthcare organizations must:

- Revise staffing policies to align with psychiatric ward demands,
- Upgrade ward infrastructure to ensure safety and functionality,
- Develop flexible, context-specific guidelines co-designed with frontline nurses,
- Enhance financial and emotional support systems to reduce burnout.

The study also underscores the impact of societal stigma and familial disapproval on nurses' motivation. Community education campaigns, involving psychologists and social workers, could improve public perceptions of psychiatric care and strengthen family support for both patients and nurses.

This study highlights the urgent need for multilevel interventions—from educational reforms to systemic policy changes—to address barriers in Iran's psychiatric care system. By aligning training, resources, and societal attitudes with clinical realities, stakeholders can enhance care quality and support the critical role of psychiatric nurses in mental health recovery.

References

1. Xiao Y, Yu Y, Zhou Z, Liu W, Luo Z, Tang C, et al. Hospital spending and length of hospital stay for mental disorders in Hunan, China. Heliyon. 2023;9(4):e14968. https://doi.org/10.1016/j.heliyon.2023.e14968

2. Bao L, Shi C, Lai J, Zhan Y. Impact of humanized nursing care on negative emotions and quality of life of patients with mental disorders.

American Journal of Translational Research. 2021;13(11):13123-8.
3. Rahmani N, Mohammadi E, Fallahi-Khoshknab M. Nurses' experiences of the causes of their lack of interest in working in psychiatric wards: A qualitative study. BMC Nursing. 2021;20:1-8. https://doi.org/10.1186/s12912-021-00766-1
4. Stavropoulou A, Rovithis M, Kelesi M, Vasilopoulos G, Sigala E, Papageorgiou D, et al. What quality of care means? Exploring clinical nurses' perceptions on the concept of quality care: A qualitative study. Clinics and Practice. 2022;12(4):468-81. https://doi.org/10.3390/clinpract12040051
5. Panneerselvam S, Ramasamy S. Psychiatric nursing: A specialty in greater demand. Journal of Integrative Nursing. 2023;5(1):73-4. https://doi.org/10.4103/jin.jin_82_22
6. Wood L, Williams C, Billings J, Johnson S. The therapeutic needs of psychiatric in-patients with psychosis: A qualitative exploration of patient and staff perspectives. BJPsych Open. 2019;5(3):e45. https://doi.org/10.1192/bjo.2019.33
7. Björk Brämberg E, Torgerson J, Norman Kjellström A, Welin P, Rusner M. Access to primary and specialized somatic health care for persons with severe mental illness: A qualitative study of perceived barriers and facilitators in Swedish health care. BMC Family Practice. 2018;19:1-11. https://doi.org/10.1186/s12875-017-0687-0
8. Reichert A, Jacobs R. The impact of waiting time on patient outcomes: Evidence from early intervention in psychosis services in England. Health Economics. 2018;27(11):1772-87. https://doi.org/10.1002/hec.3800
9. Ahad AA, Sanchez-Gonzalez M, Junquera P. Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. Cureus. 2023;15(5):e39549. https://doi.org/10.7759/cureus.39549
10. Cusack E, Killoury F, Nugent L. The professional psychiatric/mental health nurse: Skills, competencies and supports required to adopt recovery-orientated policy in practice. Journal of Psychiatric and Mental Health Nursing. 2017;24(2-3):93-104. https://doi.org/10.1111/jpm.12347
11. Bolton P, West J, Whitney C, Jordans MJ, Bass J, Thornicroft G, et al. Expanding mental health services in low- and middle-income countries: A task-shifting framework for delivery of comprehensive, collaborative, and community-based care. Cambridge Prisms: Global Mental Health. 2023;10:e16. https://doi.org/10.1017/gmh.2023.5
12. Zarea K, Fereidooni-Moghadam M, Baraz S, Tahery N. Challenges encountered by nurses working in acute psychiatric wards: A qualitative study in Iran. Issues in Mental Health Nursing. 2018;39(3):244-50. https://doi.org/10.1080/01612840.2017.1377327
13. Daliri DB, Laari TT, Abagye N, Afaya A. Exploring the experiences of mental health nurses in the management of schizophrenia in the Upper East Region of Ghana: A qualitative study. BMJ Open. 2024;14(3):e079933. https://doi.org/10.1136/bmjopen-2023-079933
14. Alyousef SM, Alhamidi SA. Nurse views of obstacles encountered by nurses in Saudi Arabia during the provision of psychiatric care. Archives of Psychiatric Nursing. 2023;44:8-17. https://doi.org/10.1016/j.apnu.2023.03.005
15. Sim IO, Ahn KM, Hwang EJ. Experiences of psychiatric nurses who care for patients with physical and psychological violence: A phenomenological study. International Journal of Environmental Research and Public Health. 2020;17(14). https://doi.org/10.3390/ijerph17145159
16. Farsi Z, Taghva A, Butler SC, Tabesh H, Javanmard Y, Atashi A. Stigmatization toward patients with mental health diagnoses: Tehran's stakeholders' perspectives. Iranian Journal of Psychiatry and Behavioral Sciences. 2020;14(3):e93851. https://doi.org/10.5812/ijpbs.93851
17. Hamidi S, Ebrahimi H, Vahidi M, Areshtanab HN. Internalized stigma and its association with hope, self-esteem, self-efficacy, and treatment adherence among outpatients with severe mental illness: A cross-sectional survey. Iranian Journal of Nursing and Midwifery Research. 2023;28(3):345-51. https://doi.org/10.4103/ijnmr.ijnmr_248_21
18. Sheikhbahaeddinzadeh E, Ashktorab T. Challenges encountered by nurses in psychiatric wards in Iran: A hermeneutic phenomenological study. Knowledge of Nursing. 2023;1(1):74-90. https://doi.org/10.61186/knjournal.1.1.74
19. Rastegar H, Morasae EK, Doshmangir L. The dynamics of mental health policy in Iran over the last century. BMC Psychology. 2025;13(1):51. https://doi.org/10.1186/s40359-025-02384-x
20. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007;19(6):349-57. https://doi.org/10.1093/intqhc/mzm042
21. Renz SM, Carrington JM, Badger TA. Two strategies for qualitative content analysis: An intramethod approach to triangulation. Qualitative

Health Research. 2018;28(5):824-31. https://doi.org/10.1177/1049732317753586
22. Polit D, Beck C. Essentials of Nursing Research: Appraising Evidence for Nursing Practice. Philadelphia: Lippincott Williams & Wilkins; 2020.
23. Hurley J, Lakeman R, Moxham L, Foster K, Hazelton M, Happell B. Under prepared for practice: A qualitative study of mental health nurse undergraduate workforce preparation in Australia. Issues in Mental Health Nursing. 2024;45(8):850-6. https://doi.org/10.1080/01612840.2024.2354385
24. Sreeram A, Cross WM, Townsin L. Mental health nurses' attitudes towards mental illness and recovery-oriented practice in acute inpatient psychiatric units: A non-participant observation study. International Journal of Mental Health Nursing. 2023;32(4):1112-28. https://doi.org/10.1111/inm.13152
25. Cisneros CJ. Experience of Burnout Among Psychiatric Hospital Staff [dissertation]. Minneapolis: Walden University; 2023.
26. Mensah DK. Perspectives of psychiatric nurses on the stigmatization of mental healthcare in Ghana: A qualitative study. Frontiers in Public Health. 2024;12:1423445. https://doi.org/10.3389/fpubh.2024.1423445
27. Sun M, Zhou H, Li Y, Wang J, Yang W, Gong Y, et al. Professional characteristics, numbers, distribution and training of China's mental health workforce from 2000 to 2020: A scoping review. The Lancet Regional Health - Western Pacific. 2024;45. https://doi.org/10.1016/j.lanwpc.2023.100992
28. Cranage K, Foster K. Mental health nurses' experience of challenging workplace situations: A qualitative descriptive study. International Journal of Mental Health Nursing. 2022;31(3):665-76. https://doi.org/10.1111/inm.12986
29. Amiri S, Vasli P, Mohtashami J, Memaryan N. Barriers to provision of spiritual care in mental health care centers: A qualitative content analysis. Iranian Journal of Psychiatry and Behavioral Sciences. 2021;15(4):e115702. https://doi.org/10.5812/ijpbs.115702
30. Hopwood H, Harris D, Sevalie S, Iyawa G, Langan Martin J. The barriers and facilitators to decentralised nurse-led mental health service delivery in Sierra Leone. Community Mental Health Journal. 2023;59(6):1071-82. https://doi.org/10.1007/s10597-023-01087-0