

**Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing
Students and Their Instructors**

MORAL DISTRESS DURING PSYCHIATRIC CLINICAL PLACEMENTS:
PERSPECTIVES OF NURSING STUDENTS AND THEIR INSTRUCTORS

Bernadine Wojtowicz

Bachelor of Nursing, University of Lethbridge, 2006

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfilment of the
Requirements for the Degree

MASTER OF SCIENCE
MAJOR: NURSING

Faculty of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

© Bernadine Wojtowicz, 2012

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

DEDICATION

To John, for your love and constant support, and for being there for me through good days and bad;

To my children, Matthew and Kaylee, for the motivation to prove I could do it . . .

Who poured me that Pepsi?

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Abstract

The purpose of this study is to gain a richer understanding of the experiences of moral distress for nursing students within the context of psychiatric-mental health clinical placements, examine strategies students use to effectively manage distress, and explore student and instructor roles as agents of change to reduce the negative impact of moral distress. Nursing students and instructors engaged in semi-structured interviews and focus groups, respectively, to examine the complexities of this phenomenon. This study utilized second-person action research based on Jürgen Habermas' *Theory of Communicative Action*. Findings indicated that nursing students experience moral distress when they are powerless and lack role models to follow in taking action to address situations that are “not right”. Nursing instructors acknowledge their responsibility to prepare students for practice, but are also powerless as “guests” within the practice setting and are powerless to effect change on a hierarchical medical system. Findings indicate that both nursing education and health care institutions must make changes in their approaches to practice if they wish to empower nursing professionals to provide safe, competent, and ethical care to patients.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Acknowledgements

I wish to express my appreciation to the participants in this study, whose commitment to mental health nursing care is inspirational and motivated me to press onward. May this research make a positive contribution to their efforts to provide quality care and promote safe and healthy environments for nurses and patients.

I am deeply indebted to my supervisor, Dr. Brad Hagen, whose flexible and supportive guidance allowed me to explore this topic with sensitivity, and whose humour kept me grounded when I was in distress. I am extremely fortunate to have been able to benefit from his vast experience and knowledge of mental health nursing.

I would also like to express appreciation to the members of my Thesis Committee. Thanks to Dr. Jean Harrowing for her wisdom, her acute attention to detail, and her passion for providing quality education to nursing students. Thanks to Linda Fehr for her unique perspectives on interactions and behaviour, and for her enthusiastic support.

Thanks also go to my family, who remained constantly supportive and understanding through every phase of this undertaking. To my colleagues at the University of Lethbridge, for your moral and practical support and advice, I am in your debt. Finally, I am profoundly grateful to Dr. Chris Hosgood, Dean of the Faculty of Health Sciences at the University of Lethbridge, for his unwavering support and advocacy for continuing education among faculty.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Table of Contents

Abstract	iv
Acknowledgements.....	v
Table of Contents.....	vi
List of Tables.....	vii
Chapter One.	
Introduction.....	1
Chapter Two.	
Moral Distress in Nursing: A Review of the Literature.....	17
Chapter Three.	
Nursing Students' Perceptions of and Responses to Moral Distress.....	34
Chapter Four.	
Nursing Student Moral Distress: A Call to Action.....	69
Chapter Five.	
Discussion.....	103
References.....	115
Appendix A – Script for Invitation to Nursing Student Participants.....	126
Appendix B – Contact Slips for Potential Student Participants.....	128
Appendix C – Letter of Invitation to Nursing Instructor Participants.....	129
Appendix D – Recruitment Poster.....	130
Appendix E – Participant Demographic Form.....	131
Appendix F – Interview Guide for Nursing Student Participants.....	132
Appendix G – Nursing Student Participant Consent Form.....	133
Appendix H – Interview Guide for Nursing Instructor Participants.....	136
Appendix I – Nursing Instructor Participant Consent Form.....	138

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

List of Tables

Table 1.	Historical development of the concept of moral distress.....	18
Table 2.	Nursing student descriptions of experiences on inpatient psychiatry.....	50
Table 3.	Nursing instructor perceptions of student moral distress experiences.....	84
Table 4.	Moral distress perceptions of nursing students and instructors.....	105

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Chapter One

Introduction

This qualitative research study was conducted to obtain a richer understanding of the experiences of moral distress for nursing students within the context of psychiatric-mental health clinical placements. This understanding is absent in current literature, and moral distress has rarely been examined within the context of psychiatric-mental health settings. Findings from the study will contribute to deeper awareness of moral distress experiences, examine potential changes needed in nursing education and practice, reflect on student and instructor roles as agents of change, and propose actions to reduce the negative impact of moral distress on nursing students in psychiatric-mental health clinical placements. The final thesis product will consist of five chapters, including an Introduction and Conclusion. The chapters in between will comprise three papers of publishable quality entitled “Moral Distress in Nursing: A Review of the Literature”, “Nursing Students’ Perceptions of and Responses to Moral Distress”, and “Nursing Student Moral Distress: A Call to Action”.

Statement of the Problem

Background and Context

Psychiatric-mental health nursing is a specialty practice area focusing on the promotion and maintenance of mental health, prevention of mental health problems, and care and treatment of individuals diagnosed with psychiatric disorders. Compared to other specialty areas—such as Paediatrics, Intensive Care Units, or Emergency—fewer nursing students include psychiatric-mental health nursing in their choice of final consolidation practicum. For some, this may be simply a desire to work in a more

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

“technically demanding” task-oriented setting. For others, negative perceptions, decreased understanding of, or feeling unprepared for psychiatric-mental health nursing practice may deter them from this specialty (Gough & Happell, 2009; Happell, 2009; Happell, Robins, & Gough, 2008a; Hoekstra, van Meijel, & van der Hoof-Leemans, 2010). The Canadian Nurses Association (CNA, 2009) projected that by the year 2022, Canada will be short almost 60 000 full-time registered nurses if health care needs continue to change similarly to past trends. This situation will greatly affect mental health nursing practice, in light of the fact that psychiatry is already not a preferred practice setting for nursing students.

Potential solutions to the pending shortage include increased enrolment in nursing education programs, and retention of currently practicing nurses. However, researchers have shown that anywhere from 33 to 61% of new nursing graduates are changing their area of practice or leaving the profession within the first year of their careers (Boychuk Duchscher & Myrick, 2008; Cowin, 2002; Dearmun, 2000). Moreover, more experienced nurses are also leaving the profession because of moral distress experiences (Boychuk Duchscher & Myrick, 2008; Hamric & Blackhall, 2007; Nathaniel, 2002, 2006). Attempts to rectify the projected nursing shortages with recruitment or retention strategies will be ineffective as long as we do not address the underlying issue of moral distress.

Rationale for the Study

Literature on moral distress has been largely quantitative and conducted in nursing areas having a predominantly medical focus, such as intensive care units (ICU). Existing research has contributed to an understanding of the factors contributing to moral

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

distress in nurses but has not examined moral distress experiences in psychiatric-mental health nursing settings extensively. Nursing students have also been notably absent from research studies. It is important for the future of mental health nursing to understand both the extent of moral distress in nursing students and how nursing educators can assist students to prepare for and manage moral distress more effectively.

Purpose of the Study

The purpose of this study is to: (a) explore the nature of moral distress experiences in nursing students in acute inpatient psychiatric settings, (b) examine strategies students use to effectively manage moral distress, and (c) explore potential student and instructor roles as agents of change to reduce the negative impact of moral distress in nursing students. The general research questions for the study are:

- 1) What is the extent, nature, and meaning of moral distress in nursing students in psychiatric clinical placements?
- 2) If moral distress is significant in nursing students, how might nursing educators improve the experience of the students?

Approach to Research

Prior research on moral distress has involved the use of quantitative instruments, such as the Moral Distress Scale (MDS) (Corley, Elswick, Gorman, & Clor, 2001) and the Moral Distress Scale for Psychiatry (MDS-P) (Ohnishi et al., 2010). These instruments provide valuable data about the type, frequency, and intensity of moral distress experienced by nurses but allow little exploration of emotional, psychological, and behavioural effects on individuals. While quantitative data can be useful in categorizing these aspects of moral distress, qualitative data is useful for examining the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

depth and the impact of these effects. Narrative descriptions of individuals experiencing moral distress provide these insights. Tavakol and Zeinaloo (2004) stated that naturalistic inquiry is appropriate when little attention has been given to a particular phenomenon, in this case, subjective perceptions of experiences of moral distress. These subjective perceptions form the basis for this research study.

Research Method

Naturalistic inquiry assumes that multiple realities exist. The researcher cannot accomplish singular resolution to the research question by gathering additional data or by applying rational process to the data. Instead, extended inquiry and increasing the amount of data gathered results in greater divergence and even more meanings emerging from complex phenomena. In contrast, ideas converge together as interrelationships and themes among elements of the data become apparent. The goal of naturalistic inquiry is to understand and reconstruct knowledge and experiences of individuals and bring that knowledge together into a shared reality, recognizing that the human experience constructs its own reality within specific contexts (Awty, Welch, & Kuhn, 2010; Bowen, 2008). Each participant ascribes meaning to a situation, and in essence, this meaning is the individual's truth.

While such experiences may result in an individual forming new knowledge upon which to base assumptions and conclusions, knowledge may also be created within the research context during interaction between the researcher and participant, resulting in increased awareness of the context within which an individual forms understanding. When numerous individuals are involved in the research, the researcher aims to find consensus among participants, but remains willing to form new interpretations of the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

phenomenon as participants relate new information, bringing the researcher to an understanding that his or her own perspective is no more or less true than that of others (Heikkinen, Huttunen, & Syrjälä, 2007). Knowledge is then interpreted, compared, and contrasted through dialogue between researcher and participants, and can be further tested and modified in light of new experiences (Guba & Lincoln, 1994).

Jürgen Habermas (1984), in his *Theory of Communicative Action*, stated that individuals use communicative action to strive for intersubjective agreement, mutual understanding, and unforced consensus regarding a direction in which to move collaboratively (Feldman, 2007; Kemmis, 2008; Rasmussen, 1997). Similarly, critical realism uses an objectivist ontology and a subjective epistemology of reflexivity that aims to expose interests; understand the effects of political, historical, and socioeconomic factors on individuals; and facilitate emancipation of individuals (Brannick & Coghlan, 2007; Paterson et al., 2008; Sundin & Fahy, 2008). The purpose of engaging in self-reflexivity is to discover and evaluate alternative solutions for situations in which prior experience and knowledge can only provide suggestions to resolving the problem, not actual solutions. Therefore, in critical action research, the researcher attempts to explore social realities of situations, by opening communicative space, to discover whether social and educational practices are sustainable and what the consequences of change may be (Kemmis, 2009; Wicks & Reason, 2009).

Action research may be conducted as first-, second-, or third-person research. First-person research centers on developing a critical approach to the researcher's own understanding of phenomenon occurring within his or her own practice and interactions with the world. Second-person research involves bringing individuals together for

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

discussion of phenomenon of mutual concern and developing common themes of interest. Third-person research involves inquiry about a phenomenon that is extended to groups too large to facilitate engagement in individual communication (Bjørn & Boulus, 2011; Coghlan, 2011; Coghlan & Shani, 2008; Wicks & Reason, 2009). This research study utilized second-person action research to explore experiences of moral distress in nursing students, examine any areas of mutual concern among nursing students and instructors, and engage participants in discussion about planning for change in mental health nursing practice education.

The research study took place in two stages. The first stage consisted of semi-structured interviews with nursing students about experiences of moral distress occurring during their inpatient psychiatric clinical educational experience. To ensure participant understanding of moral distress, the definition provided in the Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses* was given. The second stage of the study involved conducting focus groups with mental health nursing instructors who teach on inpatient psychiatric units, presenting themes extracted from analysis of student participant responses from stage one. Chapters Three and Four detail the research approaches to each participant group.

Study Setting

This study took place in a western Canadian city that hosts a nursing education program of approximately 700 undergraduate students. The purpose of including only participant experiences from acute inpatient psychiatric settings—as opposed to rehabilitative or community mental health settings—was to ensure consistency of context. As the study involved only students and instructors from the nursing education program,

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

there was no direct involvement in the study from members of the health care system at this stage. However, as the results of the study will have significant implications for nursing education in acute inpatient psychiatric settings, I will share my findings with psychiatric inpatient unit managers for the purpose of enlightenment and in the spirit of cooperation to provide improved education for nursing students. The decision to act or not act on findings relevant to inpatient unit practices will remain the responsibility of the health care institution. Findings relevant to educational practices were included in the action research process with nursing instructor participants in the second stage of the study.

Participants

Purposive sampling, specifically concept sampling, was employed to increase the scope and depth of data, ensuring that the participants had particular knowledge of the phenomenon of moral distress within the acute inpatient psychiatric setting (Awty et al., 2010; Stringer & Genat, 2004; Tavakol & Zeinaloo, 2004). Action research methods accept that specific phenomena are not consistent through time, but change with context and individuals within the situation; therefore defining data saturation and completion of data collection is an arbitrary process (Awty et al., 2010; Checkland & Holwell, 2007). The goal of data collection was theoretical saturation, in which no new themes emerged and no new issues arose regarding any specific category of data. It was more relevant to ensure sampling adequacy rather than representativeness of the data, and to sample not individuals of a population but to examine a variety of experiences within the particular context of an acute inpatient psychiatric setting (Bowen, 2008; Crouch & McKenzie, 2006; DiCicco-Bloom & Crabtree, 2006; Mason, 2010).

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Recruitment

Recruitment of student participants occurred through third-party individuals who attended nursing classrooms with an “invitation to participate” script (Appendix A) and researcher contact slips (Appendix B) for prospective participants (Awty et al., 2010). Chapter Three details the approach to this participant group. Nursing instructor participants were recruited by issuing an “invitation to participate” letter to eligible instructors (Appendix C). Chapter Four details the approach to this participant group. Participants from both groups confirmed their interest in participation through a message to my confidential e-mail address. This method of communication ensured confidentiality of the participants and allowed me to maintain an audit of the contacts with each individual.

Data Collection

Action research encourages pluralistic approaches to data collection with the goal of enhancing the research process being more important than justifying the outcomes of the research (Murphy, 2011; Streubert & Carpenter, 2011). Data collection may incorporate a variety of methods, including interviews, focus groups, surveys, workshops, and journals (Casey, 2007; McNiff & Whitehead, 2010; Paterson et al., 2008; Susman & Evered, 1978). Face-to-face semi-structured interviews were conducted with seven nursing students at various levels of education completion, (i.e. Year Three, Year Four, and previous degree holders), but who had all completed their mental health practice rotations by the time of the interviews. Two focus groups were conducted with eight nursing instructors having a minimum of five years mental health nursing experience as well as teaching experience in acute inpatient psychiatric settings, to ensure sampling

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

adequacy and knowledge of the research context. Chapters Three and Four detail data collection techniques for each participant group.

Data Management

I maintained participant anonymity by assigning pseudonyms to individuals or allowing participants to choose their own pseudonym. I reported events in a modified fashion to protect participant and patient identity, and the identity of others. Interviews and focus groups were digitally recorded and transcribed verbatim, and then reviewed while listening to the transcript to ensure accuracy during the transcription process (DiCicco-Bloom & Crabtree, 2006). All manuscripts, demographic information, and consent forms from the study were stored securely in a locked cabinet in my office. Data will remain stored in this manner and discarded appropriately as recommended (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010, p. 61).

Data Analysis

I used inductive thematic analysis with the purpose of developing abstract and descriptive themes surrounding the phenomenon of moral distress (Marshall & Rossman, 2011; Norwood, 2010; Thorne, 2008). Thematic analysis focused on qualitative aspects of individual perceptions as well as tentative explanations of why the phenomenon occurred and why the explanations were significant (Checkland & Holwell, 2007; Crouch & McKenzie, 2006; McNiff & Whitehead, 2010). This involved giving meaning to the data as it related to the context of participant belief systems and values, which in turn led to a realization of my own beliefs and values regarding the need for change to occur. Thorough analysis of the themes resulted in identification of potential changes to nursing

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

education and practice that may reduce the impact of moral distress in nursing students. Chapters Three and Four detail data analysis techniques for each participant group.

Ethical Considerations

Approval and Informed Consent

No research can ever be ethically non-problematic, and researchers must be prepared to anticipate any number of ethical issues that may arise from the onset of the study to the dissemination of the results. I have addressed two ethical concerns in the following section: (a) potential risk to participants, and (b) potential relationships between participants and researcher. This study received ethical approval through a university-affiliated research ethics board in compliance with national guidelines safeguarding participant rights and confidentiality of data (Canadian Institutes of Health Research et al., 2010). Nursing student and instructor participants signed consent forms (Appendices D and E, respectively), and all participants were deemed competent to provide fully informed consent. There was no power relationship present between the researcher and student participants, as no direct teaching relationship existed at the time of the interview, nor would exist for the duration of the students' enrolment in the nursing education program. I informed nursing instructors, as my professional colleagues, that they were under absolutely no obligation to participate in the study. No deception or partial disclosure was used in this study.

Risk to Participants

There was a minimal risk of participants experiencing psychological distress while engaging in this research study. Relating experiences of moral distress had the potential to evoke some discomfort due to the sensitive nature of and the participants'

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

emotional and psychological responses to the situations described. I informed participants of this risk and encouraged each individual to inform me if he or she experienced discomfort at any time. Resources for emotional and psychological support were available upon request, although no participant asked for this information.

Personal Situatedness in Relation to the Research Study

Ledford (2005) discussed the concepts of transference and countertransference within action research. In therapeutic relationships, transference occurs when a patient responds to conflict as though the therapist were a parent or other significant individual in the patient's life; countertransference is the defensive reaction of the therapist against emotional stimuli from the patient. Similar to therapeutic relationships between therapists and patients, there can appear to be a power dynamic that occurs between an action researcher and the organizational structure(s) under examination. In this study, the educational institution offering the nursing program and the nursing practice setting were the organizational structures examined. The assumption in both therapeutic relationships and in action research is that it is important for the patient or organization to discover areas requiring change and to take ownership and responsibility for enacting that change. For action research to be effective, the researcher must facilitate learning rather than dictate changes, a process involving mutual trust and openness. The action researcher must be self-aware, understand the roots of any dysfunctional behaviour, and be sensitive to important relationship or collaboration issues.

As a registered nurse specializing in mental health practice, I contributed considerable situational knowledge and experience to my role as a researcher. Therefore, my position, in relation to the participants of my study, was one of an informed and

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

knowledgeable “insider.” Action research involves change processes for real and particular problems and focuses on finding a solution (Brannick & Coghlan, 2007). My relationship to the data will enhance the richness of the research, as my own experiences and perceptions of situations that cause moral distress formed the basis for the interview questions. As an “inside collaborator” engaging students in discussion around potential actions for change, I attempted to contribute to the knowledge base of mental health education, improve my own practice with students, facilitate professional and organizational transformation for improved education quality, and ensure a democratic approach to planning for action with participants through facilitated discussion (Coghlan, 2011; Herr & Anderson, 2005; Rasmussen, 1997).

An advantage of engaging in insider action research for this study is my knowledge, insights and experiences—my preunderstanding—of the concept of moral distress in mental health nursing. I brought forward theoretical understanding and sensitivity for this topic, knowledge of organizational dynamics in education and practice, and my own lived experience of moral distress encountered in professional practice. While these aspects are key to developing a rich understanding of the participants’ views, there was a risk that I may have assumed too much knowledge of the situations being described, which may have led to a narrow view of possible solutions and not exposed my thinking to reframing of the problem or alternate solutions (Brannick & Coghlan, 2007; Coghlan & Shani, 2008; Dwyer & Buckle, 2009). To preserve the integrity of the interview process and data analysis, I suspended my own preconceived notions of what the participants’ experiences should be, and instead was open to the meaning each participant attributed to his or her personal experience of moral distress.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Findings

This thesis consists of three major sections in addition to the introduction and conclusion. These sections comprise individual papers of publishable quality as follows: “Moral Distress in Nursing: A Review of the Literature”, “Nursing Students’ Perceptions of and Responses to Moral Distress”, and “Nursing Student Moral Distress: A Call to Action”. The following section serves to introduce the findings and primary themes found within each chapter.

Chapter Two–Moral Distress in Nursing: A Review of the Literature

Nurses face issues of moral distress in their daily practice, and many researchers have illuminated various definitions, causes, and effects of moral distress. Rapid changes to technology, pharmacological practices, and evolving roles can leave nurses somewhat unprepared to deal with new challenges in an effective way, leading to moral distress (Nathaniel, 2006). Unresolved moral conflicts may affect the quality of decision-making regarding patient care and leave nurses further frustrated at limitations of professional autonomy, leading to moral distress. Such unrest on an individual level has a negative impact on the nursing care environment and inter-professional relationships. Some nurses experience such distress that it causes them to leave their nursing area or the nursing profession altogether. The purpose of Chapter Two is to review literature on the concept and causes of moral distress, the effects of moral distress on nurses, and examine the impact of moral distress on the nursing profession as a whole.

Chapter Three–Nursing Students’ Perceptions of and Responses to Moral Distress

Nursing students have been notably absent from discussions regarding moral distress in nursing practice areas. While their exposure to morally distressing situations

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

is admittedly limited due to the length of most clinical educational experiences, students encounter the same daily occurrences that cause moral distress in registered nurses during the execution of patient care. Limitations, such as the perceived inability to enact change or speak out against institutional practice, are inherent to the role of the nursing student contribute to distress.

Two distinct themes emerged within Chapter Three: “Why do I feel this way?” details situations or events that participants felt were “not right”, but the right thing to do was not always apparent. “It’s not my place” details the participants’ reasons for inaction in situations that were not right based on internal and external factors they felt were outside of their control. The purpose of Chapter Three is to examine themes extracted from participant experiences, to ascribe meaning to these events within the context of psychiatric-mental health nursing, and to explore the impact of these experiences on participants.

Chapter Four–Nursing Student Moral Distress: A Call to Action

Nursing instructors play a key role in assisting students to understand and manage incidents of moral distress within the clinical educational setting. How nursing instructors manage these situations may contribute significantly to students’ perceptions of and attitudes about the clinical experience. Instructor insights into the organizational structure of the clinical setting, relationships with nursing staff and management, and role modeling all affect students’ understanding of political and cultural environments in which they will be working as professionals.

Three distinct themes emerged within Chapter Four: “Yes . . . it’s a problem” reflects participants’ acknowledgement that the issues identified by nursing students as

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

not right really do exist; “The bigger picture” consists of participants’ explanations and justifications for their inaction around those troubling situations. In the third theme, “So now what?”, participants identified actions they felt would have the most benefit to students and the nursing units when events or situations cause students moral distress. The purpose of Chapter Four is to examine nursing instructors’ roles as agents of change in assisting students to manage moral distress situations effectively, while managing their own moral distress experiences when conflicted regarding professional obligations to students, patients, and institutional partners.

Significance of the Study

In light of the limited research on nursing student experiences of moral distress, it is worthwhile to investigate the extent, nature, and meaning of this phenomenon. One must also consider what nursing educators can do to prepare students for these situations more effectively. With increasing demands on nurses to deliver efficient and cost-effective patient care, the threat of compromised integrity of nursing practice may be very real if issues of moral distress continue to erode the fabric of the nursing profession. It is essential to address these issues at the level of nursing education, to prepare nursing students for real practice situations and to establish safe and supportive environments for nurses and patients alike. Happell (2009) proposed that attitudes developed as a result of life experiences are not easily influenced and tend to remain constant without a strong reason to change them. However, positive change is correlated with positive clinical placements, perceived support from staff, good role models, and proper socialization into the work environment (Alber et al., 2009; Benner, Tanner, & Chesla, 2009; Happell, 2009; Happell & Gough, 2007; Happell, Robins, & Gough, 2008b; Hoekstra et al., 2010;

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Illingworth, 2009; Maben, Latter, & Macleod-Clark, 2006). These study results have strong implications for nursing education and practical benefits to students and instructors in the delivery of mental health care in acute inpatient psychiatric settings.

Chapter Two

Moral Distress in Nursing: A Review of the Literature

Jameton (1984) observed that many of the situations nurses encounter in practice that have been described as moral dilemmas could more accurately be defined as moral distress. “Moral 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). Significant additions to this original concept include Wilkinson’s (1987) reference to “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” (p. 16). Other authors have contributed to the definition by including distinctive criteria based on their own research (Table 1).

The Canadian Nurses Association (CNA, 2008) *Code of Ethics for Registered Nurses* further expands the definition of moral distress:

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses’ identity and integrity as moral agents are affected and they feel moral distress. (p. 6)

An important inclusion in the Canadian Nurses Association (2008) definition is the recognition of fears and circumstances that may contribute to inaction on the part of the nurse. Fears may be real or perceived; nonetheless, they have an inhibitory effect on nurses’ actions. Nursing students may also encounter these fears; as students, they are only present in each practice setting for a limited period and may assume the limitations of their role as students in taking action in situations they find distressing.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Table 1

Historical Development of the Concept of Moral Distress

Date	Author(s)	Major Contributions
1984	Jameton	Distinction between moral distress and moral dilemma; Identified major factors as moral judgment of nurse and institutional constraint
1987-88	Wilkinson	Experience of moral distress as negative feeling state and psychological disequilibrium; Argued that nurses' actions violate personal beliefs
1993	Jameton	Further argued a causative agent of moral distress is the role of the nurse in participating in actions judged to be morally wrong
1994	Millette	Combined Wilkinson's definition with Yarling and McElmurry's exploration of nurses' capacity to implement decisions; Asserts that institutional forces prevent nurses from acting as moral agents
1995 & 2001	Corley	Created Moral Distress Scale based upon works of Jameton and Wilkinson; Differentiated between frequency and intensity of situations leading to moral distress
1995	Liaschenko	Identified source of moral distress when nurses become "artificial persons" who speak and act for others and risk loss of moral integrity
2000	Penticuff & Waldren	Discovered that nurses' ethical practice is influenced by practice setting in combination with perceptions of their influence and value within the institution, administrative support, views concerning quality of care, ethics resources, and satisfaction with practice environment
2000	Webster & Baylis	Identified additional source of distress as nurses failing to live up to own their own expectations of ethical practice

Adapted from "Moral distress among nurses" by A. Nathaniel, 2002, *American Nurses Association Ethics and Human Rights Issues Update* 2(1).

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

As demonstrated in Table 1, moral distress assumes many forms, and individuals deem situations distressing or not based on individual expectations, experiences, and perceptions. Moral distress is person-specific and results from individual perspectives: what one perceives to be a correct moral action, what one desires as the outcome of a situation, or what one believes constitutes an ethical issue (Austin, Kagan, Rankel, & Bergum, 2008; Pijl Zieber et al., 2008). Pijl Zieber et al. (2008) also asserted that moral distress is context specific in that one situation might cause an individual moral distress, while a similar situation has no discernible impact. It is important to consider that the absence of moral distress does not necessarily indicate an environment unhampered by ethical issues, but rather that moral sensitivity may be dulled and the impact on individuals reduced (Austin et al., 2008).

Of note is that dramatic and news-worthy events—while admittedly stressful—are less disturbing to nurses than situations that arise in daily practice (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Corley, Minick, Elswick, & Jacobs, 2005; Lützén, Blom, Ewalds-Kvist, & Winch, 2010). These are the same daily events that nursing students observe and encounter in their educational practice. Pauly, Varcoe, Storch, and Newton (2009) contended that although they may occur infrequently, situations causing moral distress have a significant impact on individuals when they do occur. Being inexperienced in dealing with these issues in practice may result in nursing students feeling doubly distressed.

Although moral distress arises from subjective experiences, Corley et al. (2001) developed the Moral Distress Scale (MDS) to quantitatively measure moral distress as a factor contributing to job stress in registered nurses. The original scale containing 32

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

items on a 5-point rating scale was revised (MDS-R) to include six additional items pertaining to pain management, managed care and competence of health care personnel, and rated items on a 7-point scale (Corley et al., 2005). The revised instrument had a content validity of 100%, a Cronbach's alpha value of 0.93 for the total scale, and test-retest reliability of 88%; this instrument is well validated and has more psychometric information than other measures (Lerkiatbundit & Borry, 2009; William F. Connell School of Nursing, 2004). Results of this and other studies conducted to measure moral distress are detailed in the following sections.

Contributors to Moral Distress

Real and perceived internal and external constraints influence nurses' abilities to carry out actions they deem morally right, leading to moral distress and affecting personal responses to stressful events (Austin, Lemermeyer, et al., 2005; Cronqvist & Nyström, 2007; McCarthy & Deady, 2008; Pijl Zieber et al., 2008; Zuzelo, 2007). In addition, nurses may be in situational binds involving conflicts between core values and practice norms, power imbalances, and deficiencies in workplace and resources (Nathaniel, 2006). Well-documented contributing factors to moral distress include fear of reprisal, lack of autonomy in decision-making, decreased confidence in their own or their colleagues' competency to practice, institutional norms and structures, environmental climate, and unethical patient care practices.

Research has shown differences in the correlation between the level of moral distress experienced and years of nursing experience. Ulrich et al. (2010) found that younger nurses experienced more stress resulting from observations of patient care and ethical issues. Nursing students also felt powerless when they witnessed inappropriate or

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

incomplete care, due to perceived limitations on their ability as students to take action (Pijl Zieber et al., 2008). The possibility exists that individuals do not know they are experiencing moral distress because they do not fully understand the concept, as may be the case for less experienced nurses (Austin, Lemermeyer, et al., 2005; Benner et al., 2009). Findings by Lützén et al. (2010) indicated that less experienced nurses felt more optimistic, less distressed, and more supported in moral situations, whereas experienced nurses cited decreased moral climate and few supports as contributing to moral distress. Corley et al. (2005) found that experienced nurses were able to identify morally disturbing situations and deal with them more effectively due to confidence in their expertise, which is supported by Wilkinson's (1987) findings. Ohnishi et al. (2010) found no correlation between intensity or frequency of moral distress and years of experience in Japanese psychiatric nurses, while Elpern, Covert, and Kleinpell (2005) cited significant correlations between moral distress and experience, possibly due to cumulative stress. The following section examines contributing factors to moral distress.

Internal Constraints

Fear of reprisal. Insecurity and uncertainty affects nurses' abilities to perform effectively and respond to situations and events occurring in practice. Satisfactory task completion is important to nursing novices and students. However, focused attention on tasks may preclude noticing questionable practices in others, or perhaps individuals new to the nursing profession do recognize problems but do not acknowledge them. Novice nurses may fear reprisals directed at them as junior members of the health care team. Experienced nurses may recall unfavourable outcomes of past situations in which they voiced concerns. These experiences may result in their reluctance to challenge

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

questionable client care practices again. Perceived or actual fear of reprisal is particularly pronounced in organizational structures in which “the overall goal is to preserve the reputation of the institution” (Austin, Rankel, Kagan, Bergum, & Lerner, 2005, p. 205).

Lack of autonomy. Autonomy refers to an individual’s fundamental right to self-determination and choice. Nurses begin to lose autonomy when there is actual or perceived powerlessness, leaving them with no sense of control over a specific situation (Austin, Lerner, et al., 2005; Cronqvist & Nyström, 2007). Nurses are in the unenviable position of having more responsibility than authority, which may result in being unable to realize fully their professional scope of practice and confuses their sense of right and wrong (Corley et al., 2001; Deady & McCarthy, 2010; Lützn et al., 2010; Pendry, 2007; Stickley & Timmons, 2007). In some cases, the nurse may be more competent and have more experience with a situation than the physician has, but the nurse is limited due to professional and legal guidelines (Cronqvist & Nyström, 2007; Hamric & Blackhall, 2007; Pijl Zieber et al., 2008). For example, a nurse on a psychiatric inpatient unit who is confident in her knowledge about a patient’s response to certain medications may be competent to administer treatment, but must receive the psychiatrist’s order before she can respond to her patient’s needs. In this way, nurses are frequently in the position of delivering a plan of care to which they have made little contribution. In a study conducted with psychiatric nurses in Ireland, Deady and McCarthy (2010) found that nurses’ observations were not given equal weighting compared to other health professionals, despite having spent more time in direct contact with patients. A significant factor in autonomy is the nurse’s confidence that

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

observations, interactions, and decisions are grounded in knowledge rather than in unquestioned rituals and tradition in practice (Mooney & Nolan, 2006). These limitations of ritual and tradition may lead to feelings of disempowerment and lack of autonomy in caring for patients.

Perceptions of competence. Competence and safety are primary concerns in any nursing environment. Using the Moral Distress Scale (MDS) and the Ethical Environment Questionnaire (EEQ), Corley et al. (2005) found that nurses' perceptions of unsafe staffing practices caused the highest frequency and intensity of moral distress. Other researchers have confirmed that nurses experienced intense moral distress when considering their own feelings of competence and the degree to which they were confident of safe and competent care being provided by other nurses and physicians (Cronqvist & Nyström, 2007; Pauly et al., 2009; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Zuzelo, 2007). Nursing students learn appropriate mental health interventions in theory, but have varying degrees of confidence in implementing these in actual practice. Novice or student nurses observing actions and interventions of more experienced nurses may lack confidence in their own abilities and hesitate to question competence in other health professionals. If novices and students perceive that the actions of others have a negative effect on patient outcomes, this reluctance to question practice may lead to moral distress.

External Constraints

Institutional structures. In institutional practice settings, factors outside of the nurse's control—such as organizational norms and structures—may affect capacity to carry out desired moral actions. Policies and procedures, limited resources and heavy

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

workloads, organizational reforms aimed at increasing efficiency, legal and professional conflicts, nursing and hospital administration, and hierarchical decision-making by physicians can impede the nurse's ability to manage situations of moral distress effectively (Austin, Lerner, et al., 2005; Deady & McCarthy, 2010; Elpern et al., 2005; Manojlovich, 2007). Pendry (2007) notes that nurses have two masters: the organization that pays them to administer client care, and the physicians who dictate the kind of care to be given. Nurses who have been socialized to follow orders may experience self-doubt, lack courage, or fear job loss and reprisals from colleagues and the community if they challenge institutional practices, all at the expense of client safety (Austin, Lerner, et al., 2005; Lützn et al., 2010). Treatment decisions may be a source of distress to psychiatric nurses in particular. Staff members often know the mental health patient quite well and may wish to implement care practices not supported by the institution's policy or by the patient's family members, despite the nurse's intimate knowledge of the patient's history and prior response to treatments (Corley et al., 2001; Gutierrez, 2005; Lützn et al., 2010; Pijl Zieber et al., 2008). In addition, nurses may not receive support from their institution's administration when dealing with the physical and emotional effects of their moral distress, thus compounding the problem.

Work environment. Moral responsiveness is an individual responsibility, but the nursing environment may affect one's ability to respond to moral dilemmas. Harrowing and Mill (2010) argued that moral distress appears within environments as a result of complex interpersonal, structural, and contextual relationships. These morally charged environments themselves are a product of spiraling changes in health care, patient complexity, and longer life spans. Negative moral climates contribute to nurses changing

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

their area of work and increase moral distress. Intensive care nurses (Hamric & Blackhall, 2007) and mental health nurses (Lützn et al., 2010) who experienced negative ethical climates, decreased satisfaction with quality of patient care, and infrequent collaboration with physicians had higher moral distress scores than nurses who worked in positive environments. Negative work environments also caused decreases in productivity and knowledge development. Benner et al. (2009) asserted that clinical expertise and skills hinge on positive and productive relationships among working colleagues.

Unethical practice. An important nursing role is to assess and evaluate the efficacy of treatments and the resulting outcomes for the patient. Substantial sources of distress regarding patient care include questionable or unethical practices by health professionals. Not only is there concern over the perceived competence of colleagues and physicians, but also over various methods used in accomplishing the health care team's treatment goals. Areas of concern identified in the literature included the unnecessary prolonging of life (Wilkinson, 1987), lack of client autonomy in decision-making (Corley et al., 2001; Corley et al., 2005; Cronqvist & Nyström, 2007; Deady & McCarthy, 2010), and poor pain management (Corley et al., 2005; Zuzelo, 2007). In the context of mental health nursing, patients' emotional and cognitive vulnerabilities make them particularly susceptible to unethical professional behaviours. Withholding relevant, accurate, complete, and realistic medical information precludes obtaining informed consent from patients and families (DeKeyser Ganz & Berkovitz, 2011; Gutierrez, 2005; Schluter, Winch, Holzhauser, & Henderson, 2008). Deception—whether deliberate or by omission—directly opposes the ethical principle of veracity (Corley et al., 2001; Corley et

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

al., 2005; Wilkinson, 1987). Deady and McCarthy (2010) found practices of coercion—including inappropriate behavioural restrictions—distressing to psychiatric nurses.

Bearing witness to unethical practices and not acting to address such behaviours have detrimental effects on nurses who want to provide safe, competent care to their patients.

Feeling the Effects of Moral Distress

Observable Manifestations

Just as individuals experience moral distress in different ways, they also feel the effects of such situations differently. Responses may be physical, such as sweating, shaking, headache, sleeplessness, nausea, diarrhea, crying, or a combination of these (Austin, Lemermeyer, et al., 2005; Nathaniel, 2006; Pendry, 2007; Wilkinson, 1987); or behavioural, as in nightmares, effects on personal relationships, compromised ability to give good patient care, leaving the care setting or profession, withdrawal from others, reluctance to return to work, or resolving oneself to the situation (Austin, Lemermeyer, et al., 2005; Deady & McCarthy, 2010; Gutierrez, 2005; Wilkinson, 1987). Others experience more emotionally based reactions, including anger, guilt, frustration, anxiety, depression, or burnout (Austin, Lemermeyer, et al., 2005; Deady & McCarthy, 2010; Manojlovich, 2007; Pendry, 2007; Wilkinson, 1987); or responses may be more psychological in nature, such as feelings of disempowerment or betrayal, compromises in personal and moral integrity, or decreased self-esteem and self-worth (Austin, Lemermeyer, et al., 2005; Deady & McCarthy, 2010; McCarthy & Deady, 2008; Nathaniel, 2002; Wilkinson, 1987). Lützén et al. (2010) noted that female nurses felt the lack of time to care for patients more acutely, and therefore suffered more from a bad conscience than their male counterparts.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Perhaps the most noteworthy effect of moral distress on nurses is the feeling of powerlessness to act or effect change in situations or the environment. Not only does powerlessness cause moral distress, it results from it as well. A study of 422 nurses indicated that 71% had experienced ethical issues about which they felt they could do nothing, and 36% reported feeling powerless (Ulrich et al., 2010). These feelings of powerlessness may arise from exclusion from decision-making processes (Deady & McCarthy, 2010; Gutierrez, 2005; Manojlovich, 2007; Nathaniel, 2006), perceived inability to utilize professional nursing skills (Manojlovich, 2007; Mooney & Nolan, 2006), observations of poorer patient outcomes and inability to advocate or provide the best possible care for patients (Cronqvist & Nyström, 2007; Deady & McCarthy, 2010; Manojlovich, 2007; Ulrich et al., 2010), and feeling powerless compared to physicians and administrators (Cronqvist & Nyström, 2007; Manojlovich, 2007; Nathaniel, 2006).

Sumner (2010) described three maturational stages of moral discourse and development as they pertain to interactions with others:

1. Pre-conventional maturity, which is self-oriented and submissive to authority
2. Conventional maturity, which is less self-absorbed and affirms initial objectivity that inhibits mindless obedience to authority
3. Post-conventional maturity, formed when one develops the ability to detach oneself from the situation to evaluate own behaviours and allow for fair and just interactions.

Inexperienced nurses have less ability to reflect on their own personal practice beliefs, are concerned with task completion, and may not be comfortable challenging organizational structure; this affects future practice. If they are unable to influence patients, health care

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

professionals, and each other, they incidentally reinforce existing stereotypes of nurse disempowerment. Powerless nurses are ineffective, more susceptible to burnout, less satisfied with their job, and contribute to poor patient outcomes (Manojlovich, 2007). All of these are persuasive arguments for promoting power in the nursing profession.

Nurse Responses to Moral Distress

To resolve the disequilibrium and physical and psychological effects of moral distress, nurses develop a variety of positive and negative coping techniques. Although not often viewed as a positive experience, moral distress may be a catalyst for growth when self-reflection leads to empowerment and autonomy (Benner et al., 2009; Deady & McCarthy, 2010; Sumner, 2010). According to Benner's (1984) *Model of Skill Acquisition in Nursing*, movement along the spectrum from novice to expert nurse depends on reflection on clinical situations, which helps to develop complex problem solving abilities (Cronqvist & Nyström, 2007). Such reflection allows less experienced nurses—and by extension, nursing students—to identify and manage morally distressing situations more effectively (Austin, Lemermeyer, et al., 2005; Corley et al., 2005; Lützén et al., 2010; Sumner, 2010), and to act in the best interests of the patient.

Positive coping responses. Nurses who possess a greater sense of autonomy and moral integrity may feel more confident in dealing with moral distress, allowing them to function effectively in the practice setting. Active coping skills include seeking compromise regarding the situation, speaking out to superiors and those in authority, addressing poor patient care, or providing patients with information to increase autonomy in decision-making (Austin, Lemermeyer, et al., 2005; Austin, Rankel, et al., 2005).

Nathaniel (2006) cited examples of nurses taking a stand against situations that cause

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

them moral distress, including refusing to follow physician's orders, administer potentially fatal doses of medication, or sign coerced surgical consents. However, in each of these cases, there was another nurse willing to step in and comply with the physician's orders. Taking a more passive approach to morally distressing situations may relieve the nurse of having to take action, while still allowing him or her to perform professional responsibilities. This may mean refusing to work with colleagues who are considered unsafe or incompetent to deliver care, or perhaps adopting a "dual moral work code" for home and work environments (Deady & McCarthy, 2010), in which an individual holds to their preferred moral code in their personal life, but alters behaviours in the workplace.

Negative coping responses. More frequently, negative behaviours emerged as nurses attempted to cope with morally distressing situations. Common themes included denying the existence of a problem, remaining silent, taking no action, or conforming to the cultural norms of the work environment (Austin, Lerner, et al., 2005; Austin, Rankel, et al., 2005; Deady & McCarthy, 2010; Lützn et al., 2010). Conforming to the norms of the work environment particularly affects newly graduated nurses who may initially behave according to individual moral codes, but eventually surrender to pressures to conform to the environmental standards just to get through the day (Deady & McCarthy, 2010; Ham, 2004; Kelly, 1998; Laabs, 2011). Austin, Rankel et al. (2005) further identified "acting in secret" to rectify or address issues of moral distress. In this way, the nurse may avoid being at risk both for disciplinary action and for putting patients or peers at risk. For example, a nurse wishing to report unethical practice may initiate a phone call outside of the workplace to avoid detection. Workarounds like this

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

may temporarily circumvent a problem, but they do not address the root of or suggest solutions to the problem. Another identified means of coping was to request not being assigned to patients whose treatment situation caused the nurse moral distress; however, this may lead to detrimental effects on patient care, such as disjointed care or poor communication among care providers (Gutierrez, 2005; Kelly, 1998; Schluter et al., 2008).

McCarthy and Deady (2008) noted that there are variations among researchers as to what moral distress really is, and argued that excessive attention is paid to the negative aspects of moral distress and its impact on nurses. While moral distress also affects other health professionals, these authors argued that too broad an examination of the pervasiveness of moral distress might minimize nurses' genuine moral concerns in complex decision-making. A focus on the negative consequences of moral distress implies nurses' powerlessness to effect change in situations causing them distress. With the evolving nature of nursing practice and financial constraints, there is a need for critical evaluation of the implications of moral distress for the current state of the nursing profession. Despite differing views on the definition of moral distress, one common element in this phenomenon is the acceptance of responsibility, regardless of the cause of the distress. Several authors indicated that if the nurse deferred responsibility to the physician as decision-maker or perceived no obligation or responsibility in the situation—as may be the case with novice nurses who lack a strong sense of autonomy—then there was less moral distress experienced (Austin, Rankel, et al., 2005; Schluter et al., 2008; Wilkinson, 1987). This emphasizes the complexity of the moral distress phenomenon

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

and reinforces the importance of critical examination of the nurse's roles and responsibilities, as well as implications for nursing practice.

Relevance to Psychiatric-Mental Health Nursing

Socialization into the work environment involves familiarity with and acceptance of the norms and attitudes of colleagues, the unit, and the employment institution. If the nurse conforms to the practice norms of the environment, his or her job satisfaction increases significantly. If, however, the nurse's perceptions and values are in opposition to others on the unit, increasing angst and dissatisfaction may impact the quality of patient care, or may lead to the nurse leaving the practice area or the profession (Austin, Lemermeyer, et al., 2005; Austin, Rankel, et al., 2005; Deady & McCarthy, 2010; Hardy, Titchen, McCormack, & Manley, 2009; Nathaniel, 2002; Schluter et al., 2008; Wilkinson, 1987). Corley et al. (2005) indicated that 25.5% of nurses had reportedly left previous nursing positions, an increase from the 15% indicated in an earlier study (Corley et al., 2001). Hamric and Blackhall (2007) found that almost half of intensive care nurses had left (17%) or considered leaving (28%) their nursing positions due to moral distress. Boychuk Duchscher and Myrick (2008) reported that between 33 and 61% of new nurse graduates changed their place of employment or exited the profession within the first year after graduation. This response to moral distress exacerbates the problem, as the absence of these nurses contributes to the very conditions that caused them to leave. Austin, Lemermeyer et al. (2005) compared attrition between nurses who had a focus on caring relationships and personal connections and those whose focus was on justice and principles for moral reasoning. They discovered that when faced with moral distress situations, nurses whose focus was on caring were the ones who left the profession, while

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

those who focused on justice remained in the practice setting. Moral distress indicates moral sensitivity; nurses who leave the profession may actually be the best patient advocates, a clear loss for their patients and colleagues.

Early interactions with professional peers greatly influence the new graduate's perception of the nursing environment and of the profession, and are essential in the socialization process. New nurses may believe they understand nursing culture and may have an idealistic view of the profession. However, when these expectations of practice do not correspond to the actual practice of the unit, nurses can experience dissonance and dissatisfaction (Boychuk Duchscher & Myrick, 2008; Illingworth, 2009; Kelly, 1998; Price, 2009). Without support, this may lead to new nurses leaving the profession very early in their careers. Maben et al. (2006) studied newly qualified Registered Nurses and found that the ideals learned in their nursing education were not consistent with the realities of practice, leaving them with a gap between theory and practice and few good role models to follow. Illingworth (2009) also stressed the importance of role models for new graduates, following on Benner and Benner's (1979) assertion that practicing nurses provide new graduates with a perception of what nurses should do in the realities of the work world, while nursing educators focus primarily on what an ideal nurse should be.

Perhaps more than in other nursing areas—or simply in different ways—psychiatric-mental health nursing may provide an environment that can lead to moral distress. Nursing students who lack the benefit of experience or guidance may not understand the rationales for treatment decisions, the political climate of acute inpatient psychiatric units, or legal and ethical implications for behavioural restrictions on clients. Nursing students encounter a variety of practice situations that may not be consistent with

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

educational preparation or idealistic expectations of the profession. This is evidenced particularly in the discrepancy between idealistic concepts of caring in psychiatric mental-health nursing and the realities of a medical model of care (Boyчук Duchscher & Myrick, 2008). If these discrepancies cause the nursing student to have negative perceptions of the practice experience, it may influence the decision to enter that practice area upon completion of education (Cleary, Walter, & Hunt, 2005; Happell & Gough, 2007; Happell et al., 2008b; Hoekstra et al., 2010; Surgenor, Dunn, & Horn, 2005). In addition, evidence suggests that negative attitudes and environments that nursing students encounter in psychiatric mental-health nursing practice settings are a significant deterrent to future careers in this area (Gough & Happell, 2009; Happell, 2009; Happell & Gough, 2007; Hoekstra et al., 2010; Surgenor et al., 2005), while supportive experiences and relationships with nursing staff reflect positively on recruitment and retention.

This literature review reveals that moral distress has many potential causes, and that individuals cope with the feelings that result from this phenomenon in a variety of ways. If nursing educators wish to address these issues with students prior to entering practice, it is necessary to have insight into how nursing students and their instructors manage incidents of moral distress in psychiatric clinical placements. This study will explore nursing students' perceptions of moral distress on an acute inpatient psychiatric unit. This study will also explore nursing instructors' responses to address students' moral distress experiences in the clinical setting and their role as agents of change within the practice environment.

Chapter Three

Nursing Students' Perceptions of and Responses to Moral Distress

Psychiatric-mental health nursing focuses on promotion, prevention, and maintenance of mental health in individuals diagnosed with psychiatric disorders. When given the choice, nursing students may be deterred from choosing this area due to a preference for more task-oriented nursing environments or feeling a lack of confidence or competence in mental health nursing skills (Gough & Happell, 2009; Happell, 2009; Happell et al., 2008a; Hoekstra et al., 2010). In light of projected nursing shortages (Canadian Nurses Association, 2009) this reluctance to work in mental health nursing practice may significantly impact attempts to recruit and retain nurses.

Potential solutions to projected nursing shortages have been to increase nursing program enrolment and develop strategies to retain current practitioners. Researchers have shown that a significant number of new nursing graduates leave the profession within the first year after graduation (Boychuk Duchscher & Myrick, 2008; Cowin, 2002; Dearmun, 2000); experienced nurses are also exiting the profession due to moral distress experiences (Boychuk Duchscher & Myrick, 2008; Hamric & Blackhall, 2007; Nathaniel, 2002, 2006). Recruitment and retention strategies may only be minimally effective if moral distress in practice is not addressed. This qualitative research study was conducted with the goal of obtain a richer understanding of the experiences of moral distress for nursing students within the context of psychiatric-mental health clinical placements.

Literature Review

Jameton's (1984) definition of moral distress focused on institutional constraints preventing an individual from pursuing the right course of action in a particular situation.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Since that time, other researchers have made significant contributions to this original concept, including but not limited to concepts of psychological disequilibrium (Wilkinson, 1987), moral integrity (Liaschenko, 1995), perceptions of influence and value (Penticuff & Walden, 2000), and professional expectations of self (Webster & Baylis, 2000).

The Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses* provides the following definition of moral distress:

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress. (p. 6)

Nursing students face events in everyday educational practice that may be more distressing than when they encounter more dramatic but less frequent traumatic events (Austin, Lemermeyer, et al., 2005; Corley et al., 2005; Lützén et al., 2010; Pauly et al., 2009). These events can cause moral distress to nursing students expected to managing these situations when they do occur, and inexperience may result in nursing students feeling doubly distressed.

Real and perceived internal and external constraints such as fear of reprisal, lack of autonomy, decreased confidence and competence, practice climate, and unethical patient care practices are well-documented and influence nurses' abilities to carry out actions they deem morally right, leading to moral distress and affecting personal responses to stressful events (Austin, Lemermeyer, et al., 2005; Cronqvist & Nyström, 2007; McCarthy & Deady, 2008; Pijl Zieber et al., 2008; Zuzelo, 2007). Researchers

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

have reported conflicting results in the correlation between the level of moral distress experienced and years of nursing experience. Some reports indicated less moral distress in experienced nurses because of confidence and support systems (Corley et al., 2005; Wilkinson, 1987). Other researchers reported more distress for experienced nurses due to moral climate, few supports, and cumulative stress (Elpern et al., 2005; Lützén et al., 2010), while Ohnishi et al. (2010) reported no correlation between intensity or frequency of moral distress and years of experience. Ulrich et al. (2010) found that younger nurses experienced more stress resulting from observations of patient care and ethical issues, and Pijl Zieber et al. (2008) noted that nursing students also felt powerless when they witness inappropriate or incomplete care, due to perceived limitations on their ability as students to take action.

Internal Constraints

Fear of reprisal. Nurses may respond to situations and events in practice according to feelings of insecurity and uncertainty. Nursing novices and students often tend to focus on satisfactory task completion. However, focused attention on tasks may not allow inexperienced nurses to identify questionable practices in others, or perhaps individuals new to the nursing profession do recognize problems but do not acknowledge them. Novices may fear reprisals directed at them as junior members of the health care team (Austin, Rankel, et al., 2005).

Lack of autonomy. Autonomy refers to self-determination and choice, which may be lost when there is actual or perceived powerlessness over a particular situation (Austin, Lemermeyer, et al., 2005; Cronqvist & Nyström, 2007). Observations, interactions, and decisions should be grounded in knowledge rather than in unquestioned

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

rituals and traditions in practice (Mooney & Nolan, 2006); however, nursing novices and students may lack confidence to practice autonomously or question practice.

Perceptions of competence. Researchers have confirmed that moral distress occurs when nurses lack confidence in themselves or in the competence of other nurses and physicians (Cronqvist & Nyström, 2007; Pauly et al., 2009; Rice et al., 2008; Zuzelo, 2007). Nursing students may lack confidence in implementing theoretical nursing concepts in actual practice, and may hesitate to question competence in other health professionals. Perceptions that the actions of others have a negative effect on patient outcomes may lead to moral distress.

External Constraints

Institutional structures. In institutional practice settings, organizational norms and structures may affect capacity to carry out desired moral actions and treatment decisions. In mental health settings, nurses often know the patient quite well and may wish to implement care practices not supported by the institution's policy or by the patient's family members (Corley et al., 2001; Gutierrez, 2005; Lütznén et al., 2010; Pijl Zieber et al., 2008). Nursing students are restricted in their ability to influence or question institutional norms, but their knowledge of the patient can be substantial, in light of their limited caseloads. Having more time to spend with patients increases their knowledge of the patient's wishes, but inability to implement care accordingly can cause moral distress.

Work environment. Responsiveness to moral dilemmas is an individual responsibility, but the nursing environment may influence an individual's ability to take action. Harrowing and Mill (2010) argued that moral distress may occur as a result of

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

complex interpersonal, structural, and contextual relationships. Decreased satisfaction with quality of patient care and infrequent collaboration with physicians caused intensive care nurses (Hamric & Blackhall, 2007) and mental health nurses (Lützén et al., 2010) to have higher moral distress scores than nurses who worked in positive environments. Benner et al. (2009) asserted that positive and productive relationships among working colleagues were essential for clinical expertise and skill acquisition. Nursing students who have negative interpersonal experiences with patients, staff nurses, or nursing instructors in the practice setting may experience distress.

Unethical practice. In the context of mental health, emotionally and cognitively vulnerable patients may be particularly susceptible to unethical professional behaviours. Relevant, accurate, complete, and realistic medical information is essential for obtaining informed consent from patients and families (DeKeyser Ganz & Berkovitz, 2011; Gutierrez, 2005; Schluter et al., 2008). Deliberate or inadvertent deception is in direct opposition to the ethical principle of veracity (Corley et al., 2001; Corley et al., 2005; Wilkinson, 1987). Deady and McCarthy (2010) found that psychiatric nurses were distressed by practices of coercion that included inappropriate behavioural restrictions. For nursing students who may not understand the complexities of caring for individuals with mental illness, restrictive and coercive practices can contribute to moral distress.

Effects of Moral Distress on Nursing Practice

Powerlessness to act or effect change for patients may be one of the most noteworthy effect of moral distress on nurses. Ulrich et al. (2010) indicated that of 422 nurses, 71% had experienced ethical issues about which they felt they could do nothing, and 36% reported feeling powerless. Powerlessness results from exclusion from

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

decision-making processes (Deady & McCarthy, 2010; Gutierrez, 2005; Manojlovich, 2007; Nathaniel, 2006), limitations to scope of practice (Manojlovich, 2007; Mooney & Nolan, 2006), poor patient outcomes and inability to advocate for patients (Cronqvist & Nyström, 2007; Deady & McCarthy, 2010; Manojlovich, 2007; Ulrich et al., 2010), and feeling powerless compared to physicians and administrators (Cronqvist & Nyström, 2007; Manojlovich, 2007; Nathaniel, 2006).

Newly graduated nurses' early interactions with professional peers may greatly influence perceptions of the nursing environment and of the profession; these interactions are essential in the socialization process. Idealistic expectations of the profession may not correspond to the actual practice of the unit, and novice nurses can experience dissonance and dissatisfaction (Boychuk Duchscher & Myrick, 2008; Illingworth, 2009; Kelly, 1998; Price, 2009), leading to new nurses leaving the profession very early in their careers. Maben et al. (2006) found that the ideals learned in nursing education were not consistent with the novice nurses' perceptions of the realities of practice, resulting in disparity between theory and practice, and few good role models to follow. Illingworth (2009) stressed the importance of role models for new graduates, supporting Benner and Benner's (1979) observations that practicing nurses demonstrate what nurses should do in the realities of the work world, while nursing educators teach nursing students what an ideal nurse should be.

Nursing students who lack the benefit of experience or guidance may not understand the rationales for treatment decisions, the political climate of acute inpatient psychiatric units, or legal and ethical implications for behavioural restrictions on clients with mental health disorders. Practice situations may not be consistent with educational

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

preparation or idealistic expectations, evidenced particularly in the discrepancy between idealistic concepts of caring and the realities of a medical model of care in psychiatric mental-health nursing (Boychuk Duchscher & Myrick, 2008).

Nursing students who have negative perceptions of their educational practice experience may be reluctant to enter that practice area upon completion of education (Cleary et al., 2005; Happell & Gough, 2007; Happell et al., 2008b; Hoekstra et al., 2010; Surgenor et al., 2005). In addition, negative attitudes and environments encountered by nursing students in psychiatric mental-health nursing practice settings affect students' career choices (Gough & Happell, 2009; Happell, 2009; Happell & Gough, 2007; Hoekstra et al., 2010; Surgenor et al., 2005), while recruitment and retention strategies are supported by positive experiences and relationships with nursing staff.

Research Method

In naturalistic inquiry, the researcher assumes that multiple realities exist and he or she strives to achieve mutual understanding of the various realities of each individual within their own experiential context. This understanding of individual knowledge and experiences results in realization that the world and reality are constructs of human experience (Awty et al., 2010; Bowen, 2008). Each participant ascribes his or her own truth and meaning to each situation.

When numerous individuals are involved in the research, consensus among participants is the goal, but the researcher remains willing to form new interpretations of the phenomenon, including understanding that his or her own perspective is as real as that of the participants (Heikkinen et al., 2007). Researcher and participants then interpret, compare, and contrast perceptions of knowledge through dialogue, further testing

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

assumptions in light of new experiences (Guba & Lincoln, 1994). Discussion in this portion of the research study focuses on this understanding of individual experiences and perceptions of the phenomenon of moral distress.

Purpose of the Research Study

Literature on moral distress has been largely quantitative and conducted in nursing areas with a predominantly medical focus. Existing research has contributed to an understanding of the factors contributing to moral distress in nurses but has not examined moral distress experiences in psychiatric-mental health nursing settings extensively. Nursing students have also been notably absent from research studies. In light of projected nursing shortages, it is important for the future of mental health nursing to understand the experience of moral distress in nursing students.

As stated in Chapter One, this study comprises two parts, with two discrete groups of participants: nursing students and nursing instructors. The focus of Chapter Three is to explore the nature of moral distress experiences in nursing students in acute inpatient psychiatric settings and examine strategies students use to effectively manage moral distress. Nursing student participants ascribed meaning to their individual experiences within the context of their understanding of psychiatric-mental health nursing practice. This portion of the research study centred on the first of two overarching research questions: What is the extent, nature, and meaning of moral distress in nursing students in psychiatric clinical placements?

Study Design

Naturalistic inquiry examines phenomena within a specific context and setting while using inductive analysis to ascribe meaning to the data (Erlandson, Harris, Skipper,

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

& Allen, 1993). I used semi-structured interviews to explore student perceptions of moral distress situations encountered on acute inpatient psychiatry. The use of semi-structured interviews and open-ended questions engaged participants and researcher in dialogue, allowed for discovery of important issues that occurred within specific contexts, and allowed participants to expand on experiences and relate issues of particular significance from their personal perspectives and in their own words (Crouch & McKenzie, 2006; DiCicco-Bloom & Crabtree, 2006).

There are advantages and disadvantages to conducting interviews as a data collection method in qualitative research. Advantages include that interviews, particularly when conducted face-to-face, have a higher likelihood of participant response rates. Interviews also provide the researcher with a greater level of control over the interview process, allowing for better understanding or clarification of questions that are ambiguous or unclear, to preclude misinterpretation by participants. Disadvantages of using interview techniques include monetary cost and time consumption in terms of organizing interviews, travel time, the length of each interview, and the time taken in transcribing and coding data. In general, the quality of the data collected is dependent on the skill and expertise of the researcher.

As I have extensive nursing experience in a variety of mental health settings, there was little risk that a lack of knowledge about mental health nursing on my part might adversely affect the quality of the interviews with the participants. However, my unfamiliarity with conducting formal research interviews had the potential to affect the quality of the data. Therefore, my professional knowledge of the psychiatric inpatient unit, moral distress experiences related to me by previous students, and my knowledge of

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

the current method of mental health practice instruction at the educational institution all guided the development of my interview questions.

Participants

I used purposive sampling—specifically concept sampling—to recruit nursing student participants, to ensure that participants had specific knowledge of situations of moral distress that occurred in the acute inpatient psychiatric setting (Awty et al., 2010; Stringer & Genat, 2004; Tavakol & Zeinaloo, 2004). Participants were recruited from an undergraduate nursing program in Western Canada. Inclusion criterion for student participants was completion of a mental health educational practice experience in acute inpatient psychiatry. Exclusion criteria were students who completed a mental health practice rotation in rehabilitative, geriatric, or solely community mental health settings, or who had not completed their mental health practice rotation at the time of the study.

The purpose of including only participants from acute inpatient psychiatric placement settings was to ensure consistency of exposure to the acute care environment and specific mental health patient care practices. The purpose of including only students who had already completed their clinical practice rotations was to eliminate the power differential between the interviewer and student participants, and minimize problems of acquiescence and social desirability in participant responses (Bryman, Teevan, & Bell, 2009). As I had not taught any of the student participants either theory or practice courses in the past, this further reduced the power differential.

Participant recruitment occurred using a third-party approach. Volunteers attended nursing classrooms and presented a prepared script (Appendix A) inviting students to participate in the study. Initial lack of response necessitated expansion of

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

recruitment techniques to include snowballing, an e-mail reminder to classes already approached, and distribution of posters (Appendix D) in areas of high student traffic. Seven female students provided informed consent to participate; no male students took part in the study. Participants ranged in age from 21 to 38 years, and were students in Year Three or Year Four of the generic baccalaureate nursing program, or the Bachelor of Nursing After Degree (BN-AD) program, a compressed course of study for degree holders. See Appendix E for participant demographic forms.

Data Collection Method

Each participant chose a convenient time and location for a face-to-face semi-structured interview lasting approximately one hour. I provided the definition of moral distress (Canadian Nurses Association, 2008) and asked participants to describe their experience of moral distress in the psychiatric setting and to focus their attention on aspects of acute inpatient psychiatric nursing that they viewed as being morally or ethically wrong but did not believe they were not in a position to address. An interview guide (Appendix F) ensured that question structure remained consistent for all interviews. Participants then provided suggestions for improving those situations, and strategies for their nursing practice instructors to help them better prepare for, and manage, those situations. Field notes made after each interview highlighted areas of key significance and recorded my observations of non-verbal cues offered by participants during the interview process. I digitally recorded and transcribed each interview verbatim.

Data Analysis

I used inductive thematic analysis to assist me in developing abstract and descriptive themes regarding nursing student perspectives of moral distress (Marshall &

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Rossman, 2011; Norwood, 2010; Thorne, 2008). Data were imported into a software program for qualitative data management–Nvivo9–to assist with organization and construction of identified categories and themes (DiCicco-Bloom & Crabtree, 2006; Leech & Onwuegbuzie, 2007; Ziebland & McPherson, 2006). Data were labelled with individual codes that stood alone as independent concepts, then were sorted into categories of concepts, and further combined into broader identified themes (Erlandson et al., 1993; Marshall & Rossman, 2011; Norwood, 2010; Taylor-Powell & Renner, 2003).

Thematic analysis focuses on qualitative aspects of individual perceptions, tentative explanations of why the phenomenon is occurring, and why these explanations are significant (Checkland & Holwell, 2007; Crouch & McKenzie, 2006; McNiff & Whitehead, 2010). This involved giving meaning to the data as they related to the context of participant belief systems and values, which in turn led to a realization of my own beliefs and values regarding the need for change to occur. Thorough analysis of the themes resulted in discussion of potential changes to nursing education to address circumstances that may reduce the impact of moral distress in nursing students.

Ethical Considerations

Ethical approval for the study was obtained through a university-affiliated research ethics board, in compliance with national guidelines safeguarding participant rights and confidentiality (Canadian Institutes of Health Research et al., 2010). It is important to note that there was no power relationship present between the researcher and participants, as no teaching relationship existed at the time of the interviews, nor would exist for the duration of the students' enrolment in the nursing education program.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

There was a minimal risk of participants experiencing psychological distress while engaging in this research study. Relating experiences of moral distress had the potential to evoke some discomfort in participants due to the sensitive nature of and the participants' emotional and psychological responses to the situations described. I informed participants of this risk and encouraged individuals to inform me if experiencing discomfort at any time. Resources for emotional and psychological support were available upon request, although no participant asked for this information.

Confidentiality of Information

A potential ethical consideration in qualitative research is the relating of real stories told by participants. Descriptions of events can be powerful in illuminating problematic areas in professional practice, but can also cause ethical problems due to the need to protect participant identity. While "anonymizing" the data can preserve individuals' privacy, there remained the potential for adverse effects on the individual whose story was related if she felt that her contributions were minimized or her perspective not accredited to her (Campbell & Groundwater-Smith, 2007; Campbell & McNamara, 2007; Somekh et al., 2005). As no participant expressed a desire for identification, I anonymized identifying information of participants or other individuals specifically referred to within the interviews. I altered direct quotes from participants only with respect to English grammar and syntax to avoid identification of any participant whose first language was not English, and took care to preserve the meaning intended. Participants each chose or were assigned a pseudonym by which they would be known. To preserve authenticity and provide perspective for each participant, I connected all demographic information collected to each participant's respective

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

pseudonym, and used the demographic information only to situate participants within the study itself.

Informed Consent

Participants provided voluntary informed consent at the time of the interviews (Appendix G). The consent form included a statement that although their individual comments or experiences were confidential, a summary of extracted themes from student interviews would be presented to nursing instructor participants for consideration in the second portion of the research study. I advised participants of the right to withdraw from the study at any time without penalty. All participants received a \$5.00 gift card from a local coffee shop in appreciation for time and contributions.

Rigour and Trustworthiness of the Data

Trustworthiness of data in qualitative research requires careful consideration of four criteria: credibility, transferability, dependability, and confirmability (Awty et al., 2010; Guba & Lincoln, 2002). Credibility refers to establishing truth in research findings, and ensuring that data and interpretations drawn are plausible, believable, and true to participant descriptions and interpretations of experiences. I asked participants to review the written transcript of their interview for accuracy of content and meaning prior to forming interpretations of the collective data; one participant declined to review the transcript. Transferability refers to the extent to which research findings apply to settings or groups outside of the current sample. Although the results of my research may not be directly transferable to other contexts, participants' rich descriptions of moral distress may be applicable to other individuals within their own unique situations (Checkland &

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Holwell, 2007; McNiff & Whitehead, 2010; Streubert & Carpenter, 2011; Stringer, 2007).

Dependability refers to the stability of data over time and varying conditions. Although it was not possible to replicate subjective reports from participants and assess validity of the data over time, I clarified and determined accuracy of participant descriptions of situations by asking participants to review their transcript, providing validation and dependability of individual interviews. Confirmability refers to the objectivity and neutrality of the final data report and to the assumption that there will be agreement between two or more independent persons about the data's relevance or meaning within a given context (Guba & Lincoln, 2002). A possibility of researcher bias existed in that I am also a mental health nurse and may have pre-existing assumptions and beliefs about the phenomenon of moral distress on inpatient psychiatric units. In order to reduce researcher bias, I maintained a neutral stance and did not present participants with my own perceptions during the interview process, to allow participants to share their own realities and perceptions within the context of their own understanding of the situations discussed. In taking these steps to ensure trustworthiness of the data, I have provided enough information that other researchers will reach similar conclusions about moral distress experiences in nursing students.

Interviews are a form of self-report, and the researcher must assume that information provided by participants is accurate within the context of the individual's understanding of the phenomenon. Human experiences are unique, and the importance of these experiences is not always accessible to validation through the senses, but through confirmation of applicability to other individuals within their own experiences. An

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

individual's reactions stem from his or her own interpretations of situations present in everyday life, and the ability to interpret these situations arises from our possession of "self" as opposed to conforming to the ideas and opinions of others (Athens, 2010). The researcher's role is to describe and analyze raw data in a way that richly illuminates the lived experiences and cultures of participants, which occurs as themes emerge from similar ideas expressed by other participants (Norwood, 2010; Streubert & Carpenter, 2011). Examination of individual responses to situations will reveal common themes and perhaps generate an idea of the most prevalent factors influencing various participant responses. It is important to preserve the integrity and meaning of the data with each participant prior to generating common themes.

Findings

Two major themes emerged following data analysis. The first theme, "Why do I feel this way", consists of descriptions of actual events or circumstances that participants felt were not right. These events formed the basis for the second theme, "It's not my place", descriptions of the reasons participants felt they did not or could not say or do anything about those situations and events identified as not right. Table 2 illustrates the core concepts and definitions of each theme and their respective sub-themes, described in detail in the following sections.

Why Do I Feel this Way?

Participants described events or situations they encountered in the acute inpatient psychiatric practice setting that they believed were not right and contributed to feelings of discomfort and angst. In some cases, participants felt they knew what the right thing to do would be, but observed that it was not happening. In other cases, they were not able

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

to articulate what the right thing to do was, but were well aware of the fact that what was happening was not right. Through identification of these events, participants described four recurring sub-themes as follows. “Who’s the boss” revealed perceptions of a hierarchical model of care, “It’s cold in here” described the experience of a cold, harsh environment, “You can’t handle the truth” detailed examples of patient coercion and withholding of treatment information, and “It’s just a checklist” identified care delivered as an itemized list of tasks to be completed.

Table 2

Nursing Student Descriptions of Experiences on Inpatient Psychiatry

Why do I feel this way?	Events and situations nursing students viewed as “not right” that contribute to discomfort and angst
Who’s the boss	Hierarchical model of care with emphasis on medical interventions
It’s cold in here	Perceptions of a harsh, cold environment; judgmental and unwelcoming
It’s just a checklist	Care is delivered as an itemized list of tasks to be completed; minimal emphasis on emotional care
You can’t handle the truth	Patient coercion, withholding of full treatment information
It’s not my place	Reasons for student inaction in situations and events deemed as “not right”
Not much of an example	Lack of good role models for students to learn from
Bottom of the totem pole	Student vulnerability in the role of a learner

Who’s the boss. Several participants perceived an emphasis on a hierarchical model of care, with all power over the patient’s health being held by physicians and

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

psychiatrists. These physicians, with limited collaboration or discussion, dictated diagnosis and treatment decisions for patients, and students perceived their authority to be unquestionable. For example, during a discussion regarding a particular diagnosis, a clinical nursing instructor negated one student's suggestion that a doctor had potentially misdiagnosed the patient. The student, Deb, was dismayed at the perception that the physician's word is the law, and felt that her instructor's comments did not coincide with the ways in which the program encouraged students to approach clinical practice. "I was like, 'Are you kidding me?' Isn't that against everything we've ever learned about critical thinking and looking at the specifics, and questioning? I think that whole mindset has to change." In addition to the hierarchical approach to care, participants had concerns about the limited interdisciplinary collaboration they observed on the inpatient unit. Deb noted that this was evident in the health care team's dynamic, commenting that "this whole thought of interdisciplinary teamwork seems like it's not happening on inpatient psychiatry . . . it feels very old school there, it feels very hierarchical".

Participants also felt that there was a lack of holistic care on the inpatient psychiatric unit, as evidenced by what they perceived to be an unseemly haste in resorting to medical or pharmacological solutions to patient health concerns. For example, Lisa noted that pharmacological interventions were an inappropriate solution to her patient's anxiety response to smoking restrictions:

He would be told he couldn't have [nicotine replacement therapy], and then he would get really upset and anxious and agitated, and then he'd start, not being aggressive, but very loud verbally and kind of "in your face" about things. So then he would end up, you know, getting Zyprexa or something to settle him down. You know, like, you're medicating something that shouldn't be an issue.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Lisa felt that using relaxation techniques, distraction, or other non-pharmacological interventions would have been just as effective and more appropriate as initial interventions to reduce her patient's anxiety.

The perception of hierarchical care and limited interdisciplinary collaboration frustrated participants, and they felt this prevented them from implementing the care they would have liked to provide for their patients. Jill recounted caring for a patient with multiple physical and mental health needs, and articulated how this practice experience on inpatient psychiatry had a negative impact on her. She became disillusioned because of her expectations that the psychiatric inpatient unit would have a primary focus on supporting patients holistically:

I don't feel mental health is somewhere that I'd want to work in a future career, just because my experience there, I felt helpless. I didn't feel that [patients] were supported, and I felt like whatever structure was in place didn't support them to be what they want, to help them into what they wanted to achieve.

Overall, participants felt that the hierarchical model of care on inpatient psychiatry severely limited their ability to contribute to their patients' care and recovery. The authoritative approach to patients was in direct conflict with the holistic aspirations of participants, and contributed to their misgivings about psychiatric nursing as a potential future nursing practice area.

It's cold in here. Although some participants identified certain staff members who were supportive and welcoming, many felt the climate on inpatient psychiatry was very cold and impersonal. Attitudes towards patients in particular were at times judgmental, harsh, and uncaring. When a staff nurse made negative comments about the reason for a patient's admission to the unit, Deb expressed her disappointment at the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

attitude she observed. Although she could understand frustrations that affect nurses when dealing with patients with multiple readmissions, she felt that every patient deserved a chance at objective care: “I get that people get jaded in there . . . but I for one don’t think that’s right, that you judge a patient before you’ve even met them”. Another participant, Kathy, was concerned about patients and visitors overhearing a conversation between two nursing staff in the nursing station, which was located in an area openly exposed to the rest of the unit:

She made very negative comments about body image, about self-esteem, and we have to understand, a lot of the mental health patients have those issues going on at the same time [as] their mental health. And then it’s just inappropriate of her to say those things, and she did make some comments about patients in the nursing station to one of the other nurses.

Participants also noted the cold, harsh environment in relationship to the amount of time staff spent in direct contact with patients. In light of the amount of time spent in group sessions and other therapies, and despite the relatively low nurse-patient ratio on the inpatient unit, Jill felt that patients had limited opportunity to speak to a nurse about their concerns. Physicians also appeared to spend a minimal amount of time consulting with patients directly:

It’s a good day if [patients] get in an hour with one person and they only have that hour time slot to express those kinds of things with someone that’s going to listen. And I watched the doctors go on their rotation, and I think the most I ever saw a doctor sit down with their patient is 15 minutes, and it was just really frustrating.

Regarding their own efforts to learn, participants expressed that they did not always feel encouraged to engage with nurses or physicians. Occasionally, even their nursing instructors appeared unsupportive or overly critical, contributing to an uncomfortable learning environment. Barb indicated her frustration with her instructor:

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

I felt more challenged than supported during this clinical with this specific instructor. I felt like I was always challenged rather than, “I’m here for you to help you through this”. It was more like, “you better do this, you better do that, and you’d better do it this way, and if it’s not done this way, then that’s not the right way”.

Some participants described reluctance to approach inpatient psychiatry staff to ask questions or engage in conversation regarding patient care. Verbal rebuke, criticism, and derision were frequent reactions from some staff when students attempted to take a more active role on the unit. Minimizing contact with health professionals was one coping strategy Deb used to manage these anticipated responses:

We weren’t invited at all by the doctors to be participating or active, and one [student] who asked a doctor a question just pretty much got his head bit off. That whole mindset or vibe down there . . . the vibe down there was awful. You didn’t want to make mistakes; you didn’t want to ask questions. You would do all the things you needed to do and have three or four things to report, and that’s part of time management, but it should be a learning experience and not because they’re going to roll their eyes at you.

While most participants acknowledged that not all staff demonstrated cold and uncaring attitudes, Barb expressed her feelings about working relationships in the acute inpatient psychiatric environment:

It depended on who the staff nurse was for the day that was looking after my clients. I remember some days completely avoiding my staff nurse because they would snark at me . . . and I remember some staff nurses being more than supportive. I don’t think I could ever work down there, because there are so many conflicts of interest for me, in the way that certain nurses deal with patients, in the way patients are treated. I can’t respect that environment anymore because of my experience there.

The prevailing impression among participants was that at times, the inpatient psychiatric environment neither supported patient well-being and health nor endorsed student learning, depending on staffing complement. This perception also contributed to participants’ reluctance to consider inpatient psychiatric nursing as a career.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

It's just a checklist. In addition to perceptions of a harsh environment, participants felt that patient care was just a checklist to be completed. Participants perceived that psychosocial aspects of patient health were minimized compared to completion of clinical tasks and a focus on discharging patients as quickly as possible. For example, Jill felt that the nurse's role conformed to an ordered approach to patient care rather than focusing on interpersonal patient interactions: "It was kind of like a checklist, 'this is done, this is done, these meds are ordered, we did this, we did a one-to-one, and that's it, that's all we need to do'." Deb corroborated this task-based approach observed in some staff nurses:

I felt that the [nurses] who were not so great were thinking, "my role is . . ." and they never said it, but that's how they acted and what they focused on. "Here's my task, here's what I need to chart, what are their meds doing." That just seemed to be the focus.

This task-based approach caused confusion among participants as to what the role of the psychiatric-mental health nurse should be. Many participants assumed they would be engaged in primarily psychosocial assessment and problem-solving skills with their patients. Deb expressed frustration when she sought assistance from nursing staff regarding her patient's disclosure of sexual abuse. Having never before encountered this issue in practice, she assumed that the correct nursing action might be to engage the patient in counseling, but expressed surprise at the response she received from staff:

And then that nurse is going, "we don't talk about that here, but I think we can try to see if her social worker can get her a referral." For me, "we don't talk about that here", and you're in an inpatient psychiatric setting with a diagnosis of major depression, it just seems so, "well, what the hell do you do here then?"

Participants also felt that skills they had learned were not valued for their importance to patient outcomes. Instead, they perceived that accomplishing specified

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

tasks was necessary in order for their nursing instructor to determine successful completion of the practice rotation. For example, Barb felt that there was an over-reliance on evaluating the technical aspects of her abilities to administer medications to her patients.

Having to give those drugs as a “checklist” sort of thing in practicum was not something that I felt should be a skill kind of thing, when you’re giving someone an antipsychotic. That’s kind of heavy. I felt like I had to tick it off my skill list and if I didn’t, I wouldn’t do well in clinical. It was just expected that we were to give the meds, and when our instructor came over, to make sure we knew everything about our meds: “what’s the med, tell me what it does, how it acts, what are the side effects?” It was never, “how do you feel about giving this med, do you really understand what [it] might do to this person, or why it might influence their [diagnosis]?”

Although participants understood the necessity of attaining sufficient knowledge and skills to be able to care for their patients safely, the overwhelming consensus was that there was more emphasis placed on task completion than on psychiatric-mental health assessment and intervention. Participants felt there needed to be more emphasis on patient health priorities and student learning priorities in this practice setting.

You can’t handle the truth. Participants’ observations of interactions between nurses and patients on the inpatient psychiatric unit included coercion into behavioural compliance using implied threats, withholding of information, and attitudes minimizing patients’ abilities to know what is in their own best interests. Participants felt that alternative approaches to behaviour management issues and treatment compliance would have been more effective in achieving favourable results and patient cooperation.

Lisa described a situation in which a patient refused to follow the expectations of staff in regard to daily activities. Instead of engaging the client in a discussion to address factors contributing to the patient’s resistance, one nurse misled the patient regarding

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

consequences for her behaviour. On her way to administer an injection to another patient, the nurse deliberately held the syringe up in front of the noncompliant patient to imply the use of medication to ensure behavioural compliance.

And I don't know if [the patient] just expected, "Okay, well in the past when I haven't behaved I've been medicated to control my behaviour", so she did [comply]. And then the nurse comes back and she doesn't have [the needle] anymore, and [the patient] is like, "that wasn't for me? I guess you tricked me, ha ha ha" and sort of laughed it off. But for me, you're tricking the patient, and how are you dealing with that trust relationship, and I wasn't comfortable with it.

Witnessing coercion of this kind in patient interactions resulted in feelings of participant complicity by engaging in what they considered unethical behaviour.

Some participants also felt pressured by inpatient staff and their instructors to deceive patients by withholding treatment information. Participants felt that not disclosing full information to patients negated the principles of informed consent and undermined patients' abilities to act on treatment information responsibly. Barb became visibly upset when considering her professional responsibility to educate her patient regarding medication.

I was specifically instructed not to explain [side effects] to him because my instructor felt that he might repeat some of these negative side effects back to his psychiatrist or start exhibiting some of them as sort of a hypochondriac kind of thing. I feel that as he was going to be on these injections that he should have some idea of the negative side effects when he is in the community. I mean, it's his body and he's going to have to be dealing with [it], and not to explain that, I kind of didn't agree with that.

Situations like this exemplified participant perceptions of inpatient staff views that patients are ill equipped to manage their own behaviours or make choices that would be appropriate to their situation. Participants expressed their belief that the lack of patient autonomy and inclusion in treatment decisions was directly related to the fact that they

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

were on the inpatient psychiatric unit. However, Lisa felt strongly that regardless of an individual's physical or mental health—barring determination of incapacity—individuals need autonomy in making decisions affecting them or their care:

People still—regardless of their health issues, regardless of their circumstances or where they are—people still have the right to make their choices. Because [they] have a mental illness, somebody has the ability to do that? Make that kind of choice for [them]?

All participants felt that there were alternative and more effective means of managing the situations that distressed them. Participants were not always able to identify an alternative solution or appropriate action, but in cases where participants could identify the right thing to do, they also identified factors that they believed prevented them from doing it. The following section discusses these factors.

It's not my place

Participants related several reasons that they felt they could not or did not say or do anything about the situations and events on inpatient psychiatry identified as being not right. Individuals attributed their inaction to both internal and external factors that they felt were not within their power to change. Two primary sub-themes emerged from the exploration of participants' inability to act: (a) "Not much of an example" or participant perceptions of a lack of good professional role modeling, and (b) "Bottom of the totem pole" or participant vulnerability in their role as learners. Overall, participants did not feel it was their place to question staff about circumstances and situations on the unit, nor to challenge their nursing instructors' quiescence in these situations.

Not much of an example. Participants felt unable to effect change in situations that they identified as not right because they observed behaviours in their clinical nursing

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

instructors that appeared to condone or perpetuate inappropriate actions. Participants expressed frustration at not having good professional examples, specifically in terms of effecting change in distressing circumstances or situations. Participants perceived that their nursing instructors' roles as teachers limited their ability to take action on the unit, which was problematic in addressing troubling situations. However, participants felt strongly that their nursing instructors had a professional responsibility to take appropriate action to address these situations within the practice setting, as an example for students to follow in their own practice.

Andrea recounted her frustration at not being able to effect change for her patient, who was concerned about the detrimental effects his mental illness was having on all other aspects of his life. Although changing his life circumstances was outside of her control, this participant felt she should have a role in advocating for appropriate resources. Upon approaching her clinical nursing instructor to discuss accessing resources, she was discouraged at what she perceived to be a dismissive response:

Sometimes you heard—even from the instructor, even though they are good—they say, “Oh, this is how life is, you cannot make changes”. I guess I probably feel that I can make changes, but sometimes I found that it’s kind of hard.

Betty also perceived this passive attitude in nursing instructors when she reported inappropriate treatment of a patient by unit nurses. She felt uncomfortable addressing the situation herself as a student, but believed that her instructor would be in a position to take action and intervene appropriately. The response she received fell far short of her expectations:

As a student, it was a little bit difficult because you can’t really say anything. We were kind of told just not to say anything and just kind of to watch it. How are

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

you supposed to watch something like that, and when we get on our own, things aren't going to be "just watch it" because you're actually in charge.

Participants commented on what they felt were the reasons for their clinical nursing instructors' passivity in addressing situations on the inpatient psychiatry unit. The primary reason identified was the clinical nursing instructors' relationships with the inpatient unit staff. Some instructors were employed as staff on the nursing unit in addition to being educators, and some had never been employed on that particular inpatient unit but had practice or educational experiences in other institutions. Although they acknowledged that clinical nursing instructors may be hesitant to address inappropriate practices by peers with whom they had close relationships, the majority of participants felt it would be more difficult for instructors who did not currently work or had never worked on that inpatient unit and therefore did not feel comfortable speaking out.

Jill acknowledged the difficulty her clinical nursing instructor had in maintaining a balance between good working relationships with the unit staff and addressing practice issues:

I think it's hard for an instructor when they're going into a facility that they're not familiar with, that they haven't practiced themselves in. Because then they don't want to step on toes. They don't want to cross any boundaries.

Kathy also observed that her instructor was sometimes in an untenable position between unit staff and nursing students. Though it appeared that the nursing instructor wanted to intercede with staff on behalf of the student, she lacked influence with the nursing staff and unit manager and felt there was no appropriate forum for her concerns regarding unit practice or student education:

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

There's not really an outlet or source for her to communicate all this frustration or all the conflict between the nurse and the student back onto the unit. She felt very frustrated about that because she's not a staff on the unit, so it's not in her place to voice her opinion.

These participants felt that their clinical nursing instructors were as helpless and powerless as they themselves were to effect change. Barb agreed in principle, but was displeased with her instructor's justification for her reluctance to address practice concerns raised by students. She recalled the response her clinical group received when they questioned inappropriate communication occurring between a nurse and patient during a one-to-one:

She did not work there and she told us, "Normally if this was my place of work, also where I was teaching students, I might question the policy or procedure, or this staff member, or this psychiatrist, for the safety of my patients. But I don't work here, so I don't know the ins and outs of this enough on this floor to be questioning the actual actions and the things that were happening". So it was, "yeah, great question, I can see how that may not be right, but we can't address that because I don't work here".

Regardless of their perceptions about their clinical nursing instructors' inability to take action, all participants felt that it was the nursing instructor's professional responsibility to take a stand and provide students with examples of how to approach difficult practice issues appropriately. Students learn by observing the actions of those in leadership and teaching positions, and having a professional role model for their own future practice is a key element in the learning process. Kathy unequivocally stated her conviction of this in regard to nurses talking inappropriately about patients in an open environment:

I understand that she doesn't want to start anything, but it's a professional conduct issue, right? I think someone should know about the issue, because if no one knows, then nothing can be changed. That should be my instructor's role, and I feel like by her doing that it also sets an example for us to follow, that if

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

something like that did happen, then we can speak up. But if our instructor isn't a role model for us, then how can we follow our practice?

Bottom of the totem pole. Participants overwhelmingly felt restricted and powerless in their role as students. They felt unable to voice concerns about situations they felt were not right, due to their limited voice and low status at the “bottom of the totem pole” on the inpatient units. Of primary concern to participants was self-preservation and successful completion of the practice course, performing their duties in a manner that would meet the expectations of the practice setting and their nursing instructor. Concerns about patient practices took a back seat to participants' feelings of vulnerability in their role as learners.

Barb keenly felt the pressure to perform adequately when instructed to administer medications to a patient without providing sufficient teaching. Already feeling challenged more than supported by her clinical instructor, she felt that to refuse to carry out the tasks given to her would negatively affect her performance evaluation:

I think had I refused to give the injection my instructor would have thought that I needed to get over it or that I had some personal conflict with psychiatric medications, or that I was intimidated or scared, or something was wrong with me, rather than the situation. You can't really talk back as a student and say, “I'm not willing to do this” because I felt it would have impacted my clinical review or my . . . mid-term evaluation, my final evaluation, and reflect on me as a person, rather than on the situation I was in.

Although another participant felt she had a supportive instructor, she also expressed feeling torn between what she knew to be best practice, and what the actual practice of the unit was. Kathy noted that her instructor had higher expectations for documentation of medication administration than did unit nursing staff, and the participant felt distressed

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

at having to defend her higher standards when her documentation was called into question by nursing staff:

I feel powerless. At the same time, I want to listen to our instructor [about] what we need to do . . . but this is not the normal practice of the unit. I feel powerless, I feel like I'm stuck in the middle.

Several participants felt challenged that their student role was a hindrance in taking action to effect change. Deb lacked confidence in being assertive in doing the right thing for patients: "I have no confidence to stand up and say, 'this is the right thing to do'. As a student, I just feel our role's different". Deb felt that once she completed her education, she would be in a more defensible position to speak out and effect change in practice, saying "eventually it's gonna be like, 'all right, enough, what's going on, something's gotta be different'. So I feel like as a staff, I could do that. I feel as a student, I could not do that". Betty expressed similar sentiments, but admitted feeling sadness and regret when describing taking a passive role and not standing up to inequitable treatment of all patients on the unit:

Sometimes for me it was just a matter of kind of just sitting back and saying, "Okay, when I become the RN in this position, this is what I would do, but right now as a student, I'm just going to have to kind of let it go" and unfortunately, that's just what I did.

The inclination to "give up" and let go of issues over which they perceived they had no control was common among all participants; inadequate support, limited confidence, and no power contributed to feelings that surrendering to the status quo was their only option.

Discussion

Narratives of disappointment, angst, and powerlessness provide a glimpse of the complexities of moral distress in nursing students. In most cases, their experiences on the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

inpatient psychiatric unit resulted in negative attitudes toward mental health nursing, and disillusionment with their nursing instructors and the profession in general. Internal and external constraints to taking action appeared to have as much impact on participants as research indicates they are to practicing nurses (Austin, Lemermeyer, et al., 2005; Cronqvist & Nyström, 2007; McCarthy & Deady, 2008; Pijl Zieber et al., 2008; Zuzelo, 2007). Two themes emerged from the research data through the process of inductive analysis. First, participants identified concrete situations and events that caused them to feel moral distress in the practice setting; these particularly addressed a hierarchical model of care and unforgiving environmental climate. Second, participants identified their frustration with their perceptions of powerlessness in nursing; this included what they felt themselves and observed in their clinical nursing instructors' behaviours.

Nursing education does not adequately prepare students to challenge the medical model as status quo, and most physicians perceive such actions as a direct challenge to their power (Stickley & Timmons, 2007). Prior studies indicated that if a nurse deferred responsibility to the physician as decision-maker or perceived no obligation or responsibility in the situation—as may be the case with novice nurses who lack a strong sense of autonomy—then there was less moral distress experienced (Austin, Rankel, et al., 2005; Schluter et al., 2008; Wilkinson, 1987). In the present study, participants deferred to nursing staff and instructors for guidance in determining appropriate action to take in distressing situations. Deference to authority may occur as a result of being oblivious that action is required, unfamiliarity with available options for action, or lack of skill in pushing boundaries (Benner et al., 2009; Corley et al., 2005; Ulrich et al., 2010). This deferring of responsibility perpetuates powerlessness in nursing. Though historically

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

more subservient members of the medical professions, nurses have effected some changes due to recent recognition of the incongruity between nursing tradition and current practice (Mooney & Nolan, 2006), but these changes will be negligible if nursing educators continue to perpetuate the practice of subservience in a medical model.

In psychiatric-mental health settings, psychomotor tasks are less prevalent than psychosocial assessments and interventions. However, participants' expectations of engaging patients in effective therapeutic interactions did not coincide with their experiences of actual unit practices. A focus on pharmacological interventions, deferring of counseling to external agencies, and limited time spent with patients all frustrated participants, who felt dissuaded by nursing staff from their efforts to advocate for patients. Participants' perceptions of the environment and some staff as being cold and uncaring permeated the data. Lack of disciplinary intervention from nursing unit managers and charge nurses also disheartened participants who felt that nursing administration had a responsibility to address unprofessional practices in staff. Current literature indicates a positive correlation between healthy environmental climates and nurse retention and recruitment (Ritter, 2011), yet Gutierrez (2005) found that staff nurses did not consider nursing management to be supportive in morally distressing situations. Many nurses felt that the manager was in most cases unaware that there was conflict present. In the present study, environmental factors were among the primary reasons cited for participants' reluctance to choose psychiatric-mental health nursing as a future practice area.

Participants identified their own powerlessness and vulnerability as students, and felt they lacked skill in challenging practice. They emphasized the need for better role

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

modeling from nursing instructors and believed their instructors had a professional responsibility to teach students how to respond to distressing situations and events in preparation for practice. Positive role models are essential in recruitment and retention (Illingworth, 2009; Maben et al., 2006; Price, 2009) and yet participants in this study indicated a paucity of role modeling from their instructors and the staff nurses. Without knowledge of how to take appropriate action in moral and ethical situations, it is no surprise that nursing students felt vulnerable and powerless. Support from nursing administration in ethics education increases retention in nursing (Hart, 2005), and it follows that receiving this support as students would have a positive impact on recruitment as well.

Implications for Nursing Education

The need for nursing students to have adequate preparation in dealing with moral distress in practice cannot be accentuated strongly enough. Educational demands and the pressure to master technical skills for successful completion of requirements preclude students from learning how to manage distressing practice situations effectively. Nursing educators have a vital role to play in demonstrating professional behaviours and advocacy skills, enhancing student practice and patient outcomes. Nursing students must have opportunities to critically reflect on their knowledge and understanding of practice issues to facilitate clinical reasoning skills, challenge assumptions, and implement best practices for patient care (Crowe & O'Malley, 2006). Although clinical discussions may provide opportunity for students to voice concerns, this forum does not lend itself to learning actual skills necessary for professional practice. Rather than advising simple observation of unit practices, instructors must teach students *how* to advocate actively for patients,

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

themselves, and their nursing peers. This occurs through example and by providing support to students as they attempt to master these skills for themselves, facilitated by healthy, supportive relationships between nursing instructors and students.

With the implementation of baccalaureate entry-to-practice requirements, nursing education values more intensely the development of critical thinking skills to enhance practice and patient outcomes. This is distinguishable from the previous nursing emphasis on task-oriented skill acquisition, and is one of the recent changes to nursing education noted by Mooney and Nolan (2006). It is unreasonable to think that change comes without responsibility or cost, and one such responsibility is that nurses act on their ability to think critically. However, if nursing educators teach students the initial step in problem solving—critical thinking—but do not role model an appropriate course of action, students may be inadequately prepared to manage these situations in their own practice. Students must have professional role models to assist them in skill development that will move them forward in the transition from student to novice nurse.

Implications for Nursing Practice

Practicing nurses must be aware of the influence they have on impressionable nursing students. Whether newly qualified or experienced, nurses must consistently demonstrate ethical and moral behaviours in accordance with their professional *Code of Ethics* (CNA, 2008). This professional document outlines specific values and ethical responsibilities for Canadian nurses, including advocacy for quality work environments; addressing social inequity; and delivery of safe, compassionate, competent, and ethical patient care. Failure to uphold these tenets—even through passivity—is a violation of nursing ethics. The belief that nurses are powerless to act dissolves when considering the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

possibility that if a nurse claims no responsibility for taking action, there really cannot be a claim to powerlessness. Bradbury-Jones, Sambrook, and Irvine (2008) argued that power belongs to everyone equally, and is exercised and embedded in every interaction, rather than individually possessed. Nursing students who enter the practice environment feeling vulnerable require the support and mentorship of practicing nurses, without concern for the positioning of power in the relationship. Nurses must be encouraged to take active mentorship and teaching roles in the practice setting to acculturate students and new graduates into the profession.

Limitations

There are several limitations to this study. The participant sample was small and provided perceptions of moral distress only within a specified clinical practice setting. Due to the limited geographic area in which the study occurred, regional environmental, cultural, and political factors may have influenced results. Although naturalistic studies do not typically expect to meet generalization criteria, findings from this study may potentially be transferable to students in other acute inpatient psychiatric-mental health settings. As there was limited connection of moral distress experiences to actual acute treatments (i.e. ECT, restraints), findings may also apply to other mental health placements in general. No male students participated in the study, and further studies may investigate possible gender differences in responses to morally distressing situations and events. It may be beneficial to include acute inpatient psychiatric nursing staff in further exploration of moral distress experiences.

Chapter Four

Nursing Student Moral Distress: A Call to Action

The Canadian Nurses Association (2009) projection of a significant shortage of 60 000 full-time registered nurses by the year 2022 will greatly affect psychiatric-mental health nursing practice. This specialty focuses on prevention, promotion, treatment, and maintenance of mental health issues in diagnosed individuals. Researchers have indicated that nursing students rarely choose this area as a career option (Gough & Happell, 2009; Happell, 2009; Happell et al., 2008a; Hoekstra et al., 2010) as compared to other nursing areas. In Chapter Three of this study, nursing students identified that negative experiences in a psychiatric educational practice placement contributed to feelings of moral distress, and influenced whether or not they would consider mental health nursing as a career choice. These factors, in combination with the projected shortages, may have a significant impact on the future of mental health nursing.

Retention and recruitment efforts will not be effective if nursing educators and administrators do not address moral distress issues among nursing students. This qualitative research study was conducted to obtain a richer understanding of the experiences of moral distress for nursing students within the context of psychiatric-mental health clinical placements, and to examine nursing instructors' perceptions of their role as agents of change for reducing student moral distress.

Literature Review

Chapter Three discussed the evolution of the definition of moral distress among researchers. Also discussed were nurses' perceptions of internal and external constraints on their ability to take action in situations deemed not right. It is important for nurses to

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

be aware that moral distress assumes many forms, and individuals may deem situations distressing or not based on individual expectations, experiences, and perceptions. Moral distress is experienced differently by each individual, based on perceptions of a correct moral action, the desired outcome of a situation, or what the individual believes constitutes an ethical issue (Austin et al., 2008; Pijl Zieber et al., 2008). Moral distress reactions may also be context-specific, affecting an individual more strongly in one situation than in another similar circumstance (Pijl Zieber et al., 2008). Absence of moral distress does not necessarily indicate ethical issues do not arise within a specific environment, but rather that the impact on individuals may be reduced due to dulled moral sensitivity (Austin et al., 2008).

Sumner's (2010) three maturational stages of moral discourse and development pertaining to interactions with others are as follows:

1. Pre-conventional maturity, self-oriented and submissive to authority
2. Conventional maturity, less self-absorbed; affirms initial objectivity inhibiting mindless obedience to authority
3. Post-conventional maturity, formed from the ability to detach oneself from the situation and evaluate own behaviours, allowing for fair and just interactions.

These maturity levels can be related to the amount of experience a nurse has, and how he or she reacts to situations that are morally distressing. Inexperienced nurses have less ability to reflect on their own personal practice beliefs, are concerned with task completion, and may not be comfortable challenging organizational structure; these limitations may affect their future practice. If they are unable to influence patients, health care professionals, and each other, they contribute to existing stereotypes of nurse

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

disempowerment. Manojlovich (2007) asserted that powerless nurses are ineffective, experience less job satisfaction, burn out more easily, and contribute to poor patient outcomes.

Socialization into the work environment involves familiarity with and acceptance of the norms and attitudes of colleagues, the unit, and the employment institution, all of which can increase job satisfaction significantly. If, however, the novice nurse's perceptions and values are in opposition to others on the unit, it may lead to the nurse leaving the practice area or the profession (Austin, Lerner, et al., 2005; Austin, Rankel, et al., 2005; Deady & McCarthy, 2010; Hardy et al., 2009; Nathaniel, 2002; Schluter et al., 2008; Wilkinson, 1987). Researchers have indicated that anywhere between 15 and 61% of nurses leave the profession or their area of practice due to moral distress situations (Boychuk Duchscher & Myrick, 2008; Corley et al., 2001; Corley et al., 2005; Hamric & Blackhall, 2007).

This response to moral distress exacerbates the problem of nursing shortages, and subsequently contributes to problems for colleagues in experiencing the same workplace conditions that may have caused the initial distress. Austin, Lerner, et al. (2005) stated that nurses whose focus was on caring were the ones who left the profession because of moral distress, while those who remained in the practice setting were focused on pursuing justice in those situations. Moral distress indicates moral sensitivity; nurses who leave the profession may actually be the best patient advocates, a clear loss for their patients and colleagues. Early interactions with professional peers greatly influence the new graduate's perception of the nursing environment and of the profession, and are essential in the socialization process. Illingworth (2009) also stressed the importance of

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

role models for new graduates, following on Benner and Benner's (1979) assertion that nursing practitioners provide new graduates with a perception of what nurses should do in the realities of the work world, while nursing educators focus primarily on what an ideal nurse should be.

All of the above effects of moral distress are persuasive arguments for the need to adequately prepare nurses to manage distressing situations. This literature review reveals that moral distress has many potential causes, and that individuals cope with the feelings that result from this phenomenon in a variety of ways. If nursing educators wishes to address these issues for students prior to entering practice, it is necessary to have insight into how nursing students and their instructors manage incidents of moral distress in psychiatric clinical placements.

Research Method

Jürgen Habermas (1984), in his *Theory of Communicative Action*, stated that in communicative action, individuals strive for intersubjective agreement, mutual understanding, and unforced consensus regarding a direction in which to move collaboratively (Feldman, 2007; Kemmis, 2008; Rasmussen, 1997). Habermas described practical interest as an orientation to—and interest in—particular and specific knowledge, involving achieving understanding of a phenomenon through interpretive methodologies and an attempt to generate knowledge that informs and guides practical judgments (Brannick & Coghlan, 2007; Herr & Anderson, 2005; Kemmis, 2009). Critical realism uses an objectivist ontology and a subjective epistemology of reflexivity that aims to expose interests; understand the effects of political, historical, and socioeconomic factors on individuals; and facilitate emancipation (Brannick & Coghlan, 2007; Paterson et al.,

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

2008; Sundin & Fahy, 2008). The purpose of engaging in self-reflexivity is to discover and evaluate alternative solutions for situations in which prior experience and knowledge can only provide suggestions to resolving the problem, not actual solutions.

The primary purpose of action research is to respond to practical concerns, give meaning to events, demonstrate how they are perceived by individuals in the setting, and to produce practical knowledge and solutions that are useful to organizations and communities (Bjørn & Boulus, 2011; Casey, 2007; Drummond & Themessl-Huber, 2007; MacLeod & Zimmer, 2005; Paterson et al., 2008; Streubert & Carpenter, 2011; Stringer & Genat, 2004). Action research may be conducted as first-, second-, or third-person research. Second-person research involves bringing individuals together for discussion of phenomena of mutual concern and developing common themes of interest (Bjørn & Boulus, 2011; Coghlan, 2011; Coghlan & Shani, 2008; Wicks & Reason, 2009). This research study utilized second-person action research to explore areas of mutual concern among nursing students and instructors, and engage participants in discussion about planning for change in mental health nursing practice education. In critical action research, the researcher attempts to explore social realities of situations by opening communicative space between him or herself and the participants to discover whether current social and educational practices are sustainable, and what the consequences of change may be (Kemmis, 2009; Wicks & Reason, 2009).

Action research is done in collaboration with—never *on* or *to*—individuals, organizations, or communities having a stake in the problem, and it employs interpretive processes throughout the investigation with the aim of finding a solution (Brannick & Coghlan, 2007; Coghlan, 2011; Herr & Anderson, 2005; Stringer, 2007). The action

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

research process can be a lengthy one, involving allowing time for implementation and evaluation of actions. Participant groups may change within these cycles—as in the case of students who progress through an academic program—and therefore the researcher’s self-reflection on learning and progress is an important aspect of action research. It is important to recognize the complexity of the context within which the participants exist.

Stringer and Genat (2004) suggest that the action researcher must:

- identify the different representations and definitions of the problem as put forth by the participants;
- reveal the unique perspectives of participants and other stakeholders;
- offer suggestions of alternate viewpoints from which the phenomenon being examined may be interpreted and assessed;
- identify strategic and meaningful points of intervention; and
- provide materials that facilitate understanding of individual experiences.

This process involves action cycles occurring throughout the research process:

developing a plan of action; implementing the plan; observing and evaluating the effects of change within the specified context; and reflection on the change effects as a basis for further planning, action, and evaluation (Brannick & Coghlan, 2007; Casey, 2007; Coghlan, 2011; Herr & Anderson, 2005; Paterson et al., 2008; Susman & Evered, 1978).

For this study, discussion focused on this practical interest in gaining understanding of the phenomenon of moral distress and the communicative action processes used in both stages of the research, and with both sets of participants, to explore potential for change. Discussion of research results will focus on these processes, rather than on an evaluation of actions taken.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Purpose of the Research Study

Literature on moral distress has been largely quantitative, and conducted in nursing areas with a predominantly medical focus, such as intensive care units (ICU). Existing research provides an understanding of the factors that may contribute to moral distress in nurses but has not examined moral distress experiences in psychiatric-mental health nursing settings extensively. Nursing students and instructors also have been notably absent from research studies. Moral distress experiences that cause nurses to leave the profession may also affect nursing students in their educational experiences. In light of projected nursing shortages (Canadian Nurses Association, 2009), it is important for the future of mental health nursing to understand both the extent of moral distress in nursing students and how nursing educators can assist students to prepare for and manage moral distress more effectively.

As stated in Chapter One, this research study consisted of two stages with two discrete groups of participants: nursing students and nursing instructors. The first stage consisted of semi-structured interviews with nursing students about their experiences of moral distress that occurred during an inpatient psychiatric clinical educational experience. The second stage of the study involved conducting focus groups with mental health nursing instructors who taught on inpatient psychiatric units, presenting themes extracted from analysis of student participant responses from stage one. The focus of Chapter Four is to explore nursing student and instructor roles as agents of change in psychiatric-mental health nursing units to potentially reduce the experiences of moral distress among nursing students. Therefore, this study centred on the second of two

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

overarching research questions: If moral distress is significant in nursing students, how might nursing educators improve the experience of the students?

Study Design

Naturalistic inquiry examines phenomena within a specific context and setting while using inductive analysis to ascribe meaning to the data (Erlandson et al., 1993). I used focus group interviews to explore nursing educators' responses to student perceptions of moral distress situations and to engage in exploration of strategies to improve student experiences. A distinguishing feature of focus groups is to observe interactions and conversations between participants as a part of the research process. Observations of how participants engaged in "telling stories" to each other assisted me in understanding the contexts in which situations occurred and prevented me from assuming knowledge of the particular meaning ascribed to events by participants (Kitzinger, 1994; Redmond & Curtis, 2009). It was important to use focus groups for this participant group to enable me to better observe how nursing educators make sense of the phenomenon of moral distress and understand the importance of context in the development of their perceptions.

There are advantages and disadvantages to conducting focus groups as a data collection method in qualitative research. Advantages include gathering a broad range of opinions on a topic in one session, mutual support for the expression of ideas that may be prevalent within the group but divergent from mainstream thought, creation of new ideas born from hearing other participant contributions, and critical examination of each others' rationales and perceptions (Hinchey, 2008; Kitzinger, 1994; Redmond & Curtis, 2009). Potential disadvantages of focus group interviews include: stronger personalities

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

inhibiting participation from other individuals; misunderstanding of points of view leading to dissention; censoring sharing of information because of group dynamic or composition; and the researcher having less control over the interview process (Kitzinger, 1994; Marshall & Rossman, 2011; Redmond & Curtis, 2009). However, even dissent and misunderstanding among group members may be positive if it engages participants in richer discussion for clarification or leads to the expansion of one's own perspectives after hearing the thoughts of others.

Participants

I used purposive sampling—specifically concept sampling—to recruit nursing instructor participants, to ensure that participants had specific knowledge of moral distress situations involving students in the acute inpatient psychiatric setting (Awty et al., 2010; Redmond & Curtis, 2009; Stringer & Genat, 2004; Tavakol & Zeinaloo, 2004). Participants were recruited from a major nursing school in Western Canada. Inclusion criteria for nursing instructor participants were five or more years of mental health nursing experience, and teaching experience on acute inpatient psychiatry. An exclusion criterion was instructors who had not taught in acute inpatient psychiatry, as they may not have particular knowledge of the learning experiences provided to students in this setting.

The purpose of including only participants familiar with the acute inpatient psychiatric unit was to ensure consistency of exposure to the acute care environment and specific patient care practices that occur on that unit. The purpose of including only instructors with five or more years of mental health nursing experience was to maximize understanding of the complexities of mental health nursing practice and the political and professional context in which patient care occurs.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Participant recruitment occurred through letters of invitation to participate in the research study (Appendix C). Eight instructors provided informed consent to participate in focus group interviews; most were female (87%) and were equally divided into those holding bachelor's and master's degrees. The average participant age was 48 years (range: 37-62 years); the average number of years in nursing was 24 years (range: 6-41 years); the average number of years as a mental health instructor was 7 years (range: 2-26 years). Half (50%) of the participants were current or former staff nurses on the inpatient psychiatric unit; the remainder had never held employment on that particular unit. See Appendix E for participant demographic forms. These differences in depth of exposure to the inpatient environment contributed positively to discussion of diverse perspectives.

Data Collection Technique

I conducted two separate focus group interviews to accommodate differing schedules among participants. Each focus group lasted approximately two hours. Participants agreed on convenient times for the focus groups, outside of clinical practice and student contact hours. I digitally recorded and transcribed each focus group interview verbatim. An interview guide for instructor participants ensured that question structure remained consistent between the groups (Appendix H). I presented participants with themes extracted from the analysis of student moral distress experiences in the earlier stage of this study, and requested they provide initial feedback on those themes. Participants then discussed how they could modify their teaching approaches to assist students in anticipating and managing morally distressing situations, and how they viewed their role as an agent of change within the acute inpatient psychiatric setting. I used non-reflective listening responses such as non-verbal acknowledgements to

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

encourage all participants to engage in discussion, and used reflective listening responses such as paraphrasing, reflecting, and summarizing to clarify participant statements and to increase the validity of inferences gathered from participant statements and data collected (Redmond & Curtis, 2009).

Data Analysis

I used inductive thematic analysis to code and analyze the research data and to assist me in developing abstract and descriptive themes regarding nursing instructor perspectives on student moral distress experiences (Marshall & Rossman, 2011; Norwood, 2010; Thorne, 2008). Data were imported into a software program for qualitative data management—Nvivo9—to assist with organization and construction of identified categories and themes (DiCicco-Bloom & Crabtree, 2006; Leech & Onwuegbuzie, 2007; Ziebland & McPherson, 2006). Data were labelled with individual codes that stood alone as independent concepts then sorted into categories of concepts, and further combined into broader identified themes (Erlandson et al., 1993; Marshall & Rossman, 2011; Norwood, 2010; Taylor-Powell & Renner, 2003).

Thematic analysis focuses on qualitative aspects of individual perceptions, tentative explanations of why the phenomenon is occurring, and why these explanations are significant (Checkland & Holwell, 2007; Crouch & McKenzie, 2006; McNiff & Whitehead, 2010). This involved giving meaning to the data as it related to the context of participants' belief systems and values, which in turn led to a realization of my own beliefs and values regarding the need for change to occur. Thorough analysis of the themes resulted in discussion of potential changes to nursing education to address circumstances that may reduce the impact of moral distress in nursing students.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Ethical Considerations

Ethical approval for the study was obtained through a university-affiliated research ethics board, in compliance with national guidelines safeguarding participant rights and confidentiality (Canadian Institutes of Health Research et al., 2010). It is important to note that there was no supervisory power relationship present between the researcher and participants. Further, I informed participants—as professional colleagues—that they were under absolutely no obligation to participate in the study.

There was a minimal risk of participants experiencing psychological distress while engaging in this research study. Relating experiences of moral distress had the potential to evoke some discomfort due to the sensitive nature of and the participants' emotional and psychological responses to the situations described. I informed participants of this risk and encouraged individuals to inform me if experiencing discomfort at any time. Resources for emotional and psychological support were available upon request, although no participant asked for this information.

Confidentiality of Information

A potential ethical consideration in qualitative research is the relating of real stories told by participants. Descriptions of events can be powerful in illuminating problematic areas in professional practice, but can also cause ethical problems due to the need to protect participant identity. Due to the nature of focus group interviews, it was impossible to guarantee anonymity between participants. However, I kept participant identity strictly confidential within the study by anonymizing the actual data and using pseudonyms in place of participant names. While anonymizing the data can preserve individuals' privacy, there remained the potential for adverse impact on the individual

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

whose story was related if there was a perception that contributions were minimized or perspectives not accredited to the source (Campbell & Groundwater-Smith, 2007; Campbell & McNamara, 2007; Somekh et al., 2005). As no participant expressed a desire for identification, I anonymized identifying information of participants or other individuals specifically referred to within the interviews. I altered direct quotes from participants only with respect to English grammar and syntax to avoid identification of any participant whose first language was not English, and took care to preserve the meaning intended. To preserve authenticity and provide perspective for each participant, I connected all demographic information collected to each participant's respective pseudonym and used this information only to situate participants within the study itself.

Informed Consent

Participants provided voluntary informed consent at the time of the focus group interviews (Appendix I), and I advised participants of the right to withdraw from the study at any time without penalty. The consent form included information that there were limitations to participant anonymity and confidentiality due to the focus group method of data collection. All participants received a \$5.00 gift card from a local coffee shop in appreciation for time and contributions.

Rigour and Trustworthiness of Data

I ensured trustworthiness of data in this stage of the research study by adhering to four criteria—credibility, transferability, dependability, and confirmability—as in the first stage of the study (Awty et al., 2010; Guba & Lincoln, 2002). In addition, action research should address specific aspects of rigour that may not be considered relevant to other types of qualitative research (McNiff & Whitehead, 2010; Murphy, 2011; Paterson

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

et al., 2008; Tavakol & Zeinaloo, 2004). Herr and Anderson (2005) describe validity criteria for action research according to the goals of the research. The five goals of action research are: (a) generation of new knowledge, (b) achievement of action-oriented outcomes, (c) education of researcher and participants, (d) results relevant to the local setting, and (e) a sound and appropriate research methodology. The generation of new knowledge requires discursive and process validity, ensuring “goodness” of research through peer reviewed academic publication; therefore, I will publish my research in academic peer-reviewed journals and disseminate results at scholarly conferences.

Achievement of action-oriented outcomes refers to outcome validity, the extent to which action occurs and leads to problem resolution; time limitations for this study preclude rapid action and problem resolution. However, this study did meet the goals of generation of new knowledge, education of researcher and participants, and results relevant to the local setting (Herr & Anderson, 2005). Education of researcher and participants requires being open to restructuring views of reality and individuals’ roles to increase depth of understanding of the phenomenon and action required for change. This study resulted in greater understanding of the complexities of moral distress and actions required for change. Relevant local results are measured using democratic validity with all interested parties; I will share my study results with relevant nursing administration within the hospital setting. Sound methodology undergoes process validity checks as it pertains to the extent to which problems are presented and whether problem resolution leads to long-term learning for individuals or systems. Process validity checks of credibility, transferability, dependability, and confirmability as defined by Guba and Lincoln (2002) were conducted and described in Chapter Three.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Findings

Participants in this portion of the study were presented with themes from Chapter Three resulting from interviews with nursing students who identified situations and events as being not right. Those themes included the perception of a hierarchical model of care, a cold and uncaring environment, the perception of patient care as a checklist to be completed, and examples of patient coercion and withholding of treatment information. Participants in this study also examined themes from Chapter Three outlining nursing students' descriptions of the reasons they took no action in those distressing situations and events.

Three major themes emerged following data analysis of the focus group interviews. The first theme, "Yes . . . it's a problem" is participant acknowledgement that students' descriptions of situations and events on inpatient psychiatry that cause moral distress really do exist and are problematic. This led to the second theme, "The bigger picture" in which participants provide rationalizations and explanations as to how and why these events occur and why they as nursing instructors took no action to effect change. The third theme, "So now what?" engaged participants in communication directed at identifying areas in which they can have a positive influence on student learning opportunities and decrease the students' moral distress experiences. Table 3 illustrates the core concepts and definition of each theme and their respective sub-themes, described in detail in the following sections.

Yes . . . It's a Problem

Prior to examining themes extracted from student data, I asked participants to identify situations they believed students would perceive to be not right or that cause

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

moral distress. Many of the participants' answers corresponded to events disclosed by nursing students in the previous stage of the study. After seeing the themes extracted from student interviews, participants acknowledged that the situations and events that nursing students found distressing on inpatient psychiatry do exist in nursing practice.

Table 3

Nursing Instructor Perceptions of Student Moral Distress Experiences

Yes . . . it's a problem	Acknowledgment of events and situations causing moral distress in nursing students
The bigger picture	Rationalizations and explanations for nursing instructor inaction in effecting change
It's complicated	Nursing students do not understand the complexities and realities of nursing practice
Be our guest	Instructors must maintain good relationships with the practice environment to serve student learning needs
So now what?	Identification of areas in which nursing instructors have autonomy and authority to effect change
Lean on me	Identifies the need for support for new instructors and among colleagues
Environmentally friendly?	Addresses the responsibility of nursing instructors to provide a safe environment for students to air concerns
Follow the leader	Emphasis on the importance of role modeling good professional behaviour for students

One participant understood the conflict that students feel in their role as learners. An experienced nursing instructor, Pat identified that students often feel caught in the middle of differing expectations from various staff members:

Students experience moral distress when they're told different things by different staff nurses. One day they're told by one nurse to give the Ativan right away as

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

soon as the patient becomes anxious; the next day they're told to wait and to use other means, and so students become very confused and morally distressed about what they should be doing.

Participants agreed that this disparity in expectations could be reflected in their own requirements of students as well, resulting in further confusion as students attempted to comply with differing educational and practice standards.

Recognition of students' concerns about a cold and harsh environment related to the attitudes and behaviours of unit staff. Having observed a number of these instances over years of experience, Taylor conceded that nursing attitudes were problematic for students and patients alike, but corroborated the perceptions that these behaviours were specific to select nursing staff:

There are nurses on the unit—and if you're there you know exactly who they are—that aren't doing their one-to-ones, that are miserable, they're crabby with the students, they're nasty to the patients. We all know who they are, but they do it day after day after day. And those kinds of people need to be dealt with, because you know what? Eighty percent of the staff is great. It's just those few rotten apples.

Another experienced instructor, Kelly indisputably assigned the responsibility of addressing staff behaviour to the unit leadership: "Nurses who behave badly are not dealt with in a way that causes them to change their behaviour or move on". All participants agreed that the situations students described were not right and required change.

Despite a substantiation of the students' concerns and a comparable desire to see those situations and behaviours change, participants unanimously expressed their own inability to take action to effect change on the inpatient units. They identified with the students' frustration in having no power to influence others' behaviours and actions and agreed that forearming students with the knowledge of the realities of practice

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

environments was essential. However, Morgan summarized how participants viewed their responsibility for changes in the practice setting:

I think we can give [students] the education that this is what's out there, but the units themselves, I definitely think, will have to change. I don't know that we have that—I would love to say we have that power—but I don't think we have that power.

Alex asserted that sometimes instructors' experiences on the inpatient unit are also less than favourable, and agreed that nursing instructors are powerless to influence the behaviours of nursing staff. Although sympathetic to the students' concerns, participants felt that students lack understanding of nursing instructors' scope of influence over some aspects of nursing practice:

There are many situations—for example, of somebody behaving badly—that the nursing instructor is not going to be able to correct. It doesn't mean you don't acknowledge that this was not the best course of action, but we can't undo that, and the nursing instructor can't chastise that staff person in a way that might make the student feel better.

These resounding claims from participants regarding their feelings of powerlessness to act formed the basis for rationalizations as to why they lack influence on the inpatient units. The following sections detail participants' responses to their students' desire to see nursing instructors take action.

The Bigger Picture

Having conceded the fact that students encounter problems dealing with distressing situations in the learning environment, participants nevertheless felt that there were rationalizations and justifications for their own inaction in those situations. Factors perceived to be outside of their control contributed to participants' hesitation to interfere with unit procedures. Some of those factors directly affect the student learning

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

experience. Two sub-themes captured those factors: (a) “It’s complicated” or the realities of nursing practice that are not understood by students, and (b) “Be our guest” or the importance of maintaining good relationships with practice environments for the benefit of student learning.

It’s complicated. When presented with circumstances and situations that nursing students feel are not right, participants felt that students did not recognize nor understand the complexity of the nursing practice environment. Participants suggested that students see circumstances and situations in simplistic black and white, right and wrong terms. Participants stated that in reality, the inpatient unit environment is quite complicated, and there may be complex reasons for the way the unit operates and the care that patients receive. All participants agreed that students often do not see or understand the big picture context in which events occur, and that students have unrealistic expectations that the instructor be able to resolve problematic issues. Taylor expressed the belief that some situations must be let go in favour of strategically asserting oneself in other situations:

I just think that students are often very idealistic and they think, “Okay, this isn’t right, so you guys should confront them, or we should confront them, somebody needs to complain”. They have to learn too that you need to pick your battles; you need to address things that are important and sometimes let the little crappy things go, because nobody’s going to listen to you after a while.

Participants acknowledged student frustration with this concept of letting go, but were unwavering in their assertion that students would have to learn to accept the realities of practice for what they are. Alex validated this belief, suggesting that sometimes there are situations where no action is possible, regardless of who might attempt to respond to the concern:

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

There are realities that are ugly, and there may be times—in fact there’s probably going to be a lot of times—that I can’t make a situation better or guide [students] in making a situation better. It is the way it is, and I think that sometimes—frequently—students have the need for us to make things better, and may not have the perception or depth of understanding that no one could make something better.

Some participants believed that some of the students’ concrete approaches to problems resulted from not understanding the historical context of situations that occur repeatedly. Although it may appear to students that no one is taking action to address troubling situations, failed attempts to resolve issues in the past may play a role in the current quiescent environment. Robin stressed the importance of reminding students that change is a process that happens gradually, or sometimes not at all:

Students are often frustrated when they see these issues come up and they’re perhaps not addressed by the staff, but the students miss out on the fact that this might have been something that has come up over and over. People have attempted to address it, maybe without any resolution.

Participants also felt that their own role on the unit was complicated. With so little influence and power, participants were often in the unenviable position of attempting to manage difficult situations quietly and privately with the unit staff, or ignoring problems altogether in order to avoid conflict within the students’ learning environment. In one instance, Taylor’s student group made known their dissatisfaction with the “putting out the fire” approach to their concerns about the actions of a staff nurse:

They probably felt like, “she swept it under the rug and she didn’t deal with the issue” but if you looked at the big picture, I was doing it to protect them . . . from the chaos that would ensue afterwards. I think a lot of what they say is totally valid, but I’m just saying a lot of times they don’t know the whole picture, they don’t know what goes on [in] the unit and who they’re dealing with, and they don’t know what’s been done in the past.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Although they acknowledged their responsibility to uphold the standards of the nursing profession, participants also recognized their obligation to provide students with a high quality of education, and to work in harmony with the inpatient psychiatry staff. Pat concurred with the difficult position of nursing instructors:

We, as instructors in any teaching situation, are always trying to sit the fence. You have to meet the needs of the staff, you have to meet the needs of the students, and you are always stuck in the middle. I think it's important that as instructors we not go too much in either direction.

This tenuous position of sitting the fence is indicative of the participants' mindfulness of their status as external to the environs of inpatient psychiatry. Participants elaborated on this positioning as guests of the unit in the following section.

Be our guest. Participants expressed the belief that they and the nursing students are invited guests on the inpatient psychiatric unit, and maintaining relationships with the practice environment is paramount to providing a safe and productive learning experience for students. Participants expressed feeling powerless to address situations and events they witnessed due to fears that they will lose their status as guests on the unit if viewed unfavourably by the nursing unit staff and management. Morgan suggested that having conversations with students about being an agent for change is beneficial, but there is a degree of vulnerability in criticizing practice issues:

We can change in our own practices amongst our teams and teach the students about advocating for change. But in the end, those units have the ability to say, "Okay, that instructor has overstepped their limits now. They're bringing out stuff we don't want to hear. Okay, we're not using you anymore".

Although apprehensive about the potential consequences of confronting issues in practice, all participants agreed that patient safety was one circumstance in which they

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

would speak out. Morgan illustrated contributing factors in deciding whether to take action, indicating that rationalizing choices to students was part of the process:

If it was a real safety issue, I probably would bring it up, but if it's something that's just a little bit—like you say, you're a guest—is it going to be a hill to die on, because we do want to have those relationships with the agencies. Because I'm very much a guest on the unit, I try not to push buttons, and I'll tell the students why—unless it's a safety issue, and then I will go to somebody.

In addition to advising caution in addressing problem situations, participants related how even in terms of encouraging best practice with students they needed to be sensitive in suggesting improvements to current inpatient unit practices. Participants required students to bring evidence-based knowledge into the inpatient setting, but had misgivings about how unit staff would interpret these activities. Chris observed the precariousness of guest status in sharing new ideas versus challenging current practices:

I feel as an instructor I have to watch my step. I have a lot of ideas and sometimes I share them with people about how things could be done better on the unit, and I have to watch myself because I'm—even though I'm looking and believe that I'm striving for best practice on that unit—it's not my unit.

Participants regarded this process of introducing new ideas in much the same way as they decided which situations warranted them speaking out for change. Kelly summarized the impact that an overly critical approach to unit practices might have on student learning:

When we are teaching in a clinical setting, we are walking somewhat of a fine line in terms of helping students understand that perhaps practice is not at what would be described as “best practice” but that the way in which we approach that can make a vast difference to how students are received on the unit. And in fact, even lead to a situation where we might be barred from a clinical setting if we don't walk that line finely enough. So, it becomes very challenging for the instructor to determine, “what must I talk about because of my commitment to patient safety, and what should I ignore because I'm a guest in the house?”

Altogether, participants felt that there were justifiable rationalizations to support their inaction on issues brought forward by students. Participants felt they had a

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

reasonable defense when one considered lack of student understanding of the historical knowledge of interventions on certain issues, the importance of maintaining relationships with the practice setting, and respecting their status as guests of the unit.

So Now What?

While participants felt they made rational arguments for why they could not or did not enact change in situations and events that occurred, they conceded that part of their role as nursing educators was to take action in areas that were within their control. The goal of making change in these other areas was to reduce the negative impact felt by students when faced with situations that caused them distress. Participants were able to identify three areas in which they had influence. Identified as sub-themes, these were: (a) “Lean on me” or support for new instructors and among colleagues, (b) “Environmentally friendly” or addressing the provision of a safe place for students to express concerns, and (c) “Follow the leader” or the acknowledgement that participants had an obligation to role model professional behaviours to students in preparation for practice.

Lean on me. Participants identified that they lacked support from their educational institution in terms of preparation for teaching roles, which are much different from nursing roles. This support was particularly necessary for new instructors, who although they may have had numerous years of nursing practice experience, had little to no teaching experience. Participants also identified the need to support each other as colleagues, and improve ways of working together as a team to help each other deal with the effects of distressing situations encountered in practice. They viewed support in these situations just as importantly for themselves as for their students.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Tracy—an experienced nurse new to formal teaching—expressed a sense of being lost upon commencing the teaching role. Although very familiar with inpatient nursing settings and practices, Tracy found that adapting to and understanding the role of an educator consumed much time and energy, and she feared that she was not always able to provide adequate emotional support to students. Pat—having both considerable teaching and nursing practice experience—understood the importance of preparation for the teaching role:

So if you don't know all of that, how do you know what your role is in terms of students' moral distress? How can you deal with that, when you don't even know what your role is as a teacher, the basic stuff?

As another participant new to the instructor role, Chris validated Tracy's concerns, but reflected that some skills are learned more than taught, and require time, experience, and good role modeling:

We do have instructors that are fairly new that haven't instructed before, and sometimes, speaking from my own perspective or my experience, is the fact of learning how to support students. Nobody gave me a lesson on how to be supportive and how to listen to them, and how to problem solve what they're going through in these situations that they're going to be in. I haven't been an instructor that long, but every single time I sit down and talk with people that have been doing it longer, I learn how to do things better, and that includes being supportive.

Overall, participants agreed that they needed to offer more support to each other as colleagues, and saw the greatest value in utilizing mentoring relationships to learn to assist students in dealing with distressing situations. However, Kelly recognized that the informal system currently in place within the educational institution fell short of being entirely beneficial, stating “Informal mentorships don't work because individuals who are overloaded with their own workload find it very hard to then make the time to do a

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

proper follow through with the person you're supposed to be mentoring". Alex valued individual peer support, but also desired to see a collaborative team approach to learning to support students:

[This] makes me want to sit down as our team and have a consistent approach, "Okay, this is the data, what can we do as a team unit? Do we all buy into the fact that we're going to make change to maybe how we view this, or how we're going to approach the students and provide information to them?" Because I think that's where the impact and the power is.

Through this discussion, participants expressed a better understanding of the struggles experienced by newer colleagues. While there did appear to be differences of opinion as to how much support the institution should provide and how much responsibility each nursing instructor had to seek necessary supports, participants generally agreed to a degree of responsibility for all parties in ensuring preparation for the complexities of the teaching role.

Environmentally friendly? While viewing support for colleagues as important, participants also wanted to provide support to students in distress. Participants believed that they have a responsibility to engage students in supportive and open dialogue about situations that occur in practice. Students need a safe environment in which to express their concerns and to receive feedback and guidance, whether verbally or within written assignments such as journals. Participants also acknowledged the need to contribute to the construction and maintenance of a more environmentally friendly practice setting.

Participants discussed the means by which they could ensure open and supportive dialogue with students. Tracy placed great emphasis on the interpersonal relationships between instructors and students: "I guess for me the biggest thing is communication. It's being able to have that sort of relationship with your students that they feel

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

comfortable enough in letting you know when they are in moral distress”. Chris agreed, but also felt that it was important to use each interaction with students as an opportunity to guide the thinking processes of sound professional decision-making:

We can have a dialogue about it. And not only that, but when you get in those debriefing sessions, you can then guide them through the fact of what we just talked about, of choosing your role models wisely, and how all of these things are connected. And not just define them, but looking at what would it look like if it was better?

Pat acknowledged that open communication with students is important, but recognized that many students may not be comfortable speaking out in groups. In addition, although conversations that happen shortly after an event will provide students with the opportunity to debrief safely with instructors and peers, they may not provide an opening for deeper insights to develop. Pat suggested that students need the opportunity to interact with instructors using a variety of strategies that will accommodate different learning needs:

I just have to put in a plug for journaling, because things turn up in students’ journals that they will not discuss with you face-to-face. This is where they get a chance to write and think and mull and analyze. You would never know about any of those things if they didn’t have that opportunity.

Participants also recognized safety in the practice environment as important for student learning. Conflicts within the unit, between students and staff, and between instructors and staff all can result in breakdowns in communication. In order to maintain open communication with the practice environment, it was necessary to re-evaluate the reasons underlying the conflicts experienced between educators and practitioners. Robin related her perceptions of the tensions between students and staff:

I think sometimes nurses that have been practicing for a while, that are confident in their skills and abilities, perhaps sometimes are threatened by evidence-based

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

practice, some of the knowledge that students are bringing. so we need to very much open up that dialogue, so it is open and supportive, and we're not critical and confrontational in our approaches with the students working as a team, and the staff working as a team.

Robin also noted that improved communication between instructors and staff facilitates better relationships between students and staff: "As an instructor, if you have a good working relationship with the staff on the unit, then you can be an agent in facilitating the dialogue between students and staff".

Looking beyond good communication, participants felt that establishing and maintaining respectful working relationships with the staff and management on the inpatient units was vital to the creation of a safe learning environment for students. Establishing relationships was significantly more difficult for some participants, being less familiar with that teaching environment. Kelly emphasized the importance of collaboration with nursing leadership in the practice setting:

It's important for us to have open communication with the leadership in whatever facility we're in, to develop the relationship that we have with them on a human to human basis, professional to professional basis, which then creates that environment where if they have issues they can feel more comfortable coming to us, and we to them.

By establishing strong relationships between nursing instructors and practice, participants felt that they would be more able to provide support and guidance to students experiencing distressing situations.

Follow the leader. Participants were cognizant of their inability to effect change in the behaviours of other nurses working on the inpatient unit. However, all agreed that they must at the very least model appropriate professional behaviours themselves, and set an example of doing the right thing, even if it had no effect on the overall system.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Aspects of this included encouraging students to internalize basic nursing values and think critically about nursing culture and leadership. Participants felt that developing these abilities would assist students most in preparing for actual practice. Kelly related her experiences in exploring students' views of themselves as professionals:

I have asked a couple of students who are less assertive, less confident in themselves, "Do you see yourself as a professional nurse?" and they are set back on their heels by the question and then usually admit, "No, I don't". So then we have to say, well, what is that? What does it mean to be a professional nurse, and how do you get to the point where you wear that like a garment, rather than something you think of as being something distant and apart from yourself as "Suzie the citizen".

Participants felt that the only way that students were going to view themselves as professionals was if their instructors were strong role models. Morgan felt that changes in the nursing profession, nursing education, and students themselves make role modeling crucial to student development: "Some of it is definitely our education of the students today, and it's not 'do as I say', it's definitely 'do as I do'. And so I think the role modeling is so much more important". Part of that role modeling includes decisions to take action in situations and events that are identified as not right. Robin reinforced earlier sentiments about the complex nature of those decision-making processes and the role modeling that occurs:

Definitely, we need to be that role model for them, in how do you pick your battles, which ones are important, how do we prioritize those things, and maybe what's being pushed by the wayside. How do we make those decisions?

Students who encounter situations that are not right need to be prepared for managing those situations when they are independent practitioners. Unequivocally, participants felt that it was part of a nursing instructor's role to teach students how to do this. Although there are undoubtedly a number of things that students would learn on the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

job as new graduates, Chris did not feel that this ability was one of them. “When you’re looking at the moral distress picture and you’re asking whose job is it to prepare them for that, I kind of feel like it’s our job as instructors to prepare them for that”. Pat felt that the instructor’s role was to actively prepare students for the harsh realities of practice:

That’s our responsibility, to take on these hard issues sometimes, or have students take them on with our support, and let them see that this is what we as nurses—that this is our responsibility. If we don’t do that, what are they learning?

Participants also identified the role of nursing leaders in effecting change in situations that are not right. However, they acknowledged that approaching leadership with student concerns over things like unprofessional staffing behaviours might only serve to isolate their practice partners. Instead, participants suggested that by increasing student awareness of the effect that leadership has on the profession, they would recognize the importance of being an agent of change. Morgan felt students would appreciate this knowledge fully by learning about effective leadership practices:

How can we affect [negativity]? I think by identifying the leadership and teaching students about the positiveness of the whole transformational kind of “servant” leadership; how do they empower? I don’t know that I can influence change on the unit, but I can influence and say to the students, “So what do you think about this leader? What impact is that having on the staff?” So teaching them again about the culture of nursing and how they can affect change themselves.

Overall, participants agreed that they had a responsibility to prepare students for professional practice, and that included being able to develop critical approaches to problems encountered in practice. Participants felt that acknowledging the difficulties students have in managing morally distressing situations in practice was only the first step in being able to take action to effect change. If immediate change to contributing circumstances was not possible, then participants felt that they could at least effect

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

changes in the way students learned to deal with situations that were not right. Chris recognized the long-term value of this approach for nursing practice in general:

If you acknowledge and you don't do anything, it becomes acceptance, right? And I'm not saying we can do anything about it, but you get those processes going, so when they do become a nurse on the floor, that maybe they won't be one of those ones that sit idly by and not challenge the status quo.

Discussion

Nursing educators have a complex role that consists of accountability to students, the educational institution, the practice setting, and their professional peers. Much like situations in practice cause students moral distress, discordant expectations from all of these factions can be a source of distress for nursing instructors entering practice settings with students. However thoroughly nursing instructors may attempt to instill professional values and ideals in their students, they may still find that until students internalize these values, there will be fractionation of the self into personal and professional parts. Like their students, nursing instructors may experience this division of self and find it difficult to remain fully integrated if professional responsibility, personal morality, and employment obligations are separate from each other (Austin et al., 2008).

One primary reason participants cited for not taking action in situations that cause students' moral distress is that they consider themselves guests of nursing practice in the institutional setting. To compromise this relationship is perceived to have detrimental effects on educational placement opportunities and to limit learning experiences for students. However, one must question why nurses would regard as "outsiders" those whose experience and passion for the nursing profession has compelled them to teach students. Participants in this study acknowledged that there is a disparity between what

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

students learn in theory and what occurs in actual practice. Perhaps some nurses in the inpatient psychiatric environment feel threatened by the new knowledge and challenges to current practice that nursing students bring. Perhaps hearing students' perceived concerns regarding patient care practices reinforces nurses' own feelings of powerlessness to effect change within a hierarchical medical model. Whatever the reasons, the tenuous hold nursing education has on nursing practice placements directly impacts nursing instructors' power to prepare students adequately for their chosen profession.

Although they felt powerless to effect change in nursing practice, participants took ownership of their responsibility to students in terms of role modeling and provision of a safe learning environment. Participants agreed that modeling appropriate professional behaviours was the most influential factor in student learning and in supporting students to manage perceived dichotomy between theory and practice (Illingworth, 2009; Maben et al., 2006; Price, 2009). Participants felt that they already attempted to provide safe learning environments for students, but acknowledged that establishing trusting relationships was the cornerstone of a safe environment. Some newer instructors still felt conflicted in finding a balance between being too nice or too harsh in their relationships with students. To build on role modeling and teaching skills, nursing instructors felt they required more support from each other and from their educational institution.

Participants in this study acknowledged that nursing students encounter morally distressing situations in practice, and identified their own accountability in some situations. However, the complexities of nursing practice, politics, and patient needs

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

contribute to nursing instructors not assuming a direct role in rectifying the wrongs experienced by students. Although instructors may experience autonomy in their own professional practice, they may not experience the same self-determination in their role as educators, leading to feelings of powerlessness. Manojlovich (2007) suggested that powerless nurses are ineffective and need to regain control over the content, context, and competence of nursing practice. To be effective educators, nursing instructors perhaps might do the same. In this way, they will enable nursing students to move past pre-conventional maturity levels into the conventional or post-conventional stages described by Sumner (2010), resulting in empowered nurses for the future.

Implications for Nursing Education

The need for nursing students to have increased preparation in dealing with moral distress in practice cannot be accentuated strongly enough. Educational demands and the pressure to master nursing skills for successful completion of requirements preclude students from learning how to manage real practice situations effectively. Without these skills, nursing students will be inadequately prepared to address ethical issues or give an account of their own professional responsibilities in this area (Hunink, van Leeuwen, Jansen, & Jochemsen, 2009; Ulrich et al., 2010). Benner et al. (2009) describe this lack of knowledge as “secondary ignorance” (p. 234) in that they cannot know what they have not learned and may be unaware of their responsibilities in taking action. Nursing educators have a vital role to play in demonstrating professional behaviours and advocacy skills, enhancing student practice and patient outcomes. Nursing students must have opportunities to critically reflect on their knowledge and understanding of practice issues

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

to facilitate clinical reasoning skills, challenge assumptions, and implement best practices for patient care (Crowe & O'Malley, 2006).

An initial step in addressing the disparity identified between nursing theory and practice is to strengthen ethics content in nursing courses and to encourage students to think critically about situations that occur in practice. Currently, students learn to develop critical thinking skills, but educators do not always furnish the opportunity to practice interventions that would uphold principles of advocacy, social justice, or patient autonomy. Nursing students must gain greater proficiency in making and enacting moral decisions, and engage in ethical self-reflection to reveal how core beliefs interact with professional and institutional norms (Hunink et al., 2009; Nathaniel, 2006). Cummings (2010) suggested that ethical case studies be included in nursing curricula to assist students in practicing advocacy skills prior to entering the clinical environment. Alber et al. (2009) support this notion of anticipatory guidance as a key step in increasing confidence and competence as a novice nurse.

In addition to increasing ethical content in nursing curricula, Cummings (2010) also emphasized the importance of a retribution-free environment in which to voice concerns. Although directed at nursing administrators and their staff, this responsibility also falls to nursing instructors. However, in light of the difficulty encountered by some instructors in assisting students in resolving moral distress issues, educational institutions need to develop ways to enhance supports for newer instructors, and instructors themselves must seek out these opportunities. In this way, extensive nursing expertise and enhanced teaching ability will combine to provide the best possible nursing education for students.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Implications for Nursing Practice

In light of the important role that practice experience has in nursing education, it is essential to develop strong working partnerships between educational institutions and the community health institutions that play host to nursing students. Both nursing educators and practicing clinicians must strive to provide quality learning experiences, role modeling, critical thinking opportunities, mentorship, and socialization into the nursing profession. Perceptions that nursing students and instructors are external guests in the health care system must undergo critical re-examination for the long-term impact of these beliefs on the nursing profession. Nursing administrators must also examine potential reasons for failure of some nurses to exercise professional and ethical behaviours in the workplace, resulting in poor modeling for nursing students who require integration into practice. Nursing administrators must consider the impact of the environmental climate in attracting and retaining nurses to inpatient psychiatric-mental health nursing.

Limitations

There are several limitations to this study. The participant sample was small and provided perceptions of moral distress only within a specified clinical practice setting. Due to the limited geographic area of the study, it does not account for broader environmental, cultural, and political influences on the data. Although naturalistic studies do not typically expect to meet generalization criteria, findings from this study may potentially be transferable to nursing instructors and students in other acute inpatient psychiatric mental health settings, and other mental health placements in general. There is much value also in exploring acute inpatient psychiatric nursing staff and

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

administrators' perceptions of moral distress experiences in practice. It would also be beneficial to examine the perceptions of nursing practitioners about their role in mitigating moral distress for students and supporting nursing education.

Chapter Five

Discussion and Recommendations

Discussion of Findings

The purpose of this qualitative research study was to obtain a richer understanding of the experiences of moral distress for nursing students, examine strategies students use to effectively manage moral distress, and explore roles of students and instructors as agents of change in reducing the negative effects of moral distress in nursing students. Austin, Bergum, and Goldberg (2003) asserted that increased identification, awareness and understanding of the moral distress experience empower nurses to action. Interviews and focus groups conducted with nursing students and instructors, respectively, provided insight into the complexities of this phenomenon. An interesting finding in this study was that there were a number of areas of mutual concern for the two participant groups, specifically in regards to the realities of nursing practice, student preparedness for the profession, and shared feelings of powerlessness. Table 4 compares nursing students' and instructors' experiences and perceptions of moral distress during psychiatric clinical placements.

For most nursing students, their experiences on the inpatient psychiatric unit resulted in negative attitudes toward mental health nursing, and disillusionment with their nursing instructors and the profession in general. Two themes emerged through the process of inductive analysis of the data. First, nursing student participants identified concrete situations and events that caused them to feel moral distress in the practice setting; these particularly addressed a hierarchical model of care and unforgiving environmental climate. Second, student participants identified their frustration with their

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Table 4

<i>Moral Distress Perceptions of Nursing Students and Instructors</i>		
Student Perceptions	Instructor Perceptions	Mutual Experience
Hierarchical model, cold environment, task-oriented care, coercion to enforce behaviours	Mental health practice is complex politically, medically, behaviourally	Realities of practice
Inability to act due to student status	Inability to act due to “guest” status	Powerlessness
Taught to think, but not to act	Encourage critical thinking and observation, caution against action	Frustration with practice experience

perceived powerlessness; this included both what they felt themselves and what they observed in their clinical nursing instructors’ behaviours. With these combined experiences, student participants felt disillusioned, frustrated, and distressed with clinical practice.

Similarly, nursing instructors also identified the realities of practice that students fail to understand but will eventually encounter. Feelings of inability to protect students from these realities left instructors feeling powerless and frustrated with the practice experience. In describing the underlying causes for their own frustrations, nursing instructors identified the complexity of their accountabilities to students, the educational institution employing them, the practice setting, and their professional peers. Discordant expectations from different factions caused distress upon taking student groups into the practice setting. Instructors may attempt to instil nursing values into their students, but if

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

professional and personal value systems collide, integration of the whole self is difficult (Austin et al., 2008), a feeling mutual to both groups.

Nursing education does not adequately prepare students to challenge the medical model as status quo, and most physicians perceive such actions as a direct challenge to their power (Stickley & Timmons, 2007). Prior studies indicated that if a nurse deferred responsibility to the physician as decision-maker or perceived no obligation or responsibility in the situation—as may be the case with novice nurses who lack a strong sense of autonomy—then there was less moral distress experienced (Austin, Rankel, et al., 2005; Schluter et al., 2008; Wilkinson, 1987). In Chapter Three of this study, participants deferred to nursing staff and instructors for guidance in determining appropriate action to take in distressing situations. Deference to authority may occur as a result of being oblivious that action is required, unfamiliarity with available options for action, or lack of skill in pushing boundaries (Benner et al., 2009; Corley et al., 2005; Ulrich et al., 2010). This deferring of responsibility addresses the complexity of moral distress itself and perpetuates powerlessness in nursing. Though historically more subservient members of the medical professions, nurses have effected some changes due to recent recognition of the incongruity between nursing tradition and current practice (Mooney & Nolan, 2006), but these changes will be negligible if nursing education continues to perpetuate the practice of subservience in a medical model.

In Chapter Four of this study, one primary reason nursing instructor participants cited for not taking action in situations that cause student moral distress is that they consider themselves guests of the hospital setting. To compromise this relationship was feared to have detrimental effects on educational placement opportunities and limit

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

learning experiences for students. However, one must question why practitioners might regard as “outsiders” those whose experience and passion for the nursing profession has compelled them to teach students. Participants in this study acknowledged that there is a tension between what students learn in theory and what occurs in actual practice.

Perhaps some practitioners feel threatened by nursing students bringing forward evidence-based knowledge that challenges current practice. Perhaps hearing students’ concerns regarding patient care practices reinforces practitioners’ frustrations with their own inability to effect change within a hierarchical medical model. Whatever the reasons, nursing instructors’ perceptions of their tenuous relationships with practitioners influences their ability to prepare students adequately for their chosen profession.

Student participants identified their own powerlessness and vulnerability, and felt they lacked skill in challenging practice. They emphasized the need for better role modeling from nursing instructors and believed instructors had a professional responsibility to teach students how to respond to distressing situations and events in preparation for practice. Positive role models are essential in recruitment and retention (Illingworth, 2009; Maben et al., 2006; Price, 2009) and yet participants in this study indicated a paucity of role modeling from instructors and the staff nurses. Without knowledge of appropriate action to take in moral and ethical situations, it is no surprise that nursing students felt vulnerable and powerless. Support from nursing administration in ethics education increases retention in nursing (Hart, 2005), and it follows that receiving this support as students would have a positive impact on recruitment as well.

In response to student concerns, although they felt powerless to effect change in nursing practice, nursing instructor participants took ownership of their responsibility to

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

provide role modeling and a safe learning environment for students. Participants agreed that modeling appropriate professional behaviours was the most influential factor in student learning and in supporting them in the dichotomy between theory and practice (Illingworth, 2009; Maben et al., 2006; Price, 2009). Participants felt that they already attempted to provide safe learning environments for students, but acknowledged that establishing trusting relationships was the cornerstone of a safe environment. Some newer instructors still felt conflicted in finding a balance between being too nice or too harsh in their relationships with students. To build on role modeling and teaching skills, nursing instructors felt they required more support from each other and from their educational institution.

Nursing instructors acknowledged that nursing students encounter morally distressing situations in practice, and identified their own accountability in some situations. However, the complex nature of nursing practice, politics, and patient needs conspire to prevent nursing instructors from assuming a direct role in rectifying the wrongs experienced by students. Although instructors may experience autonomy in their own professional practice, they may not experience the same self-determination in their role as educators, leading to feelings of powerlessness. Manojlovich (2007) suggested that powerless nurses are ineffective and need to regain control over the content, context, and competence of nursing practice. To be effective educators, nursing instructors must do the same. In doing so, they will enable nursing students to move past pre-conventional maturity levels into the conventional or post-conventional stages described by Sumner (2010), resulting in empowered nurses for the future.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Current literature indicates a positive correlation between healthy environmental climates and nursing retention and recruitment (Ritter, 2011), yet Gutierrez (2005) found that staff nurses did not consider nursing management to be of support in morally distressing situations, and indeed felt that the manager was in most cases unaware that there was conflict present. In the present study, environmental factors were among the primary reasons cited for participants' reluctance to choose psychiatric-mental health nursing as a future practice area.

Implications for Nursing Education

The need for nursing students to have increased preparation in dealing with moral distress in practice cannot be accentuated strongly enough. Educational demands and the pressure to master nursing skills for successful completion of requirements preclude students from learning how to manage real practice situations effectively. Without these skills, nursing students will be inadequately prepared to address ethical issues or give an account of their own professional responsibilities in this area (Hunink et al., 2009; Ulrich et al., 2010). Benner et al. (2009) describe this lack of knowledge as "secondary ignorance" (p. 234) in that they cannot know what they have not learned and may be unaware of their responsibilities in taking action. Nursing educators have a vital role to play in demonstrating professional behaviours and advocacy skills, enhancing student practice and patient outcomes. Nursing students must have opportunities to critically reflect on their knowledge and understanding of practice issues to facilitate clinical reasoning skills, challenge assumptions, and implement best practices for patient care (Crowe & O'Malley, 2006). Although clinical discussions may provide opportunity for students to voice concerns, this forum does not lend itself to learning actual skills

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

necessary for professional practice. Rather than advising simple observation of unit practices, instructors must teach students *how* to advocate actively for patients, themselves, and their nursing peers. This occurs through example and by providing support to students as they attempt to master these skills for themselves, facilitated by healthy, supportive relationships between nursing instructors and students.

With the implementation of Baccalaureate entry-to-practice requirements, nursing education values more intensely the development of critical thinking skills to enhance practice and patient outcomes. This is distinguishable from the previous nursing emphasis on skill acquisition, and is one of the recent changes to nursing education noted by Mooney and Nolan (2006). It is unreasonable to think that change comes without responsibility or cost, and one such responsibility is that nurses act on their ability to think critically. However, as this study demonstrated, some nursing educators only teach students the initial step in problem solving—critical thinking—but then advise sitting back to only observe the realities of nursing practice without implementing action. If this were the practice of all nursing educators, it speaks to nursing education's significant failure to preparing students for practice and presents a bleak outlook for the future of the nursing profession. Students must have professional role models to assist them in skill development that will move them forward in the transition from student to novice nurse.

An initial step in addressing the disparity identified between nursing theory and practice is to strengthen ethics content in theoretical courses and to encourage students to think critically about situations that occur in practice. Currently, students learn to develop critical thinking skills, but educators do not always furnish the opportunity to practice interventions that would uphold principles of advocacy, social justice, or patient

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

autonomy. Nursing students must gain greater proficiency in making and enacting moral decisions, and engage in ethical self-reflection to reveal how core beliefs interact with professional and institutional norms (Hunink et al., 2009; Nathaniel, 2006). Cummings (2010) suggested that ethical case studies be included in nursing curricula to assist students in practicing advocacy skills prior to entering the clinical environment. Alber et al. (2009) support this notion of anticipatory guidance as a key step in increasing confidence and competence as a novice nurse.

In addition to increasing ethical content in nursing curricula, Cummings (2010) also emphasized the importance of a retribution-free environment in which to voice concerns. Although directed at nursing administrators and their staff, this responsibility also falls to nursing instructors. In light of the conflict felt by some instructors in assisting students in resolving moral distress issues, educational institutions need to develop ways to enhance supports for newer instructors. In this way, nursing expertise and teaching ability combined will offer the best possible nursing education for students.

Implications for Nursing Practice

Practicing nurses must be aware of the influence they have on impressionable nursing students. Whether newly qualified or experienced, nurses must consistently demonstrate ethical and moral behaviours in accordance with their professional *Code of Ethics* (CNA, 2008). This professional document outlines specific values and ethical responsibilities for nurses, including advocacy for quality work environments; addressing social inequity; and delivery of safe, compassionate, competent, and ethical patient care. Failure to uphold these tenets—even through passivity—is a violation of nursing ethics. The stereotypical belief that nurses are powerless to act dissolves when considering the

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

possibility that if a nurse claims no responsibility for taking action, there really cannot be a claim to powerlessness. From a poststructural approach, power belongs to everyone equally, and it is the utilization of that power between individuals that is important (Bradbury-Jones et al., 2008). Nursing students who enter the practice environment feeling vulnerable require the support and mentorship of practicing nurses, without concern for the positioning of power in the relationship. Nurses must be encouraged to take active mentorship and teaching roles in the practice setting to acculturate students and new graduates into the profession.

In light of the important role that practice experience has in nursing education, it is essential to develop strong working partnerships between educational institutions and the community health institutions that play host to nursing students. Both nursing educators and practicing clinicians must strive to provide quality learning experiences, role modeling, critical thinking opportunities, mentorship, and socialization into the nursing profession. Perceptions that nursing education is an external guest to the health care system must undergo critical re-examination for the long-term impact of these beliefs on the nursing profession. Clinical practice must also examine potential reasons for failure of some nurses to exercise professional and ethical behaviours in the workplace, resulting in poor role modeling for nursing students who require integration into practice. Nursing administration must consider the impact of the environmental climate in attracting and retaining nurses to inpatient psychiatric-mental health nursing.

Limitations

There are several limitations to this study. The participant sample was small and provided perceptions of moral distress only within a specified clinical practice setting.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Due to the limited geographical area of the study, it does not account for broader environmental, cultural, and political influences on the data. Although naturalistic studies do not typically expect to meet generalization criteria, findings from this study may potentially be transferable to nursing students and instructors in other acute inpatient psychiatric mental health settings. As there was limited connection of moral distress experiences to actual acute treatments (i.e. ECT, restraints), findings may also apply to other mental health placements in general. No male students participated in the study, limiting examination of gender differences in responses to morally distressing situations and events.

Recommendations

Based on the limitations noted for this study, one recommendation for future research is to expand the geographical area to include a more diverse population and examine moral distress experiences of nursing students at other educational institutions and in other nursing practice areas. It would be beneficial to explore perceptions of moral distress experiences among acute inpatient psychiatric nursing staff, and to examine the perceptions these individuals have about their role in mitigating moral distress for students and supporting nursing education.

Conclusion

This qualitative research study examined the experiences of moral distress among nursing students within the context of psychiatric-mental health clinical placements, and explored the role of nursing students and instructors as agents of change to reduce these experiences in practice. Chapters One and Five served as introduction and conclusion to the research study. In Chapter Two, I examined literature pertaining to moral distress and

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

its relationship to recruitment and retention of nurses. Chapter Three detailed the results of qualitative interviews with seven nursing students about their experience of moral distress on acute inpatient psychiatry. Chapter Four contained nursing instructors' perceptions of the students' moral distress experiences and explored the role of participants as agents of change.

This study illuminated the shared experiences of nursing students and their instructors in facing the realities of practice, feeling powerless, and their frustration with clinical practice experiences. Gaining insight into these mutual concerns will form the basis for forward movement in making change to nursing education, to enhance student learning and better prepare them for practice. In moving forward, there must be a renewed emphasis on transforming critical thinking into actual practice for students to feel confident and competent on entry to the nursing profession.

Dissemination of Research

This thesis constitutes one method of knowledge transfer of the research findings, and I intend to engage in additional dissemination activities. These include: (a) provision of an executive summary of research findings to all study participants; (b) provision of a summary of research findings to the administration of the inpatient psychiatric unit referred to in this study; (c) presentation at scholarly conferences; and (d) submission of Chapters Two, Three, and Four as separate papers for publication in scholarly, peer-reviewed journals.

Stroul et al. (2010) cautioned that dissemination of research findings are not always presented in a manner useful to those with the power to enact change, and therefore little impact is made in practice or within systems. Little change may occur

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

initially within the health care institution due to political and resource constraints;

therefore, I intend to encourage my nursing colleagues to focus on changes that they can enact within the educational institution to improve learning experiences for students.

Stroul et al. also offered caution about the perception of “punishment” because recipients do not appreciate the results of the data. I desire that all participants and parties implicated in this study will examine the findings in the spirit of cooperation and reflect on their potential to contribute to the provision of improved educational experiences for nursing students.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

References

- Alber, L., Augustus, L., Hahn, S., Penkert, J., Sauer, R., & DeSocio, J. (2009). Applying Benner's model to psychiatric mental health nurse practitioner self-ratings of role competence. *Journal of the American Psychiatric Nurses Association, 15*(2), 126-137. doi: 10.1177/1078390309333181
- Athens, L. (2010). Naturalistic inquiry in theory and practice. *Journal of Contemporary Ethnography, 39*(1), 87-125. doi: 10.1177/0891241609343663
- Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experience of moral distress. *Nursing Inquiry, 10*(3), 177-183. doi: 10.1046/j.1440-1800.2003.00181.x
- Austin, W., Kagan, L., Rankel, M., & Bergum, V. (2008). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy, 11*(1), 89-97. doi: 10.1007/s11019-007-9083-1
- Austin, W., Lemermeyer, G., Goldberg, L., Bergum, V., & Johnson, M. S. (2005). Moral distress in healthcare practice: The situation of nurses. *HEC Forum, 17*(1), 33-48. doi: 10.1007/s10730-005-4949-1
- Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behavior, 15*(3), 197-212. doi: 10.1207/s15327019eb1503_1
- Awty, P., Welch, A., & Kuhn, L. (2010). A naturalistic inquiry of registered nurses' perspectives and expectations of psychodynamic therapeutic care in acute psychiatric inpatient facilities. *Archives of Psychiatric Nursing, 24*(2), 104-113. doi: 10.1016/j.apnu.2009.05.001
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Benner, P., & Benner, R. V. (1979). *The new nurse's work entry: A troubled sponsorship*. New York, NY: Tiresias Press.
- Benner, P., Tanner, C. A., & Chesla, C. A. (2009). *Expertise in nursing practice: Caring, clinical judgment, and ethics* (2nd ed.). New York, NY: Springer.
- Bjørn, P., & Boulus, N. (2011). Dissenting in reflective conversations: Critical components of doing action research. *Action Research, 9*(3), 282-302. doi: 10.1177/1476750310396949
- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152. doi: 10.1177/1468794107085301

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Boychuk Duchscher, J., & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum*, 43(4), 191-206. doi: 10.1111/j.1744-6198.2008.00113.x
- Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing*, 62(2), 258-266. doi: 10.1111/j.1365-2648.2008.04598.x
- Brannick, T., & Coghlan, D. (2007). In defense of being “native”: The case for insider academic research. *Organizational Research Methods*, 10(1), 59-74. doi: 10.1177/1094428106289253
- Bryman, A., Teevan, J. J., & Bell, E. (2009). *Social research methods* (2nd Canadian ed.). Don Mills, ON: Oxford University Press.
- Campbell, A., & Groundwater-Smith, S. (Eds.). (2007). *An ethical approach to practitioner research: Dealing with issues and dilemmas in action research*. New York, NY: Routledge.
- Campbell, A., & McNamara, O. (2007). Ways of telling: The use of practitioners' stories. In A. Campbell & S. Groundwater-Smith (Eds.), *An ethical approach to practitioner research: Dealing with issues and dilemmas in action research* (pp. 99-112). London, UK: Routledge.
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2010). *Tri-Council policy statement: Ethical conduct for research involving humans*. Ottawa, ON: Author.
- Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa, ON: Author.
- Canadian Nurses Association. (2009). *Tested solutions for eliminating Canada's registered nurse shortage*. Ottawa, ON: Author Retrieved from http://www2.cna-aic.ca/CNA/documents/pdf/publications/RN_Highlights_e.pdf
- Casey, D. (2007). Using action research to change health-promoting practice. *Nursing & Health Sciences*, 9(1), 5-13. doi: 10.1111/j.1442-2018.2007.00297.x
- Checkland, P., & Holwell, S. (2007). Action research. In N. Kock (Ed.), *Information systems action research* (Vol. 13, pp. 3-17). New York, NY: Springer.
- Cleary, M., Walter, G., & Hunt, G. (2005). The experience and views of mental health nurses regarding nursing care delivery in an integrated, inpatient setting. *International Journal of Mental Health Nursing*, 14(2), 72-77. doi: 10.1111/j.1440-0979.2005.00362.x

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Coghlan, D. (2011). Action research: Exploring perspectives on a philosophy of practical knowing. *The Academy of Management Annals*, 5(1), 53-87. doi: 10.1080/19416520.2011.571520
- Coghlan, D., & Shani, A. B. (2008). Insider action research: The dynamics of developing new capabilities. In H. Bradbury & P. Reason (Eds.), *The SAGE Handbook of Action Research: Participative Inquiry and Practice* (pp. 643-655). Los Angeles, CA: Sage.
- 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. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2648](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648)
- Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, 12(4), 381-390. doi: 10.1191/0969733005ne809oa
- Cowin, L. (2002). The effects of nurses' job satisfaction on retention: An Australian perspective. *Journal of Nursing Administration*, 32(5), 283-291. doi: 10.1097/00005110-200205000-00008
- Cronqvist, A., & Nyström, M. (2007). A theoretical argumentation on the consequences of moral stress. *Journal of Nursing Management*, 15(4), 458-465. doi: 10.1111/j.1365-2834.2007.00764.x
- Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social Science Information*, 45(4), 483-499. doi: 10.1177/0539018406069584
- Crowe, M. T., & O'Malley, J. (2006). Teaching critical reflection skills for advanced mental health nursing practice: A deconstructive–reconstructive approach. *Journal of Advanced Nursing*, 56(1), 79-87. doi: 10.1111/j.1365-2648.2006.03982.x
- Cummings, C. L. (2010). Moral distress and the nursing experience. *Nurse Leader*, 8(6), 37-39. doi: 10.1016/j.mnl/2010.03.014
- Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care*, 46(3), 209-220. doi: 10.1111/j.1744-6163.2010.00260.x
- Dearmun, A. K. (2000). Supporting newly qualified staff nurses: The Lecturer Practitioner contribution. *Journal of Nursing Management*, 8(3), 159-165. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2834](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2834)

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- DeKeyser Ganz, F., & Berkovitz, K. (2011). Surgical nurses' perceptions of ethical dilemmas, moral distress and quality of care. *Journal of Advanced Nursing*, Advance online publication. Retrieved from <http://dx.doi.org/10.1111/j.1365-2648.2011.05897.x>
- DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314-321. doi: 10.1111/j.1365-2929.2006.02418.x
- Drummond, J. S., & Themessl-Huber, M. (2007). The cyclical process of action research. *Action Research*, 5(4), 430-448. doi: 10.1177/1476750307077317
- Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1), 54-63.
- 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. Retrieved from <http://ajcc.aacnjournals.org/>
- Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods*. Newbury Park, CA: Sage.
- Feldman, A. (2007). Validity and quality in action research. *Educational Action Research*, 15(1), 21-32. doi: 10.1080/09650790601150766
- Gough, K., & Happell, B. (2009). Undergraduate nursing students attitude to mental health nursing: A cluster analysis approach. *Journal of Clinical Nursing*, 18(22), 3155-3164. doi: 10.1111/j.1365-2702.2008.02764.x
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.
- Guba, E. G., & Lincoln, Y. S. (2002). Epistemological and methodological bases of naturalistic inquiry. *Evaluation Models in Human Services*, 49(4), 363-381. doi: 10.1007/0-306-47559-6_19
- Gutierrez, K. M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, 24(5), 229-241. Retrieved from <http://journals.lww.com/dccnjournal/pages/default.aspx>
- Habermas, J. (1984). *The theory of communicative action* (Beacon Press, Trans. Vol. 1). Boston, MA: Beacon Press.
- Ham, K. (2004). Principled thinking: A comparison of nursing students and experienced nurses. *Journal of Continuing Education in Nursing*, 35(2), 66-73.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- 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
- Happell, B. (2009). Influencing undergraduate nursing students' attitudes toward mental health nursing: Acknowledging the role of theory. *Issues in Mental Health Nursing, 30*(1), 39-46. doi: 10.1080/01612840802557113
- Happell, B., & Gough, K. (2007). Undergraduate nursing students' attitudes towards mental health nursing: Determining the influencing factors. *Contemporary Nurse, 25*(1-2), 72-81.
- Happell, B., Robins, A., & Gough, K. (2008a). Developing more positive attitudes towards mental health nursing in undergraduate students: Part 1 – does more theory help? *Journal of Psychiatric & Mental Health Nursing, 15*(6), 439-446. doi: 10.1111/j.1365-2850.2007.01203.x
- Happell, B., Robins, A., & Gough, K. (2008b). Developing more positive attitudes towards mental health nursing in undergraduate students: Part 2 - the impact of theory and clinical experience. *Journal of Psychiatric & Mental Health Nursing, 15*(7), 527-536. doi: 10.1111/j.1365-2850.2007.01233.x
- Hardy, S., Titchen, A., McCormack, B., & Manley, K. (Eds.). (2009). *Revealing nursing expertise through practitioner inquiry*. Ames, IA: Wiley-Blackwell.
- Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: A critical ethnography. *International Journal of Nursing Studies, 47*(6), 723-731. doi: 10.1016/j.ijnurstu.2009.11.010
- 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
- Heikkinen, H. L. T., Huttunen, R., & Syrjälä, L. (2007). Action research as narrative: Five principles for validation. *Educational Action Research, 15*(1), 5-19. doi: 10.1080/09650790601150709
- Herr, K., & Anderson, G. L. (2005). *The action research dissertation: A guide for students and faculty*. Thousand Oaks, CA: Sage.
- Hinchey, P. H. (2008). *Action research primer*. New York, NY: Peter Lang.
- Hoekstra, H. J., van Meijel, B. B., & van der Hooft-Leemans, T. G. (2010). A nursing career in mental health care: Choices and motives of nursing students. *Nurse Education Today, 30*(1), 4-8. doi: 10.1016/j.nedt.2009.05.018

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Hunink, G., van Leeuwen, R., Jansen, M., & Jochemsen, H. (2009). Moral issues in mentoring sessions. *Nursing Ethics, 16*(4), 487-498.
- Illingworth, P. (2009). Exploring mental health students' perceptions of role models. *British Journal of Nursing, 18*(13), 812-815.
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliff, NJ: Prentice-Hall.
- Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing, 28*(5), 1134-1145.
- Kemmis, S. (2008). Critical theory and participatory action research. In P. Reason & H. Bradbury (Eds.), *The SAGE handbook of action research: Participative inquiry and practice* (2nd ed., pp. 121-138). Los Angeles, CA: Sage.
- Kemmis, S. (2009). Action research as a practice-based practice. *Educational Action Research, 17*(3), 463 - 474. doi: 10.1080/09650790903093284
- Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103-121. doi: 10.1111/1467-9566.ep11347023
- Laabs, C. (2011). Perceptions of moral integrity: Contradictions in need of explanation. *Nursing Ethics, 18*(3), 431-440. doi: 10.1177/0969733011398101
- Ledford, G. E. (2005). Transference and countertransference in action research relationships. In B. Cooke & J. W. Cox (Eds.), *Fundamentals of action research* (Vol. 3, pp. 201-218). London, UK: Sage.
- Leech, N. L., & Onwuegbuzie, A., J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly, 22*(4), 557-584. doi: 10.1037/1045-3830.22.4.557
- Lerkiatbundit, S., & Borry, P. (2009). Moral distress Part II: Critical review of measurement. *Thai Journal of Pharmacy Practice, 1*(1), 12-22.
- Liaschenko, J. (1995). Artificial Personhood: Nursing Ethics in a Medical World. *Nursing Ethics, 2*(3), 185-196. doi: 10.1177/096973309500200302
- Lütznén, 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
- Maben, J., Latter, S., & Macleod-Clark, J. (2006). The theory–practice gap: Impact of professional–bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing, 55*(4), 465-477. doi: 10.1111/j.1365-2648.2006.03939.x

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- MacLeod, M. L. P., & Zimmer, L. V. (2005). Rethinking emancipation and empowerment in action research: Lessons from small rural hospitals. *Canadian Journal of Nursing Research*, 37(1), 68-85.
- Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Online Journal of Issues in Nursing*, 12(1), 1-15. Retrieved from <http://www.nursingworld.org/ojin/> doi:10.3912/OJIN.Vol12No01Man01
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Los Angeles, CA: Sage.
- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Qualitative Social Research*, 11(3). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/1428/3028>
- McCarthy, J., & Deady, R. (2008). Moral distress reconsidered. *Nursing Ethics*, 15(2), 254-262. doi: 10.1177/0969733007086023
- McNiff, J., & Whitehead, J. (2010). *You and your action research project* (3rd ed.). London: Routledge.
- Mooney, M., & Nolan, L. (2006). A critique of Freire's perspective on critical social theory in nursing education. *Nurse Education Today*, 26(3), 240-244. Retrieved from <http://www.nurseeducationtoday.com/>
- Murphy, J. (2011, March 31). *How triangulation strengthens action research*. Retrieved May 16, 2011, from <http://www.brighthub.com/education/postgraduate/articles/112609.aspx>
- Nathaniel, A. K. (2002). Moral distress among nurses. *American Nurses Association Ethics and Human Rights Issues Update* 2(1). Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Resources/IssuesUpdate/UpdateArchive/IssuesUpdateSpring2002/MoralDistress.aspx>
- Nathaniel, A. K. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research*, 28(4), 419-438. doi: 10.1177/0193945905284727
- Norwood, S. L. (2010). Data analysis and qualitative research. In *Research essentials: Foundations for evidence-based practice* (pp. 340-359). Upper Saddle River, NJ: Pearson Prentice Hall.
- Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., . . . Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nursing Ethics*, 17(6), 726-740. doi: 10.1177/0969733010379178

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Paterson, M., Chapman, C., Medves, J. M., Schroder, C., Verma, S., Broers, T., & O'Riordan, A. (2008). Action research in health sciences interprofessional education. *Journal of Social Intervention: Theory and Practice*, 17(3), 7-19.
- Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. *Nursing Ethics*, 16(5), 561-573. doi: 10.1177/0969733009106649
- Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economic\$,* 25(4), 217-221. Retrieved from <http://www.nursingconomics.net/cgi-bin/WebObjects/NECJournal.woa>
- Penticuff, J. H., & Walden, M. (2000). Influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas. *Nursing research*, 49(2), 64-72.
- Pijl Zieber, E., Hagen, B., Armstrong-Esther, C., Hall, B., Akins, L., & Stingl, M. (2008). Moral distress: An emerging problem for nurses in long-term care? *Quality in Ageing*, 9(2), 39-48. Retrieved from <http://www.emeraldinsight.com/journals.htm?articleid=1935597&show=html>
- Price, S. L. (2009). Becoming a nurse: A meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, 65(1), 11-19. doi: 10.1111/j.1365-2648.2008.04839.x
- Rasmussen, S. (1997). Action research as authentic methodology for the study of nursing. In S. E. Thorne & V. E. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 254-266). Thousand Oaks, CA: Sage.
- Redmond, R. A., & Curtis, E. A. (2009). Focus groups: Principles and process. *Nurse Researcher*, 16(3), 57-69.
- Rice, E. M., Rady, M. Y., Hamrick, A., Verheijde, J. L., & Pendergast, D. K. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management*, 16(3), 360-373. doi: 10.1111/j.1365-2834.2007.00798.x
- Ritter, D. (2011). The relationship between healthy work environments and retention of nurses in a hospital setting. *Journal of Nursing Management*, 19(1), 27-32. doi: 10.1111/j.1365-2834.2010.01183.x
- 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

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Somekh, B., Burman, E., Delamont, S., Meyer, J., Payne, M., & Thorpe, R. (2005). Research communities in the social sciences. In B. Somekh & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 1-14). London, UK: Sage.
- Stickley, T., & Timmons, S. (2007). Considering alternatives: Student nurses slipping directly from lay beliefs to the medical model of mental illness. *Nurse Education Today*, 27(2), 155-161. doi: 10.1016/j.nedt.2006.03.007
- Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Stringer, E. T. (2007). *Action research* (3rd ed.). Los Angeles, CA: Sage.
- Stringer, E. T., & Genat, W. J. (2004). *Action research in health*. Upper Saddle River, NJ: Pearson.
- Stroul, B. A., Heflinger, C. A., Alegría, M., Slaton, E., Farmer, E. M. Z., Betts, V. T., . . . Gruttadaro, D. (2010). Improving the linkage between research and system change: Making it real. *Administration and Policy in Mental Health and Mental Health Services Research*, 37(1-2), 125-127. doi: 10.1007/s10488-009-0261-8
- Sumner, J. (2010). Reflection and moral maturity in a nurse's caring practice: A critical perspective. *Nursing Philosophy*, 11(3), 159-169. doi: 10.1111/j.1466-769X.2010.00445.x
- Sundin, D., & Fahy, K. (2008). Critical, post-structural, interpretive interactionism: An update on Denzin's methodology. *Nurse Researcher*, 16(1), 7-23.
- Surgenor, L. J., Dunn, J., & Horn, J. (2005). Nursing student attitudes to psychiatric nursing and psychiatric disorders in New Zealand. *International Journal of Mental Health Nursing*, 14(2), 103-108. doi: 10.1111/j.1440-0979.2005.00366.x
- Susman, G. I., & Evered, R. D. (1978). An assessment of the scientific merits of action research. *Administrative Science Quarterly*, 23(4), 582-603.
- Tavakol, M., & Zeinaloo, A. A. (2004). Medical research paradigms: Positivistic inquiry paradigm versus naturalistic inquiry paradigm. *Journal of Medical Education*, 5(2), 75-80. Retrieved from <http://www.journals.sbmu.ac.ir/index.php/jme/article/viewFile/804/705>
- Taylor-Powell, E., & Renner, M. (2003). *Analyzing qualitative data*. Cooperative Extension Publishing Operations. Madison, WI. Retrieved from <http://learningstore.uwex.edu/assets/pdfs/g3658-12.pdf>
- Thorne, S. E. (2008). Data analysis in qualitative research. In R. B. Haynes, S. Marks, N. Cullum & D. Ciliska (Eds.), *Evidence-based nursing: An introduction* (pp. 93-100). Oxford, UK: Blackwell.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

- Ulrich, C. M., Taylor, C., Soeken, K., O'Donnell, P., Farrar, A., Danis, M., & Grady, C. (2010). Everyday ethics: Ethical issues and stress in nursing practice. *Journal of Advanced Nursing*, 66(11), 2510-2519. doi: 10.1111/j.1365-2648.2010.05425.x
- Webster, G. C., & Baylis, F. E. (2000). Moral Residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-231). Hagersown, MD: University Publishing Group.
- Wicks, P. G., & Reason, P. (2009). Initiating action research: Challenges and paradoxes of opening communicative space. *Action Research*, 7(3), 243-262. doi: 10.1177/1476750309336715
- Wilkinson, J. M. (1987). Moral distress in nursing practice: Experience and effect. *Nursing Forum*, 23(1), 16-29. doi: 10.1111/j.1744-6198.1987.tb00794.x
- William F. Connell School of Nursing. (2004). *Ethics Tool Database*. Boston College. Boston, MA. Retrieved from www.bc.edu/bc_org/avp/son/ethics/pdf/tools.pdf
- Ziebland, S., & McPherson, A. (2006). Making sense of qualitative data analysis: An introduction with illustrations from DIPEX (personal experiences of health and illness). *Medical Education*, 40(5), 405-414. doi: 10.1111/j.1365-2929.2006.02467.x
- Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, 14(3), 344-359. doi: 10.1177/0969733007075870

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix A

Script for Invitation to Nursing Student Participants

Study Title: Moral distress during Psychiatric Clinical Placements: Perspectives of Nursing Students and their Instructors

Hello everyone, my name is _____, and I am a (define role at the U of L, e.g. graduate student).

I am here today to inform you about a research project that is being conducted by Bernadine Wojtowicz, a registered nurse and graduate student in the Faculty of Health Sciences at the University of Lethbridge. I would like to ask you to listen to the information I have about the study, and I would also invite you to consider being an active participant in this research process.

The research study will explore nursing students' experiences of moral distress within acute inpatient mental health nursing settings. Moral distress is defined by the Canadian Nurses Association *2008 Code of Ethics* as: "situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress".

Participants must have already completed their mental health practicum in acute care at the time of participation. As a participant in the study, you will be interviewed one time regarding moral distress experiences you may have had, strategies you have used to manage moral distress situations, and suggestions for change in education and/or the acute care mental health setting to assist you in preparing for and managing moral distress situations more effectively. When that information is analyzed and identifying information is removed, the summary will be presented to mental health nursing instructors within the NESAs program for their views on their role as agents of change for students experiencing moral distress in acute psychiatric settings. None of your **individual** comments or experiences will be shared with instructor participants. Student interviews will last approximately sixty to ninety minutes each and will be conducted at a mutually agreeable location.

In appreciation of your time and contributions through participation in this study, you will receive a \$5.00 gift card. If you withdraw from the study prior to its conclusion, you will still be presented with the gift card.

Thank you for your consideration of this request. If you are interested in participating in this research study, please contact Bernadine at her confidential e-mail address (provide same as bernadine.wojtowicz@uleth.ca) to ask any further questions, discuss your participation, and/or schedule an interview. For additional information, please call

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Bernadine or contact her via confidential e-mail (remind students of address) or at 403-329-2784, or you may contact her thesis supervisor, Dr. Brad Hagen at brad.hagen@uleth.ca or 403-329-2299.

Thank you very much for your time and attention. Thank you, also, (instructor of class) for allowing me some of your class time to present this exciting opportunity to your students.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix B

Contact Slips for Potential Student Participants

Study Topic: Moral Distress during Psychiatric Clinical Placements: Perspectives of Nursing Students and their Instructors

Moral distress: "...situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm" (Canadian Nurses Association 2008 *Code of Ethics*, p.6).

Your thoughts and experiences are very important to me. If interested in participating in this study, please contact:

Bernadine Wojtowicz (Bernie)
Office: M3118 (Markin Hall, 3rd floor)
Phone: 403-329-2784
E-mail: bernadine.wojtowicz@uleth.ca

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix C

Letter of Invitation to Nursing Instructor Participants

Study Title: Moral distress during Psychiatric Clinical Placements: Perspectives of Nursing Students and their Instructors

September 01, 2011

Dear prospective nursing instructor participant,

My name is Bernadine Wojtowicz, and I am a registered nurse in Graduate Studies at the University of Lethbridge working towards my Master of Science in Nursing. I am conducting research as part of the requirements for this degree, and I would like to invite you to participate in my study.

I am conducting an action research study exploring nursing students' experiences of moral distress within acute inpatient mental health nursing settings, and their suggestions for change to education and practice to assist them in preparing for and managing moral distress situations. The invitation to participate in this study is extended to nursing instructors who have instructed students in the acute inpatient psychiatric unit at Chinook Regional Hospital. As a participant in the study, you will be presented with themes derived from student information on proposed changes to education and practice, and will be asked to describe how you view your role as an agent of change. Instructor participants will engage in a focus group discussion lasting approximately two hours, and will be held on the University of Lethbridge campus.

In appreciation of your time and contributions through participation in this study, you will receive a \$5.00 gift card. If you withdraw from the study prior to its conclusion, you will still be presented with the gift card.

Thank you for your consideration of my request. If you are interested in participating in my research study, please contact me at the confidential e-mail address below to discuss your participation and scheduling for the interview process. For questions or additional information, please call me or contact me via confidential e-mail at bernadine.wojtowicz@uleth.ca or 403-329-2784, or contact my supervisor, Dr. Brad Hagen at brad.hagen@uleth.ca or 403-329-2299.

Respectfully,
Bernadine Wojtowicz RN, BN
MSc Student, Faculty of Health Sciences
University of Lethbridge
Work: 403-329-2784
Cell: 403-380-9685
Confidential E-mail: bernadine.wojtowicz@uleth.ca

Appendix D

Recruitment Poster

**Nursing Students:
Research Opportunity**

*Moral Distress during Psychiatric
Clinical Placements:
Perspectives of Nursing Students and
Their Instructors*

All participation is completely confidential and voluntary. Participants will receive a \$5.00 Tim Horton's gift card in appreciation of your time and contributions.

**If you have completed your mental health
practice placement on CRH inpatient
psychiatry, please contact:**

Moral Distress Study
bernadine.woitowicz@nlcjh.ca
403-329-2784

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix E

Participant Demographic Form

Please indicate the applicable answers to the following questions. Responses will not be used to identify individual participants, but rather to locate participants within the study itself.

Section A: (applies to all)

1. Are you: _____ nursing student
 _____ nursing instructor
2. Gender: _____ male _____ female
3. Age: _____

Section B: (*nursing students only* – instructors proceed to section C)

4. In what year of the program did you complete your mental health practice rotation?
_____ Year 3 _____ Year 4 _____ BN After-Degree summer session

Thank you for your participation, nursing students may exit the demographic survey.

Section C: U of L NESAs instructors

5. How many years have you been a registered nurse/registered psychiatric nurse?

6. How many years have you been a mental health instructor?

7. Do you currently work on inpatient psychiatry in addition to instructing? YES NO
8. If you answered YES to the previous question, how many shifts do you work (on average) per month _____

Thank you for your participation.

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix F

Interview Guide for Nursing Student Participants

Definition of Moral distress to be provided to participants:

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress (Canadian Nurses Association, 2008, p. 6).

1. Please give me any examples of experiences you had on inpatient psychiatry that appear to fit within this definition. Please describe the situation in detail.
2. What do you feel would have been the "right" thing to do? Explain how you feel the "right" outcome was or was not possible in this situation. What facilitated or prevented the right thing from being done?
3. In reflecting back on what *should have* been done in the situation, what nursing value or moral principle that is important to you comes into effect?
4. Please describe for me how you felt about the situation. How did you, or are you currently dealing with, the situation? What actions do you take to resolve the feelings these issues evoke in you personally?
5. Please describe any factors that you perceive to contribute to these situations occurring, and give some examples of how you think things need to change on the inpatient psychiatric unit to prevent these occurrences. How do you think these things could be changed?
6. How do you think your nursing practice instructor could have helped you through times when you encountered situations that "weren't right"? Could he or she have done anything else to help you?
7. How have the situations you described influenced your decision of whether to work in mental health nursing areas?

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix G

Nursing Student Participant Consent Form

Study Title: Moral distress during Psychiatric Clinical Placements: Perspectives of Nursing Students and their Instructors

Date, 2011

Dear nursing student,

You are being asked to participate in a research study about moral distress experiences as experienced by nursing students in acute psychiatric inpatient settings. Specifically, you will be asked about your experiences of moral distress in mental health nursing practice, and describe how you feel your instructors can act as an agent of change within the inpatient setting. The purpose of this study is to a) explore the nature of moral distress experiences in nursing students in acute inpatient psychiatry, b) if moral distress is an issue, to examine strategies students use to manage it effectively, and c) explore potential student and instructor roles as agents of change on psychiatric inpatient units.

You have been invited to participate because I believe that students experience moral distress situations that they may or may not be prepared to manage effectively in practice. For this study, nursing students must have completed a mental health practicum.

Participation in the study is voluntary and includes one interview taking approximately sixty to ninety minutes, at a mutually agreed upon location, with the exception of any location designated as an Alberta Health Services site. With your permission, interviews will be digitally recorded for accuracy, and transcribed by the interviewer exactly as spoken. As the interview progresses, you may choose not to answer any question asked, without negative consequences, and will also have the option of stopping the interview and/or the recording at any time during the interview process. You have the option to withdraw from the study at any time without consequence and all of your data obtained up to that point will be shredded and destroyed as confidential waste. Your grades and progress in the program will not be affected if you choose to not answer a question or indicate that you wish to withdraw from the interview and/or study. Once the completed interview has been transcribed, the digital interview recording will be destroyed. You will be asked to review the typed manuscript of your interview for accuracy of content and meaning.

You will be asked to complete a demographic information sheet addressing gender, age, and year of the nursing program in which you completed your mental health practice rotation. Your anonymity will be maintained through use of a pseudonym. Identifying events will be reported in a modified fashion to protect the identity of students, clients, and others referred to in the course of the interview. None of your individual comments or experiences will be shared with instructor participants, but a **summary** of themes

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

extracted from student participants will be presented to the instructor participants for consideration in the second portion of the study. All manuscripts and demographic information from the study will be stored in a locked cabinet located in my office. Data will be kept for five years, and will be shredded and destroyed as confidential waste after that time.

Each participant will receive a gift card valued at \$5.00, as a token of appreciation for time and contributions to the study. Non-monetary benefits include the knowledge that you are participating in research that may improve mental health teaching practices and better prepare students for situations of moral distress.

There are no known physical risks associated with participation in this study. However, you may at times feel emotionally uncomfortable if reflecting on an unpleasant experience. This is highly unlikely, and if this does occur, feelings are likely to be relatively minimal. If this does occur, or feelings are more than minimal, simply contact me at 403-329-2784 or let me know at the end of the interview session. You will be provided with names and contact information for support services available to you.

Findings from this study will be shared with others via presentations and publications in relevant nursing journals in a manner that protects participant anonymity and confidentiality. Data may also be used for teaching purposes. The purpose in sharing the findings is so that a) strategies may be identified that enhance education for nursing students, b) nurse educators may better support nursing students when morally distressing situations arise in clinical practice rotations, and c) nurse educators can better prepare students for managing situations in nursing practice after program completion.

This research is being conducted by Bernadine Wojtowicz RN, BN as part of the Masters of Health Sciences program, Faculty of Health Sciences, University of Lethbridge. If you require further information about the study, please contact the Principal Investigator at bernadine.wojtowicz@uleth.ca or 403-329-2784, or Dr. Brad Hagen (Supervisor) at brad.hagen@uleth.ca or 403-329-2299.

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (phone: 403-329-2747 or e-mail: research.services@uleth.ca)

Your signature below indicates that you have read (or have been read) and understand the nature and the purpose of this study. You are agreeing to participate in not more than two interviews and to be recorded for accuracy. You have been given the opportunity to have all questions answered by the researcher prior to participating. If you wish to obtain an executive summary of the findings or would like a copy of your individual interview transcript, please indicate this in the applicable areas below.

I would like a copy of my transcript I wish to receive a summary of findings

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

(e-mail address) _____ Contact number _____

(Include e-mail and telephone contact information ONLY if you checked either box above)

Name of participant (printed)

Signature

Date

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix H

Interview Guide for Nursing Instructor Participants

1. What are your reactions or thoughts to the themes derived from situations that students encounter that they felt “weren’t right” morally in inpatient psychiatry?
2. What are your reactions or thoughts to the students’ ideas on the instructor’s role in supporting students in situations that they find morally distressing?
3. Please describe any factors that you perceive to contribute to these situations occurring.
4. Please give some examples of what could be changed on the inpatient psychiatric unit to prevent these occurrences.
5. How do you think you could modify your teaching approach to assist students to better deal with their reactions to these difficult situations?
6. How can you influence the units and/or the hospital system in ways that would help them reduce the kinds of morally distressing situations that the students described?

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

Appendix I

Nursing Instructor Participant Consent Form

Study Title: Moral distress during Psychiatric Clinical Placements: Perspectives of Nursing Students and their Instructors

Dear nursing instructor,

You are being asked to participate in a research study about moral distress experiences as experienced by nursing students in acute psychiatric inpatient settings. Specifically, you will be asked to review themes elicited from student experiences of moral distress, explore and contribute to a discussion of potential changes to education and practice, and describe how you view your role as an agent of change. The purpose of this study is to a) explore the nature of moral distress experiences in nursing students in acute inpatient psychiatry, b) if moral distress is an issue, to examine strategies students use to manage it effectively, and c) explore potential student and instructor roles as agents of change on psychiatric inpatient units.

You have been invited to participate because I believe your experience in mental health nursing will enable you to provide insight into current and potential educational preparation of students. In this study, experienced nurses are defined as those having five or more years of mental health nursing experience.

Participation in the study is voluntary and includes your participation in a focus group – lasting approximately two hours – with other mental health instructors. The focus group will be conducted on the University of Lethbridge campus. With your permission, the focus group discussion will be digitally recorded for accuracy, and transcribed by the interviewer exactly as spoken. As the discussion progresses, you may choose not to answer any question asked, without negative consequences, and will also have the option of stopping the session and/or the recording at any time during the interview process. Once the focus group session has been transcribed, the digital recording will be destroyed. You will be asked to review the typed manuscript of the focus group for accuracy of content and meaning. You have the option to withdraw from the study at any time without consequence, but due to the nature of the focus group discussion, your data will be retained as part of the data set.

You will be asked to complete a demographic information sheet addressing gender, age, years of nursing practice, and years of mental health experience. Your anonymity will be maintained by use of a pseudonym. Identifying events will be reported in a modified fashion to protect your identity and the identity of students, clients, or individuals you work with. All manuscripts and demographic information from the study will be stored in a locked cabinet located in my office. Data will be kept for five years, and will be shredded and destroyed as confidential waste after that time. Please note that due to the focus group method used for data collection that there are some limits to anonymity and

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

confidentiality. If you require further information regarding this, please contact me for an explanation of these limitations.

Each participant will receive a gift card valued at \$5.00, as a token of appreciation for time and contributions to the study. Non-monetary benefits include the knowledge that you are participating in research that may improve mental health teaching practices and better prepare students for situations of moral distress.

There are no known physical risks associated with participation in this study. However, you may at times feel emotionally uncomfortable if reflecting on an unpleasant experience. This is highly unlikely, and if this does occur, feelings are likely to be relatively minimal. If this does occur, or feelings are more than minimal, simply contact me at 403-329-2784 or let me know at the end of the interview session. You will then be provided with names and contact information for support services that are available to you.

Findings from this study will be shared with others via presentations and publications in relevant nursing journals in a manner that protects participant anonymity and confidentiality. Data may also be used for teaching purposes. The purpose in sharing the findings is so that a) strategies may be identified that enhance education for nursing students, b) nurse educators may better support nursing students when morally distressing situations arise in clinical practice rotations, and c) nurse educators can better prepare students for managing situations in nursing practice after program completion.

This research is being conducted by Bernadine Wojtowicz RN, BN as part of the Masters of Health Sciences program, Faculty of Health Sciences, University of Lethbridge. If you require further information about the study, please contact the Principal Investigator at bernadine.wojtowicz@uleth.ca or 403-329-2784, or Dr. Brad Hagen (Supervisor) at brad.hagen@uleth.ca or 403-329-2299.

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (phone: 403-329-2747 or e-mail: research.services@uleth.ca)

Your signature below indicates that you have read (or have been read) and understand the nature and the purpose of this study. You are agreeing to participate in a focus group of approximately two hours in duration and to be recorded for accuracy. You have been given the opportunity to have all questions answered by the researcher prior to participating. If you wish to obtain an executive summary of the findings or would like a copy of your individual interview transcript, please indicate this in the applicable areas below.

I would like a copy of my transcript I wish to receive a summary of findings

(e-mail address) _____ Contact number _____

Moral Distress During Psychiatric Clinical Placements: Perspectives of Nursing Students and Their Instructors

(Include e-mail and telephone contact information ONLY if you checked either box above)

Name of participant (printed)

Signature

Date