Moral Distress

Identification among inpatient oncology nurses in an academic health system

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BACKGROUND: Moral distress occurs when clinicians know the morally correct action to take but are unable to follow through because of internal and external constraints. It is associated with negative consequences, such as burnout, decreased job satisfaction, avoidance, and turnover.

OBJECTIVES: The purpose of this study was to describe the frequency and level of moral distress among inpatient oncology nurses and to identify possible associations among nurses' demographic characteristics, work experience, and moral distress levels.

METHODS: Ninety-three inpatient oncology nurses from a large academic health system completed the Moral Distress Scale–Revised (MDS-R). Additional questions included intent to leave and requests for changes in patient assignments because of moral distress.

FINDINGS: Years as a nurse, changing or considering changing patient assignments, and changing care provided to a patient because of moral distress were statistically significantly associated with higher MDS-R scores. Participants reported using palliative care consultations, pastoral care, and social work to assist with their moral distress.

KEYWORDS
moral distress; oncology nursing; stress; psychological; staffing

MORAL DISTRESS WAS FIRST DESCRIBED AS KNOWING the morally correct action to take but being unable to follow through because of internal and external constraints (Jameton, 1984). Internal constraints include self-doubt and perceived powerlessness, and external constraints include inadequate staffing, lack of administrative support, and hierarchies within the healthcare system (Hamric et al., 2012). More recently, moral distress has been defined as "one or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable" (Campbell et al., 2016, p. 6). In the context of health care, moral distress occurs when "providers believe that they are being involuntarily complicit in acting unethically—they are doing something that they believe to be morally wrong but have little power to act differently or to change the situation" (Hamric & Epstein, 2017, p. 127).

The Moral Distress Scale (MDS) was originally created to measure moral distress among critical care nurses (Corley et al., 2001). In 2007, Hamric and Blackhall shortened the scale and narrowed the focus to end-of-life care and validated it for use by nurses and physicians. In 2012, Hamric et al. further revised the instrument to include more root causes of moral distress, expand the use beyond intensive care settings, and make it appropriate for use among multiple disciplines. Currently, the MDS-Revised (MDS-R) is the most widely used instrument to quantify the phenomenon (Hamric et al., 2012). The MDS-R presents 21 scenarios that could potentially invoke moral distress. Scores range from 0 to 336, with lower scores indicating lower moral distress and higher scores indicating higher moral distress. Hamric et al. (2012) have not identified specific cut points within the scoring to discretely identify low, moderate, or high moral distress.

A nascent body of literature describes moral distress among multiple healthcare providers in various clinical settings nationally and internationally (Austin et al., 2017; Fumis et al., 2017; Neumann et al., 2017; Whitehead et al., 2015). Austin et al. (2017) studied nurses and physicians across the midwestern United States. Other investigators evaluated moral distress among nurses, physicians, chaplains, dietitians, pharmacists, social workers, and therapists in Virginia (Whitehead et al., 2015). Neumann et al. (2017) described moral distress among hematopoietic cell transplantation professionals, including nurses, physicians, pharmacists, and social workers, who completed the survey. A study of critical care and step-down providers in Brazil included physicians, nurses, nurse technicians, and respiratory therapists (Fumis et al., 2017). Across these studies, moral distress was present

among interprofessional representative groups at varying levels. In general, nurses tended to have higher scores.

The moral distress experience of nurses has been described across various specialties and geographic settings. Dyo et al. (2016) surveyed adult and pediatric critical care and noncritical care nurses across a five-hospital system in California using the original MDS by Corley et al. (2001); they reported that critical care nurses had higher levels of moral distress than noncritical care nurses. Similarly, Sirilla et al. (2017) evaluated moral distress among nurses in a large academic health system and reported higher rates among critical care nurses but an overall average score of 94.97 (range = 44.57–134.58). Lusignani et al. (2017) surveyed nurses working across 46 medical, surgical, and intensive care units at a hospital in Italy and reported that nurses working in medical settings had the highest levels of moral distress. Hamaideh (2014) used a version of the MDS created specifically for psychiatric nurses to evaluate moral distress among a sample of mental health nurses in Jordan and reported that moral distress was present at moderately high levels. One qualitative study of moral distress among chief nursing officers described themes regarding how they experienced moral distress (Prestia et al., 2017).

Only three studies were identified among oncology nurses that have examined moral distress. Ameri et al. (2016) evaluated nurses across eight hospitals in Iran and reported that moral distress was present at moderate to high levels. Sirilla (2014) evaluated nurses from a National Cancer Institute–designated cancer center in the midwestern United States. The mean moral distress score was 81.36 (range = 4–266); the majority of nurses reported lower levels of moral distress. Lazzarin et al. (2012) used the pediatric version of the MDS (MDS-PV) to describe moral distress among pediatric nurses in Italy. The adapted MDS-PV has a score range from 0 to 1,188, with higher scores indicating higher levels of moral distress. The overall mean MDS-PV score was 229.41 (range = 0–956). In summary, the frequency and level of disturbance of moral distress among nurses specializing in oncology has limited understanding.

Negative consequences of moral distress have also been described. Moral distress has been correlated with emotional and psychological exhaustion and burnout among nurses (McCarthy & Gastmans, 2015; Wiegand & Funk, 2012). Some studies have found that moral distress can decrease job satisfaction, leading to avoidance, nursing turnover, and nurses leaving the profession altogether (Austin et al., 2017; Dyo et al., 2016; Henrich et al., 2017; Huffman & Rittenmeyer, 2012; McCarthy & Gastmans, 2015; Sirilla, 2014; Sirilla et al., 2017; Wiegand & Funk, 2012). Nursing turnover is estimated to cost $44,380 to $63,400 per nurse, which can ultimately cost hospitals $4.21 million to $6.02 million per year (Yarbrough et al., 2017). In addition, morally distressing situations may become time consuming, leading to the neglect of other patients (Henrich et al., 2017).

There have been few studies of oncology nurses and their moral distress experience. In addition, studies have evaluated data with various instruments, affecting the interpretation of the results. Oncology nurses in particular may be exposed to specific stressors, including using new technology, administering aggressive treatment with adverse effects, and caring for patients with increased lengths of stay and repeat admissions (Cohen & Erickson, 2006; Shepard, 2010). The current study aims to describe moral distress among inpatient oncology nurses and identify possible associations among nurses' demographic characteristics, work experience, and moral distress levels.

"Avoidance behaviors can place unintentional stress on other staff and may also lead to staff shortages and limited patient interaction."

Methods

Design, Sample, and Setting

This study used a descriptive correlational design to describe the frequency and level of moral distress among oncology nurses within Penn Medicine, an academic health system with acute care hospitals in Pennsylvania and New Jersey. A convenience sample of 293 inpatient direct care nurses were invited to participate. Certified nursing assistants and nurses not involved in direct patient care were excluded. Demographic variables, including gender, race, ethnicity, highest level of education, years of nursing experience, years of oncology nursing experience, and age, were collected.

Measures

The MDS-R is a Likert-type scale survey containing 21 distressing scenarios (Hamric et al., 2012). Participants rate the frequency and level of disturbance for each scenario from 0 to 4. Frequency scores range from 0 (never) to 4 (very frequently), and the level of disturbance ranges from 0 (none) to 4 (great extent). The individual scenario score is calculated as the product of the frequency times the level of disturbance, leading to a potential score of 0–16. Each scenario is then totaled for the overall score, ranging from 0 to 336. A higher MDS-R composite score indicates higher levels of moral distress. Additional questions inquired about intent to leave, calling out sick, requesting a change in assignment, how

moral distress changed or influenced the care provided, and resources used related to moral distress.

Procedures

Institutional review board approval was obtained prior to study initiation. Participants were recruited via flyers, email invitation, and nursing huddles at unit leadership's request. Research participation was voluntary. Survey data were collected via Qualtrics, a web-based software application used for survey administration. Survey completion required about 20 minutes of the participant's time. The survey invitation was open to health system inpatient oncology nurses from July to October 2018. Nurses could complete the survey at a time that was convenient for them.

Data Analysis

Univariate statistics were used to describe the sample. MDS-R scores were compared across survey participants' responses to demographic and work experience responses using t test and analysis of variance (ANOVA). Statistical significance was set at $p < 0.05$. The final sample size achieved sufficient power (96%) to detect a change in the mean MDS-R score as small as 1.2 points, with a standard deviation of 0.6 using linear regression at a significance level set to $p < 0.05$. Participants had the opportunity to answer open-ended questions, including describing situations in which moral distress influenced or changed the care they provided. On completion of the survey, participants were asked to respond to the following question: "In 300 words or less, please describe how you feel after completing this survey." Responses were reviewed and examined for common themes.

Results

Sample Characteristics

Ninety-three nurses completed the survey (response rate = 32%). The sample was predominantly female (93%), White (83%), and bachelor's-prepared (90%). Participants were, on average, aged 31.4 years, with an average of 5.8 years of nursing experience. Similar years of experience in both oncology and current position were observed. The majority of participants were full-time employees working day shift (see Table 1).

MDS-R Scores

The mean MDS-R score was 78.3. The top three morally distressing scenarios identified were as follows (see Table 2):

- Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.
- Witness healthcare providers giving "false hope" to a patient or family.
- Initiate extensive life-saving actions when I think it only prolongs death.

Almost half of the participants reported considering leaving or having left a clinical practice position because of a morally distressing situation (see Table 3). However, only 13% of participants indicated considering leaving a clinical oncology nursing position because of moral distress. More than one-third called

TABLE 1.
SAMPLE CHARACTERISTICS (N = 93)

CHARACTERISTIC	$\bar{X}$	SD
Hours worked weekly	35.8	5.2
Age (years)	31.4	8.8
Years as an RN in any organization	5.8	6
Years as an oncology RN in any organization	4.3	4.7
Years as an oncology RN in current organization	3.9	4.1
CHARACTERISTIC		**n**
Gender		
Female		86
Male		7
Race (N = 92)		
White		77
Other		15
Ethnicity (N = 81)		
Non-Hispanic/Latino		75
Hispanic/Latino		6
Highest level of completed education		
Bachelor's degree		84
Other		9
Primary shift		
Day		43
Night		30
Evening		20
Chemotherapy certified/chemotherapy competent		
Yes		86
No		7
Nurse residency program		
Yes		54
No		39

out of work because of moral distress, and another one-third considered it.

ANOVA revealed a statistically significant difference in MDS-R scores based on an individual's response to calling out, requesting to change their patient assignment, and endorsing changing the care they provided because of moral distress. Individuals who called out from work and who considered calling out both had statistically significantly higher MDS-R scores than those who did not call out or consider calling out. In addition, 43% of participants requested a different assignment because of moral distress, and 40% considered doing so ($p = 0.026$). Individuals requesting to change their patient assignment scored statistically significantly higher than those who had not. More than half of the participants reported that moral distress influenced or changed the care they provided in some way. Individuals who endorsed changing the care they provided because of moral distress had statistically significantly higher MDS-R scores than those who did not. Few participants felt they worked in an unethical environment.

TABLE 2.
ONCOLOGY NURSE MORAL DISTRESS: MDS-R SCORES FOR INDIVIDUAL SCENARIOS (N = 93)

MDS-R ITEM	$\bar{X}$	SD
Overall	78.3	37.8
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	7.78	4.91
Witness healthcare providers giving "false hope" to a patient or family.	6.69	4.78
Initiate extensive life-saving actions when I think it only prolongs death.	6.62	4.91
Witness diminished patient care quality because of poor team communication.	6.31	4.29
Watch patient care suffer because of a lack of provider continuity.	5.33	4.75
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	5.19	4.27
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	4.94	3.94
Follow the family's request not to discuss death with a dying patient who asks about dying.	4.49	4.19
Work with levels of nurse or other care provider staffing that I consider unsafe.	4.32	4.88
Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.	3.68	4.24
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	3.56	3.61
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	3.52	4.25
Assist a physician who, in my opinion, is providing incompetent care.	2.81	3.07
Provide less than optimal care because of pressures from administrators or insurers to reduce costs.	2.45	3.59
Be required to care for patients I do not feel qualified to care for.	2.26	2.59
Ignore situations in which patients have not been given adequate information to ensure informed consent.	1.84	3.08
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	1.53	2.3
Witness medical students perform painful procedures on patients solely to increase their skill.	1.39	3.05
Continue to participate in care for a hopelessly ill person who is sustained on a ventilator when no one will make a decision to withdraw support.	1.34	3.09
Take no action about an observed ethical issue because involved staff member or someone in a position of authority requested that I do nothing.	1.31	2.59
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	0.98	1.64

MDS-R—Moral Distress Scale–Revised
Note. Individual scenario scores = frequency x level (range = 0–16). All MDS-R items are ranked in order by participants' perceived frequency and level of disturbance.
Note. Higher scores indicate greater levels of moral distress.
Note. Based on information from Hamric et al., 2012.

TABLE 3.
ONCOLOGY NURSE MORAL DISTRESS AND WORK HISTORY: MDS-R SCORES

QUESTION	n	$\bar{X}$ MDS-R	SD	p
Have you ever left or considered leaving a clinical position because of a morally distressing situation? (N = 92)				0.051[a]
No	48	70.7	38.5	
Yes, considered	38	89.3	34.4	
Yes, left	6	63.5	39.6	
Are you considering leaving your current position because of moral distress? (N = 92)				0.09[a]
Yes	12	92.8	37.1	
No	61	71.8	37.7	
Maybe	19	88.1	35.7	
Have you ever called out from work because of moral distress? (N = 91)				0.002[a]
Yes	32	84.2	37.6	
No, but considered	34	88.7	34.5	
No, did not consider	25	56.1	35	
Have you ever requested a different patient assignment or to not care for a patient because of moral distress? (N = 91)				0.026[a]
Yes	39	85.2	35.6	
No, but considered	36	80.5	35.8	
No, did not consider	16	55.6	41.6	
Did you ever feel that moral distress influenced or changed the care you provided to a patient in any way? (N = 92)				0.002[b]
Yes	56	87.3	29.4	
No	36	63.2	44.7	
Do you feel you work in an ethical work environment that can mitigate moral distress? (N = 90)				0.066[b]
Yes	79	75.3	37	
No	11	99.7	37.3	

[a] Analysis of variance
[b] t test
MDS-R—Moral Distress Scale–Revised
Note. Total scores range from 0 to 336, with higher scores indicating greater levels of moral distress.
Note. Based on information from Hamric et al., 2012.

A multivariable linear regression indicated that years as a nurse, individuals who requested or considered requesting a change in patient assignment because of moral distress, and those who changed the care they provided in any way were significantly associated with moral distress (see Table 4). Each additional year of nursing experience was associated with a nearly two-point increase in MDS-R scores (p = 0.003). Requesting a change in patient assignment was associated with a 25-point increase in MDS-R scores compared to those who never considered requesting a change (p = 0.016). Feeling that moral distress influenced or changed the care provided was associated with a 25.5-point increase in MDS-R scores (p = 0.001).

Resources

To understand resources used by staff related to their moral distress, participants were asked to identify resources from a list of

TABLE 4.
ONCOLOGY NURSE MORAL DISTRESS VARIABLES: MULTIVARIABLE LINEAR REGRESSION MORAL DISTRESS SCALE–REVISED ESTIMATED SCORES (N = 93)

VARIABLE	COEFFICIENT (β)	95% CI	p
Intercept	34.4	[14.5, 54.2]	0.001
Years as RN	1.8	[0.6, 3]	0.003
Have you ever requested a different patient assignment or to not care for a patient because of moral distress?			
No, never considered	Reference	–	–
Yes	25.1	[4.8, 45.5]	0.016
No, but considered	17.2	[–3.9, 38.3]	0.109
Did you ever feel that moral distress influenced or changed the care you provided to a patient in any way?			
No	Reference	–	–
Yes	25.5	[10.1, 41]	0.001

CI—confidence interval

options available at the organization where the study took place (see Table 5). Participants most frequently used palliative care consultations, pastoral care or chaplain, and social work departments. Participants were then asked to select resources they would be interested in using if they were available. Individuals reported most interest in annual retreats for nursing staff, individual self-care activities, and regular debriefing sessions to address moral distress.

Responses to Open-Ended Questions

Participants were asked if moral distress had ever influenced or changed the care they provided in any way. Those who answered "yes" were asked to further describe this change. Some participants reported why their care changed, and others described how their care changed. For example, some responses included the following:

- "Burnout or moral distress can cause a nurse to shut down."
- "I may detach and just go through the motions."

Others described how these emotional responses affected their care. One participant stated, "I am not whole when this [is] occurring, so I am not all there and present. I am distracted." Similarly, another participant responded, "I have had to 'pull away' emotionally from certain patients because of moral distress, and it's affecting my concentration at work and at home." Two participants described the effect moral distress has on their attendance as follows:

- "At times, it has caused me to not want to come to work."
- "[I] was handling a morally distressing patient, so I called out the next day because I did not feel I could adequately perform my job."

Although some described moral distress's negative consequences related to patient care, some participants reported positive effects. One participant stated, "In a good way, [it] made me more sincere and provide emotional support."

Discussion

This descriptive correlational study of moral distress among oncology nurses practicing in an academic health system sheds light on an important phenomenon. The findings of the current study demonstrate that although moral distress appears to be present at low to moderate levels ($\bar{X}$ MDS-R score = 78.3), morally distressing situations may lead to negative effects. Because of these situations, nurses reported considering leaving their positions, calling out of work, requesting changes in their patient assignments, and changing the care they provide to patients.

Mean MDS-R scores in this study were similar to those reported in the literature. Sirilla et al. (2017) reported that medical/surgical nurses at an academic medical center had a mean score of 76.04, but this study did not exclusively include oncology nurses. Among studies focusing on oncology nurses, Neumann et al. (2017) reported a mean MDS-R score of 62.3 and Sirilla (2014) reported a mean MDS-R score of 81.36. However, response rates for these studies were low (16% and 20%, respectively), limiting their generalizability. Despite existing descriptive literature on moral distress, study results are limited and not completely descriptive of oncology nurses, particularly those in academic medical centers where oncology care may be more intense. This study contributes to the existing literature by providing evidence

of moral distress in a larger sample of oncology-specific nurses at an academic medical center.

Two of the top three morally distressing scenarios—follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient, and initiate extensive life-saving actions when I think it only prolongs death—were in the top scenarios in other studies among interprofessional healthcare providers (Hamric et al., 2012; Whitehead et al., 2015). The differences in scenarios contributing to the development of moral distress may be because of the varying patient populations, differences in the nursing populations, and variability or inconsistency in measuring instruments. Although Neumann et al. (2017) and Sirilla (2014) studied similar populations, they did not report top morally distressing scenarios. Understanding specific morally distressing situations oncology nurses experience is a vital first step to inform the development and targeted implementation of interventions capable of mitigating moral distress.

Findings related to nursing turnover were similar in other studies as well. Hamric et al. (2012) reported that 20% of healthcare professionals considered leaving their current position. Another study of nurses providing direct patient care at an academic medical center reported that nurses considering quitting at the time of the survey scored 30.33 points higher for MDS-R than those who were not considering quitting ($p < 0.0001$) (Sirilla et al., 2017). These earlier studies' findings are consistent with the results from the current study. Nurses experiencing high levels of moral distress are also considering leaving the workforce, underscoring the need for occupation-specific workplace interventions to mitigate moral distress.

Results from this study suggest that years as a nurse, requesting or considering requesting a different assignment, and influencing or changing patient care were significantly associated with increased MDS-R scores. This is particularly important given the negative consequences associated with moral distress, such as avoidance and decreased quality of care (Austin et al., 2017; Dyo et al., 2016; Henrich et al., 2017; Huffman & Rittenmeyer, 2012; McCarthy & Gastmans, 2015; Sirilla et al., 2017; Wiegand & Funk, 2012). Avoidance behaviors, such as calling out of work and requesting new patient assignments, can place unintentional stress on other staff and may also lead to staff shortages and limited patient interaction. These results highlight the need to support experienced nurses at risk for moral distress to ensure a healthy nurse workforce, which provides high-quality care, specifically in oncology.

Results from this study indicate that nurses who request a different assignment experience higher levels of moral distress. This study's findings contribute to the foundation of quality clinical care. With this study's additional findings, nurse leaders can better identify nurses who may be experiencing moral distress. For nurses calling out of work after involvement in one of the top three morally distressing scenarios, nurse leaders can proceed to offer nurses interventions to alleviate moral distress.

Strengths and Limitations

Overall, the moral distress instrument had good reliability based on Cronbach alpha ($\alpha = 0.91$), indicating a high reliability of the findings regarding the authors' detection of moral distress. The

TABLE 5.
ONCOLOGY NURSE MORAL DISTRESS: RESOURCES USED AND RESOURCES OF INTEREST (N = 93)

CHARACTERISTIC	n
Have you ever used these hospital resources or attended these trainings because of moral distress?	
Palliative care consultation	54
Pastoral care/chaplain	47
Social work department	42
Ethics consultation	28
Patient and guest relations	21
Employee assistance programs	19
Additional ethics or end-of-life training	10
External (patient's own) clergy	9
Risk management	8
Critical incident debriefing team/emotional incident stress debriefing	4
Schwartz Center rounds	3
Office of General Counsel	–
If they were available, in what type of interventions would you be interested to address moral distress?	
Annual retreats for nursing staff	54
Individual self-care activities	51
Regular debriefing sessions	46
Mentoring program between more seasoned nurses and newer nurses	40
Deep breathing/meditation exercises	35
Talking with patients and families	35
Ethics committee meetings	34
Additional education related to moral distress	32
Other	2

Note. Participants could select more than 1 response.

response rate for this study was 32%. Although this response rate was higher than those reported in other moral distress studies, it is not sufficient to generalize the study's results to nurses who were not study participants (Dillman et al., 2014). Reasons for nonparticipation may include lack of interest in the study topic, unfamiliarity with the study principal investigator, unwillingness to participate in research, and challenges with research recruitment (Dillman et al., 2014; Groves & Peytcheva, 2008).

Because this study used a convenience sample in one academic health system, results may not be representative of other care settings. Although this study was sufficiently powered, further studies with larger samples are needed. To understand associations related to moral distress, studies can evaluate relationships of variables such as nurse demographics, work histories, and moral distress.

Implications for Practice

Oncology nurses' experiences of moral distress are a concerning phenomenon that warrants further attention from healthcare administrators, policymakers, and researchers. Attention should be given to nurses with more years of experience who call out of work, request new patient assignments, or change the care they provide patients, particularly when these nurses are involved in one of the top three morally distressing scenarios. These particular behaviors may indicate the presence of moral distress. This study also suggests that nurses may not be taking full advantage of the resources available to support their experience with moral distress. Hospital leaders can increase the visibility of resources so nurses can choose to access them.

To this end, nurses in this study identified resources not currently available to them that they believed may address their moral distress (e.g., retreats, team debriefing). Establishing additional resources and creating policies and processes for the management of morally distressing situations could protect nurses and other interprofessional team members from developing moral distress and the subsequent negative effects. Lastly, more research is needed to further quantify the phenomenon and to develop and test interventions aimed at preventing and/or mitigating moral distress. The Measure of Moral Distress for Healthcare Professionals (MMD-HP) is the newest instrument to study moral distress among a variety of healthcare providers and includes the most currently understood causes of moral distress (Epstein et al., 2019). To standardize moral distress assessment in future studies, use of the MMD-HP instrument should be considered.

Conclusion

To date, few studies have been published about the moral distress experience of oncology nurses. This study's findings further clarify strategies to describe and identify moral distress, confirming the experience of oncology nurses. With more attention to this concept in a variety of settings, this evidence can help establish effective interventions to address moral distress.

IMPLICATIONS FOR PRACTICE

- Assess moral distress and be aware of possible associations (e.g., calling out of work, requesting new assignments) that may lead to avoidance and nursing turnover.
- Identify morally distressing situations included in the Moral Distress Scale–Revised and characteristics of nurses who are potentially experiencing moral distress.
- Encourage accessing resources to mitigate moral distress (e.g., palliative care consultations, ethics training) and explore new ways to prevent and mitigate moral distress (e.g., debriefing sessions, self-care activities).

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