# The Experience of Moral Distress in Psychiatric Nurses

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Abstract

Background: Moral distress has been studied in critical care nurses and has shown to have deleterious effects on nurses' physical and psychological well-being. To date, little research has been conducted on the experience of moral distress in Psychiatric Mental Health Nurses (PMHNs).

Purpose: The purpose of this research is to describe the experience of moral distress in PMHNs.

Method: The study utilized a descriptive cross-sectional electronic survey design to collect demographic data and responses to the Moral Distress Scale for Psychiatric Nurses (MDS-P) in a sample of PMHNs (n=28) drawn from a professional community psychiatric nursing organization in the Commonwealth of Virginia.

Results: Moral distress scores for this sample were low to moderate with a mean score of 1.50 (SD=1.31). The lowest score mean score of 0.54 (SD=1.20) was reported for one question related to being honest with the patient. The highest mean score was 3.36 (SD =2.45) was reported for questions related to nurses being treated like a machine. A statistically significant difference ($p < 0.05$) was found between those who had not considered leaving (total mean MDS-P score of 0.83) and those who left (total mean MDS-P score of 3.03).

Conclusion: This study found low to moderate levels of moral distress in PMHNs in the Commonwealth of Virginia. The results from this sample support other research findings indicating a relationship between moral distress and the intent to leave.

*Keywords: moral distress, psychiatric, nurses, Moral Distress Scale for Psychiatric Nurses (MDS-P)*

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## Moral Distress in Psychiatric Nurses

Decades of research have shown that nurses encounter moral distress, which can lead to negative outcomes including nurse burnout and disengagement (Schluter et al., 2008). Psychiatric nurses are one of the largest providers of care to individuals with mental illness in hospitals and in community-based clinics. Psychiatric nurses work in a highly stressful environment fraught with ethical challenges; therefore, it is reasonable to assume that nurses would experience moral distress in this environment. While a link has been established between moral distress, burnout, and disengagement in acute care nurses, relatively little is known about the phenomenon of moral distress in psychiatric nurses in the Unites States.

Moral distress is a response to knowing an ethical and appropriate action, but not being able to provide it due to constraints. Moral distress compounds with each interaction that conflicts with the nurses' values, leaving the nurses with lingering negative emotions (Epstein & Delgado, 2010). After an event has passed, it is common for the nurse to continue to recall and re-experience the feelings with the same or increased intensity during subsequent morally distressing events. The feelings and emotions that remain with the nurse are known as moral residue. Epstein and Hamric (2009) found that over time nurses' reactions intensify with each subsequent ethically compromising interaction. Experts believe that frequently being placed in morally distressing clinical situations contributes to nurse burn out and the intent to leave the position (Corley, 1995; Hamric, Borchers, and Epstein, 2012).

The intrapsychic trauma of moral distress manifests itself in both physical and psychological symptoms. These experiences can lead to feelings of guilt, self-doubt, frustration, anger, depression, and inadequacy (Schluter et al., 2008; Deady & McCarthy, 2010). Commonly experienced physical symptoms include headache, neck and shoulder tension, and stomachaches

(Gutierrez et al., 2005; Ludwick & Silva, 2003; Wilkinson, 1998). Documented psychological symptoms of moral distress include feelings of anger, frustration, anxiety, guilt, and depression (Austin et al., 2005; Gutierrez et al., 2005; Ludwick & Silva, 2003; Wilkinson, 1998). Gutierrez and colleagues (2005) found that moral distress impacted patient care, specifically, the interactions with family and patients decreased; nurses became more withdrawn; and less personalized care was provided to the patient in critical care units. In light of these findings, it is not surprising that increased levels of moral distress have been found to be associated with job dissatisfaction, lack of work engagement, burnout, and intent to leave the profession (Hamric and Blackhall, 2007; Meltzer and Huckabay, 2004).

Most of the research has focused on acute care nurses and specific clinical challenges related to that field of nursing. Validation measures to assess moral distress reflect situations common to critical care units, such as providing futile care. However, an ever increasing amount of evidence shows that nurses from a wide variety of settings are also experiencing moral distress. According to Epstein and Hamric (2009), providers cite the inability to deliver necessary treatment as morally distressing.

Psychiatric nurses face distinct ethical challenges depending on the population and setting in which they provide care. Specifically, issues concerning patient autonomy, freedom of choice, and consent to treatment are ethical issues that routinely occur in mental health care (Austin et al., 2008; Deady & McCarthy, 2010; Musto & Schreiber, 2012). Although it is known that mental health care nurses face unique ethical challenges, relatively little is known about the experience of moral distress in Psychiatric Mental Health Nurses (PMHNs). Limited research describes themes reported by mental health nurses and their accounts of moral distress. In 2010, Ohnishi and colleagues developed the first validated measure, specifically designed to evaluate

the intensity of moral distress experienced by psychiatric nurses. The measure was utilized to quantify moral distress in Japanese and Jordanian psychiatric nurses; however, to date, no qualitative studies or measurements have assessed moral distress in PMHNs in the United States (Ohnishi, et al., 2010; Hamaideh, 2014).

Unlike Japan's Universal healthcare system, the United States health care system more closely resembles Jordan's health care system. The healthcare system in the United States is highly fragmented and provides coverage for most individuals through public programs or private managed care organizations. Individuals may receive government subsidies for purchasing private insurance, while health care organizations may receive reimbursements for providing services for low income and uninsured or underinsured patients. With regards to mental health, specifically in the Commonwealth of Virginia, the state operates nine psychiatric hospitals, four rehabilitation centers, and 40 Community Service Boards across the state. The psychiatric hospital provides intensive treatment for acute mental health needs for all ages. The Community Services Boards provide services for individuals with mental health needs, intellectual disabilities and substance abuse issues to disabled, low income, and uninsured individuals in crisis. Additionally, private, for profit, and not for profit organizations provide a variety of psychiatric services including acute psychiatric hospitalization, intensive outpatient treatment, and medication management services.

## Purpose and Significance

The purpose of this study was to conduct a preliminary investigation to evaluate the experience of moral distress in the United States. The sample was drawn from a small group of PMHNs in the Commonwealth of Virginia. Unlike other specialties, PMHNs often establish long-term, close, and professional relationships with patients. The relationship between the

PMHN and the patient transcends the medical model and requires intimacy and trust in order to determine the appropriate course of action and improve patient outcomes (Lieberman, 2015 p.12). Research shows that it is important for individuals with mental illness to feel a sense of personal connectedness to the provider and that developing a therapeutic nurse-patient relationship can build new neural connections in the brain, which support essential neurological functions such as emotional balance and response flexibility (Polacek et al., 2015). Suffering from moral distress has the potential to reduce the PMHNs' ability to develop a professional level of intimacy, trust, and attachment that is necessary to provide optimal care for the patient. If the PMHN is suffering from moral distress it may inhibit his or her ability to establish a therapeutic relationship.

Moral distress impacts nurses emotionally and physically both within and outside of the workplace (Lützén et al., 2010). The continued experience of morally distressing events leads the PMHN to develop maladaptive coping mechanisms which allow him or her to work, albeit not fully engaged, with a limited ability to meaningfully participate in therapeutic PMHN-patient relationships (Deady & McCarthy, 2010; Lützén et al, 2010). In time, the PMHN may even begin to question the treatment and care provided to the patient causing him or her to doubt his or her ability to care for the patient. Deady and McCarthy (2010) found that Irish psychiatric nurses coped by avoiding conflict, acquiescing to patient's rights violations, and denying and minimizing ethical issues. Additionally, it has been shown that higher levels of moral distress were related to higher levels of education, exhaustion and cynicism, and burnout in Jordanian and Japanese psychiatric nurses (Ohnishi et al., 2010; Hamaideh, 2014). It is reasonable to assume that PMHNs in the United States may react and respond similarly, but more research is needed to affirm this assumption. Knowing the consequences of moral distress and the ethical

issues that PMHNs encounter, it is important to understand the phenomenon's impact on PMHNs.

## Theoretical Framework

The phenomenon of moral distress among nurses has been discussed for decades and extensively researched in critical care nurses, to a lesser extent, in non-critical care units, and in inpatient and outpatients multidisciplinary clinics. Moral distress differs from an ethical dilemma in that one or more ethical choices can be made when presented with an ethical dilemma; whereas, moral distress is the result of knowing which ethically appropriate actions to take but being unable to take that action (Epstein and Delgado, 2010). Jameton (1984) first introduced the concept of moral distress when he postulated that an individual could be negatively affected when the individual "knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Later Jameton went on to differentiate between initial and reactive moral distress. Initial moral distress is the feeling of frustration, anger, and anxiety when faced with an obstacle. Reactive distress is the emotional anguish that remains after the event has passed (Jameton, 1993).

Corley (1995) added that two characteristics impact the severity of moral distress, which is the seriousness of the situation and the frequency at which it occurs (p.280). In 2001, Corley and colleagues also developed a measurement to assess moral distress in nurses working in acute care hospital settings (Corley, Elswick, Gorman and Clor). The following year she proposed a theory of moral distress, suggested areas for further research and discussed the impact moral distress has on nurses and organizations (Corley, 2002).

Contributions from Epstein and Hamric (2009) clarified moral distress as being "the result of a perceived violation of one's core values and duties, concurrent with a feeling of being

constrained from taking ethically appropriate action" (p.2) and coined the term "moral residue" to more accurately describe the experience of reactive distress. Moral residue is the lingering negative feelings that remain long after a morally distressing event. In addition to experiencing the moral conflict and the development of moral residue, both concepts appear to have a crescendo effect. That is, with each morally distressing event, moral residue increases and creates a higher baseline level of moral distress and residue; thereby evoking stronger reactions in the nurse as he or she is re-traumatized by another morally distressing event.

In 2012, Hamric, Borchers and Epstein revised Corley's Moral Distress Scale (MDS) and identified three major root causes of moral distress. The Moral Distress Scale-Revised (MDS-R) version included measures for both intensity and frequency of events that triggered moral distress in the nurse to evaluate the crescendo effect. Question regarding considering leaving a position in the past remained unchanged, however an additional question evaluating if participants were currently considering was added. Since moral distress has been associated with the intent to leave in multiple studies, having participant with elevated MDS-R scores, who also answer yes to this question supports the validity of the MDS-R.

The three major root causes of moral distress were classified as clinical situations, internal constraints, and external constraints in the situation or the environment. Psychiatric mental health nurses experience moral distress when caring for their patients due to clinical, internal, and external constraints. Clinical situations reported to cause moral distress involve the existence of conflicting duties, care not being in the patient's best interest, a disregard for the patient's wishes and a lack of truth telling (Hamric, Borchers & Epstein, 2012). Internal constraints refer to nurses' characteristics and include perceived powerlessness, self-doubt, and a lack of assertiveness. External constraints are related to institutional and systemic constraints

such as: inadequate communication between team members, differing interdisciplinary perspectives, inadequate staffing, tolerance of abusive behavior, compromised patient care due to pressure from payers, or an institutional fear of litigation (Hamric, Borchers, & Epstein, 2012).

## Review of Literature

An exhaustive review of literature through 2015 was performed in order to identify and evaluate how PMHNs experienced moral distress. The electronic databases CINAHL, PubMed, MEDLINE and the Joanna Briggs Institute were used to retrieve research articles. The keyword, "moral distress" was combined with keywords "mental health", and "psychiatry" to search all relevant articles when searching CINAHL, Pubmed, MEDLINE and the Joanna Briggs Institute databases. Search results revealed that research studies regarding moral distress on PMHNs were quite limited in both number and scope. The search yielded 19 studies, one of which was a duplicate study. Three editorials and articles were written in languages other than English leaving only 16 articles to review.

Following a review of the abstracts, published research articles that examined moral distress in mental health settings were included in the review of literature. Eight articles were determined to be relevant and met the criteria for inclusion. After an ancestry search, one additional article was found to be appropriate for inclusion in the literature review. A summary of the literature can be found in Table 1 of this manuscript. The literature review has been organized to reflect the major root causes of moral distress in psychiatric nurses as identified by Hamric, Borchers and Epstein (2012), clinical constraints, internal constraints and external constraints.

## Clinical Constraints

### Lack of Engagement

According to the literature, clinical constraints experienced by mental health nurses include lack of engagement, high reliance on medications, and minimizing patient autonomy (Austin et al., 2003; Austin et al., 2008, Musto & Schreiber, 2012; Wojtowicz et al., 2014; Wojtowicz & Hagen, 2014). Engagement represents two connected relationships - the relationship the nurse has with the patient and the relationship the nurse has with the work environment. Engagement with the patient is essential to the role of a psychiatric nurse and involves deliberate interactions by the nurse to establish a trusting relationship with the patient. Work engagement is the degree of personal fulfillment the nurse experiences within his or her profession and organization. Work engagement is negatively correlated with burnout and moral distress (Lawr, 2011; Polacek et al., 2015).

Therapeutic relationships are the foundation of psychiatric nursing. In Musto and Schreiber's (2012) research, participants began to experience moral distress when they felt they had not lived up to the nurse-patient relationship. Specifically, a nurse recalled that "it put me in distress because I doubted my practice, I doubted my decision, I doubted what I had done for the patient " (p.140). A participant in a study conducted by Austin, Bergum, and Goldberg (2003) expressed distress because the demands of the role limited her from "knowing" her patients. Instead she was limited to focusing on the patients' medications and diagnoses. One nurse expressing these feelings of disconnectedness saying "you are not even introduced to your patients because you won't be here tomorrow. You sort of feel more like a machine than a person" (p. 181). Another nurse in the study expressed distress regarding the perceived inability to provide quality care and reported that her peers "stopped listening to the call of their patients",

"very few talk to their patients" and many "won't come out of the office no matter what" (p.181). Nurses in a study by Wojtowicz et al. (2014), expressed frustration that staff was more concerned about completing a "checklist" rather than talking to the patient about his or her problems or offering emotional support.

**Reliance on Medication**

Over the last half a century, more psychopharmacological medications have become available to reduce psychiatric symptoms experienced by individuals. However, an over-reliance on medication is not beneficial to society or persons with mental illness. Deady and McCarthy (2010) reported that nurses expressed disappointment because there is an overemphasis on the use medications and lack of emphasis on establishing a relationship with the patient. For example, when a patient's behavior escalated because he was not allowed to smoke on the unit he was given an antipsychotic medication for his "agitation" instead of the nurse talking to him about his anxiety. Time was not spent talking to the patient about his concerns. PMHNs also reported feeling morally distressed when coercive practices were used to administer medications and when information regarding side effects of medications was withheld (Deady & McCarthy, 2010; Wojtowicz et al., 2014). Austin et al. (2003), found that nurses felt pressured by outside agencies and other providers to "medicate" patients against their will, or to provide medications that had limited benefit, which increased moral distress among the nurse in the study.

**Minimizing Patient Autonomy**

Mental illness can impair an individual's perception and ability to reason, leaving him or her vulnerable to threats against his or her autonomy (Sjöstrand & Juth, 2014). A patient's autonomy may be further constrained when members of the treatment team determine that the individual's ability to make decisions is impaired due to the mental illness. The use of restraints,

court ordered detainment, and court ordered medication administration are ethical issues routinely encountered in mental health care. More nuanced accounts of restrictions on patients' autonomy were reported as causing moral distress in mental health settings. Giving patients the illusion of choices has been cited as morally distressing (Austin et al., 2007). One participant in the study recounts the following example:

> "You know, you are more or less telling him, "This is the way it's going to be." "So, yes he has the freedom to say "No!" but if he were to say "no" he has to leave the group home and he has no money", "So he has many years of being coerced and he is kind of trapped in this situation and he objects to it, he doesn't like it, he says he's always angry" (Austin et al., 2007, p. 94).

Additional findings from the study highlighted that participants felt conflicted by balancing patients' rights with the rights and protection of others, or putting a family's interest over the patient's best interest and forcing treatment on patients (Austin et al., 2007). Nurses also reported that patient autonomy was minimized when excessive force was used to bring individuals into treatment (Musto & Schreiber, 2012). Irish nurses recounted morally distressing clinical situations; specifically, one nurse described a terminally ill patient being involuntarily committed because she desired to end her life. The nurse caring for her believed that the patient's had the right to choose to live or die and she should not have been involuntarily committed because of her belief (Deady & McCarthy, 2010).

## Internal Constraints

### Hopelessness

Moral distress can lead to unresolved feelings that negatively impact the PMHN and leave him or her feeling hopeless, isolated, or powerless. Hopelessness has many definitions

and, in this context, the most relevant definition is the feeling of being incapable of a solution, management, or accomplishment (Merriam-Webster online dictionary). Given that many PMHNs believe they have an ethical and moral duty to care for the patient, it is understandable that they would begin to feel hopeless following continued exposure to morally distressing situations.

Participants in Musto and Schreiber's (2012), study expressed being dismissed by supervisors when a morally distressing event was brought to their supervisor's attention. For example one participant recounted "you go in there with your concerns and your fears and you lay it out on the table…You know it's like, "Oh well, we can't change anything. Too bad that happened" (p. 141). This interaction left the nurse feeling hopeless and without guidance regarding how to effectively address moral conflicts in the future. Nurse's feelings of disappointment and unpreparedness to resolve future ethical conflicts grew due to a perceived lack of role modeling. In Wojtowicz et al.'s (2014) research participants excused their inability to resolve conflict by limiting their own culpability. For example, one nurse stated the following:

> "They probably felt like, "well she just swept it under the rug, and she didn't deal with the issue. But if you look at the big picture, I was doing it to protect them…from the chaos that would ensue if we tried to change things on the unit" (p.124). Another participant retorted that "we can't fix these patients, and there are realities that are ugly, and a lot of times we can't make the situation better…There are some practices in psychiatry that are very different from other practices…even if they may feel like a violation" (Wojtowicz et al.'s, 2014, p. 124).

A participant in Austin et al.'s (2003) study reported feeling frustrated by the actions of peers,

while at the same time feeling hopeless to influence the actions of their co-workers "see[ing] no way to influence" (p.181) their actions. Specifically stating the following:

> They've just kind of given up on things they should be doing. I guess maybe that is their way of dealing with their, you know, their own distress. Maybe they're just burned out...How do you, how do you, you know, get your colleagues to do their job, basically? So, I just, I don't see any answer. I just make sure I look after my patients and spend my time with my patients. But it's very sad. (Austin et al., 2003**,** p. 181).

**Isolation**

In addition to feeling hopeless to change the status quo, nurses felt alone and with no "place to turn" (p.261) for support (Wojtowicz et al., 2014). For example, Austin et al. (2003) found that a nurse reported feeling disconnected and *"*so isolated…I feel like I am on my own" (p.181). PMHNs also experienced moral distress and the fear of isolation when challenging a peer's standard of practice (Deady & McCarthy, 2010; Musto & Schreiber, 2012). As such, PMHNs reported keeping to themselves and no longer attempting to resolve the internal moral conflict they were feeling, ultimately resulting in disengagement from the patient. Nurses in Deady & McCarthy's (2010) investigations reported it was difficult to challenge a peer's standard of practice for fear of retaliation and isolation. Subtle isolating behaviors include indirect questions regarding a nurse's level of competence, withdrawal of support in key moments and being "seen as splitting the team by taking the side of the patient" (p.214)

**Powerlessness**

Multiple studies have reported that PHMNs felt powerless to change the actions of other nurses or the institutional culture. PMHNs felt unable to provide the most appropriate care for patients due to organizational restraints, government agency restraints, and restrictions imposed

by service payers (Austin et al., 2003; Austin et al., 2007; Deady & McCarthy, 2010; Lützén et al., 2010; Musto & Schreiber 2012; Wojtowicz et al., 2014). According to Austin et al. (2007), PMHNs reported feeling like an "outsider" when attempting to resolve ethical conflicts. They felt that it was difficult to engage in a positive dialogue in an effort to achieve a resolution with peers in the mental health field. The PMHNs interviewed by Musto and Schreiber (2012) reiterated this sentiment. The moral residue that remained due to this lack of resolution led nurses to feeling the need to protect themselves, essentially, going into a "survival" mode so that they can continue to work. This unresolved moral residue leads to behavioral changes within the nurse that negatively impacts his or her ability to provide quality health care.

## External Constraints

### Low staffing levels

In mental health care the risk exists that patients' behavior may escalate and become volatile, thereby putting staff and patients at risk of physical harm. Therefore, mental health units require sufficient staffing in order to properly monitor and intervene should a volatile event occur. Several studies have identified inadequate staffing, time constraints on patient care, and institutional policies as triggers for moral distress in mental health care and in critical care environments (Corley et al., 2001; Nalley, 2013; Ohnishi et al., 2010; Schluter et al., 2008). Other studies showed that increased levels of moral distress and low staffing levels had a positive correlation (Corley et al., 2001; Hamaideh, 2014; Ohnishi et al., 2010). Ohnishi et al. (2010), found that Moral Distress Scale for Psychiatric nurses (MDS-P) scores were rather low in psychiatric mental health nurses in Japan, which has a socialized health care system with MDS-P intensity scores ranging from 1.45 (SD ± 1.52) to 3.80 (SD ± 1.84) with a mean total of 2.47 (SD± 1.71) out of a total score of six.

The highest levels of moral distress were reported in relation to low staffing levels (Ohnishi, 2010). Low staffing levels can increase workload and negatively impact quality of care, thus increasing the moral distress experienced by nurses. Nurses in the Austin et al.'s (2003), study expressed distress from feeling overwhelmed by having "too much to do", "not having enough time" and feeling "unsafe" having a 14:1 patient ratio (p.141). Another nurse described hearing the screams of a dying patient, knowing that his screams would not be attended to because the "nursing staff will not have time tonight" to comfort him (p. 141). The moral residue from this situation left the nurse able to vividly recall the pain of that night years after the event. Furthermore, nurses expressed feeling frustration, disgust, anger, and sadness, due to their inability to respond to the needs of their patients (Austin et al., 2003). Moral distress was higher among younger, less experienced nurses with higher caseloads (Hamaideh, 2014).

**Acquiescence to patient's rights violations**

Jordanian nurses reported the highest levels of moral distress related to unethical conduct by caregivers, with intensity scores of 3.86, 3.94, 3.90 and 3.68 out of a high score of six on the MDS-P. Specifically, responses to the questions regarding not taking action when a colleague makes a medication error and does not report it, discontinuation of treatment due to lack of payment, and ignoring suspected patient abuse by caregiver had the most elevated scores (Hamaideh, 2014). Avoiding taking action when it was discovered that a nurse colleague had made a medication error and did not report it had the highest individual score (Hamaideh, 2014). Similar research has found that moral distress increased when a patient's rights were violated. Minimizing, withholding information and using coercive tactics to gain patient medication compliance created concern in nurses as well (Deady & McCarthy, 2010; Wojtowicz et al., 2013). Nurses in Ireland experienced moral distress when inappropriate restrictions were made

based on the clients' lifestyle rather than client safety or mental health status (Deady & McCarthy, 2010).

**Hierarchies within healthcare systems**

Nurses conveyed emotional conflict related to feeling responsible for a patient's wellbeing, and feeling dismissed by other health care providers and supervisors when raising questions about medication interactions and patients decompensating (Austin et al., 2003; Deady & McCarthy, 2010; Lützén et al., 2010; Musto & Schreiber, 2012; Wojtowicz et al., 2014). In a study conducted by Deady & McCarthy (2010), nurses reported feeling that they had little power over clinical decision-making. They felt that clinical observations were given little consideration even though the nurse spent more time with the patient, which led to feelings of frustration. Participants in the Wojtowicz et al.'s (2014), study felt frustrated because doctors, at the top of the hierarchy, were "seemingly infallible and unchallengeable" (p.260). Participants in Musto and Schreiber's (2012), study reported feelings of distress when co-workers engaged with patients in ways that were contradictory to the agreed upon approach. One participant felt "set-up" (p.141) by the team for following the plan of care when other team members did not follow the same plan.

## Summary

The effects of moral distress have far reaching consequences. The organizational impact of moral distress can include employee burnout and increased turnover. The impact on the individual can include feelings of guilt, self-doubt, frustration, anger, depression, and inadequacy. These feelings can increase a nurse's sense of hopelessness causing detachment from work.

Though research exists regarding moral distress and its impact on nurses. The literature

review conducted for this study suggests that PMHNs experience moral distress in a unique and different way as compared to other nurses. A scant amount of research has studied moral distress within psychiatric nurses and only two international studies have been conducted using the MDS-P to quantify the experience of moral distress in psychiatric mental health nurses. Further research is needed to determine the incidence of moral distress and demonstrate the reliability of the MDS-P in psychiatric nurses in the United States. Having a greater appreciation of these experiences can provide essential information that can be used to develop interventions to address moral distress in PMHNs in the United States.

## Question

What is the experience of Moral Distress by psychiatric mental health nurses in the United States of America?

## Methods

A substantial portion of the current research pertaining to moral distress has examined the phenomenon within nursing, particularly in areas of acute care clinical practice. There is limited research examining the experience of moral distress in psychiatric mental health nurses throughout the world, and no research was identified on this topic in PMHNs in the United States. This study assessed the level of moral distress in PMHNs in the Commonwealth of Virginia by using the Moral Distress Scale for Psychiatric Nurses (MDS-P). The research examined the intensity of moral distress in PMHNs, as well as whether or not there is a relationship between the moral distress scores of PMHNs and demographic characteristics.

### Research Design

The study used a descriptive, cross-sectional electronic survey design to examine moral distress among PMHNs in the United States. Precisely, the study explored the phenomenon of

moral distress among PMHNs in a professional psychiatric nursing organization in the Commonwealth of Virginia. The study was designed to answer three questions:

1. What is the experience of moral distress in PMHNs?

2. Do relationships exist between MDS-P scores and demographic characteristics?

3. Is the MDS-P a reliable measurement to assess moral distress in psychiatric nurses?

To address the primary question, a previously validated measure was used to analyze the experience of moral distress in a sample of PMHNs. The scores were then compared to scores from previous studies to determine similarities and consistencies.

Additionally, the relationships between nurse characteristics and moral distress scores were investigated. Specifically, this study aimed to examine whether a statistical relationship exists between moral distress scores and demographic characteristics, including gender, level of education, and years of nursing experience. Finally, this study examined whether the MDS-P is an appropriate measure of moral distress in PMHNs in the United States of America.

**Setting**

The setting of the study was the Commonwealth of Virginia, and data collection took place in early 2016. Data were collected via electronic survey and accessed by e-mail invitations. E-mail invitations were sent to members (n=41) of the Virginia Association of Community Psychiatric Nurses (VACPN). This organization was founded with the intention of forming a network of psychiatric nurses to share ideas, expertise information, and experience. The purpose of this statewide organization is to provide mutual support, promote improvements in nursing practice, and to promote professional growth (VACPN, n.d.).

**Sample**

The members of the VACPN work as psychiatric mental health nurses in various mental

health settings across the Commonwealth of Virginia. The VACPN has an eclectic group of members who represent a variety of demographic characteristics such as gender, age, years of experiences, and ethnicity. The majority of members are Caucasian females, which is representative of the nursing work force (Department of Labor, n.d.). The inclusion criteria were as follows: member of the VACPN, licensed as a nurse, currently working or past experience working in a psychiatric mental health setting, and considers English as their primary language. The VACPN has approximately 41 members. While the traditional survey response rate is 25%, due to the small population size, a goal of having a response rate of 50% was considered adequate for this study.

There were a total of 31 respondents; however, three did not provide responses for more than 20% of the MDS-P section. These three respondents were removed from the analysis. All the other participants (n = 28) provided an answer to all the questions in the MDS-P section. There were twenty-seven women and one man in the study ranging in age from 26 to 67 years (M = 48.8 years, SD = 12.3 years). Eighty-two percent of subjects were Caucasian, and 17.9% were of African American. With regards to years licensed as a nurse, the respondents indicated between 4.5 to 48 years (M = 25.1, SD = 14.3), while the years of practicing in the mental health varied between 2 to 40 years (M = 20.1, SD = 13.1). Similarly, subjects reported between 1 to 30 years (M = 8.6, SD = 7.8) in their current position. The highest level of education achieved by most respondents (32.1%) was a Diploma, followed by an Associates' degree (21.4%), Baccalaureate degree (21.4%), Masters degree (21.4%) and Doctoral degree (3.6%). With regards to the highest level achieved in nursing education, most respondents had an RN (77.8%), followed by an APRN (14.8%), an LPN (3.7%), and a DNP (3.7%); one respondent did not indicate highest nursing education obtained. The employment status was designated as full time

most often (85.2%) or part time (14.8%); one respondent did not indicate their employment status. The majority of respondents acted in the role of RNs (84.6%), while the rest were either the role of LPN (3.8%), APRN (7.7%), or educator (3.8%), respectively; two respondents did not indicate their primary role. Finally, the subjects were employed in the following settings: psychiatric outpatient clinic (44.4%), community mental health center (48.1%), psychiatric assertive community treatment program (3.7%), or addiction outpatient program (3.7%); one respondent did not indicate their primary place of employment (see Table 2 for additional details on Sample Characteristics).

**Procedure**

The leadership of VACPN agreed to distribute an e-mail invitation to members for participation in the study (see Appendix A for e-mail correspondence from VACPN). The principal investigator emailed an invitation to participate in the study to a member of the VACPN leadership. The invitation to participate in the study included a link to access the study (see Appendix B for Invitation to Participate in Survey), and the VACPN leadership then forwarded the e-mail, with link attached, to the VACPN members. The initial invitation to participate in the study was distributed in January 2016. The survey remained open for 4 weeks, the survey was to remain open for four weeks or until the 50% response rate was reached. After two weeks the initial response rate was less than 50%; therefore, a second e-mail encouraging participation was sent to VACPN leadership to distribute to members (see Appendix C for e-mail invitation 2nd request). A final attempt was made by VACPN leadership the final week of the survey to reach the goal of a 50% response rate.

The link routed participants to a secure computer-based online survey program to access the survey, in which they provided demographic data and responses to the MDS-P. The first

page of the study provides information about the purpose of the study and informed consent (see Appendix D for additional information on Informed Consent). At the bottom of the first page, participants were asked whether they reviewed the information and agreed to participate in the study. If participants did not agree to participate, they were routed to the last page of the survey, thanked for their consideration, and no data was collected.

Participants that agreed to participate were routed to page 2 of the study and demographic information was collected (see Figure 1 for Participant Demographic Information). After demographic information was collected, participants were routed to page 3 which consist of questions on the MDS-P (for additional information see Figure 2). After completion of the MDS-P, participants were given information regarding how to provide contact information to be entered into a raffle for one of two $25 Visa gift cards as an incentive for participation. Finally, participants were routed to page 5, the last page of the questionnaire and thanked for their participation.

**Measures**

The study utilized the MDS-P, developed by Ohnishi and colleagues (2010) to collect information regarding the intensity of moral distress. The experience of moral distress in psychiatric mental health nurses was measured using the MDS-P. Descriptive and inferential statistics were computed to answer the research questions. The developer of the MDS-P granted permission to this investigator to use the instrument (for more information refer to Appendix E).

The MDS-P is composed of 15 questions that are grouped into three factors: unethical conduct by caregivers, low staffing, and acquiescence to patient' rights violations. Each item is evaluated using a 7-point Likert scale ranging from 0 to 6. Zero indicates not experiencing the clinical situation, whereas 1 indicates experiencing very little distress and 6 indicates

experiencing extreme stress. The measure was used previously in psychiatric mental health nurses in Japan and was determined to have an overall Cronbach's alpha coefficient of 0.90, while factor 1 had a score of 0.85, factor 2 had a score of 0.82, and factor 3 had a score of 0.79. These scores support the overall reliability of this measure (Ohnishi et al., 2010). Hamaideh (2014) used the measure to study moral distress in psychiatric mental health Jordanian nurses. The internal consistency and reliability in that study was found to have a Cronbach's alpha of 0.89, with subscales of 0.74, 0.78, and 0.80 (Hamaideh, 2014).

Cronbach's alpha tested the reliability of the 15-item MDS-P used in the current study as well as the three sub-factors. All four internal consistency reliability results were within acceptable limits, with alphas > 0.5: overall MDS-P ($\alpha = 0.916$), unethical conduct by caregivers ($\alpha = 0.754$), low staffing ($\alpha = 0.845$) and acquiescence to patient's right violations ($\alpha = 0.887$). The internal consistency of the MDS-P in previous studies was consistent with the results from this study.

Demographic and work-related characteristics were collected to evaluate whether a relationship exists between moral distress scores and individual characteristics of psychiatric nurse's. Data was collected on years of education, gender, and levels of education (refer to Table 2 for additional details). The data was used to determine whether statistically significant differences existed by comparing sub-groups.

**Data Analysis**

After data collection was complete, the raw score data from the questionnaire was entered into Statistical Package for the Social Sciences Version 23.0 (SPSS v23.0). Coded information from the measure and demographic information were entered into data files. The principal investigator was responsible for all data entry and screening and cleaning of all fields. Zero

percent error in the data entry was accepted for this study. When an item was left blank on the questionnaire, a decimal point was entered to indicate that data was missing. Two participants did not provide answers for demographic information related to employment, primary role and place of employment. Any subject submitting a questionnaire missing responses for seven or more items, or approximately 20% of the total responses on the MDS-P, were not included in the analysis to avoid bias or non-representative results from the substitution of the means for large amounts of missing data.

To confirm the integrity of the data frequency distributions were examined for all items to identify outliers and subjects not meeting the inclusion criteria. The analysis used descriptive statistics, inferential and reliability analyses to answer the research questions. In support of the primary aim of the study, descriptive statistics were computed on the data from the MDS-P. Measures of central tendency were used to identify mean moral distress scores for the overall measure and each of the sub-factors. The secondary aim of the study was to identify relationships between moral distress scores and demographic characteristics. Regression analysis assessed correlations among variables to answer the secondary aim of the study. The demographic variables of gender, level of education, years of experience, and intensity of moral distress were analyzed to determine whether correlations existed.

**Protection of Human Subjects**

The proposal was submitted to the University of Virginia Institutional Review Board (IRB) for the Social and Behavioral Sciences for review and approval (see Appendix F for IRB approval for study). Approval from the IRB was obtained prior to the start of the study. Participants in this study were healthy, licensed nurses between the ages of 18-80. There were approximately 41 members from the VACPN who were invited to participate in the study. This

sample was selected due to their expertise in the nursing specialty area of interest.

Data collection methods, including the questionnaire, included data obtained specifically for research purposes. All data was anonymous and the principal investigator was not aware of any subjects' identities. Participants had a low risk of becoming upset by the questions asked on the questionnaire and the overall potential risks related to participating in the study were minimal. Participants were recruited by e-mail invitation, which provided an electronic link to the online questionnaire. Prior to completing the questionnaire the participants acknowledged electronically that they had read and agreed with the Informed Consent disclosure.

Participants acknowledged an understanding of risk involved with participation and were able to refuse to answer any of the survey questions. The confidentiality of the information provided could not be guaranteed. In order to maintain privacy, participants were able to complete the survey anonymously through the electronic survey program.

## Results

### The Experience of Moral Distress in PMHNs

Nurses in this study experienced low to moderate levels of moral distress. Participants in the study endorsed each item on the MDS-P questionnaire (see Table 3 for additional information on participant responses). The mean score, standard deviations, skewness and kurtosis for each question were calculated from the sample data (n=28). For additional details refer to Table 4 for results.

Intensity scores ranged from 0= not experienced, or 1= very little distress to 6 = severe distress, with a high mean intensity score of 3.36 (SD = 2.45) for the question "work at a facility where nurses are treated like machines causing them to quit." The lowest mean score of 0.54 (SD = 1.20) was for the question "follow the doctor's order not to tell the patient the truth when

he/she asks for it." Overall, the standard deviation for the mean score of a question increased as the mean score increased, indicating a higher spread of answers on the Likert scale. The mean score for all responses was 1.50 (SD = 1.31), while the score for the three sub-factors were as follows: low staffing a mean score of 2.21 (SD = 1.77), acquiescence to patient's right violations a mean score of 1.33 (SD = 1.51), and unethical conduct by caregivers a mean score of 1.03 (SD = 1.17). The lowest overall score was 0, while the highest overall score was 4.33. In regards to the three sub-factors, for low staffing the lowest score was 0 and the highest score was 5.8, for acquiescence to patient's right violations the lowest score was 0 and the highest score was 4.75, while for unethical conduct by caregivers the lowest score was 0 and the highest score was 3.50**.**

When asked whether they had ever considered quitting a clinical position due to moral distress with the way patient care was handled, the majority never considered (60.7%), while some considered but did not quit (10.7%), and some considered and left the position (28.6%). The majority of respondents were not considering leaving the current position (82.1%), while some (17.9%) were considering this option.

**Relationships between MDS-P scores and demographic characteristics**

The chi square statistic was applied to all fifteen questions in terms of ethnicity (see Table 5 for additional details). The test yielded significant results for question 4, "Assist a doctor who performs a test or treatment without informed consent." $\chi^2(4, N = 28) = 10.47$, $p = 0.033$ in terms of ethnicity, with more African Americans experiencing a distress level of 5 or 6 (40%) versus White/Caucasian (0.00%). The other grouping variables of interest, such as education level, yielded too few counts per case per question. Thus the chi-square was not applied to the other possible groupings.

The normality of the mean MDS-P score, as well as the mean score for the three sub-

factors, was tested using the Shapiro-Wilk test. The null hypothesis that the MDS-P score was normally distributed was rejected ($p = 0.011$), as well as the mean score for unethical conduct ($p = 0.000$) and the mean score for patients' rights ($p = 0.000$) at a 95% confidence level. The null hypothesis that the mean low staffing score is normally distributed could not be rejected ($p = 0.078$) at a 95% confidence level.

As a result, to compare the mean MDS-P score, as well as the scores of the sub-factors across different groupings (see Table 6 for additional details), the Kruskal-Wallis non-parametric test was employed. There were no statistically significant differences between genders, ethnicities, highest education level, highest nursing education level or currently considering leaving the position across any of the mean scores ($p > 0.05$). There were, however, statistically significant differences in terms of considering leaving or left a position in the past ($p < 0.05$).

To further explore which groups were different, the Mann-Whitney U test was applied for two independent samples. There were no statistically significant differences between respondents who did not consider leaving and those who did consider leaving, but did not across all means. There were, however, statistically significant differences between those who did not consider leaving and those who left ($p < 0.05$) across all means. Those who never considered leaving had a total mean MDS-P score of 0.83, while those who did leave had a total mean MDS-P score of 3.03. In regards to the sub-factors, for unethical conduct those who did not consider leaving scored a mean of 0.43, while those who did leave scored 2.33. Similarly, the mean scores for the sub-factor low staffing was 1.32 and 4.33, and the mean scores for the sub-factor patient rights violations was 0.82 and 2.47, for participants who never considered leaving compared to those who left, respectively.

A two step regression analysis was conducted with the mean MDS-P score as the

dependent variable, gender and ethnicity as the control variables (entered in the first step) and highest level of education, highest nursing education, number of years practicing mental health, left or considered quitting a clinical position, and considering leaving the current position as dependent variables (entered in the second step). The first model, with gender and ethnicity as the only predictors, has an adjusted $R^2$ of -0.042, indicating a poor fit to the data (see Table 7 for additional results).

In the second model, the adjusted $R^2$ was 0.683; this indicated that approximately 68% of the variation observed in the mean MDS-P score could be attributed to the predictor variables included in the model. Thus, years practicing mental health, highest education level, highest nursing education level, left or considered quitting, and consider leaving current position should be included in the model. In the second model gender and "left or considered quitting" had an unstandardized beta coefficient that is statistically significant ($p = 0.02$, $p = 0.00$) at the 0.05 level. When this condition was relaxed to a statistically significant level of $p = 0.10$, then "consider leaving current position" became statistically significant as well ($p = 0.06$). With respect to the question had a PMHN left or considered quitting a clinical position due to moral distress, the mean MDS-P score increased by 1.21 (s.e. = 0.18) points for participant who answered Yes, I have considered leaving but did not compared to participants who responded No, I have never considered leaving. This was also true for participants who answered Yes, I have left compared to those who considered leaving but did not. Lastly, answering yes to the question of considering leaving the current position increases the mean MDS-P score by 0.90 (s.e. = 0.45).

**Reliability of the MDS-P in the PMHNs**

The MDS-P was developed and tested in a population (n=264) of Japanese nurses

(Ohnishi et al., 2010). The questionnaire originally consisted of 43 items and included scores for both frequency and intensity. Factor analysis was used to identify the most relevant questions. Analysis determined that 15 items and three factors explained 60.1% of the variance; therefore, these items were included in the MDS-P. Further analysis revealed that correlation coefficients between intensity and frequency were high ($r$=0.57 to 0.81) for the 15 items that were included in the MDS-P. Final analysis of the overall measure was based on intensity and not frequency.

To measure internal consistency Cronbach's alpha was calculated. The newly created MDS-P had a Cronbach's alpha coefficient of 0.90 while factor 1, unethical conduct by caregivers was 0.85, factor 2, low staffing was 0.82, and factor 3, acquiescence to patient's rights violations was 0.79. In 2014, Hamaideh used the 15-item MDS-P in a sample of Jordanian nurses (n=131). The internal consistency of the same measure was calculated to have a Cronbach's alpha of 0.89 for the overall MDS-P, with each sub-factor having a score of 0.74 for factor 1, 0.78 for factor 2, and 0.80 for factor 3. In this sample (n=28), the internal consistency was calculated revealing a score for the whole MDS-P and each of the 3 sub-factors to be 0.92, 0.75, 0.85, and 0.89 respectively.

## Discussion

The primary goal of the study was to determine whether PMHNs in the U.S. encountered moral distress; and if so, what was their experience. The study confirms that the sample of PMHNs in this study from the Commonwealth of Virginia in fact have experienced moral distress. Previous studies using the MDS-P focused on nurses working in inpatient or long-term care settings. In this sample, the majority of the respondents were employed in less restrictive outpatient settings. Since there is increased autonomy for patients in community settings, low levels of moral distress may be expected. The current results indicate that participants in this

sample experienced lower levels of moral distress compared to Japanese nurses in Ohnishi et al.'s study (2010), and Jordanian nurses in Hamaideh's (2014) research. Those in this sample also reported significantly lower scores than participants in Corley et al.'s (2005) study of American acute care nurses, using a different measure. Although direct comparisons cannot be made Corley's Moral Distress Scale (MDS) was used in the development of Ohnishi's MDS-P thus compared to Corley, the nurses in this sample reported a lower intensity of moral distress.

Within this sample external and organizational constraints that resulted in reduced staffing were the most negative to nurses. Most significantly, items related to nurses being treated like machines, unsafe staffing levels and having no time to talk with patients who do not cause trouble were endorsed as the most distressing. Further analysis of sub-factors revealed that results were congruent with Ohnishi et al.'s (2010) study, which reported that the "low staffing" sub-factor were the most distressing, whereas Hamaideh (2014) reported higher mean scores from "low staffing" than in this sample but the most elevated scores were endorsed on items related to unethical conduct by caregivers. Overall, low staffing was a trigger for moral distress in several studies (Austin et al., 2003; Corley et al., 2001; Hamaideh, 2014; Nalley, 2013; Ohnishi et al., 2010; Schluter et al., 2008). Further research is needed to determine whether the results from this study are characteristic of psychiatric nurses nationally.

The reason for the relatively low mean MDS-P scores is not known. The available Moral Distress Scale for Psychiatric nurses may be best suited to evaluate moral distress in inpatient settings and may not address the subtle nuances of outpatient practice. Results may reflect characteristics of the mental health care system in Virginia. Due to their involvement in a professional psychiatric nursing organization, participants may be well equipped to resolve moral distress because they have developed a support network (Epstein and Delgado, 2010; Musto &

Schreiber, 2012). On the other hand, the low level of responses may be rooted in feelings of hopelessness and powerlessness to change the system that are similar to feelings expressed by nurses in other studies (Austin et al., 2003; Austin et al., 2007; Deady & McCarthy, 2010; Lützén et al., 2010; Musto & Schreiber 2012; Wojtowicz et al., 2014).

There was no significant difference found between demographic variables such as gender, ethnicity, level of education, level of nursing education or individuals considering leaving the position. However, nurses who had left a position in the past due to moral distress had significantly higher MDS-P mean scores compared to those who never considered leaving a position. While the MDS-P, does not capture intent to leave this information was collected within the demographic data in this study to compare results with previous studies using the Moral Distress Scale-Revised (MDS-R). The results from this sample support other research findings indicating a relationship between moral distress and the intent to leave (Hamric, Borchers & Epstein, 2012; Trautmann et al., 2015; Whitehead et al., 2015). While direct comparisons cannot be made, using the MDS-R, Hamric, Borchers & Epstein (2012), Trautmann, Epstein, Rovnyak, et al. (2015) and Whitehead, Herbertson, Hamric, et al. (2015), found elevated MDS-R scores in participants who had considered leaving clinical positions in the past or who were currently considering leaving. Specifically, Trautmann et al., and Whitehead et al., (2015), found that those who had left a position due to moral distress and those who had considered leaving but did not, had higher levels of moral distress compared to those who had not considered leaving a clinical position. Whereas, Hamric, Borchers & Epstein (2012), and Whitehead et al., (2015), found that MDS-R scores were significantly higher for those currently considering leaving clinical positions.

Results related to gender and moral distress have been inconsistent. Previous studies

examining moral distress using the MDS-R and gender (Trautmann et al., 2015; O'Connell, 2015) found that females reported higher MDS-R scores. In this sample, no significant difference was found between MDS-P scores and gender. This is consistent with results of Ohnishi et al. (2010). Regarding levels of education, Ohnishi et al., (2010) did not find a significant difference between MDS-P scores when comparing LPN's and RN's. In contrast, Hamaideh (2014) found a significance difference between levels of education and MDS-P scores.

Previous studies using the MDS-P did not account for ethnicity as a variable; however, an unexpected and interesting finding in this study suggests that a statistically significant difference exists between African American respondents who reported higher levels of moral distress when assisting a doctor with performing a test or treatment without informed consent as compared to Caucasian respondents. Given the historical significance of African American involvement in medical research, it seems reasonable that African Americans may be more sensitive to performing medical services with a lack of informed consent and thus more distressed by these situations. Limited research is available which specifically addresses this question, but further investigation would be warranted. Further research is also warranted to determine why the scores of Caucasian nurses did not indicate similar levels of distress.

Corley et al.'s (2001) MDS narrowly focused on issues pertaining to end-of life care. Hamric, Borchers and Epstein (2012) revised the MDS "to expand its use in non ICU settings and make it appropriate for multiple healthcare disciplines." While the MDS-R measures moral distress among several disciplines, it is heavily focused on situations related to futility, life saving measures and end-of life care. However, issues pertaining to end of life care and futility are not regularly seen in psychiatry but that does not mean that PMHNs and other clinicians

working in the specialty do not encounter clinical situations where they feel constrained from taking action that they consider to be ethically appropriate on a routine basis. Therefore having a reliable and valid measure that assesses moral distress among psychiatric professionals is essential.

Reliability measures for the MDS-P have demonstrated strong internal consistency. Ohnishi et al., (2010) reported an overall Cronbach's alpha of 0.90. In 2014, Hamaideh calculated a Cronbach's alpha of 0.89. In the current study the overall internal consistency was also measured by Cronbach's alpha and yielded a value of 0.91. The results indicate that the MDS-P is a reliable measure to assess moral distress in psychiatric nurses when used in industrialized populations. The internal consistencies of the three sub-factors are slightly less consistent than the overall measure; however, the internal consistency of the sub-factors reveals a fair to strong level of reliability for each factor.

Although the measure does appear to have strong internal consistency, adding components to measure frequency and intent to leave would strengthen the validity of the measure and reflect valuable modifications made in the MDS seen in the MDS-R. In the development of the MDS-P, differences in intensity and frequency were examined which added to the validity of the original study (Ohnishi et al., 2010). Ultimately, only intensity was included in the MDS-P. Incorporating intensity and frequency into the MDS-P would allow for more in-depth analysis of each factor. Additionally, the crescendo effect asserts that a relationship exist between the frequency that morally distressing events are encountered and the intensity of the nurses experience (Epstein and Hamric, 2009). Without both dimensions being included in the MDS-P it is difficult to analyze whether this is relationship is true for PMHNs.

Further, moral distress has been associated with nurse's intent to leave. Most

importantly, it has been hypothesized that high levels of moral distress and nurse's intent to leave are related (Epstein and Hamric, 2009; Hamric, Borchers and Epstein, 2012). Integrating questions related to considering leaving past clinical positions and currently considering leaving would provide consistency with other moral distress scales. Also, since the intent to leave in the past or currently has been reported in several studies, incorporating this element into the MDS-P would increase the validity of the measure.

## Strengths and Weaknesses

This study is the first published examination of the experience of moral distress in psychiatric nurses in the United States using the MDS-P. The MDS-P provides an opportunity for the experience of moral distress in psychiatric nurses to be defined using quantitative data. Doing so allows statistical relationships to be analyzed to illustrate the severity of this phenomenon. The study was practical and cost effective and individual participants were able to provide a large amount of anonymous data with limited constraints on their time. Finally, the results from this study contribute to the limited research that is currently available regarding moral distress in psychiatric nurses.

The small sample was limited to members of a statewide psychiatric nurses association. Participants primarily worked in outpatient settings whereas other studies focused on inpatient settings. Additionally, mental health laws, insurance regulations and access to care vary from state to state and these policies may influence the nurses' experience and responses thus limiting the generalizability of the findings of this study.

## Conclusion

This study adds to the current literature on moral distress, and more specifically, on the experience of moral distress by American psychiatric nurses primarily working in outpatient

settings. The results from this study confirm that this population does experience low to moderate levels of moral distress with the highest levels of distress related to low staffing. Low staffing can result in nurses feeling like they are treated like machines - working with unsafe staffing levels and not having time to speak with patients who do not cause trouble. The findings provided additional support for the association between elevated moral distress scores and nurses leaving clinical positions.

Overwhelming evidence indicates a relationship between moral distress and employee disengagement, burnout and turnover. Employee turnover can negatively impact health care organizations expenses. Interventions and programs aimed at decreasing the experience of moral distress can provide a cost savings for organizations. More importantly, nurses will not suffer the negative emotional and physical consequences associated with moral distress. Organizational priorities should focus on creating staffing levels that allow psychiatric nurses to feel safe and able to provide ethically appropriate care to all patients. Other programs aimed at increasing awareness about moral distress and providing resources to assist in resolving ethical issues may prevent moral distress in nurses.

## Implications for Nursing Practice

Moral distress can lead to both physical and psychological impairments in nurses. Psychological impairments include depression, anxiety and frustration. These negative feelings can lead to burnout, disengagement and a desire to leave the position. In addition to the physical and emotional toll that moral distress can take on a nurse, it may impair a nurse's ability to engage with psychiatric patients. This preliminary study validated that moral distress was experienced by a sample of psychiatric nurses in the Commonwealth of Virginia. This study confirmed that PMHNs working primarily in outpatient settings do experience low levels of

moral distress. Due to the limited availability of research, continued exploration to determine the levels of distressed experience, causes and outcomes of moral distress in this population of nurses is warranted. Additionally, results from the MDS-P demonstrated that the scale serves as a reliable measure to capture the experience of moral distress in American psychiatric nurses. Lastly, the results from this study can inform individuals and organizations about moral distress in PMHNs, which can be used to develop programs to combat the physical and emotional toll that can be caused by events that trigger moral distress.

## Products of the DNP Project

Multiple products have been prepared to disseminate the knowledge gained from the study. An electronic manuscript of the study and conclusions will be stored in Libra at the University of Virginia Health library. Additionally, a revised manuscript that complies with the specifications of the journal will be submitted to *Issues in Mental Health Nursing* with the goal of publication. See Appendix G, H, I, for additional information on publication criteria, a copy of the publication manuscript and the associated tables. The findings of the study will be shared with the Virginia Association of Community Psychiatric Nurses association and presented at the Spring, 2017 Conference.

References

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.

Austin, W., Kagen, L., Rankel, M., Bergum, V. (2008). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy, 11(1),* 89-97.

Austin, W., Lenermeyer, G., Goldberg, L., Bergam, V., and Johnson, M.S. (2005). Moral Distress in Healthcare practice: The situation of nurses. *HEC Forum, 17(1*), 33-48.

Corley, M. C. (2002). Nurse moral distress: a proposed theory and research agenda. *Nursing Ethics,* 9 (6), 636-650.

Corley, M.C., Elswick, R.K., Gorman, M., Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33,* 250-256.

Corley, M.C., Minick, P., Elswick, R.K., Jacobs, M. (2005). Nurses moral distress and ethical work Environment. *Nursing Ethics, 12(4),* 381-390.

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.

Epstein, E., Delgado, S., (2010). Understanding and addressing Moral Distress. *The Online Journal of Issues in Nursing,* 15(3), manuscript 1.

Epstein, E., Hamric, A. (2009). Moral distress, moral residue and the crescendo effect. *Journal of Clinical Ethics, 20(4),* 330-342.

Gutierrez, K.M., (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing, 24(5)*, 229-241.

Hamaideh, S. (2014). Moral distress and its correlates among mental health nurses in Jordan. *International Journal of Mental Health Nursing, 23,* 33-41.

Hamric, A.B., and 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.

Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research*, *3*(2), 1-9.

Hopelessness. 2015. Merriam-Webster's online dictionary. Retrieved October 31, 2015, from http://www.merriam-webster.com/dictionary/hopeless.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Lawrence, L. (2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing Forum,* 46(4), 256-268.

Lieberman, J. (2015). *Shrinks: The untold story of Psychiatry*. New York, NY: Little Brown and Company.

Ludwig, R., Silva, M.C. (2003). Errors, the nursing shortage and ethics: survey results. Online *Journal of Issues in Nursing, 8(3*), 5.

Lützén, K., Blom, T., Ewalds-Kvist, B., Winch, S. (2010). Moral Stress, moral climate, and moral sensitivity among psychiatric professionals. *Nursing Ethics, 17(2),* 213-224.

Meltzer, L.S., and Huckabay, L.M. (2004). Critical care nurses perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13(3),* 202-208.

Musto, L., Schreiber, R.S. (2012). Doing the best I can do: Moral distress in adolescent mental health nursing. *Issues in Mental Health Nursing, 33,* 137-144.

Nalley, C. (2013). Moral Distress Takes Toll on Nurses. Retrieved February 19, 2015, from http://nursing.advanceweb.com/Features/Articles/Moral-Distress-Takes-Toll-on-Nurses.aspx.

O'Connell, C. (2015). Gender and the experience of moral distress in critical care nurses. *Nursing Ethics, 22(1)*, 33-42.

Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., Nakahara, J., Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nursing Ethics, 17(6),* 726-740.

Polacek, M., Allen, D., Damin-Moss, R. S., Schwartz, A., Sharp, D., Shattell, M., Souther, J., and Delaney, K. (2015). White Paper: Engagement as an element of safe inpatient psychiatric environments. *Journal of the American Psychiatric Nurses Association*, 21(3), 181-190.

Schluter, J., Winch, S., Holzhauser, K., Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nursing Ethics, 15(3),* 305-320. Doi: 10.1177/0969733007088357.

Sjöstrand, M., Juth, N. (2014). Authenticity and psychiatric disorders: does autonomy of personal preference matter? *Medicine, Health Care and Philosophy, 17(1),* 115-122.

Trautmann, J., Epstein, E., Rovnyak, V., Snyder, A. (2015). Relationships among moral distress, level of practice independence, and intent to leave nurse practitioners in emergency departments: Results from a national survey. *Advanced Emergency Nursing Journal, 37(2),* 134-145.

Virginia Association of Community Psychiatric Nurses. About Us. Retrieved from http://www.vacpn.net/About-Us.html.

Whitehead, P., Herbertson, R., Hamric, A., Epstein, E., Fisher, J. (2015). Moral Distress among health professionals: report of an institution-wide survey. *Journal of Nursing Scholarship, 47(2)*, 117-125.

Wilkinson, J. M. (1988). Moral Distress in Nursing Practice: experience and effect. *Nursing Forum, 23(1)*, 16-29.

Wojtowicz, B., Hagen, B., Van Daalen-Smith, C. (2014). No place to turn: Nursing students' experiences of moral distress in mental health settings. *International Journal of Mental Health Nursing, 23,* 257-264.

Wojtowicz, B., & Hagen, B. (2014). A guest in the house: nursing instructors' experience of moral distress felt by students during inpatient psychiatric clinical rotations. *International Journal of Nursing Education Scholarship, 11(1),* 121-128.

United States Department of Labor. Quick facts on Registered Nurses. Accessed on November 13,2015 at http://www.dol.gov/wb/factsheets/Qf-nursing.htm.

Table 1.

*Summary of Literature Search Results*

| Author | Sample | Method | Findings |
|---|---|---|---|
| Austin et al., 2003 | 9 nurse one to one interviews in Canada. | Qualitative Hermeneutic phenomenological study. Participant were asked to discuss their experience of morally distressing situations with researchers | Described moral distress experienced by nurses working in mental health settings. Strength- added to the limited research that exists which describes moral distress in mental health nursing. Weakness- Small sample size. |
| Austin et al., 2007 | 6 Psychiatrist through one to one interviews in Canada. | Hermeneutic phenomenological. Participant were asked to discuss their experience of morally distressing situations with researchers | Described moral distress experienced by Psychiatrist working in mental health settings. Strength- added to the limited research that exists which describes moral distress in mental health workers. Weakness- Small sample size. |
| Deady & McCarthy, 2010 | 9 Registered Psychiatric Nurses in Ireland. | Qualitative descriptive. Data was collected through semi-structured interviews with researchers. | Described moral distress in Irish psychiatric nurses. Strength- added to the limited research that exists which describes moral distress in mental health nursing. Weakness- Small sample size. |
| Hamaideh, 2014 | 130 Psychiatric Registered Nurses in Jordan. | Descriptive correlation cross sectional design. MSD-P, Maslach burnout inventory and Job satisfaction scale were used. | Identified levels of moral distress, and relationships to related factors and predictors of moral distress. Strength- Large sample size, Quantitative research design. Weakness- MDS-P was developed for Japanese psychiatric nurses it may or may not be generalizable to psychiatric nursing population. |
| Lützén et al., 2010 | 49 Mental health workers employed by a clinic in Sweden. | Linear regression and ANOVA analysis. | Investigated relationships between moral stress, moral climate and moral sensitivity in mental health workers. Strengths- Quantitative research design. Supported existing body of research. Weakness- Moderate response rate. |
| Musto & Schreiber, | 12 Psychiatric Registered | Grounded theory was used. Data was | Explored coping strategies utilized by mental health workers when faces with |

| Author | Sample | Method | Findings |
|---|---|---|---|
| 2012 | Nursed working in adolescent mental health in Canada. | collected through 60-120 minute semi-structured interviews. | moral distress. Strengths-Data supported existing body of research. Weaknesses- small sample size, narrow focus on mental health, nursing, adolescents. |
| Ohnishi et al., 2010 | 391 Japanese Psychiatric Nurses | Cross-sectional and quantitative research. Data obtained through questionnaires. | Developed and evaluated MDS-P, examined the intensity of moral distress in Japanese Psychiatric nurses, explored the association between moral distress and burn-out. Strengths-Moral Distress scale specific to psychiatry was evaluated. Weaknesses- MDS-P designed for Japanese nurses may not be generalizable to all nurses. Convenience sampling was used. |
| Wojtowicz & Hagen, 2014 | Eight nursing instructors in Canada. | Naturalistic qualitative design. Two - 2 hour group interview | Examined the instructor's reaction and perception of moral distress in nursing students Strengths- Added the experience of moral distress in psychiatric nursing instructors. Weaknesses-Small sample size. |
| Wojtowicz et al., 2014 | Seven Canadian BSN Nursing students | Naturalistic qualitative design. Two - 2 hour group interview | Evaluated the experience of moral distress during psychiatric rotation in nursing students. Strengths- Added the experience of moral distress in psychiatric nursing students. Weaknesses- Small sample size. |

Table 2.

*Sample Demographic Information*

| | | | |
|---|---|---|---|
| Gender | | | |
| Female | 27 | | |
| Male | 1 | | |
| Ethnicity | | | |
| Caucasian | 82.1% | | |
| African American | 17.9% | | |
| | Range | Mean | Std.Dev |
| Age | 26-67 | 48.8 | 12.3 |
| Years Licensed | 4.5-48 | 25.1 | 14.3 |
| Years in Mental Health | 2-40 | 20.1 | 13.1 |
| Level of Education | | | |
| Diploma | 32.1% | | |
| Associates | 21.4% | | |
| Baccalaureate | 21.4% | | |
| Masters | 21.4% | | |
| Doctoral | 3.6% | | |
| Nursing Education | | | |
| LPN | 3.7% | | |
| RN | 77.8% | | |
| APRN | 14.8% | | |
| DNP | 3.7% | | |
| Employment Setting | | | |
| Outpatient Clinic | 44.4% | | |
| Community MH Center | 48.1% | | |
| ACT Program | 3.7% | | |
| Addiction Outpatient | 3.7% | | |

Table 3.

*Participants MDS-P Responses*

| Question | Intensity | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit. | 14 | 3 | 3 | 6 | 1 | 0 | 1 |
| Follow instructions of the doctors, who prioritizes the wishes of the family over the patient. | 11 | 4 | 3 | 4 | 3 | 1 | 2 |
| Carry out a doctor's order for unnecessary tests and treatment. | 14 | 3 | 1 | 4 | 3 | 3 | 0 |
| Assist a doctor who performs a test or treatment without informed consent. | 21 | 4 | 1 | 0 | 0 | 1 | 1 |
| Ignore situations of suspected patient abuse by caregivers. | 20 | 3 | 2 | 0 | 0 | 1 | 2 |
| Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it. | 16 | 6 | 2 | 1 | 1 | 0 | 2 |
| Work with levels of nurse staffing that I consider "unsafe." | 8 | 3 | 2 | 2 | 2 | 5 | 6 |
| Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay. | 15 | 3 | 2 | 1 | 3 | 1 | 3 |
| Observe without taking action when health care personnel ridicule a patient. | 16 | 3 | 2 | 1 | 3 | 1 | 3 |
| Follow the doctor's order not to tell the patient the truth when he/she asks for it. | 22 | 2 | 1 | 1 | 2 | 0 | 0 |
| Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization. | 20 | 2 | 1 | 2 | 0 | 1 | 2 |
| Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing. | 17 | 1 | 2 | 2 | 2 | 1 | 3 |
| Secretly mix medication into a patient's food or drink when he/she refuses it. | 19 | 4 | 1 | 3 | 1 | 0 | 0 |
| Have no time to talk with patients who do not cause trouble. | 9 | 3 | 4 | 5 | 1 | 1 | 5 |
| Work at a facility where nurses are treated like machines causing them to quit. | 6 | 2 | 4 | 2 | 2 | 2 | 10 |

Table 4.

*Descriptive Statistics for MDS-P questionnaire (n = 28)*

| | | | Skewness | | Kurtosis | |
|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Statistics | Std. Error | Statistics | Std. Error |
| Work at a facility where nurses are treated like machines causing them to quit. | 3.36 | 2.45 | -0.19 | 0.44 | -1.65 | 0.86 |
| Work with levels of nurse staffing that I consider "unsafe." | 2.93 | 2.45 | -0.01 | 0.44 | -1.74 | 0.86 |
| Have no time to talk with patients who do not cause trouble. | 2.32 | 2.23 | 0.56 | 0.44 | -1.03 | 0.86 |
| Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient. | 1.82 | 1.96 | 0.77 | 0.44 | -0.53 | 0.86 |
| Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay. | 1.61 | 2.18 | 1.05 | 0.44 | -0.41 | 0.86 |
| Carry out a doctor's order for unnecessary tests and treatment. | 1.57 | 1.89 | 0.71 | 0.44 | -1.13 | 0.86 |
| Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing. | 1.50 | 2.19 | 1.13 | 0.44 | -0.21 | 0.86 |
| Observe without taking action when health care personnel ridicule a patient. | 1.46 | 2.10 | 1.14 | 0.44 | -0.20 | 0.86 |
| Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit. | 1.32 | 1.63 | 1.08 | 0.44 | 0.67 | 0.86 |
| Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it. | 1.04 | 1.73 | 2.01 | 0.44 | 3.46 | 0.86 |
| Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization | 0.96 | 1.88 | 1.94 | 0.44 | 2.64 | 0.86 |
| Ignore situations of suspected patient abuse by caregivers. | 0.86 | 1.80 | 2.28 | 0.44 | 4.17 | 0.86 |
| Secretly mix medication into a patient's food or drink when he/she refuses it. | 0.68 | 1.19 | 1.68 | 0.44 | 1.65 | 0.86 |
| Assist a doctor who performs a test or treatment without informed consent. | 0.61 | 1.47 | 2.99 | 0.44 | 8.63 | 0.86 |
| Follow the doctor's order not to tell the patient the truth when he/she asks for it. | 0.54 | 1.20 | 2.26 | 0.44 | 4.00 | 0.86 |

(Likert scale: 0 = no experience to 6 = extreme stress)

Table 5.

*Chi- Square Results*

| Assist a doctor who performs a test or treatment without informed consent | | | | | | |
|---|---|---|---|---|---|---|
| | MDS-P Score | | | | | |
| | 0 | 1 | 2 | 5 | 6 | Total |
| Caucasian | 18 | 4 | 1 | 0 | 0 | 23 |
| African American | 3 | 0 | 0 | 1 | 1 | 5 |
| | 21 | 4 | 1 | 1 | 1 | 28 |

Chi-Square Statistic $x^2$=10.47, p=0.033

Table 6.

*Mean scores for the total MDS-P and the three sub-factors across various groupings*

| | | | Mean | | |
|---|---|---|---|---|---|
| Gender | N | Total | Unethical Conduct | Low Staff | Patient rights |
| Male | 1 | 1.33 | 0.67 | 3.20 | 0.00 |
| Female | 27 | 1.51 | 1.04 | 2.18 | 1.38 |
| Race | | | | | |
| White/Caucasian | 23 | 1.42 | 0.97 | 2.16 | 1.15 |
| African American | 5 | 1.91 | 1.63 | 2.09 | 2.27 |
| Highest education level | | | | | |
| Diploma program | 9 | 1.32 | 0.91 | 1.76 | 1.39 |
| Associates Degree | 6 | 0.93 | 0.75 | 1.40 | 0.63 |
| Baccalaureate degree | 6 | 1.51 | 0.92 | 2.43 | 1.25 |
| Master degree | 6 | 2.17 | 1.53 | 3.17 | 1.88 |
| Doctoral degree | 1 | 2.60 | 1.50 | 4.20 | 2.25 |
| Highest nursing degree | | | | | |
| LPN | 1 | 3.07 | 2.50 | 3.40 | 3.50 |
| RN | 21 | 1.24 | 0.79 | 1.96 | 1.02 |
| APRN | 4 | 2.33 | 2.04 | 2.90 | 2.06 |
| DNP | 1 | 2.60 | 1.50 | 4.20 | 2.25 |
| Left or considered quitting | | | | | |
| No | 17 | 0.83 | 0.43 | 1.32 | 0.82 |
| Yes, but didn't leave | 3 | 1.24 | 0.94 | 1.67 | 1.17 |
| Yes, left | 8 | 3.03 | 2.33 | 4.33 | 2.47 |
| No compared to Yes | | p=0.00 | p=0.00 | p=0.00 | p=0.01 |
| Consider leaving current position | | | | | |
| No | 23 | 1.52 | 1.08 | 2.25 | 1.27 |
| Yes | 5 | 1.43 | 0.80 | 2.04 | 1.60 |

Table 7.

*Regression models for MDS-P mean score*

| Model | | Unstandardized Coefficients | | | |
|---|---|---|---|---|---|
| | | B | Std. Error | t | Sig. |
| Model 1 | | | | | |
| | (Constant) | 0.62 | 1.54 | 0.40 | 0.69 |
| | Gender | 0.09 | 1.39 | 0.06 | 0.95 |
| | Ethnicity | 0.71 | 0.74 | 0.97 | 0.34 |
| Model 2 | | | | | |
| | (Constant) | -4.76 | 1.31 | -3.63 | 0.00 |
| | Gender | 2.31 | 0.93 | 2.48 | 0.02 |
| | Ethnicity | 0.52 | 0.44 | 1.18 | 0.25 |
| | Years practicing mental health | -0.01 | 0.01 | -1.11 | 0.28 |
| | Highest education level | 0.18 | 0.16 | 1.13 | 0.27 |
| | Highest nursing education level | 0.49 | 0.31 | 1.60 | 0.13 |
| | Left or considered quitting | 1.21 | 0.18 | 6.87 | 0.00 |
| | Consider leaving current position | 0.90 | 0.45 | 2.01 | 0.06 |

Figure 1.

***Participant Demographic Information***

1. What is your gender? Male or Female
2. What is your age?
3. What is your race/ethnicity? White/Caucasian African American Hispanic/Latino Native American Asian or Pacific Islander Arabic Biracial
4. How many years have you been licensed as a Nurse?
5. How many years have you been practicing in mental health?
6. Years in your current position?
7. What is the highest educational level? Diploma program Associates Degree Baccalaureate degree Master degree Doctoral Degree
8. What is you highest nursing education? LPN RN APRN MSN DNP PhD
9. What is your employment status? Fulltime Part-time PRN
10. What is your major role in your place of employment? LPN RN APRN Educator
11. What is your major place of employment? (choose the best fit) Inpatient psychiatry Psychiatric outpatient clinic State inpatient mental health facility Community Mental Health Center Psychiatric Assertive Community Treatment Program
    Addiction outpatient treatment program Addiction inpatient treatment program
12. Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled? No, I've never considered Yes, I considered but didn't Yes, I've left
13. Are you considering leaving your current position? Yes No

Figure 2.
**Moral Distress Scale for Psychiatric Nurses (MDS-P)**

Moral Distress is defined as a painful feeling and/or psychological disequilibrium caused by a situation where:
1) You believe you know the ethically appropriate action to take, and
2) You believe you cannot carry out that action because of institutionalized obstacles, such as lack of time, supervisory disinterest, medical power, institution policy or legal limits.

| **The following situations occur in clinical practice. Have you ever experienced these situations? In case of no, please select '0.'** | **If you have experienced any, how intensely are you distressed by the situation?** **Distress level: 1=Very little 6=Very much** |
|---|---|

| **Please check the appropriate column "0" to "6" according to the extent of your distress.** | **I have not experienced 0** | **1** | **2** | **3** | **4** | **5** | **6** |
|---|---|---|---|---|---|---|---|
| Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit. | | | | | | | |
| Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient. | | | | | | | |
| Carry out a doctor's order for unnecessary tests and treatment. | | | | | | | |
| Assist a doctor who performs a test or treatment without informed consent. | | | | | | | |
| Ignore situations of suspected patient abuse by caregivers. | | | | | | | |
| Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it. | | | | | | | |
| Work with levels of nurse staffing that I consider "unsafe." | | | | | | | |
| Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay. | | | | | | | |
| Observe without taking action when health care personnel ridicule a patient. | | | | | | | |
| Follow the doctor's order not to tell the patient the truth when he/she asks for it. | | | | | | | |
| Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization. | | | | | | | |
| Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing. | | | | | | | |
| Secretly mix medication into a patient's food or drink when he/she refuses it. | | | | | | | |
| Have no time to talk with patients who do not cause trouble. | | | | | | | |
| Work at a facility where nurses are treated like machines causing them to quit. | | | | | | | |

## Appendix A

### Correspondence from Virginia Association of Community Psychiatric Nurses

**From:** Jennifer Phelps <Jennifer.Phelps@horizonbh.org>
**Date:** September 23, 2015 at 1:22:54 PM EDT
**To:** 'Michele Morgan' <michelemorganrn@gmail.com>, "Stacey (mom) Lambour" <shagy53309@me.com>
**Cc:** Crystal Hicks <Crystal.Hicks@horizonbh.org>
Subject: RE: Information request

Hi Stacey,

We could help with a survey, you can send it to me we could do one of two things for you, e-mail it to all our members, or if you do survey monkey I can e-mail that link to everyone and you can collect the results directly yourself.

Or we can post a survey on-line on our website and send that information to you.

Survey monkey may be easier for you to collect the data and it is free.

Jen Phelps LPN III, QMHP-A
PACT Nurse, Program for Assertive Community Treatment
PHONE: 434-455-2065
FAX: 434-455-2719
jennifer.phelps@HorizonBH.org
HorizonBH.org | 620 Court St, Lynchburg, VA 24504
**See More** from Michele Morgan
IMPORTANT NOTICE: This email / FAX communication and any attachments to it may contain privileged or other confidential information protected by HIPAA legislation (45CFR, Parts 160 and 164), and/or other state and federal laws, regulations, and limitations. If you are not the intended recipient, or believe that you have received this communication in error, please do not print, copy, retransmit, or otherwise use or distribute the information. Also, please indicate to the sender, Horizon Behavioral Health that you have received this communications in error, and delete the copy you received. You may contact the sender at:

Horizon Behavioral Health, 2241 Langhorne Road, Lynchburg, VA 24501 phone 434-847-8050 FAX 434-455-3079. You may contact the Horizon Behavioral Health Privacy Officer regarding any questions or concerns you may have about privacy and confidentiality of information you have received at 434-485-8881 or by email at privacy@HorizonBH.org. You may also contact the Horizon Behavioral Health Security Officer regarding any questions or concerns you may have about the electronic security of information you have received at 434-847-8050 or by email at security@HorizonBH.org.

## Appendix B

## Invitation to Participate in Survey

Dear Virginia Association of Community Psychiatric Nurses,

I'm completing my Doctorate of Nursing Practice (DNP) course work at the University of Virginia. As part of my final capstone project, I have chosen to examine the experience of moral distress in Psychiatric Mental Health Nurses in Virginia.

According to a recent Gallop poll, many people believe that nurses have a high to very high standard of honesty and ethics. This high ethical standard at times can cause an internal conflict when constraints within the work place do not allow the nurse to care for their patients in a way that the nurse believes is ethical. This can lead to moral distress, which can lead the nurse to experience emotional and physical pain. This phenomenon has been extensively studied in critical care nurses. Internationally, a limited amount of research exists on this phenomenon within the context of psychiatric nurses. ***This study will be the first study that will examine moral distress in psychiatric nurses in the United States. Given your expertise in psychiatric nursing in the Virginia, you are the ideal candidate to participate in this research.***

The results of this study will provide information that will be useful to Nursing Organizations, Healthcare Systems and Educational Systems in developing interventions to address moral distress. I also intend to share this information with VACPN at the Annual Conference.

The study consists of a survey that will be administered to participants online. ***Participation in this survey will require approximately 10 minutes of your time. At the end of the survey you will have an opportunity to participate in a raffle where two winners will be chosen to receive a $25 Visa gift card.*** Your information will be completely anonymous. If you wish to participate in this study please click the link below by SURVEY END DATE to be taken to the survey. All instructions will be provided on the website.

https://surveyapp.nursing.virginia.edu/TakeSurvey.aspx?PageNumber=1&SurveyID=l6K24l4&Preview=true#

If you wish to discuss the survey, please contact me by email at snl4zv@virginia.edu or by phone at 301-788-5608. Alternatively you my contact my Committee Chair, Dr. Edie Barbero at ed5z@virginia.edu.
Thank you for your time and consideration.

Sincerely

Stacey Lambour, MSN, DNPc, PMHNP-BC

## Appendix C

## 2nd Request for Participation

Dear Virginia Association of Community Psychiatric Nurses,

As mentioned in the Invitation to Participate in Survey email, I'm completing my Doctorate of Nursing Practice (DNP) course work at the University of Virginia and I am in need of your assistance in support of my final capstone project. As part of my final capstone project, I have chosen to examine the experience of moral distress in Psychiatric Mental Health Nurses in Virginia. ***In order to have a sample size sufficient to support my research, I sincerely request 10-minutes of your time to complete the attached survey.***

According to a recent Gallop poll, many people believe that nurses have a high to very high standard of honesty and ethics. This high ethical standard at times can cause an internal conflict when constraints within the work place do not allow the nurse to care for their patients in a way that the nurse believes is ethical. This can lead to moral distress, which can lead the nurse to experience emotional and physical pain. This phenomenon has been extensively studied in critical care nurses. Internationally, a limited amount of research exists on this phenomenon within the context of psychiatric nurses. ***This study will be the first study that will examine moral distress in psychiatric nurses in the United States. Given your expertise in psychiatric nursing in the Virginia, you are the ideal candidate to participate in this research.***

The results of this study will provide information that will be useful to Nursing Organizations, Healthcare Systems and Educational Systems in developing interventions to address moral distress. I also intend to share this information with VACPN at the Annual Conference.

The study consists of a survey that will be administered to participants online. ***Participation in this survey will require approximately 10 minutes of your time. At the end of the survey you will have an opportunity to participate in a raffle where two winners will be chosen to receive a $25 Visa gift card.*** Your information will be completely anonymous. If you wish to participate in this study please click the link below by SURVEY END DATE to be taken to the survey. All instructions will be provided on the website.

PLACE LINK HERE
If you wish to discuss the survey, please contact me by email at snl4zv@virginia.edu or by phone at 301-788-5608. Alternatively you may contact my Committee Chair, Dr. Edie Barbero at ed5z@virginia.edu.
Thank you for your time and consideration.

Sincerely
Stacey Lambour, MSN, DNPc, PMHNP-BC

## Appendix D

## Participant Informed Consent

Informed Consent Agreement

**Please read this consent agreement carefully before you decide to participate in the study.**

**Purpose of the research study:** The purpose of this study is to examine the experience of moral distress in psychiatric mental health nurses in Virginia using the Moral Distress Scale for Psychiatric Nurses (MDS-P). The project is worth doing because little research exists on the subject of moral distress in mental health nurses. This measure has been used to measure moral distress in nurses in Japan and Jordan but the research does not exist using this measure to evaluate moral distress in nurse in the United States. The goal is to explore the intensity of moral distress in mental health nurses in Virginia.

**What you will do in the study:** You will complete a computer-based survey incorporating demographic information and the MDS-P information.

**Time required:** The study will require about 10 minutes of your time.

**Risks:** There are no anticipated risks in this study.

There is little potential risk to you to participate in the study. The potential risk may be an increased awareness of the experience of moral distress.

**Benefits:** There are no direct benefits to you for participating in this research study. The information gained from this study may help inform nursing practice and provide information on the experience of moral distress in psychiatric nurses in the Commonwealth of Virginia.

**Confidentiality:** Because of the nature of the data, it may be possible to deduce your identity; however, there will be no attempt to do so and your data will be reported in a way that will not identify you.

**Voluntary participation:** Your participation in the study is completely voluntary.

**Right to withdraw from the study:** You have the right to withdraw from the study at any time without penalty.

**How to withdraw from the study:** If you want to withdraw from the study, do not complete the survey. There is no penalty for withdrawing.

**Payment:** You will receive no payment for participating in the study. At the end of the survey you will have an opportunity to participate in a raffle where two winners will be chosen to receive a $25 Visa gift card. Odds of winning depend on the number of participants, however your odds will be no worse than 1 out of 20.

**If you have questions about the study, contact:**
Stacey Lambour
University of Virginia,
School of Nursing
225 Jeanette Lancaster Way
Telephone: (301)-788-5608
Email address: snl4zv@virginia.edu

Faculty Advisor
Edie Barbero
University of Virginia,
School of Nursing
225 Jeanette Lancaster Way
Charlottesville, VA 22903.
Telephone: (434) 924-2704
Email address: ed5z@virginia.edu

**If you have questions about your rights in the study, contact:**
Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences
One Morton Dr Suite 500
University of Virginia, P.O. Box 800392
Charlottesville, VA 22908-0392
Telephone: (434) 924-5999
Email: irbsbshelp@virginia.edu
Website: www.virginia.edu/vpr/irb/sbs

**Agreement:**
By clicking 'Yes" on this page, you have provided consent for the study.
You may print a copy if you would like it for your records.

## Appendix E

### Permission for use of the MDS-P

On Sep 23, 2015, at 9:11 PM, kohnishi@sonoda-u.ac.jp wrote:

Dear Ms. Stacey Lambour,

Thank you for your interest in my study.

I think the mental health system in the US is extremely different from Japan, where people can easily access to psychiatric care, but the period of staying in hospitals is too long. Comparing the results would be interesting.

The whole scale is in the attached file. You can use it.
As shown in the article, we measured moral distress with 7-point Likert both in intensity and frequency. But now we measure it with 7-Likert in intensity, and ask having experienced, because the scores of frequency were strongly correlated with intensity, and asking in both aspects seemed to be redundant.

I hope your success in your research!

Best regards

---
Kayoko OHNISHI, RN, MPH, PhD
professor of mental health nursing
Department of Human Nursing
Sonoda Women's University

TEL: +81-6-6429-9358
---

## Appendix F

## Approval of Study by Institutional Review Board for the Social and Behavioral Sciences

UNIVERSITY of VIRGINIA
OFFICE OF THE VICE PRESIDENT FOR RESEARCH
INSTITUTIONAL REVIEW BOARD FOR THE SOCIAL AND BEHAVIORAL SCIENCES

In reply, please refer to: Project # 2015-0510-00

January 13, 2016

Stacey Lambour and Edie Barbero
Academic Divisions
6870 Hurd Lane
Haymarket, VA 20169

Dear Stacey Lambour and Edie Barbero:

Thank you for submitting your project entitled: "The Experience of Moral Distress in Psychiatric Mental Health Nurses" for review by the Institutional Review Board for the Social & Behavioral Sciences. The Board reviewed your Protocol on January 8, 2016.

The first action that the Board takes with a new project is to decide whether the project is exempt from a more detailed review by the Board because the project may fall into one of the categories of research described as "exempt" in the Code of Federal Regulations. Since the Board, and not individual researchers, is authorized to classify a project as exempt, we requested that you submit the materials describing your project so that we could make this initial decision.

As a result of this request, we have reviewed your project and classified it as exempt from further review by the Board for a period of four years under 45 CFR Â§46.101 (b)(2), research involving the use of anonymous survey procedures. This means that you may conduct the study as planned and you are not required to submit requests for continuation until the end of the fourth year.

This project # 2015-0510-00 has been exempted for the period January 8, 2016 to January 7, 2020. If the study continues beyond the approval period, you will need to submit a continuation request to the Board. If you make changes in the study, you will need to notify the Board of the changes.

Sincerely,

Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences

One Morton Drive, Suite 500 • Charlottesville, VA 22903
P.O. Box 800392 • Charlottesville, VA 22908-0392
Phone: 434-924-5999 • Fax: 434-924-1992
www.virginia.edu/vpr/irb/sbs.html

# Appendix G

## Criteria for Publication in *Issues of Mental Health Nursing*

Instructions for Authors

*Issues in Mental Health Nursing* conforms to the guidelines of the Publication Manual of the American Psychological Association (2010) regarding plagiarism and self-plagiarism. To wit,"Just as researchers do not present the work of others as their own (plagiarism), they do not present their own previously published work as new scholarship (self-plagiarism) (American Psychological Association, 2010, p. 16). The potential for self-plagiarism is greatest when several aspects of a study are reported in different articles. To avoid this ethical violation, make sure that each article makes a unique contribution to the science. Clearly delineate where other articles about the study have been reported. Extensive duplication of one's own words (for example, in a methods section) requires a citation of the previously published work.

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April 24, 2016

Editor-in-Chief
Issues in Mental Health Nursing

Dear Editor,

Enclosed is a manuscript to be considered for publication in Issues In Mental Health Nursing. The research reported in this manuscript was prepared in part for completion of my Doctoral Degree in Nursing at the University of Virginia. As the lead author I developed the hypothesis, collected and analyzed data and wrote the paper. The co-authors wrote the paper and provide expertise in the subject area.

The study investigates moral distress in psychiatric nurse in the United States. To date, there is limited research on moral distress in psychiatric nurses and there was no research on psychiatric nurses in the United States. This was the first study to address this population. It adds to the current literature and provides evidence that support the theory that a relationship exists between moral distress and intent to leave.

This manuscript has not been published and is not under consideration for publication elsewhere. There are no conflicts of interest to disclose. Thank you for your consideration. My contact information is listed below. Please feel free to contact me with any questions or comments.

Sincerely,

Stacey Lambour, DNP, PMHNP-BC
Doctoral Student
University of Virginia

# The Experience of Moral Distress in Psychiatric Nurses in the United States: A Pilot Study

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## Abstract

Moral distress has been shown to have deleterious effects on nurses' well-being, however; little research has been conducted on moral distress in Psychiatric Mental Health Nurses (PMHNs). To describe the experience of moral distress in PMHNs this study utilized a descriptive cross-sectional survey design to collect demographic data and responses to the Moral Distress Scale for Psychiatric Nurses (MDS-P) in a sample of PMHNs (n=28) drawn from psychiatric nurse's in the Commonwealth of Virginia. A statistically significant difference ($p < 0.05$) was found between those who had not considered leaving and those who left. The results from this sample support other research findings indicating a relationship between moral distress and the intent to leave.


*Keywords: moral distress, psychiatric, nurses, Moral Distress Scale for Psychiatric Nurses (MDS-P)*

## Introduction

Decades of research have shown that nurses encounter moral distress, which can lead to negative outcomes including nurse burnout and disengagement (Schluter et al., 2008). Psychiatric nurses are one of the largest providers of care to individuals with mental illness in hospitals and in community-based clinics. Psychiatric nurses work in a highly stressful environment fraught with ethical challenges; therefore, it is reasonable to assume that nurses would experience moral distress in this environment. While a link has been established between moral distress, burnout, and disengagement in acute care nurses, relatively little is known about the phenomenon of moral distress in psychiatric nurses in the Unites States.

Moral distress is a response to knowing an ethical and appropriate action, but not being able to provide it due to constraints. Moral distress compounds with each interaction that conflicts with the nurses' values, leaving the nurses with lingering negative emotions (Epstein & Delgado, 2010). After an event has passed, it is common for the nurse to continue to recall and re-experience the feelings with the same or increased intensity during subsequent morally distressing events. The feelings and emotions that remain with the nurse are known as moral residue. Epstein and Hamric (2009) found that over time nurses' reactions intensify with each subsequent ethically compromising interaction. Experts believe that frequently being placed in morally distressing clinical situations contributes to nurse burn out and the intent to leave the position (Corley, 1995; Hamric, Borchers, and Epstein, 2012).

The intrapsychic trauma of moral distress manifests itself in both physical and psychological symptoms. These experiences can lead to feelings of guilt, self-doubt, frustration, anger, depression, and inadequacy (Schluter et al., 2008; Deady & McCarthy, 2010). Commonly experienced physical symptoms include headache, neck and shoulder tension, and stomachaches

(Gutierrez et al., 2005; Ludwick & Silva, 2003; Wilkinson, 1998). Documented psychological symptoms of moral distress include feelings of anger, frustration, anxiety, guilt, and depression (Austin et al., 2005; Gutierrez et al., 2005; Ludwick & Silva, 2003; Wilkinson, 1998). Gutierrez and colleagues (2005) found that moral distress impacted patient care, specifically, the interactions with family and patients decreased; nurses became more withdrawn; and less personalized care was provided to the patient in critical care units. In light of these findings, it is not surprising that increased levels of moral distress have been found to be associated with job dissatisfaction, lack of work engagement, burnout, and intent to leave the profession (Hamric and Blackhall, 2007; Meltzer and Huckabay, 2004).

Most of the research has focused on acute care nurses and specific clinical challenges related to that field of nursing. Validation measures to assess moral distress reflect situations common to critical care units, such as providing futile care. However, an ever increasing amount of evidence shows that nurses from a wide variety of settings are also experiencing moral distress. According to Epstein and Hamric (2009), providers cite the inability to deliver necessary treatment as morally distressing.

Psychiatric nurses face distinct ethical challenges depending on the population and setting in which they provide care. Specifically, issues concerning patient autonomy, freedom of choice, and consent to treatment are ethical issues that routinely occur in mental health care (Austin et al., 2008; Deady & McCarthy, 2010; Musto & Schreiber, 2012). Although it is known that mental health care nurses face unique ethical challenges, relatively little is known about the experience of moral distress in Psychiatric Mental Health Nurses (PMHNs). Limited research describes themes reported by mental health nurses and their accounts of moral distress. In 2010, Ohnishi and colleagues developed the first validated measure, specifically designed to evaluate

the intensity of moral distress experienced by psychiatric nurses. The measure was utilized to quantify moral distress in Japanese and Jordanian psychiatric nurses; however, to date, no qualitative studies or measurements have assessed moral distress in PMHNs in the United States (Ohnishi, et al., 2010; Hamaideh, 2014).

Unlike other specialties, PMHNs often establish long-term, close, and professional relationships with patients. The relationship between the PMHN and the patient transcends the medical model and requires intimacy and trust in order to determine the appropriate course of action and improve patient outcomes (Lieberman, 2015 p.12). Research shows that it is important for individuals with mental illness to feel a sense of personal connectedness to the provider and that developing a therapeutic nurse-patient relationship can build new neural connections in the brain, which support essential neurological functions such as emotional balance and response flexibility (Polacek et al., 2015). Suffering from moral distress has the potential to reduce the PMHNs' ability to develop a professional level of intimacy, trust, and attachment that is necessary to provide optimal care for the patient. If the PMHN is suffering from moral distress it may inhibit his or her ability to establish a therapeutic relationship. Moral distress impacts nurses emotionally and physically both within and outside of the workplace (Lützén et al., 2010). The continued experience of morally distressing events leads the PMHN to develop maladaptive coping mechanisms which allow him or her to work, albeit not fully engaged, with a limited ability to meaningfully participate in therapeutic PMHN-patient relationships (Deady & McCarthy, 2010; Lützén et al, 2010).

In time, the PMHN may even begin to question the treatment and care provided to the patient causing him or her to doubt his or her ability to care for the patient. Deady and McCarthy (2010) found that Irish psychiatric nurses coped by avoiding conflict, acquiescing to patient's

rights violations, and denying and minimizing ethical issues. If the PMHN is suffering from moral distress it may inhibit his or her ability to establish a therapeutic relationship. Knowing the consequences of moral distress and the ethical issues that PMHNs encounter, it is important to understand the phenomenon's impact on PMHNs. It is reasonable to assume that PMHNs in the United States may react and respond similarly, but more research is needed to affirm this assumption. The purpose of this study is to conduct a preliminary investigation to evaluate the experience of moral distress in the United States. The sample was drawn from a small group of PMHNs in the Commonwealth of Virginia.

## Theoretical Framework

Moral distress differs from an ethical dilemma in that one or more ethical choices can be made when presented with an ethical dilemma; whereas, moral distress is the result of knowing which ethically appropriate actions to take but being unable to take that action (Epstein and Delgado, 2010). Jameton (1984) first introduced the concept of moral distress when he postulated that an individual could be negatively affected when the individual "knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Later Jameton went on to differentiate between initial and reactive moral distress. Initial moral distress is the feeling of frustration, anger, and anxiety when faced with an obstacle. Reactive distress is the emotional anguish that remains after the event has passed (Jameton, 1993).

Corley (1995) added that two characteristics impact the severity of moral distress, which is the seriousness of the situation and the frequency at which it occurs (p.280). In 2001, Corley and colleagues also developed a measurement to assess moral distress in nurses working in acute care hospital settings (Corley, Elswick, Gorman and Clor). The following year she proposed a

theory of moral distress, suggested areas for further research and discussed the impact moral distress has on nurses and organizations (Corley, 2002).

Contributions from Epstein and Hamric (2009) clarified moral distress as being "the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (p.2) and coined the term "moral residue" to more accurately describe the experience of reactive distress. Moral residue is the lingering negative feelings that remain long after a morally distressing event. In addition to experiencing the moral conflict and the development of moral residue, both concepts appear to have a crescendo effect. That is, with each morally distressing event, moral residue increases and creates a higher baseline level of moral distress and residue; thereby evoking stronger reactions in the nurse as he or she is re-traumatized by another morally distressing event.

In 2012, Hamric, Borchers and Epstein revised Corley's Moral Distress Scale (MDS) and identified three major root causes of moral distress. The Moral Distress Scale-Revised (MDS-R) version included measures for both intensity and frequency of events that triggered moral distress in the nurse to evaluate the crescendo effect. Question regarding considering leaving a position in the past remained unchanged, however an additional question evaluating if participants were currently considering was added. Since moral distress has been associated with the intent to leave in multiple studies, having participant with elevated MDS-R scores, who also answer yes to this question supports the validity of the MDS-R.

The three major root causes of moral distress were classified as clinical situations, internal constraints, and external constraints in the situation or the environment. Psychiatric mental health nurses experience moral distress when caring for their patients due to clinical, internal, and external constraints. Clinical situations reported to cause moral distress involve the

existence of conflicting duties, care not being in the patient's best interest, a disregard for the patient's wishes and a lack of truth telling (Hamric, Borchers & Epstein, 2012). Internal constraints refer to nurses' characteristics and include perceived powerlessness, self-doubt, and a lack of assertiveness. External constraints are related to institutional and systemic constraints such as: inadequate communication between team members, differing interdisciplinary perspectives, inadequate staffing, tolerance of abusive behavior, compromised patient care due to pressure from payers, or an institutional fear of litigation (Hamric, Borchers, & Epstein, 2012).

## Review of Literature

An exhaustive review of literature through 2015 was performed in order to identify relevant research. Search results revealed that research studies regarding moral distress on PMHNs was quite limited in both number and scope. The literature review has been organized to reflect the major root causes of moral distress in psychiatric nurses as identified by Hamric, Borchers and Epstein (2012), clinical constraints, internal constraints and external constraints.

According to the literature, clinical constraints experienced by mental health nurses include lack of engagement, high reliance on medications, and minimizing patient autonomy (Austin et al., 2003; Austin et al., 2008, Musto & Schreiber, 2012; Wojtowicz et al., 2014; Wojtowicz & Hagen, 2014). Psychiatric nurses from several studies reported that moral distress led to unresolved feelings that negatively impact the PMHN and leave him or her feeling hopeless, isolated, or powerless (Austin et al., 2003; Austin et al., 2007; Deady & McCarthy, 2010; Lützén et al., 2010; Musto & Schreiber 2012; Wojtowicz et al., 2014). Several studies have identified inadequate staffing, time constraints on patient care, and institutional policies as triggers for moral distress in mental health care and in critical care environments (Corley et al., 2001; Nalley, 2013; Ohnishi et al., 2010; Schluter et al., 2008). The effects of moral distress

have far reaching consequences. The organizational impact of moral distress can include employee burnout and increased turnover. The impact on the individual can include feelings of guilt, self-doubt, frustration, anger, depression, and inadequacy. These feelings can increase a nurse's sense of hopelessness causing detachment from work. A scant amount of research has studied moral distress within psychiatric nurse and only two international studies have been conducted using the MDS-P to quantify the experience of moral distress in psychiatric mental health nurses. Further research is needed to determine the incidence of moral distress and demonstrate the reliability and validity of the MDS-P in psychiatric nurses in the United States. Having a greater appreciation of these experiences can provide essential information that can be used to develop interventions to address moral distress in PMHNs in the United States.

## Methods

A substantial portion of the current research pertaining to moral distress has examined the phenomenon within nursing, particularly in areas of acute care clinical practice. There is limited research examining the experience of moral distress in psychiatric mental health nurses throughout the world, and no research was identified on this topic in PMHNs in the United States. This study assessed the level of moral distress in PMHNs in the Commonwealth of Virginia by using the Moral Distress Scale for Psychiatric Nurses (MDS-P). The research examined the intensity of moral distress in PMHNs, as well as whether or not there is a relationship between the moral distress scores of PMHNs and demographic characteristics.

The study used a descriptive, cross-sectional electronic survey design to examine moral distress among PMHNs in the United States. Precisely, the study explored the phenomenon of moral distress among PMHNs in a professional psychiatric nursing organization in the Commonwealth of Virginia. The study was designed to answer three questions:

1. What is the experience of moral distress in PMHNs?

2. Do relationships exist between MDS-P scores and demographic characteristics?

3. Is the MDS-P a reliable measurement to assess moral distress in psychiatric nurses?

To address the primary question, a previously validated measure was used to analyze the experience of moral distress in a sample of PMHNs. The scores were then compared to scores from previous studies to determine similarities and consistencies.

Additionally, the relationships between nurse characteristics and moral distress scores were investigated. Specifically, this study aimed to examine whether a statistical relationship exists between moral distress scores and demographic characteristics, including gender, level of education, and years of nursing experience. Finally, this study examined whether the MDS-P is an appropriate measure of moral distress in PMHNs in the United States of America.

**Setting**

The setting of the study was the Commonwealth of Virginia, and data collection took place in early 2016. Data were collected via electronic survey and accessed by e-mail invitations. E-mail invitations were sent to members (n=41) of the Virginia Association of Community Psychiatric Nurses (VACPN). This organization was founded with the intention of forming a network of psychiatric nurses to share ideas, expertise information, and experience. The purpose of this statewide organization is to provide mutual support, promote improvements in nursing practice, and to promote professional growth (VACPN, n.d.).

**Sample**

The members of the VACPN work as psychiatric mental health nurses in various mental health settings across the Commonwealth of Virginia. The VACPN has an eclectic group of members who represent a variety of demographic characteristics such as gender, age, years of

experiences, and ethnicity. The majority of members are Caucasian females, which is representative of the nursing work force (Department of Labor, n.d.). The inclusion criteria were as follows: member of the VACPN, licensed as a nurse, currently working or past experience working in a psychiatric mental health setting, and considers English as their primary language. The VACPN has approximately 41 members. While the traditional survey response rate is 25%, due to the small population size, a goal of having a response rate of 50% was considered adequate for this study.

There were a total of 31 respondents; however, three did not provide responses for more than 20% of the MDS-P section. These three respondents were removed from the analysis. All the other participants (n = 28) provided an answer to all the questions in the MDS-P section. There were twenty-seven women and one man in the study ranging in age from 26 to 67 years (M = 48.8 years, SD = 12.3 years). Eighty-two percent of subjects were Caucasian, and 17.9% were of African American. With regards to years licensed as a nurse, the respondents indicated between 4.5 to 48 years (M = 25.1, SD = 14.3), while the years of practicing in the mental health varied between 2 to 40 years (M = 20.1, SD = 13.1). Similarly, subjects reported between 1 to 30 years (M = 8.6, SD = 7.8) in their current position. The highest level of education achieved by most respondents (32.1%) was a Diploma, followed by an Associates' degree (21.4%), Baccalaureate degree (21.4%), Masters degree (21.4%) and Doctoral degree (3.6%). With regards to the highest level achieved in nursing education, most respondents had an RN (77.8%), followed by an APRN (14.8%), an LPN (3.7%), and a DNP (3.7%); one respondent did not indicate highest nursing education obtained. The employment status was designated as full time most often (85.2%) or part time (14.8%); one respondent did not indicate their employment status. The majority of respondents acted in the role of RNs (84.6%), while the rest were either

the role of LPN (3.8%), APRN (7.7%), or educator (3.8%), respectively; two respondents did not indicate their primary role. Finally, the subjects were employed in the following settings: psychiatric outpatient clinic (44.4%), community mental health center (48.1%), psychiatric assertive community treatment program (3.7%), or addiction outpatient program (3.7%); one respondent did not indicate their primary place of employment (see Table 1 for additional details on Sample Characteristics).

**Measures**

The study utilized the MDS-P, developed by Ohnishi and colleagues (2010) to collect information regarding the intensity of moral distress. The experience of moral distress in psychiatric mental health nurses was measured using the MDS-P. Descriptive and inferential statistics were computed to answer the research questions. The developer of the MDS-P granted permission to this investigator to use the instrument.

The MDS-P is composed of 15 questions that are grouped into three factors: unethical conduct by caregivers, low staffing, and acquiescence to patient' rights violations. Each item is evaluated using a 7-point Likert scale ranging from 0 to 6. Zero indicates not experiencing the clinical situation, whereas 1 indicates experiencing very little distress and 6 indicates experiencing extreme stress. The measure was used previously in psychiatric mental health nurses in Japan and was determined to have an overall Cronbach's alpha coefficient of 0.90, while factor 1 had a score of 0.85, factor 2 had a score of 0.82, and factor 3 had a score of 0.79. These scores support the overall reliability of this measure (Ohnishi et al., 2010). Hamaideh (2014) used the measure to study moral distress in psychiatric mental health Jordanian nurses. The internal consistency and reliability in that study was found to have a Cronbach's alpha of 0.89, with subscales of 0.74, 0.78, and 0.80 (Hamaideh, 2014).

Cronbach's alpha tested the reliability of the 15-item MDS-P used in the current study as well as the three sub-factors. All four internal consistency reliability results were within acceptable limits, with alphas > 0.5: overall MDS-P ($\alpha = 0.916$), unethical conduct by caregivers ($\alpha = 0.754$), low staffing ($\alpha = 0.845$) and acquiescence to patient's right violations ($\alpha = 0.887$). The internal consistency of the MDS-P in previous studies was consistent with the results from this study.

Demographic and work-related characteristics were collected to evaluate whether a relationship exists between moral distress scores and individual characteristics of psychiatric nurse's. Data was collected on years of education, gender, and levels of education. The data was used to determine whether statistically significant differences existed by comparing sub-groups.

**Data Analysis**

After data collection was complete, the raw score data from the questionnaire was entered into Statistical Package for the Social Sciences Version 23.0 (SPSS v23.0). Coded information from the measure and demographic information were entered into data files. The principal investigator was responsible for all data entry and screening and cleaning of all fields. Zero percent error in the data entry was accepted for this study. When an item was left blank on the questionnaire, a decimal point was entered to indicate that data was missing. Two participants did not provide answers for demographic information related to employment, primary role and place of employment. Any subject submitting a questionnaire missing responses for seven or more items, or approximately 20% of the total responses on the MDS-P, were not included in the

analysis to avoid bias or non-representative results from the substitution of the means for large amounts of missing data.

To confirm the integrity of the data frequency distributions were examined for all items to identify outliers and subjects not meeting the inclusion criteria. The analysis used descriptive statistics, inferential and reliability analyses to answer the research questions. In support of the primary aim of the study, descriptive statistics were computed on the data from the MDS-P. Measures of central tendency were used to identify mean moral distress scores for the overall measure and each of the sub-factors. The secondary aim of the study was to identify relationships between moral distress scores and demographic characteristics. Regression analysis assessed correlations among variables to answer the secondary aim of the study. The demographic variables of gender, level of education, years of experience, and intensity of moral distress were analyzed to determine whether correlations existed.

## Results

### The Experience of Moral Distress in PMHNs

Nurses in this study experienced low to moderate levels of moral distress. Participants in the study endorsed each item on the MDS-P questionnaire. The mean score, standard deviations, skewness and kurtosis for each question were calculated from the sample data (n=28). For additional details refer to Table 2 for results.

Intensity scores ranged from 0= not experienced, or 1= very little distress to 6 = severe distress, with a high mean intensity score of 3.36 (SD = 2.45) for the question "work at a facility where nurses are treated like machines causing them to quit." The lowest mean score of 0.54 (SD = 1.20) was for the question "follow the doctor's order not to tell the patient the truth when he/she asks for it." Overall, the standard deviation for the mean score of a question increased as

the mean score increased, indicating a higher spread of answers on the Likert scale. The mean score for all responses was 1.50 (SD = 1.31), while the score for the three sub-factors were as follows: low staffing a mean score of 2.21 (SD = 1.77), acquiescence to patient's right violations a mean score of 1.33 (SD = 1.51), and unethical conduct by caregivers a mean score of 1.03 (SD = 1.17). The lowest overall score was 0, while the highest overall score was 4.33. In regards to the three sub-factors, for low staffing the lowest score was 0 and the highest score was 5.8, for acquiescence to patient's right violations the lowest score was 0 and the highest score was 4.75, while for unethical conduct by caregivers the lowest score was 0 and the highest score was 3.50**.**

When asked whether they had ever considered quitting a clinical position due to moral distress with the way patient care was handled, the majority never considered (60.7%), while some considered but did not quit (10.7%), and some considered and left the position (28.6%). The majority of respondents were not considering leaving the current position (82.1%), while some (17.9%) were considering this option.

**Relationships between MDS-P scores and demographic characteristics**

The chi square statistic was applied to all fifteen questions in terms of ethnicity (see Table 3 for additional details). The test yielded significant results for question 4, "Assist a doctor who performs a test or treatment without informed consent." $\chi^2(4, N = 28) = 10.47$, $p = 0.033$ in terms of ethnicity, with more African Americans experiencing a distress level of 5 or 6 (40%) versus White/Caucasian (0.00%). The other grouping variables of interest, such as education level, yielded too few counts per case per question. Thus the chi-square was not applied to the other possible groupings.

The normality of the mean MDS-P score, as well as the mean score for the three sub-factors, was tested using the Shapiro-Wilk test. The null hypothesis that the MDS-P score was

normally distributed was rejected ($p = 0.011$), as well as the mean score for unethical conduct ($p = 0.000$) and the mean score for patients' rights ($p = 0.000$) at a 95% confidence level. The null hypothesis that the mean low staffing score is normally distributed could not be rejected ($p = 0.078$) at a 95% confidence level.

As a result, to compare the mean MDS-P score, as well as the scores of the sub-factors across different groupings (see Table 4 for additional details), the Kruskal-Wallis non-parametric test was employed. There were no statistically significant differences between genders, ethnicities, highest education level, highest nursing education level or currently considering leaving the position across any of the mean scores ($p > 0.05$). There were, however, statistically significant differences in terms of considering leaving or left a position in the past ($p < 0.05$).

To further explore which groups were different, the Mann-Whitney U test was applied for two independent samples. There were no statistically significant differences between respondents who did not consider leaving and those who did consider leaving, but did not across all means. There were, however, statistically significant differences between those who did not consider leaving and those who left ($p < 0.05$) across all means. Those who never considered leaving had a total mean MDS-P score of 0.83, while those who did leave had a total mean MDS-P score of 3.03. In regards to the sub-factors, for unethical conduct those who did not consider leaving scored a mean of 0.43, while those who did leave scored 2.33. Similarly, the mean scores for the sub-factor low staffing was 1.32 and 4.33, and the mean scores for the sub-factor patient rights violations was 0.82 and 2.47, for participants who never considered leaving compared to those who left, respectively.

A two step regression analysis was conducted with the mean MDS-P score as the dependent variable, gender and ethnicity as the control variables (entered in the first step) and

highest level of education, highest nursing education, number of years practicing mental health, left or considered quitting a clinical position, and considering leaving the current position as dependent variables (entered in the second step). The first model, with gender and ethnicity as the only predictors, has an adjusted $R^2$ of -0.042, indicating a poor fit to the data (see Table 5 for additional results).

In the second model, the adjusted $R^2$ was 0.683; this indicated that approximately 68% of the variation observed in the mean MDS-P score could be attributed to the predictor variables included in the model. Thus, years practicing mental health, highest education level, highest nursing education level, left or considered quitting, and consider leaving current position should be included in the model. In the second model gender and "left or considered quitting" had an unstandardized beta coefficient that is statistically significant ($p = 0.02$, $p = 0.00$) at the 0.05 level. When this condition was relaxed to a statistically significant level of $p = 0.10$, then "consider leaving current position" became statistically significant as well ($p = 0.06$). With respect to the question had a PMHN left or considered quitting a clinical position due to moral distress, the mean MDS-P score increased by 1.21 (s.e. = 0.18) points for participant who answered Yes, I have considered leaving but did not compared to participants who responded No, I have never considered leaving. This was also true for participants who answered Yes, I have left compared to those who considered leaving but did not. Lastly, answering yes to the question of considering leaving the current position increases the mean MDS-P score by 0.90 (s.e. = 0.45).

**Reliability of the MDS-P in the PMHNs**

The MDS-P was developed and tested in a population (n=264) of Japanese nurses (Ohnishi et al., 2010). The questionnaire originally consisted of 43 items and included scores for

both frequency and intensity. Factor analysis was used to identify the most relevant questions. Analysis determined that 15 items and three factors explained 60.1% of the variance; therefore, these items were included in the MDS-P. Further analysis revealed that correlation coefficients between intensity and frequency were high ($r$=0.57 to 0.81) for the 15 items that were included in the MDS-P. Final analysis of the overall measure was based on intensity and not frequency.

To measure internal consistency Cronbach's alpha was calculated. The newly created MDS-P had a Cronbach's alpha coefficient of 0.90 while factor 1, unethical conduct by caregivers was 0.85, factor 2, low staffing was 0.82, and factor 3, acquiescence to patient's rights violations was 0.79. In 2014, Hamaideh used the 15-item MDS-P in a sample of Jordanian nurses (n=131). The internal consistency of the same measure was calculated to have a Cronbach's alpha of 0.89 for the overall MDS-P, with each sub-factor having a score of 0.74 for factor 1, 0.78 for factor 2, and 0.80 for factor 3. In this sample (n=28), the internal consistency was calculated revealing a score for the whole MDS-P and each of the 3 sub-factors to be 0.92, 0.75, 0.85, and 0.89 respectively.

## Discussion

The primary goal of the study was to determine whether PMHNs in the U.S. encountered moral distress; and if so, what was their experience. The study confirms that the sample of PMHNs in this study from the Commonwealth of Virginia in fact have experienced moral distress. Previous studies using the MDS-P focused on nurses working in inpatient or long-term care settings. In this sample, the majority of the respondents were employed in less restrictive outpatient settings. Since there is increased autonomy for patients in community settings, low levels of moral distress may be expected. The current results indicate that participants in this sample experienced lower levels of moral distress compared to Japanese nurses in Ohnishi et

al.'s study (2010), and Jordanian nurses in Hamaideh's (2014) research. Those in this sample also reported significantly lower scores than participants in Corley et al.'s (2005) study of American acute care nurses, using a different measure. Although direct comparisons cannot be made Corley's Moral Distress Scale (MDS) was used in the development of Ohnishi's MDS-P thus compared to Corley, the nurses in this sample reported a lower intensity of moral distress.

Within this sample external and organizational constraints that resulted in reduced staffing were the most negative to nurses. Most significantly, items related to nurses being treated like machines, unsafe staffing levels and having no time to talk with patients who do not cause trouble were endorsed as the most distressing. Further analysis of sub-factors revealed that results were congruent with Ohnishi et al.'s (2010) study, which reported that the "low staffing" sub-factor were the most distressing, whereas Hamaideh (2014) reported higher mean scores from "low staffing" than in this sample but the most elevated scores were endorsed on items related to unethical conduct by caregivers. Overall, low staffing was a trigger for moral distress in several studies (Austin et al., 2003; Corley et al., 2001; Hamaideh, 2014; Nalley, 2013; Ohnishi et al., 2010; Schluter et al., 2008). Further research is needed to determine whether the results from this study are characteristic of psychiatric nurses nationally.

The reason for the relatively low mean MDS-P scores is not known. The available Moral Distress Scale for Psychiatric nurses may be best suited to evaluate moral distress in inpatient settings and may not address the subtle nuances of outpatient practice. Results may reflect characteristics of the mental health care system in Virginia. Due to their involvement in a professional psychiatric nursing organization, participants may be well equipped to resolve moral distress because they have developed a support network (Epstein and Delgado, 2010; Musto & Schreiber, 2012). On the other hand, the low level of responses may be rooted in feelings of

hopelessness and powerlessness to change the system that are similar to feelings expressed by nurses in other studies (Austin et al., 2003; Austin et al., 2007; Deady & McCarthy, 2010; Lützén et al., 2010; Musto & Schreiber 2012; Wojtowicz et al., 2014).

There was no significant difference found between demographic variables such as gender, ethnicity, level of education, level of nursing education or individuals considering leaving the position. However, nurses who had left a position in the past due to moral distress had significantly higher MDS-P mean scores compared to those who never considered leaving a position. While the MDS-P, does not capture intent to leave this information was collected within the demographic data in this study to compare results with previous studies using the Moral Distress Scale-Revised (MDS-R). The results from this sample support other research findings indicating a relationship between moral distress and the intent to leave (Hamric, Borchers & Epstein, 2012; Trautmann et al., 2015; Whitehead et al., 2015). While direct comparisons cannot be made, using the MDS-R, Hamric, Borchers & Epstein (2012), Trautmann, Epstein, Rovnyak, et al. (2015) and Whitehead, Herbertson, Hamric, et al. (2015), found elevated MDS-R scores in participants who had considered leaving clinical positions in the past or who were currently considering leaving. Specifically, Trautmann et al., and Whitehead et al., (2015), found that those who had left a position due to moral distress and those who had considered leaving but did not, had higher levels of moral distress compared to those who had not considered leaving a clinical position. Whereas, Hamric, Borchers & Epstein (2012), and Whitehead et al., (2015), found that MDS-R scores were significantly higher for those currently considering leaving clinical positions.

Results related to gender and moral distress have been inconsistent. Previous studies examining moral distress using the MDS-R and gender (Trautmann et al., 2015; O'Connell,

2015) found that females reported higher MDS-R scores. In this sample, no significant difference was found between MDS-P scores and gender. This is consistent with results of Ohnishi et al. (2010). Regarding levels of education, Ohnishi et al., (2010) did not find a significant difference between MDS-P scores when comparing LPN's and RN's. In contrast, Hamaideh (2014) found a significance difference between levels of education and MDS-P scores.

Previous studies using the MDS-P did not account for ethnicity as a variable; however, an unexpected and interesting finding in this study suggests that a statistically significant difference exists between African American respondents who reported higher levels of moral distress when assisting a doctor with performing a test or treatment without informed consent as compared to Caucasian respondents. Given the historical significance of African American involvement in medical research, it seems reasonable that African Americans may be more sensitive to performing medical services with a lack of informed consent and thus more distressed by these situations. Limited research is available which specifically addresses this question, but further investigation would be warranted. Further research is also warranted to determine why the scores of Caucasian nurses did not indicate similar levels of distress.

Corley et al.'s (2001) MDS narrowly focused on issues pertaining to end-of life care. Hamric, Borchers and Epstein (2012) revised the MDS "to expand its use in non ICU settings and make it appropriate for multiple healthcare disciplines." While the MDS-R measures moral distress among several disciplines, it is heavily focused on situations related to futility, life saving measures and end-of life care. However, issues pertaining to end of life care and futility are not regularly seen in psychiatry but that does not mean that PMHNs and other clinicians working in the specialty do not encounter clinical situations where they feel constrained from

taking action that they consider to be ethically appropriate on a routine basis. Therefore having a reliable and valid measure that assesses moral distress among psychiatric professionals is essential.

Reliability measures for the MDS-P have demonstrated strong internal consistency. Ohnishi et al., (2010) reported an overall Cronbach's alpha of 0.90. In 2014, Hamaideh calculated a Cronbach's alpha of 0.89. In the current study the overall internal consistency was also measured by Cronbach's alpha and yielded a value of 0.91. The results indicate that the MDS-P is a reliable measure to assess moral distress in psychiatric nurses when used in industrialized populations. The internal consistencies of the three sub-factors are slightly less consistent than the overall measure; however, the internal consistency of the sub-factors reveals a fair to strong level of reliability for each factor.

Although the measure does appear to have strong internal consistency, adding components to measure frequency and intent to leave would strengthen the validity of the measure and reflect valuable modifications made in the MDS seen in the MDS-R. In the development of the MDS-P, differences in intensity and frequency were examined which added to the validity of the original study (Ohnishi et al., 2010). Ultimately, only intensity was included in the MDS-P. Incorporating intensity and frequency into the MDS-P would allow for more in-depth analysis of each factor. Additionally, the crescendo effect asserts that a relationship exist between the frequency that morally distressing events are encountered and the intensity of the nurses experience (Epstein and Hamric, 2009). Without both dimensions being included in the MDS-P it is difficult to analyze whether this is relationship is true for PMHNs.

Further, moral distress has been associated with nurse's intent to leave. Most importantly, it has been hypothesized that high levels of moral distress and nurse's intent to leave

are related (Epstein and Hamric, 2009; Hamric, Borchers and Epstein, 2012). Integrating questions related to considering leaving past clinical positions and currently considering leaving would provide consistency with other moral distress scales. Also, since the intent to leave in the past or currently has been reported in several studies, incorporating this element into the MDS-P would increase the validity of the measure.

## Strengths and Weaknesses

This study is the first published examination of the experience of moral distress in psychiatric nurses in the United States using the MDS-P. The MDS-P provides an opportunity for the experience of moral distress in psychiatric nurses to be defined using quantitative data. Doing so allows statistical relationships to be analyzed to illustrate the severity of this phenomenon. The study was practical and cost effective and individual participants were able to provide a large amount of anonymous data with limited constraints on their time. Finally, the results from this study contribute to the limited research that is currently available regarding moral distress in psychiatric nurses.

The small sample was limited to members of a statewide psychiatric nurses association. Participants primarily worked in outpatient settings whereas other studies focused on inpatient settings. Additionally, mental health laws, insurance regulations and access to care vary from state to state and these policies may influence the nurses' experience and responses thus limiting the generalizability of the findings of this study.

## Conclusion

This study adds to the current literature on moral distress, and more specifically, on the experience of moral distress by American psychiatric nurses primarily working in outpatient settings. The results from this study confirm that this population does experience low to

moderate levels of moral distress with the highest levels of distress related to low staffing. Low staffing can result in nurses feeling like they are treated like machines - working with unsafe staffing levels and not having time to speak with patients who do not cause trouble. The findings provided additional support for the association between elevated moral distress scores and nurses leaving clinical positions.

Overwhelming evidence indicates a relationship between moral distress and employee disengagement, burnout and turnover. Employee turnover can negatively impact health care organizations expenses. Interventions and programs aimed at decreasing the experience of moral distress can provide a cost savings for organizations. More importantly, nurses will not suffer the negative emotional and physical consequences associated with moral distress. Organizational priorities should focus on creating staffing levels that allow psychiatric nurses to feel safe and able to provide ethically appropriate care to all patients. Other programs aimed at increasing awareness about moral distress and providing resources to assist in resolving ethical issues may prevent moral distress in nurses.

## Implications for Nursing Practice

Moral distress can lead to both physical and psychological impairments in nurses. Psychological impairments include depression, anxiety and frustration. These negative feelings can lead to burnout, disengagement and a desire to leave the position. In addition to the physical and emotional toll that moral distress can take on a nurse, it may impair a nurse's ability to engage with psychiatric patients. This preliminary study validated that moral distress was experienced by a sample of psychiatric nurses in the Commonwealth of Virginia. This study confirmed that PMHNs working primarily in outpatient settings do experience low levels of moral distress. Due to the limited availability of research, continued exploration to determine the

levels of distressed experience, causes and outcomes of moral distress in this population of nurses is warranted. Additionally, results from the MDS-P demonstrated that the scale serves as a reliable measure to capture the experience of moral distress in American psychiatric nurses. Lastly, the results from this study can inform individuals and organizations about moral distress in PMHNs, which can be used to develop programs to combat the physical and emotional toll that can be caused by events that trigger moral distress.

## Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

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.

Austin, W., Kagen, L., Rankel, M., Bergum, V. (2008). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy, 11(1),* 89-97.

Austin, W., Lenermeyer, G., Goldberg, L., Bergam, V., and Johnson, M.S. (2005). Moral Distress in Healthcare practice: The situation of nurses. *HEC Forum, 17(1*), 33-48.

Corley, M. C. (2002). Nurse moral distress: a proposed theory and research agenda. *Nursing Ethics,* 9 (6), 636-650.

Corley, M.C., Elswick, R.K., Gorman, M., Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33,* 250-256.

Corley, M.C., Minick, P., Elswick, R.K., Jacobs, M. (2005). Nurses moral distress and ethical work Environment. *Nursing Ethics, 12(4),* 381-390.

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.

Epstein, E., Delgado, S., (2010). Understanding and addressing Moral Distress. *The Online Journal of Issues in Nursing,* 15(3), manuscript 1.

Epstein, E., Hamric, A. (2009). Moral distress, moral residue and the crescendo effect. *Journal of Clinical Ethics, 20(4),* 330-342.

Gutierrez, K.M., (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing, 24(5)*, 229-241.

Hamaideh, S. (2014). Moral distress and its correlates among mental health nurses in Jordan. *International Journal of Mental Health Nursing, 23,* 33-41.

Hamric, A.B., and 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.

Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research*, *3*(2), 1-9.

Hopelessness. 2015. Merriam-Webster's online dictionary. Retrieved October 31, 2015, from http://www.merriam-webster.com/dictionary/hopeless.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Lawrence, L. (2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing Forum,* 46(4), 256-268.

Lieberman, J. (2015). *Shrinks: The untold story of Psychiatry*. New York, NY: Little Brown and Company.

Ludwig, R., Silva, M.C. (2003). Errors, the nursing shortage and ethics: survey results. Online *Journal of Issues in Nursing, 8(3*), 5.

Lützén, K., Blom, T., Ewalds-Kvist, B., Winch, S. (2010). Moral Stress, moral climate, and moral sensitivity among psychiatric professionals. *Nursing Ethics, 17(2),* 213-224.

Meltzer, L.S., and Huckabay, L.M. (2004). Critical care nurses perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13(3),* 202-208.

Musto, L., Schreiber, R.S. (2012). Doing the best I can do: Moral distress in adolescent mental health nursing. *Issues in Mental Health Nursing, 33,* 137-144.

Nalley, C. (2013). Moral Distress Takes Toll on Nurses. Retrieved February 19, 2015, from http://nursing.advanceweb.com/Features/Articles/Moral-Distress-Takes-Toll-on-Nurses.aspx.

O'Connell, C. (2015). Gender and the experience of moral distress in critical care nurses. *Nursing Ethics, 22(1)*, 33-42.

Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., Nakahara, J., Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nursing Ethics, 17(6),* 726-740.

Polacek, M., Allen, D., Damin-Moss, R. S., Schwartz, A., Sharp, D., Shattell, M., Souther, J., and Delaney, K. (2015). White Paper: Engagement as an element of safe inpatient psychiatric environments. *Journal of the American Psychiatric Nurses Association*, 21(3), 181-190.

Schluter, J., Winch, S., Holzhauser, K., Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nursing Ethics, 15(3),* 305-320. Doi: 10.1177/0969733007088357.

Sjöstrand, M., Juth, N. (2014). Authenticity and psychiatric disorders: does autonomy of personal preference matter? *Medicine, Health Care and Philosophy, 17(1),* 115-122.

Trautmann, J., Epstein, E., Rovnyak, V., Snyder, A. (2015). Relationships among moral distress, level of practice independence, and intent to leave nurse practitioners in emergency departments: Results from a national survey. *Advanced Emergency Nursing Journal, 37(2),* 134-145.

Virginia Association of Community Psychiatric Nurses. About Us. Retrieved from http://www.vacpn.net/About-Us.html.

Whitehead, P., Herbertson, R., Hamric, A., Epstein, E., Fisher, J. (2015). Moral Distress among health professionals: report of an institution-wide survey. *Journal of Nursing Scholarship, 47(2)*, 117-125.

Wilkinson, J. M. (1988). Moral Distress in Nursing Practice: experience and effect. *Nursing Forum, 23(1)*, 16-29.

Wojtowicz, B., Hagen, B., Van Daalen-Smith, C. (2014). No place to turn: Nursing students' experiences of moral distress in mental health settings. *International Journal of Mental Health Nursing, 23,* 257-264.

Wojtowicz, B., & Hagen, B. (2014). A guest in the house: nursing instructors' experience of moral distress felt by students during inpatient psychiatric clinical rotations. *International Journal of Nursing Education Scholarship, 11(1),* 121-128.

United States Department of Labor. Quick facts on Registered Nurses. Accessed on November 13,2015 at http://www.dol.gov/wb/factsheets/Qf-nursing.htm.

Table 1.

*Sample Demographic Information*

| | | | |
|---|---|---|---|
| Gender | | | |
| Female | 27 | | |
| Male | 1 | | |
| Ethnicity | | | |
| Caucasian | 82.1% | | |
| African American | 17.9% | | |
| | Range | Mean | Std.Dev |
| Age | 26-67 | 48.8 | 12.3 |
| Years Licensed | 4.5-48 | 25.1 | 14.3 |
| Years in Mental Health | 2-40 | 20.1 | 13.1 |
| Level of Education | | | |
| Diploma | 32.1% | | |
| Associates | 21.4% | | |
| Baccalaureate | 21.4% | | |
| Masters | 21.4% | | |
| Doctoral | 3.6% | | |
| Nursing Education | | | |
| LPN | 3.7% | | |
| RN | 77.8% | | |
| APRN | 14.8% | | |
| DNP | 3.7% | | |
| Employment Setting | | | |
| Outpatient Clinic | 44.4% | | |
| Community MH Center | 48.1% | | |
| ACT Program | 3.7% | | |
| Addiction Outpatient | 3.7% | | |

Table 2.

*Descriptive Statistics for MDS-P questionnaire (n = 28)*

| | | | Skewness | | Kurtosis | |
|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Statistics | Std. Error | Statistics | Std. Error |
| Work at a facility where nurses are treated like machines causing them to quit. | 3.36 | 2.45 | -0.19 | 0.44 | -1.65 | 0.86 |
| Work with levels of nurse staffing that I consider "unsafe." | 2.93 | 2.45 | -0.01 | 0.44 | -1.74 | 0.86 |
| Have no time to talk with patients who do not cause trouble. | 2.32 | 2.23 | 0.56 | 0.44 | -1.03 | 0.86 |
| Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient. | 1.82 | 1.96 | 0.77 | 0.44 | -0.53 | 0.86 |
| Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay. | 1.61 | 2.18 | 1.05 | 0.44 | -0.41 | 0.86 |
| Carry out a doctor's order for unnecessary tests and treatment. | 1.57 | 1.89 | 0.71 | 0.44 | -1.13 | 0.86 |
| Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing. | 1.50 | 2.19 | 1.13 | 0.44 | -0.21 | 0.86 |
| Observe without taking action when health care personnel ridicule a patient. | 1.46 | 2.10 | 1.14 | 0.44 | -0.20 | 0.86 |
| Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit. | 1.32 | 1.63 | 1.08 | 0.44 | 0.67 | 0.86 |
| Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it. | 1.04 | 1.73 | 2.01 | 0.44 | 3.46 | 0.86 |
| Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization | 0.96 | 1.88 | 1.94 | 0.44 | 2.64 | 0.86 |
| Ignore situations of suspected patient abuse by caregivers. | 0.86 | 1.80 | 2.28 | 0.44 | 4.17 | 0.86 |
| Secretly mix medication into a patient's food or drink when he/she refuses it. | 0.68 | 1.19 | 1.68 | 0.44 | 1.65 | 0.86 |
| Assist a doctor who performs a test or treatment without informed consent. | 0.61 | 1.47 | 2.99 | 0.44 | 8.63 | 0.86 |
| Follow the doctor's order not to tell the patient the truth when he/she asks for it. | 0.54 | 1.20 | 2.26 | 0.44 | 4.00 | 0.86 |

(Likert scale: 0 = no experience to 6 = extreme stress)

Table 3.

*Chi- Square Results*

| Assist a doctor who performs a test or treatment without informed consent | | | | | | |
|---|---|---|---|---|---|---|
| | MDS-P Score | | | | | |
| | 0 | 1 | 2 | 5 | 6 | Total |
| Caucasian | 18 | 4 | 1 | 0 | 0 | 23 |
| African American | 3 | 0 | 0 | 1 | 1 | 5 |
| | 21 | 4 | 1 | 1 | 1 | 28 |

Chi-Square Statistic $x^2$=10.47, p=0.033

Table 4.

*Mean scores for the total MDS-P and the three sub-factors across various groupings*

| | | | Mean | | |
|---|---|---|---|---|---|
| Gender | N | Total | Unethical Conduct | Low Staff | Patient rights |
| Male | 1 | 1.33 | 0.67 | 3.20 | 0.00 |
| Female | 27 | 1.51 | 1.04 | 2.18 | 1.38 |
| Race | | | | | |
| White/Caucasian | 23 | 1.42 | 0.97 | 2.16 | 1.15 |
| African American | 5 | 1.91 | 1.63 | 2.09 | 2.27 |
| Highest education level | | | | | |
| Diploma program | 9 | 1.32 | 0.91 | 1.76 | 1.39 |
| Associates Degree | 6 | 0.93 | 0.75 | 1.40 | 0.63 |
| Baccalaureate degree | 6 | 1.51 | 0.92 | 2.43 | 1.25 |
| Master degree | 6 | 2.17 | 1.53 | 3.17 | 1.88 |
| Doctoral degree | 1 | 2.60 | 1.50 | 4.20 | 2.25 |
| Highest nursing degree | | | | | |
| LPN | 1 | 3.07 | 2.50 | 3.40 | 3.50 |
| RN | 21 | 1.24 | 0.79 | 1.96 | 1.02 |
| APRN | 4 | 2.33 | 2.04 | 2.90 | 2.06 |
| DNP | 1 | 2.60 | 1.50 | 4.20 | 2.25 |
| Left or considered quitting | | | | | |
| No | 17 | 0.83 | 0.43 | 1.32 | 0.82 |
| Yes, but didn't leave | 3 | 1.24 | 0.94 | 1.67 | 1.17 |
| Yes, left | 8 | 3.03 p=0.00 | 2.33 p=0.00 | 4.33 p=0.00 | 2.47 p=0.01 |
| Consider leaving current position | | | | | |
| No | 23 | 1.52 | 1.08 | 2.25 | 1.27 |
| Yes | 5 | 1.43 | 0.80 | 2.04 | 1.60 |

Table 5.

*Regression models for MDS-P mean score*

| Model | | Unstandardized Coefficients | | | |
|---|---|---|---|---|---|
| | | B | Std. Error | t | Sig. |
| Model 1 | | | | | |
| | (Constant) | 0.62 | 1.54 | 0.40 | 0.69 |
| | Gender | 0.09 | 1.39 | 0.06 | 0.95 |
| | Ethnicity | 0.71 | 0.74 | 0.97 | 0.34 |
| Model 2 | | | | | |
| | (Constant) | -4.76 | 1.31 | -3.63 | 0.00 |
| | Gender | 2.31 | 0.93 | 2.48 | 0.02 |
| | Ethnicity | 0.52 | 0.44 | 1.18 | 0.25 |
| | Years practicing mental health | -0.01 | 0.01 | -1.11 | 0.28 |
| | Highest education level | 0.18 | 0.16 | 1.13 | 0.27 |
| | Highest nursing education level | 0.49 | 0.31 | 1.60 | 0.13 |
| | Left or considered quitting | 1.21 | 0.18 | 6.87 | 0.00 |
| | Consider leaving current position | 0.90 | 0.45 | 2.01 | 0.06 |