Doing the Best I Can Do:

Moral Distress in Adolescent Mental Health Nursing

by

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BSN, University of Victoria, 2004

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of the Requirements for the Degree of

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in the Department of Human and Social Development

Supervisory Committee

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Abstract

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The purpose of this research was to explore the process used by mental health nurses working with adolescents to ameliorate the experience of moral distress. Using grounded theory methodology, a substantive theory was developed to explain the process. All the incidents that lead to the experience of moral distress were related to safety and resulted in the nurse asking themselves the question, "Is this the best I can do?" Engaging in dialogue was the primary means nurses used to work through the experience of moral distress. Engaging in dialogue was an ongoing process and nurses sought out dialogue with a variety of people as they tried to make sense of their experience. Participants identified qualities of dialogue that were helpful or unhelpful as they sought to resolve their moral distress. Participants who had a positive experience of dialogue were able to answer the question, and continue working with adolescents with a renewed focus on the therapeutic relationship. Participants who have a negative experience of dialogue are unable to answer the question and either leave the unit or agency, or talk about leaving.

Keywords: moral distress, mental health nurses, adolescents

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Finally, I would like to thank my family and friends who tolerated my long absences from their lives and lovingly welcomed me back when time permitted.

Dedication

This thesis is dedicated to my family, Mark, Cora, and Ian Tonn.

This work was not possible without their encouragement, support, humour, and sacrifice.

Thank you very much.

Chapter 1: Moral Distress in Adolescent Mental Health Nursing

So let's leave it alone, 'cause we can't see eye to eye.
There ain't no good guys, there ain't no bad guys.
There's only you and me and we just disagree.
We just disagree
Sung by Dave Mason, Lyrics by Jim Krueger, 1977

Working with clients who struggle with mental health concerns is fraught with ethical issues in the current healthcare context. With a focus on programs being cost effectiveness and limited resources, there is a sense that patients receive care based on what the healthcare system can provide rather than what is considered best practice. Psychiatric clients often present with complex problems that can put various members of the mental health team at odds with each other as solutions are sought. Issues of autonomy, justice, and beneficence are often at the root of the conflict between and among staff members. For example, there are diverse opinions around our ethical and legal responsibilities in providing care to patients who have compromised decision-making capacity. Differences of opinion on how best to serve the client are based in professional and interpersonal perspectives and assumptions about what is in the best interest of the client (Lützén & Schreiber, 1998; Redman & Fry, 2000).

In the case of adolescents, issues of autonomy, justice and beneficence become more pronounced due to the age of the client, developmental processes, family involvement, and vulnerability of the youth. Legal and ethical implications add to the complexity of providing care for youth as multidisciplinary teams attempt to weave together the legislation that impacts care with the obligation to provide care according to professional standards of practice. Factors that impact on the team's decision making

processes include experience, education, understanding of professional roles, and an environment that does or doesn't support open communication on these complex issues.

Formal processes for discussing and working through ethical issues are often not available to multidisciplinary teams due to the absence of any written policy, support for this process, lack of awareness of resources, and time. These conflicts can go unresolved, buried underground, and brought consciously or unconsciously into the next conflict. Ongoing unresolved ethical conflict can impact the functioning of the multidisciplinary team and the care given to the client (Lützén & Schreiber, 1998; Wilkinson, 1988). Unresolved ethical conflict can also lead to moral distress, an experience whereby a professional will set aside a deeply held set of values and act in ways that severely compromises their moral integrity. If this moral distress is left unresolved, it can accumulate over time and lead to moral residue. The experience of moral residue is carried by the individual, and may have lasting, negative effects (Webster & Baylis, 2000).

Past research indicates that moral distress can lead nurses to leave their position and/or the profession (Corley, 2002). Both qualitative and quantitative research has been conducted to explicate the experience of moral distress; identify factors that contribute to moral distress frequency and intensity; measure existing levels of moral distress, and explore the effectiveness of interventions. Some of the issues that create moral distress for nurses have been identifies as staffing issues, patient workload, control over profession practice, and the competency level of other health care professionals (Corley, Ptlene, Elswick, & Jacobs, 2005; Hart, 2005). More recently, researchers have begun to make the connection between ethical work environments and the experience of moral

distress (McDaniel, Veledar, LaConte, Peltier, & Maciuba, 2006; Pauly, Varcoe, Storch & Newton, 2009; Wilkinson, 1987-1988). Most of the research on moral distress has been carried out in specialty medical areas such as, ICUs, Oncology, Paediatrics, and Palliative Care with little attention focused on moral distress experienced by nurses in mental health (Austin, Bergum, & Goldberg, 2003; Lützén & Schreiber, 1998). No research has been carried out on the process nurses go through when they experience moral distress. The process of nurses' experience of moral distress in youth mental health nursing is the focus of the current research and aims to fill the gaps above.

Situating Myself

My acquaintance with the concept of moral distress began when I started to question why nurses made decisions that seemed counterintuitive to what I understood as common nursing values. I remember working as a Psychiatric Liaison Nurse (PLN) in the Emergency Department (ED) of an urban hospital. A draft policy was being circulated that stated all patients admitted under the Mental Health Act were to be stripped of their belongings and locked in a security room until a bed could be found for them on a psychiatric unit. A woman came in voluntarily to the ED, having thoughts of suicide and wanting help before she acted on her impulses. The woman was certified under the Mental Health Act and I was told I had to put her in hospital pajamas and lock her into a security room. All my nursing experience and knowledge told me that this woman felt completely isolated and that the actions of locking her in a security room would only increase her sense of isolation. I also had questions about the legalities of confining someone who came into the hospital voluntarily, and about that the draft policy that seemed to reflect the needs of the ED and not the needs of the patient. I presented

my concerns to the nurse in charge and was told that if I did not follow this draft policy, the security guards would be called and the woman would have to comply anyway. Thus, I complied with the draft policy. In that moment, and in the weeks that followed, I had many questions about how these actions upheld "safe, compassionate, competent and ethical care."

The incident described above was the beginning of my journey to try intentionally to understand what it meant to be an ethical practitioner. Initially, I thought nurses made these questionable decisions based on a lack of theoretical knowledge, skill, awareness of ethical resources available to them, or because of convenience, or perhaps a lack of courage. As I researched and spoke with peers I came to understand that many nurses had a deeply held set of values that they felt unable to live out in their day-to-day practice. I turned my attention back to the literature in an attempt to understand the factors that influenced ethical decision-making and what made it difficult for nurses to practice according to the values they espoused. Reading the literature brought me to the place of understanding that ethical decision-making was a complex intra and interpersonal process.

Although individual decision-making processes originate from within the person, many factors that influence decision- making are external, unspoken, and embedded within the organizations and political contexts in which we work (Austin, Rankel, Kagan, & Bergum, 2005). Nurses also used, consciously or unconsciously, many strategies that helped maintain their moral integrity as they attempted to deliver care in a health care system that challenged their values on a daily basis (Lützén & Schreiber, 1998; Wilkinson, 1987/88). Some of the strategies nurses employed to maintain their moral

integrity supported nurses so they could feel good about their practice; other strategies left nurses questioning the "goodness" of their practice (Doane, 2002).

Although the literature moved me to consider nursing practice from a broader context, including the factors that influence ethical practice and the potential outcomes of nurses' experience of moral distress, the literature did not delineate the steps that nurses took to work through the experience of moral distress. I wanted to understand the process nurses went through as they tried to ameliorate the experience of moral distress. It also became clear that the process could not be understood from the literature. Rather, it needs to be understood from the place of those living the experience.

When I started working with adolescents who struggled with mental health issues, the factors that influenced the provision of care became more complex. At times, diverse opinions created a deep division amongst the multidisciplinary team that could not be bridged. In such cases, a consistent therapeutic approach with an adolescent could not be achieved, and many staff voiced frustration that they were not able to provide care according to their professional standards. Understanding situations that create moral distress for staff working with youth, and knowledge of existing strategies staff use for resolving ethical issues, may provide insight into how to support staff to manage moral distress in a way that does not result in moral residue. Supporting staff to work through ethical issues may also contribute to the healthy functioning of multidisciplinary teams and enhance the quality of care they provide to their clients.

Purpose and Research Questions

The purpose of this study is to develop a substantive theory of the processes mental health nurses participate in when they experience moral distress. Specific research questions were related to discovering:

1.) What situations create moral distress for mental health nurses working with adolescents?

2.) How do mental health nurses experience moral distress?

3.) What do nurses do to ameliorate the experience of moral distress?

4.) What do nurses perceive as supports and barriers to resolving the experience of moral distress?

Assumptions

Assumptions about the experience of moral distress relevant to the findings of this research are: a) nurses experience moral distress in their day to day practice and are able to talk about that experience, b) the experience of moral distress will have an impact on the quality of care provided to the patient, c) the experience of moral distress influences nurse retention, and d) the environmental context influences the nurse's ability to resolve the experience of moral distress.

In regards to the assumptions listed above, all participants identified that they had experienced distress in their practice and most were able to relate their distress to closely held values they felt had been violated. As well, many of the participants described how the experience of moral distress impacted on them personally and how it affected their practice. Wilkinson (1987/88) initially speculated about the relationship between the experience of moral distress and its impact on the care nurses give. Participants in her

study described how the experience of moral distress influenced the care they gave by either avoiding the patient or becoming more attentive towards the patient. Subsequent research supports speculation that the experience of moral distress can influence the therapeutic relationship (Austin et al., 2003; Lützén & Schreiber, 1998).

A second underlying assumption of this research was that the experience of moral distress might impact the quality of the therapeutic relationship, which in turn, will influence patient outcomes. In the current context of healthcare delivery and best practice, measurable patient outcomes have become an indicator of the quality of care being delivered. The Canadian Nurses Association (CNA, 2002), in their position statement on evidence-based decision making state, "evidence-based decision-making is an important element of quality care in all domains of nursing practice. Evidence-based decision-making is essential to optimize outcomes for patients, improve clinical practice, achieve cost-effective nursing care and ensure accountability and transparency in decision-making". It is interesting to note that, although there is a focus on evidence-based decision-making to optimize patient outcomes, an aspect of patient outcomes is that of patient satisfaction. A significant factor in patient satisfaction is the quality of the therapeutic relationship (Marriage, Petrie, & Worling, 2001). Patient satisfaction did not necessarily correlate with improvement in symptoms. Rather, "if consumers believe the problems they have identified have been addressed, they are more positive about the services received" (Marriage et al., 2001). Additionally, in a study with nurses, and clients who had been identified as "difficult", the clients were able to identify qualities of the nurse-patient relationship that they found helpful and that were less likely to lead to acting out behaviours by the clients (Breeze & Repper, 1998). The quality of the nurse-

patient relationship will effect the development of a therapeutic alliance and the ability of the nurse to engage the patient in a collaborative relationship, which in turn, affects patient outcomes.

As with the concept of moral distress, measurement of patient outcomes is complex and the variables that positively or negatively impact on these outcomes are not easily delineated. The process by which interventions are delivered will also affect patient outcomes (LeFort, 2003; Sidani & Epstein, 2003). Delivery of patient care occurs within the context of the therapeutic relationship. An underlying assumption of this research is that if the experience of moral distress negatively impacts the therapeutic relationship, there will be a correlated negative impact on patient outcomes. Although the purpose of this research was not to test the relationship between these two concepts, a greater awareness of how the experience of moral distress impacts the therapeutic relationship could lead to recommendations that foster use of strategies that support a positive therapeutic alliance between the nurse and client.

A third assumption of this research is that moral distress influences retention of nurses. The nursing shortage in Canada has led government agencies at all levels of the healthcare system to develop strategies, both corporately and individually, for dealing with the lack of human resources (Committee on Health Human Resources, 2002; 2006/07 – 2008/09 Service Plan – Ministry of Health; Fraser Health Authority, 2003). These organizations acknowledged some of the difficulties that currently exist in the health care system, including an aging work force, lack of autonomy in practice, increased acuity of patients, and too few nurses graduating to replace retiring nurses. The indicators of a quality work environment identified included respect, autonomy,

leadership, and maximized scopes of practice for nurses (Canadian Nurses Advisory Council, 2002). In all these documents there is a plan for recruitment on a global level and identification of professional growth and development as strategies for retention. However, only the Canadian Nurses Advisory Council (CNAC, 2002) discussed the need to create quality work environments.

A final assumption embedded in this research is that the ethical culture of the environment will influence a nurse's ability to resolve his or her experience of moral distress. Researchers have only recently begun to explore the impact of an ethical work environment on the quality of nursing care. These researchers have suggested that by establishing mechanisms that support an ethical work environment the experience of moral distress could be mitigated (Corley et al., 2005; Hart, 2005; McDaniel et al., 2006; Storch et al., 2009). The results from my research may contribute to a better understanding of the factors in the work environment that influence and help ameliorate moral distress. Having nurses identify situations that influence or create moral distress, and perceived supports and barriers to resolving the experience of moral distress, will present opportunities to intervene and support nurses to successfully navigate this experience.

Organization of Thesis

What follows is a review of the literature on moral distress to provide background and current understanding of the concept. I will present the research process for grounded theory in the methodology chapter along with a description of the recruitment of participants, data collection, data analysis, and ethical considerations. I will then present the findings of the research focusing on categories that emerged from the data.

The categories included: **Doing the Best I Can Do; Engaging in Dialogue; Experiencing Dialogue; Shifting Perspective**; and **Resolution**. I will present and describe each of the categories and their dimensions identified from the data followed by a discussion of the findings, implications and recommendations for practice.

Chapter 2: Review of the Literature

Jameton (1993) first identified moral distress in the literature in 1984 when he noticed nurses would relay stories that they identified as moral dilemmas but that Jameton identified as "distress" stories. Jameton later clarified the definition to include *initial* and *reactive* distress. He stated that nurses experienced initial distress when faced with institutional obstacles and conflict with others about values, and reactive distress when they failed to act upon their initial distress (1993). Wilkinson, an early researcher in the area of moral distress, defined the phenomena as the "psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through" (1988, p. 16). Webster and Baylis (2000) further refined the definition when they identified that unresolved moral distress can lead to moral residue and have a lasting effect on the individual.

Since that time, nurse researchers have sought to develop a greater understanding of the concept of moral distress. Using qualitative methods researchers have identified some of the factors that impact the experience of moral distress such as lack of time and resources, perceived lack of competence of other health care professionals, and disagreement over what constitutes "in the best interest of the patient" (Austin et al., 2003; Corley, 2002; Pauly et al., 2009; Redman & Fry, 2000). Nurse researchers have also explored and measured the outcomes of moral distress on nurses using qualitative and quantitative research (Corley, Elswick, Gorman, & Clor, 2001; Corley et al, 2005; Lützén & Schreiber, 1998; Wilkinson, 1987/8).

Although the concept of moral distress remains unclear, some common themes seem to exist. What has been both speculated about and supported by the literature is that

moral distress has both a psychological and physiological impact on nurses (Austin et al., 2003; Kelly, 1998; Wilkinson, 1988). Wilkinson (1987/8) was one of the first researchers to speculate on the relationship between the experience of moral distress and the quality of patient care given by the nurse. Subsequent researchers identified negative coping strategies employed by nurses to mediate the experience of moral distress. Some of the negative coping strategies included avoiding conflict or avoiding the patient; minimizing the problem; adopting a dual moral code: one for work and one for home; or leaving the work environment (Austin et al., 2003; Deady & McCarthy, 2010; Lützén & Schreiber, 1998).

Another aspect of the impact of moral distress on nurses that has been studied is the relationship between the experience of moral distress and nurses leaving their current position or the profession. Wilkinson (1987/8) noted, in her original research, that nurses who seemed more sensitive to moral issues and who were unable to cope with moral distress, left bedside nursing. Subsequent research by Kelly (1998), Corley et al. (2001) and Hart (2005) supports these findings. Kelly's research explored the process graduate nurses experience as they transition from being a student to being a frontline nurse. Her findings revealed that unresolved moral distress led to self-criticism and self-blame. Some of the coping strategies identified to deal with moral distress included "leaving the unit in search of better conditions, decreasing the stress by working fewer hours, dropping out of nursing…." (p.1139). The research done by Corley et al. (2001) on the development of a moral distress scale showed that 15% of participants in their study had left a previous position because of moral distress. Finally, Hart's (2005) study explored the connection between hospital ethical climate and nurses' turnover intentions and found

that ethical climate was an important consideration in nurses' decision to leave a position or the profession.

As noted above, although there are emerging themes regarding the concept of moral distress, factors that impact moral distress, mediate the experience of moral distress, as well as the relationship between these factors and themes remain unclear. The experience of moral distress has mainly been studied in nurses working on inpatient units on medical or in specialty areas such as intensive care, oncology, and medical/surgical units with little attention given to the area of mental health (Austin et al., 2003; Corley et al., 2001; Corley et al., 2005; Raines, 2000). Some issues nurses identified as creating ethical or moral distress included: prolonging life; performing unnecessary tests and treatments; lying to patients; incompetent care; working with unsafe staffing levels, ineffective pain management, and inadequate resources (Corley et al., 2005; Wilkinson, 1988; Zuzelo, 2007). Kelly (1998), in a follow-up study with nurses who had graduated from nursing school in the previous 12 – 18 months, identified that "the current emphasis on bioethical quandaries, and what may be an obsession with 'ethical dilemmas', tends to obscure the ordinary everyday moral actions nurses engage in by responding to another human being in distress" (p. 1136).

More recently, researchers have expanded to study moral distress experienced by professionals from other disciplines. Evidence from these studies indicated that although the situations that create moral distress vary across disciplines, moral distress is a pervasive problem in healthcare (Austin et al., 2005; Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). Work by McDaniel et al. (2006) examined the relationship between moral distress, ethical environments and patient outcomes.

Although tentative, their research linked moral distress and ethical environment to positive patient outcomes. It has also been noted that early research on moral distress tended to focus on the high profile questions of bioethics such as life and death issues, and overlooked the ethical decision-making nurses face in their day-today practice (Varcoe, 2004). More recently studies have been conducted with a focus on the experience of moral distress in the context of the every day practice of nurses (Austin et al., 2003; Erlen, 2001).

As research on moral distress continues, there is awareness that moral distress is experienced in the day-to-day practice of nurses and as part of the human experience (Austin, et al., 2005). A review of the literature revealed a scarcity of research in the area of mental health and the experience of moral distress.. When the term ”adolescent” was added to the keyword search, no results were found. Thus, there is a gap in research on the phenomena of moral distress in mental health nursing practice with youth. In this research I proposed to contribute to knowledge in this area.

The general purpose of this research was to gain an understanding of moral distress as experienced by mental health nurses who work with adolescents on an inpatient unit, so that a substantive theory can be developed. To achieve this purpose the qualitative methodology of grounded theory was utilized. As noted above, the research questions included:

1. What situations create moral distress for mental health nurses working with adolescents;
2. How do mental health nurses experience moral distress and what do nurses do to ameliorate the experience of moral distress

3. What do nurses perceive as supports and barriers to resolving the experience of moral distress?

It is hoped that findings from this research will contribute to the knowledge base in the area of moral distress. As well, the findings may reveal points of intervention or areas where mental health nurses can be supported to work successfully through issues that create the experience of moral distress. Finally, I hope to provide recommendations for how an Advanced Practice Nurse (ANP) can support an ethical practice environment.

Chapter 3: Methodology

In this chapter I will present a brief overview of grounded theory. Also, a description of the participants, data collection and analysis are presented. Finally, I will offer a means for evaluating grounded theory and discuss the ethical considerations of this study. Creswell (1998) presents a list of reasons for undertaking qualitative research that include: the nature of the research question; a topic that needs to be *explored;* a need to present a detailed view of the topic; and awareness of who is the audience. Qualitative inquiry emphasizes the researcher's role as an active learner, telling the story from the perspective of the participant, not the perspective of expert. Milliken and Schreiber (2001) distinguish between methodology and method, stating that methodology is the link between epistemology and the conduct of research.

What is known about the experience of moral distress is that it is a complex inter and intra personal process. As noted above, the general purpose of this study is to gain a greater understanding of the *processes* that surround mental health nurses' experience of moral distress. Because this research is about understanding process and wanting to understand the process from the perspective of the participant, I determined a qualitative methodology would be best suited to the research questions. It was my intention that subsequent findings of this research could add to the existing body of knowledge on moral distress, and the ensuing theory could provide some direction for changes in nursing practice. In light of the purpose of the research, the research questions, and a review of the qualitative methods available, I decided that grounded theory provided the best fit for conducting this research. A key feature of conducting research using

grounded theory is that the emergent theory is relevant to day-to-day practice because data are drawn from those who live the experience.

Philosophical Underpinnings of Grounded Theory

Grounded theory was developed in the 1960s by Barney Glaser and Anselm Strauss and is a research approach that results in the development of a substantive theory (Glaser, 1978; Baker, Wuest, & Stern, 1992; Wuest, 2007). Wuest (2007) states that Glaser and Strauss wrote comparatively little about the basic underpinnings of grounded theory. However, many grounded theorists agree that the philosophical underpinnings of grounded theory are rooted in symbolic interactionism and pragmatism (Baker et al., 1992; Milliken & Schreiber, 2001; Wuest, 2007). Baker et al. (1992) state that, "Symbolic interactionism is focused on the meaning of events to people and the symbols they use to convey that meaning" (p. 1356). Blumer (1969) identifies three basic premises of symbolic interactionism as being:

> (1) people act toward things and people on the basis of meanings they have for them, (2) meanings stem from interaction with others, and (3) people's meaning are modified through an interpretive process used to make sense of and manage their social worlds (p. 2).

From these basic premises one surmises meaning is socially derived, interpretive, and modifiable through social interaction.

Pragmatism refers to a "theoretical perspective that emphasizes the practical, giving primacy to usefulness over theoretical knowledge; as such, the goal is transformative" (Siegfried, as cited in Wuest, 2007, p. 242). Pragmatism

includes the beliefs that truth is modifiable and relative to time and place, and that knowledge is not value free and historically contextualized. Wuest also states "Under pragmatism the goals of inquiry are judged in terms of their usefulness for making change" (p. 243). Baker et al. (1992) identify the researcher's purpose for using grounded theory is to "explain a given social situation by identifying the core and subsidiary processes operating in it" (p. 1357). Therefore, appropriate circumstances for using a grounded theory approach are when the researcher is attempting to understand human behaviour in context (Wuest, 2007).

Grounded theory is a process by which theory is constructed directly from the data. Data collection and analysis occur simultaneously. As data are analyzed, conceptual categories are created, and relationships between categories are hypothesized. Through the processes of theoretical sampling and constant comparison, these hypotheses are tested against the data to see if they have fit and relevance, and are used to guide further data collection, therefore, the emerging theory remains grounded in the data. Glaser (1978) states that initially the criteria for judging a grounded theory were that it must "fit" the data, have "grab" (immediate relevance), and it must "work" to explain the action in the data; later a forth criterion as added, that the theory should be "modifiable" in light of new data.

Data may be collected through participant observation, focus groups, interviews, written material, self-reflection, and the literature (Baker et al., 1992). For the purposes of this research, participant interviews were used to obtain data. Using constant comparison, all data are coded as they are collected and the

emerging theory guided further data collection. Although the process of developing theory from data can be laborious and complex, it is important to note that the philosophical underpinnings of qualitative research are reflected in both the roots and the process of grounded theory.

Participants

The sample population for this research was drawn from Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) who work on inpatient units or in the community with adolescents who have mental health issues (Please refer to Appendix A for a summary of demographics). Twelve nurses participated in this research, including four men and eight women. Participants had a range of education and experience and included: four diploma prepared psychiatric/general nurses, five baccalaureate prepared nurses, two Master's prepared nurses, and one nurse with a doctoral degree in business. Inclusion criteria included belonging to a registered nursing body, working with youth, and working in mental health. The participants ranged in age from 26 to 56 years old, with the average age being 45.3 years of age. Participant experience in nursing ranged from 2 to 33 years, with the average length of time in practice being 20.1 years.

A review of the grounded theory and qualitative research literature revealed that sample size is determined by saturation of identified categories and not the number of participants (Schreiber, 2001). A category is considered saturated when no new information about the category or its properties occurs as the researcher reviews the data (Glaser, 1978; Schreiber, 2001). Wuest (2007) suggests that, at the narrow focus of a Masters level research, 10 to 15 participants are adequate to reach saturation. In the province of British Columbia there are currently six adolescent inpatient units. Four of

these units specifically serve the health region they are based in, one unit serves both a regional and provincial mandate, and one unit is primarily a provincial resource. The regional units range from 6 – 25 inpatient beds, with a staff mix of Youth Care Counselors, Registered Nurses and Registered Psychiatric Nurses providing direct patient care. Therefore the sample population to draw on was small and the inclusion of multiple sites was necessary in order to establish a large enough sample and ensure anonymity.

Data Collection

The majority of participants were recruited through word of mouth using snowball technique. I placed an advertisement in the registered nurses and registered psychiatric nurses' professional journals, and this yielded several phone calls but only one participant. Participants were asked to contact me if they were interested in participating in a study on moral distress in youth mental health care. When potential participants contacted me, they were given further information on the parameters of the study and the commitment required of them. If the participant agreed, further arrangements were made to conduct an interview. The interviews were semi-structured and ranged from 1 to 2 hours, with the majority of the interviews being approximately 1.5 hours in length. Three interviews were conducted via phone and nine interviews were conducted in person in a location identified by the participant as comfortable and allowing for confidentiality.

Participants were given a copy of the Draft Interview Guide (Appendix B) prior to commencement of the interview so they had awareness of the questions being asked. Participants who were interviewed over the phone had the Interview Guide mailed to them prior to the interview and participants who were interviewed in person were given a

copy of the Interview Guide to review before the interview began. Participants were also made aware that the Interview Guide would be used to direct the interview process but that other questions might be asked for further clarification and exploration of the participant's experience. In keeping with the process of grounded theory, as data were collected and analyzed, the Interview Guide was altered to reflect emerging categories.

Data Analysis

One of the concerns noted by Schreiber (2001) is that novice researchers using grounded theory can remain at a descriptive level of the phenomena under study and fail to move to a level of abstraction that will produce theory. Higher levels of abstraction are achieved by using techniques that are central to grounded theory methodology and include theoretical sampling, coding and categorizing the data, constant comparison, writing memos and diagramming, and inclusions of "strange data" or "negative cases" (Glaser, 1978; 2003; Schreiber, 2001). Omission or failure to utilize these techniques makes it difficult to elevate the data from a description of the data to a theory.

In grounded theory, theoretical sampling is used to develop theory. Glaser (1978) describes theoretical sampling as the process by which the researcher "jointly collects, codes, and analyzes his data and decides what data to collect next" (p. 36). Utilizing constant comparative analysis, raw data are analyzed at increasingly abstract levels of codes and these codes are then used to direct further data collection. Theoretical sampling is a complex process that requires the researcher to move back and forth between the data and concepts, and as a conceptual framework emerges, the data itself will be used to confirm the fit of the analysis and determine further direction for data collection (Glaser, 1978). Through comparing the data as it is collected, the researcher

creates more abstract levels of theoretical connections. Theoretical sampling on any one code ceases when the code is saturated and no new properties for that code are discovered (Glaser, 1978).

In order to help researchers move to a higher level of abstraction, in her description of data analysis, Schreiber (2001) presents a process by which the researcher turns raw data into theory. She describes coding in grounded theory as occurring at three different levels, each level of coding requiring a higher level of abstraction. First-level codes occur when small portions of data are conceptualized by a code or using the participant's words. Second-level coding occurs when first-level codes are collapsed into categories and represent a higher level of abstraction. Third-level codes attempt to explain the relationship between categories. Glaser (1978) also distinguishes between substantive and theoretical codes stating, "Substantive codes conceptualize the empirical substance of the area of research. Theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (p. 55). First and second-level codes are substantive codes and third-level codes are theoretical codes. It should be noted that, although the description of coding is presented in a linear manner, in reality coding is a dynamic process and coding at all three levels may occur simultaneously (Schreiber, 2001). The iterative process of moving back and forth between substantive and theoretical codes keeps the emerging theory grounded in the data and provides direction for further data collection.

Glaser (1978) identified three questions to be kept in mind by the researcher during data analysis: What is this data a study of? What category does this incident indicate? What is actually happening in the data? Glaser (1978) states "These three types

of questions keep the analyst theoretically sensitive and transcending when analyzing, collecting and coding his data. They force him (sic) to focus on patterns among incidents which yield codes, and to rise conceptually above fascinating experiences" (p. 57). Questioning the data forces the researcher to a higher level of abstraction as he or she tries to explain what is happening in the data.

In grounded theory, writing theoretical memos is used in the generation of theory (Glaser, 1978). It is also utilized as a means of facilitating saturation of categories, recording ideas and reasons for the direction taken in developing the theory, and hypothesizing about the relationships between the categories. Memos can take different forms and there is no set requirement for how they are written. Therefore, the researcher is not inhibited by expectations of form or structure and is free to just get the idea out. This freedom allows the researcher to hypothesize about the data and relationships between categories, thus raising the level of abstraction (Glaser, 1978). Diagramming in grounded theory is used to create visual representations of the emerging theory (McCann, 2003). Another function of writing a memo is the development of theoretical sensitivity. Writing a memo allows the researcher to explicate and bring into the open ideas, thoughts, assumptions, and beliefs about the substantive area that the researcher brings to the research. The researcher can then intentionally bring this information to the data to see if it is supported or not (Schreiber, 2001).

As described above, data collection and analysis occurred simultaneously throughout this research. Initially line-by-line coding was used to review the data. Using constant comparison, codes were created and subsumed as conceptual categories emerged from the data. For example, codes such as "talking", "getting advice", and "What was

helpful" eventually became the core category "Engaging in Dialogue". As categories emerged, I used theoretical sampling to test the concepts against the data and determine the next steps in the research. For example, I noted early in the process that participants did not directly link working with adolescents with the incident that created moral distress for them. After discussion with people experienced in using grounded theory, the interview schedule was adjusted to see if this concept could or should be explored further. Following adjustment to the interview schedule participants expressed they felt a greater sense of responsibility to protect the patient when working with adolescents than they experienced when working with adults. Using theoretical sampling, categories were elaborated and saturated if they were supported by the data or discarded if not supported by the data. For example, the concept of having someone in close proximity to talk to came up in the first few interviews as a category. However, through the use of theoretical sampling, the category of "proximity" was eventually discarded, as it was not supported in the data.

Throughout the research process I used memos to keep track of ideas, connections, questions and thoughts as data were collected and analyzed. Memos were updated and elaborated as new data were collected and analyzed. Diagrams were used as a visual representation of the emerging theory, and revealed gaps and contradictions in the theory and provided direction for theory development. At different stages of the analysis and diagramming I presented the data at an advanced grounded theory research seminar for feedback. I used the questions that arose from the feedback to further clarify the data and theoretical connections.

Rigor

Rigor refers to the credibility or trustworthiness of the research and the research process (Morse, 2002; Polit & Beck, 2008). For this research I used the four criteria identified by Glaser and Strauss of fit, grab, work, and that the theory should be "modifiable" to evaluate the theory for credibility (Glaser, 1978). Fit means that the categories emerged from the data and were not imposed on the data. Properties of fit include refit and emergent fit. Refit occurs as the researcher goes back to the data and must continually adjust the categories to reflect new data. Emergent fit refers to categories that fit with pre-existing categories or extant theory. Pre-existing categories or extant theories must earn their way into the theory as data emerges (Glaser, 1978). "Work" refers to the fact that the emerging theory must be able to explain what is going on in the data and potentially predict what will happen; for a theory to work, it must have relevance. Glaser (1978) states that "Grounded theory arrives at relevance, because it allows core problems to process and emerge." (p. 5). Finally, the grounded theory must be modifiable as new data come in. As well, Glaser (2003) argues that the techniques of grounded theory, in and of themselves, are a rigorous process and the end result of "explaining how the main concern is continually resolved" (p. 137) provides evaluation of credibility. Pertinent to this research are the steps that I took to ensure the techniques of grounded theory were adhered to throughout the research process.

To facilitate adherence to grounded theory techniques, my supervisory committee included a member with expertise in grounded theory to help guide the process. Methods

for data collection and sampling were discussed with my committee members. All interviews were digitally recorded and transcribed verbatim. I took notes during the interview process. Feedback was sought and received on my interview skills and techniques from my thesis advisor and a committee member reviewed my initial coding. As data analysis proceeded the emerging theory was presented to an advanced seminar group of grounded theorists for review and questions to make sure the emerging theory was grounded in the data. These discussions presented opportunities to develop theoretical sensitivity, to provide direction for theoretical sampling and to identify potential emergent fit in other substantive areas. For example, during an early discussion with the advanced seminar group I was encouraged to explore the idea of concept of a "moral tipping point" for each participant. As I reviewed the data with this concept in mind it became apparent that for some participants the experience of moral distress helped them clarify their values. This idea fit with the work of Webster and Baylis (2000) and Nathaniel (2006). I also shared the emerging theory selectively with members of the healthcare team to assess for grab and relevance. These members were immediately able to relate the theory to an experience in their own practice.

Evaluation of Grounded Theory Research

Schreiber (2001) describes the goal of a good grounded theory research as:

> the construction of a parsimonious theory with concepts lined together in explanatory relationships that, in accounting for the variation in the data, explains how participants resolve their basic social problem. The theory should be abstract… but must be immediately recognizable to

> participants, must fit the data, and must compellingly illuminate the action and interaction surrounding the phenomenon of study (p. 778).

Mackey (2007) offers a historical overview and current thinking about the evaluation of qualitative research. For grounded theory, she presents Glaser and Strauss's (1967) original criteria for evaluating the quality of grounded theory. These elements include "fit", have "grab", it must "work" to explain the action in the data, and that the theory should be "modifiable" in light of new data. These are the elements that were used as the criteria for evaluating this ground theory described above.

Ethical Considerations

Ethical approval was received from the Human Research Ethics Board (HREB) at the University of Victoria in March 2009. Prior to the interview, participants were given a letter that provided information on the purpose, procedure, requirements, and the risks and benefits of participating in the research. Informed consent was reviewed with the participant, and each participant signed a consent form. Participation in the research was voluntary; all participants were made aware that they could withdraw consent at any time without penalty. Due to the limited size of the population to draw on, which might have made confidentiality of participants difficult to maintain, a decision was made that data collection would be conducted through individual interviews. Anonymity is further protected in that no personal identifying information was used in the findings, and locations of work are identified only as "urban" or "rural". I also discussed with participants was the concern that the experience of moral distress that prompted them to engage in this research may be reactivated simply by talking about the incident again. A

contingency plan was developed should this situation have arisen, but was never required by the participants.

All material and information pertaining to this research will remain locked in a safe in the researcher's residence for one year following completion of this research.

Chapter 4: Findings

Should I stay or should I go?
If I go there will be trouble
If I stay it will be double.
Should I stay or should I go?
The Clash, 1982

In this chapter I will introduce the categories that arose from the data. I will then describe the dimensions that make up each category. Schreiber (2001) states that the first goal of a researcher using grounded theory is to discover the "shared basic social problem" (p. 62) from the perspectives of the participants. The basic social problem that is the focus of this research is the experience of moral distress. The purpose of this research was to understand the experience of moral distress from the perspective of the participants and explicate the process participants used to ameliorate it.

Resolving or ameliorating the experience of moral distress is accomplished through the basic social process of **Doing the Best I Can Do. Doing the Best I Can Do** is the background against which the participants enact their day-to-day practice. Although it seemed to be an unconscious process most of the time, participants clearly described elements they believed were necessary to enact good practice. The elements included the concepts of keeping the adolescent safe, providing individualized care, practicing from a theory base, practicing according to the professional standards, and emotional engagement. They also reflect the values nurses bring to the nurse/patient relationship, and when these values were compromised, participants consciously entered a process whereby they asked themselves the question, "Is this the best I can do?" As participants sought to answer this question, they measured their practice against these

elements. In some cases participants came to understand their practice in the larger context of a complex health care system impacted by intra and interpersonal factors, resource allocation issues, legal parameters, and multiple government systems involvement.

As noted earlier, some participants worked in community and other worked in inpatient settings. The incidents identified as creating moral distress all concerned issues of safety. In all cases, ensuring the safety of the adolescent was the central to the experience of moral distress. Examples of safety incidents created by adolescents included self-injurious behaviour and acts of aggression. Examples of safety incidents that resulted from working in the health care system included orders by a physician to administer inappropriate dosages of medication, the use of extreme force to initiate treatment, disagreement about what was in the best interest of the adolescent and lack of hope for change. Although each participant identified unique incidents that created moral distress, the common thread that ran through all the incidents was that of safety. Experiencing Moral Distress was initiated by participants' actual or perceived inability to keep the adolescent or themselves safe.

Categories of **Doing the Best I Can Do** include **Experiencing Moral Distress**, **Engaging in Dialogue**, **Experiencing Dialogue**, **Shifting Perspective**, and **Resolution**. In most cases participants described incidents that impacted on their ability to keep the adolescent patient safe and led to Experiencing Moral Distress. The experiencing of moral distress triggered the participant to ask him or herself the question "Is this the best I can do?" To answer the question participants entered an iterative process that began with **Engaging in Dialogue** and included **Experiencing Dialogue** and **Shifting**

Perspective. The length of time participants remained in this iterative process varied, however, eventually participants moved towards **Resolution** and answering the question, "Is this the best I can do?"

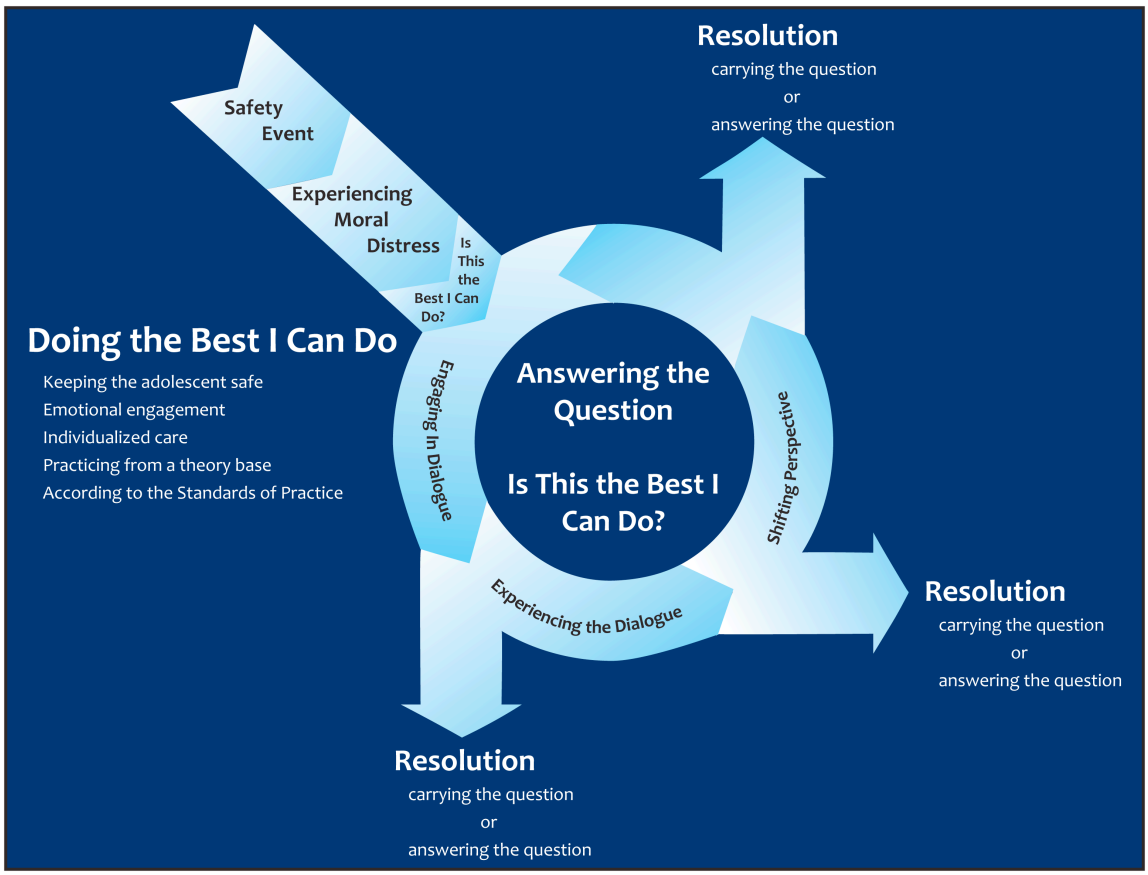

Figure 1 - Doing the best I can do.

As is seen in the diagram above, participants practice against the background of **Doing the Best I Can Do.** An event happens that involves safety. The concept of safety as discussed by the participants is complex and multifaceted. It included the ideas of physical, emotional, and environmental safety and encompassed both adolescents and staff. In most but not all cases, it involves the participant's actual or perceived inability to keep the adolescent safe. After the safety event, participants describe a time of reflecting on the event and over time participants begin **Experiencing Moral Distress**.

The experience of moral distress gives rise to the question "Is this the best I can do?" Participants then enter an iterative process of **Engaging in Dialogue, Experiencing the Dialogue** and **Shifting Perspective** in order to answer the question. At some point in this process the participant has had enough dialogue and moves to **Resolution.**

Doing the Best I Can Do

When participants talked about the incident that created moral distress for them, they presented the incident against a background of **Doing the Best I Can Do**. Although participants were not asked to define **Doing the Best I Can Do**, it became apparent that participants were actually speaking about the elements nurses bring to the nurse/patient relationship that are valued in nursing. A common phrase heard throughout the interviews was "A good nurse would…". It seemed participants had an ideal in their head about how a "good nurse" would practice, and when something went wrong, they reflected back on the incident and their practice trying to understand the part they played and what they could have done differently. The elements of being a good nurse that threaded through participant interviews were the concepts of keeping the adolescent safe, providing individualized care, practicing from a theory base, practicing according to the professional standards, and emotional engagement. There was considerable overlap between concepts, and as participants tried to answer the question "Is this the best I can do?" they measured their practice against these concepts.

Participants viewed keeping the adolescent safe as one of the primary responsibilities of their nursing care. All the critical incidents described by participants resulted from their perceived or actual inability to keep the adolescent safe. The

importance of safety as a primary responsibility of nursing is epitomized in these statements made by one participant:

> …that's a safety issue, so there's my responsibility, to keep the patient safe…so the distress for me was… did I.. was I really… did I put my patient and our unit at risk? (Jay[1])

Participant discussions of the concept of safety were broad and complex. For some participants *keeping the adolescent safe* meant interceding in the moment of crisis, and their focus was on maintaining physical safety of the adolescent and staff. One of the participants described a 30-minute period of time in which three youth on the unit made significant self-injury attempts. The participant described the decision-making process as:

> …the decision was kind of – it was just so easy to make. I mean it was systematic, I mean, somebody's got a deadly bleed – to the hospital – that's a no-brainer. So, you know it was easy. And then the second boy, I mean, we were more worried about self-harm and harm to the staff, that he wasn't presenting as an imminent danger in the seclusion unit…. (James)

Other participants discussed safety from a context of the difficulties they experienced trying to create emotional safety for an adolescent where there were multiple agencies and systems involved in the planning of care, and each had a different agenda. For participants who provided care for youth where multiple government systems were involved, such as the Ministry for Child and Family Development (MCFD), Child and Youth Mental Health (C&YMH), the legal system, the police, and Aboriginal Services,

[1] Names of the Participants have been changed to protect their anonymity

moral distress arose for two reasons. Moral distress arose as a result of being unable to provide emotional safety because of the differing agendas of the involved agencies. For example, Joy was responsible to provide support for an adolescent and family struggling with mental health issues. Joy's efforts focused on supporting the family to stay together. However, MCFD eventually removed the youth from the home due to concerns of neglect. Joy's belief was that the family environment provided the most nurturing environment for the youth and that the perceived neglect was related to his mental health issues.

> Joy: … An intact family can provide better love, caring and support way beyond what any agency can. And … because of the nature of the FASD piece … and they need something that's consistent and warm and loving and that was disrupted ….I don't think at any point, for any reason … that families should be torn apart like that or that we have a power other than the power within the family to make decisions about what happens in their life

MCFD identified the youth's lack of school attendance as an indicator of neglect. Joy's experience of moral distress resulted from being unable to maintain the adolescent in the place she believed provided the most safety.

Moral distress also arose because the participant felt he or she was a collaborator in creating an unsafe environment by virtue of the fact he or she was part of the health care system, as this participant explained:

> …So it's sort of…you know, the difference between the court system, mental heath, and morality. The court system isn't addressing the morality of the situation in any way, shape, or form. And truly the outcome for her [patient]

> has the potential to be catastrophic. My expectation for her is that somewhere along the way we'll find her dead in a ditch some place. And that's just wrong and having a piece of that, that's just wrong. (Grace)

In this instance, Grace experienced moral distress because the agency she worked in required her to prepare the adolescent, with significant cognitive deficits, to face charges in the court system. If the youth was found fit for court, she would most likely be released from the agency. Unfortunately, this youth was homeless and would be discharged back to living on the streets, prostitution and drug use. Grace's distress was directly linked to her professional and personal values about what it meant to keep the adolescent safe.

An added dimension of safety for participants was that of professional safety. When participants spoke about professional safety they spoke specifically about patients or families who threatened to report them to professional bodies or publically call participants' practice into question. Several participants alluded to, or discussed directly, the fact that their work environment also lacked safety, and when they attempted to address issues directly with co-workers or management, they were confronted with suggestions that their own practice was sub-par. However, these suggestions were often indirect or inferred. Several participants identified that the experience of moral distress was accentuated because of an inability to address the issues directly with their co-workers, as this participant described:

> I was undermined by a colleague and it was not directed face to face, with that person telling me how she felt and what she thought… if I'm going to learn from it, it needs to come from that person telling me what I could have done

> better or what I needed to do differently, not go off… be behind everybody else and … say we're all incompetent. (Jay)

Having their professional credibility threatened by adolescents, by their families, or by co-workers directly or indirectly heightened the experience of moral distress.

When participants spoke about providing individualized care, practicing from a theory base, and being emotionally engaged with the adolescent, they often had different resources or interventions to choose from. Participants intentionally tried to choose the resources or interventions best suited to the needs of the youth, and in making these decisions, participants had to balance competing factors. These factors included limited resources, the needs of other youth in their care, the skill and knowledge level of other team members, and the agendas of other systems and professionals involved in the care of the adolescent. Grace provided an example trying to balance these competing factors when she described trying to organize the day at the beginning of her shift. She worked on a unit with adolescents who had diverse needs for support. She was required to balance the needs of the individual adolescent with limited staff resources:

> …in my program I have one boy who does better off the unit than in the unit. When he's on the unit … he gets into more trouble than I care to talk about, just silliness. He gets the other kids worked up and so we all recognize that taking him out and doing stuff with him is far more helpful…. Of my kids, most of my kids need to be out and about at this point in time. Some of my kids are not so inclined to want to go anywhere...and oh yeah, at this point in time I have a kid whose about 6 steps away from catatonic so he has to have a staff there all the time, not

> that he needs more than one staff to look after him, so I stay home with him and disperse everyone around him. I have one kid who flips out and is off the wall on a pretty regular basis. Although she's more stable than she used to be she's still somewhat unpredictable so I need a second staff whose going to stay with me…. So that's 4 [staff] already and nobody got a break. Right?

Grace, who was a shift head, not only tried to organize the shift so each adolescent could receive the support they needed, also tried to balance the youths' needs with the skill levels of the staff. As well, many of the patients in her care were mandated there by the court system and had formal legal requirements that needed to be met as part of their care.

Practicing from a theory base and being emotionally engaged with adolescents were considered integral to being able to decide what resources or interventions would best meet the needs of each youth. Several participants talked about evidence-based practice, using best-practice guidelines, and/or the underlying theory of a diagnosis to direct their interventions for the adolescent. These same participants talked about being emotionally engaged with the adolescent to draw him or her into the therapeutic relationship. Taking action or planning care from this foundation gave them a sense of confidence that they could manage any situation with an adolescent. Generally participants accepted this complex balancing act as part of their daily practice. However, at times it was not possible to balance these competing forces, and the results led to moral distress**.** This complex balancing act is reflected in the following excerpts from

participant interviews. One participant spoke of the clinical team, which supplied resources for the plan of care:

> Well, by and large they certainly try to, but the other piece is that we are now in a time of restraint so there is a certain expectation that you do the same job that you're doing with less resources. (Grace)

Another spoke about the difficult balance

> So there's an outpatient team… and emergency response team… like emergency response mobile team that would be a part of it... and then it would have been the police, you know, in the Emergency Department…. …the problem is everyone's got their own timetable and agenda right? …police have other calls to go to, emergency departments have other patients they need to deal with and an outpatient team basically has other clients… and it seems like the quickest way to do it is just to "get it done"… right? (Elaine)

Elaine is responding to a situation where excessive force is used to bring an adolescent into the hospital for treatment. For Elaine, moral distress resulted from this situation because she has seen it happen several times and was unable to intervene. The above quote reflects her recognition that other systems, such as the RCMP, the Outpatient team, and the ED, have different priorities. These different priorities can lead to actions that can harm the adolescent.

Doing the Best I Can Do is presented as the enactment of day-to-day nursing practice and includes the elements nurses believe they bring to the nurse/patient relationship. It is also the process participants used after an incident that created moral distress as they seek to answer the question "Is this the best I can do?" Categories

contained in **Doing the Best I Can Do** include **Experiencing Moral Distress**, **Engaging in Dialogue, Experiencing Dialogue**, **Shifting Perspective**, and **Resolution**.

Experiencing Moral Distress

Experiencing Moral Distress is what happens for participants after a safety event occurs and leads to the question "Is this the best I can do?" The experience of moral distress did not occur in the moment but over time as participants reflected back on the incident. As participants reflected on the incident they entered a stage characterized by uncertainty, where they began to question how they should have, or could have, interceded to keep the adolescent safe. For some this process included beginning to doubt their nursing judgment and question their decisions. One participant described her thinking process as she reviewed the incident "… I went into this big distress right… [I thought]...'I should… that was really my fault'… I was taking on that piece" (Jay). Another participant expressed how she began to question her role in the healthcare system and consider how her role actually contributed to the situation. "If I hadn't done that [prepared the severely compromised adolescent for court] …potentially the outcome would be a bit better" (Grace). Participants also began to question their professional responsibilities to the client and how these professional responsibilities fit within their current work environment. The experience of moral distress increased over time as participants reflected on the incident or situation and measured their actions against their ideal of what it meant to be "a good nurse".

The specific incidence or situation that led to the experience of moral distress for the participants was unique to each individual but related to the participant's actual or perceived inability to keep the adolescent and themselves safe. These incidents included:

a) adolescent self-harm, b) aggression, c) administering a dosage of medication outside the recommended norm, d) the use of excessive force on the adolescent, e) team conflict, and f) disagreement on what was in the best interest of the youth. As participants identified factors that contributed to Experiencing Moral Distress, three dimensions emerged. These dimensions include: *feeling caught in conflicting values, hearing contradictory messages*, and *experiencing obstructed learning*.

Conflicting values Conflicting values emerged as participants were able to identify how their own values around taking care of adolescents came into conflict with the expectations of co-workers, the agency they worked in, or other systems involved in the care of the youth. A frequent source of *Conflicting values* was the differing agendas of the agencies involved in the care of the adolescent. For example, the courts may mandate an adolescent to a hospital because the adolescent is found unfit to stand trial for an offense. The expectation of the agency is that the nurse will work toward getting the adolescent fit for trial, regardless of the adolescent's developmental or cognitive capacity to make decisions for him or her self. Another source of conflicting values can come from the different agendas of family members. One participant talked about the difficulties that arose when families admitted their child into her treatment program and the family wanted something other than treatment:

> it's trying to work in a very engaging way with families and systems and then having it go sideways because the family has a different agenda than treatment, that's … that's where I have a hard time… then they start to fight to protect the agenda (Noelle)

Conflicting values could also arise from differing agendas within the agency or team in which the participant worked. Within the agencies, participants expressed having their values challenged by agency policy and practices. James described agency policy that prohibited him from doing a personal search of adolescents when they returned from a pass. Because adolescents could not be searched, they continued to bring in items that could be used as weapons to harm themselves or others, and/or drugs.

During the interviews participants often noted a plethora of agencies involved with adolescents. Adolescents presenting with mental health issues often have other complicating factors that make it difficult to separate mental health issues from developmental issues and/or family issues. Cognitive deficits, learning disabilities, drug and alcohol use, unstable family background, history of physical or sexual abuse, and legal issues may mean that other agencies or systems are already providing services to the adolescent. Depending on the needs of the particular adolescent, other potential agencies involved in providing services could include the Ministry of Children and Family (MCFD), Child and Youth Mental Health (CYMH) Services, Out-patient Teams, the legal system – the court system and Probation Services, RCMP, the education system, Community Living British Columbia (CLBC), and Aboriginal Services. Each of these agencies has a different, and often quite limited, purpose and services to offer the adolescent, and coordination between and among them is sparse. Noelle described the difference between the adult mental health system and the adolescent mental health system, "With kids you've got 20 people in the support system, that all think they know better…" Participants acknowledged inadequate financial or human resources limited the purpose and services of the other agencies, however, limited resources and services often

left participants in a position of having to provide care for adolescents beyond their expertise. For example, Grace relayed that the court system is now using her agency, a mental health facility, to provide services for adolescents with significant cognitive deficits but no mental health issues, because there is a dearth of services for this client group. The process of having to provide care for an adolescent beyond the expertise of the nurse brought about a conflict in values. Al talked about the experience of having a very difficult to manage youth on the unit because the behaviours of the adolescent were beyond the expertise of the staff:

> There's a contradiction going on with – I don't want them [difficult youth] here because they're assaultive to us and the other kids. I don't want them out in the community because they're assaultive to the community… I don't want them out there hurting themselves… there's no place for them to go in the community so they have to stay with us….

As can be seen, Al was caught in the dilemma of wanting to keep the patient safe, the other youth on the unit safe, and the community safe, without knowing how he could accomplish any of this.

As participants found themselves in the position of having to provide care for adolescents whose behaviours were beyond their expertise, their values were challenged on several different levels. Some participants found themselves at odds with their co-workers and treatment team. Elaine, for example, experienced *conflicting values* when she found herself questioning the balance of whose needs to meet. Like Al, her experience was that the needs of one adolescent made it impossible to provide services or safety to other adolescents in their care. She identified initially experiencing *conflicting*

values when she found herself trying to balance the need of the adolescent for connection to her community with the need to protect the community from the adolescent's behaviours. Elaine's experience of *conflicting values* was eventually reflected in her relationship with the whole treatment team, and she found herself ostracized from her team when she expressed her views about "the needs of one surpassing the need of others."

Agency policy also impacted participants' ability to act and created *conflicting values* for participants. James described how agency policy inhibited his ability to keep adolescents safe and led to the actual incident that created moral distress for him. James described a critical incident that occurred at the beginning of his shift. A chain of events occurred and within a thirty-minute span of time, three youth engaged in significant self-injury. One youth cut her jugular, a second youth set himself on fire with lighter fluid, and the third youth banged his head until he was unconscious. James believed the hospital policy of not being allowed to do a personal search of adolescents when they returned from a pass made it difficult for staff to ensure the safety of the adolescents in their care.

He also discussed how his experience of moral distress developed over time and was directly related to how his personal values on parenting were in conflict with the agency care plan:

> But morally there are a lot of decisions that need to be made [around how to care for a particular adolescent] that conflict…. A good clinical care plan might not be the best thing a parent might say…. I wouldn't allow my kid to still possess stuff that was dangerous to them or to their health.

James' words reflect the internal conflict participants experience as they tried to make sense of the incident that created a crisis for them.

Contradictory messages. Several participants identified *Contradictory messages* from the employer or co-workers contributed to their moral distress. The *Contradictory messages* most often took the form of stated expectations by the employer or co-workers that were directly contradicted by their actions. For example, Kate talked about how her agency introduced a new model of care, that required staff be more available to the patients, and yet would not supply the human resources necessary to adequately implement the new model of care. Participants described several different ways in which *Contradictory messages* were conveyed, that ranged from blatant to subtle, and were either verbal or non-verbal.

Emma discussed the contradiction that existed in the agency where she worked. The agency had adopted a model of care that emphasized creating a safe environment for adolescent patients, yet this was ignored in specific areas. Emma discussed the contradiction of insisting on creating a safe environment for adolescents in one area of the hospital, yet actually creating trauma in another area. For example, at the initial point of entry to care in the Emergency Department (ED), excessive force is often used to bring some adolescents in for treatment. This same force, if used on the unit, would result in a formal reprimand from the supervisor placed on the employee file, because it made the environment unsafe for the youth. Emma also pointed out the contradiction between the model of care, based on creating a safe environment for the adolescent, that did not extend to creating a safe environment for staff. She gave several examples of staff being physically or verbally assaulted by adolescents, as a result of limitations placed on staff

by management on how staff could intervene with adolescent behaviours. Several participants noted examples in which management encouraged staff to use their clinical judgment in managing adolescent behaviours, and then the staff were formally reprimanded and/or suspended without pay for the decisions they made because the decisions were not in line with unstated agency expectations.

Distressing situations existed where contradictory actions came from co-workers. In cases where participants experienced contradictory actions from their co-workers, these contradictory actions had to do with the approach taken with adolescents. Participants described situations in which a clinical discussion would take place about therapeutic approaches with an adolescent. In these discussions it appeared that consensus was reached about how to work with an adolescent in a way that was considered consistent and therapeutic. Yet co-workers continued to engage with the adolescent in ways that contradicted the agreed approach. Although this behaviour is not uncommon in any work setting, in these situations, participants attributed co-workers' contradictory actions to increasing their experience of moral distress. This was because the participant often felt "set-up" by the team when she followed the care plan and her team members did not.

At times the stated expectations of the agency were not possible to achieve due to inadequate resources provided by the agency. Lack of resources included inadequate staffing levels, to provide the kind of care expected by the agency, and inadequate clinical support/supervision for frontline staff as they implemented the new model of care. In situations where these contradictory actions existed, participants experienced ambiguity and had difficulty making clinical decisions. Kate talked about an incident

involving a patient who was becoming aggressive. Kate was in-charge of the shift, she talked about feeling frustrated because the incident was predictable and that she had asked for an extra staff only to be told that was not possible because the agency did not have the money. Management encouraged the staff to come up with creative ways of dealing with the clients. Kate describes what it was like for her to try and make decisions during the incident

> -- they [the patients] were trashing the place, … and I was afraid to do anything because I had had a colleague who had been working with… who had been reprimanded by management for choosing a certain course of action. And -- and I was basically afraid of getting into trouble. (Kate)

Other participants described similar situations in which they felt unable to make a decision due to *contradictory messages* from management. They began to question their clinical judgment, their relationship with their colleagues, and their role in the agency as they were no longer certain peers or management would support their decisions.

Experiencing obstructed learning. Several participants described distressing incidents or situations that occurred and identified that no learning took place from these incidents. In these instances, often the mechanism for discussion, such as talking to a supervisor or debriefing, was available to the participant. However, due to the way the discussion or debriefing was managed, actual learning from the incident was impeded. Examples of incidents of *experiencing obstructed learning* are: inappropriate use of the court system to access services for cognitively impaired adolescents; the ongoing excessive use of force to bring a youth in for treatment; repeated incidents of self-harm

by the adolescent due to agency policy; and unit cultures that participants identified as being unsafe for them to express a contrary opinion.

One of the threads that ran through the experience of moral distress when participants experienced obstructed learning was the repetitive nature of the incidents. Common phrases used by participants were of the "here we go again" variety. The moral distress created by these incidents did not occur in the moment, but over time, as participants were a part of, or observed, the same pattern of responding to adolescent or team behaviours. This happened even when these patterns of response proved ineffective. Emma told a disturbing story of excessive force being used to bring a youth in for treatment when he becomes ill "…you just have to mention this individual's name and you know how it's going to be for him." Emma laments that, although this youth is brought in approximately every six months, there seems to be no attempt to change this pattern: "If we know all that, then can we not talk about another way to do this?" Participants involved in these situations often took action initially in the hopes of creating change. More often than not, however, participants reported their action did not result in change.

Other participants talked about situations involving co-workers not learning from the incident because genuine dialogue about the incident or situation did not occur and/or it was unsafe to express a contrary opinion. Several participants talked about how, after the incident occurred, a debriefing was scheduled for staff to review the incident and to provide a forum for discussion. Participants noted that the debriefing was ineffective because the discussion were superficial, participants felt they were not heard by others, and key staff involved were not in attendance. Jay recalls her experience of a debriefing

after an incident in which a co-worker went on a tirade, telling staff and patients that her co-workers were incompetent. Jay described the debriefing as superficial: "[the supervisor] was not addressing the key player… not addressing [the issues] with the people face to face, given the opportunity and the arena and the forum that we had … it was fluffed over." Jay identified that part of her moral distress was related to the fact that no learning took place, because no one was actually held accountable for his or her actions. She disclosed her frustration that both the staff behaviour, and the management response, were a long-term pattern that existed on the unit and made it impossible to learn from situations that arose with the adolescents.

Other participants talked about attempting to use the debriefing process or team conferences to discuss therapeutic approaches to deal with specific adolescent behaviours. Their experience in the moment was that they were not heard, or that the team would agree on the need for a different approach; nonetheless, no changes to the care plan or approach would be forthcoming. Participants expressed that the long-term effect was that they felt their opinions were not valued and they were isolated from the clinical decision-making process. In both instances, feeling like their opinions were not valued and being isolated from the clinical decision-making process, the debriefing process was a mechanism established by management intended to facilitate dialogue. However, because of the way in which the debriefing process was managed, participants stated that debriefing only exacerbated their experience of distress. For example, when describing his experience of a formal debriefing, James stated, "It was the worst experience I ever had…. You go in there with your concerns and your fears and you lay it out on the table… So I don't even bother with those". For James, the formal debriefing

process was not a venue where he might have honest dialogue with his colleagues about the incident. For participants who identified the situations described above, the experience of moral distress was twofold; not only did the incident occur, but they also felt like nothing was learned from it, so creating change was not possible.

Experiencing Moral Distress is about what happens for participants after an incident occurs that leads to the question "Is this the best I can do?" Moral distress did not occur instantly, but developed over time as participants spent time reflecting on the incident. When morally distressed, participants described a sense of uncertainty, questioning their nursing judgment, decisions, and roles within the organization. Experiencing moral distress included *Conflicting values, Contradictory messages*, and *Experiencing obstructed learning*. As participants grappled with the question "Is this the best I can do?" they entered into an iterative process beginning with **Engaging in Dialogue** to try and make sense of their experience.

Engaging in Dialogue

After a crisis occurred and the question "Is this the best I can do?" was raised, most participants took action. The action took the form of entering into a process of dialogue as a means of answering the question. Dialogue entailed an iterative process made up of three categories: **Engaging in Dialogue, Experiencing Dialogue,** and **Shifting Perspective**. Participants remained in this process for varying lengths of time but eventually, through **Experiencing Dialogue** and **Shifting Perspective,** participants moved on to **Resolving the Question**. Participants gave different reasons for **Engaging in Dialogue,** and these were because they wanted to: make sense of a difficult situation;

understand the role they played in the incident or situation; and learn what, if anything, they could do differently if this situation happened again.

Many of the participants talked about personal responsibility that is a part of experiencing moral distress. For these participants, personal responsibility included being self-reflective, looking at how their actions contributed to the experience, exploring what other personal and work related factors contributed to the incident, being aware of the resources available to them to work through the experience of moral distress, and figuring out what they would do differently the next time. Participants used phrases such as "a good nurse would…" (Al) and "self-reflection is part of what it is to be professional" (Elaine) to indicate the centrality of examining themselves in their efforts to understand the incident. For all of the participants who spoke about their personal responsibility, **Engaging in Dialogue** was the primary mechanism for working through their the questions.

Engaging in dialogue could be formal or informal, and the people participants sought out for dialogue included supervisors, peers/co-workers, professional bodies, and friends and family, in that order. The length of time participants remained in this process varied and seemed to depend on the participant's overall experience of dialogue. What became clear was that **Engaging in Dialogue** was not a "one time" experience; rather, participants continued to seek out dialogue with a variety of people as they worked their way through the experience of moral distress. Participants sought dialogue from more than person and were able to identify attributes of the dialogue or qualities of the person that made the dialogue helpful or unhelpful in ameliorating the experience of moral distress.

Dialogue took the form of both formal and informal processes. Formal processes took place through such avenues as structured debriefings, clinical team rounds, clinical supervision, consultation with a professional body and accessing the Employee Assistance Program (EAP) offered by the agency. Generally, when participants sought formal dialogue through debriefings or clinical rounds, they were seeking to engage the larger team in a collaborative problem-solving process. At times participants indicated a larger forum for discussion was not appropriate, and sought dialogue through clinical supervision, consultation with their professional body, or EAP. Informal dialogue took place with supervisors, peers or co-workers, and family and friends. Most participants sought out their supervisor to discuss the incident that initiated the experience of moral distress. Often the Supervisor determined if a formal debriefing process would be required, although occasionally the participant would request one. Regardless of who initiated the formal debriefing, the supervisor would make the appropriate arrangements. Formal debriefing either took place as a separate, voluntary meeting that involved multiple disciplines, or was scheduled during the weekly clinical rounds.

There was no clear set of circumstances under which the supervisor would determine a formal debriefing was necessary. As James talked about the incident that initiated his experience of moral distress, he relayed a story that involved a significant suicide attempt and an act of self-harm. When asked if there was a debriefing he stated "No, surprisingly not. They have critical-incident debriefing for some of the weirdest things, but not this one." Thus, he was denied an avenue of dialogue that was potentially helpful for him to deal with his distress.

Participants' discussion of the helpfulness of formal debriefings was mixed, however. The expressed purpose of a formal debriefing was to explore the incident as a larger team and potentially look at how things could be done differently. Several participants noted that formal debriefings were poorly attended and the discussion was superficial. Only one participant identified the formal debriefing process as a helpful forum for discussing difficult situations. As she stated "…I felt like we were all in it together… it was frustrating because there still wasn't clarity…. It made me aware that we needed a bigger process to talk about all this stuff" (Kate).

More often participants used phrases such as "superficial", "not [being] heard" and that it was not a safe environment to discuss personal feelings about the incident to describe the formal debriefing process. One of the reasons given for feeling unsafe was that of not wanting to feel incompetent in front of supervisors or co-workers. Steven reported that it was difficult for him to have a debriefing with his supervisor because he wanted his supervisor to view him as capable and professional. It was more helpful for him to talk privately to a team member because "I could actually express 'it was really messed up'… I just told him exactly how I felt in my own words… he won't think that I'm incapable of working there". Jay also described the formal debriefing process as superficial and unhelpful as issues were not addressed and no one took responsibility for their actions so learning from the incident was not possible.

In contrast, several participants who had clinical supervision built into their weekly practice noted this forum was helpful in ameliorating their experience of moral distress. Factors that made clinical supervision helpful were that the people involved were familiar with the participant, and therefore, knew his or her intentions. Noelle, for

example, has weekly clinical supervision built into the program that she works in. When asked how that worked for her she stated "Wonderful 'cause I can say anything I want to them [clinical supervision group] and they know where my heart is about the work…" She went on to describe clinical supervision as a safe place where people have the courage to ask questions, talk about their feelings about patients, and name issues without fear of being judged. Anita talked about clinical supervision in a broader sense, stating that it wasn't always about talking about how you feel about a situation; sometimes it was about seeking information on how to navigate a situation or the system. Regardless of the reasons for seeking clinical supervision, the common features for participants who were able to use clinical supervision to ameliorate their experience of moral distress were that the people involved in the process had participants' respect, they were trusted, and they worked in the field, and therefore had an understanding of the circumstances the participant faced.

Other participants talked about the benefits of clinical supervision, but were not able to access it for a few couple of reasons. In some cases, the people they would normally get supervision from were involved in the situation that was actually creating the distress. Therefore, they were no longer a safe group to talk with about what was going on. In other cases clinical supervision from other nurses who understood the work environment was not readily available due to distance. Participants who found clinical supervision helpful in the past, sought supervision either through their professional bodies; from other health care professionals such as psychiatrists, psychologists and social workers; or they accessed EAP services. Participants felt that other professionals who understood the work environment could be helpful. Participants who experienced

clinical supervision as a formal process repeatedly reported that clinical supervision was a supportive environment in which they could discuss difficult situations and issues.

Previous experiences with the supervisor often determined whether on not the participant would seek out their supervisor to discussion the situation that created moral distress for him or her. Most participants initially sought dialogue with supervisors after the incident or situation occurred. Supervisors were viewed as having the power to change the situation or intercede so the situation didn't occur again. For example, Al described several difficult situations that he took immediately to his supervisors. His experience of his supervisors was that they were generally supportive of him and that he had credibility with them. Al stated, "… I've been really fortunate, … I've had a lot of support from management to say, 'Okay, so now we need to ask you about questions about things that we can do to make things better for other people as well.'" When he presented situations to them he trusted that they would take action because of his previous experiences with them. In contrast, however, another participant, Emma described her experiences with her supervisor as unsupportive and invalidating, and she found the supervisor unavailable and unaware of the circumstances of Emma's job. Therefore, she felt she could not approach her supervisor when the situation that initiated moral distress arose.

Participants described a variety of responses from supervisors that ranged from supportive to invalidating. Participants' experience of seeking out dialogue with a supervisor was also sometimes mixed, in that they experienced the supervisor as supportive in one setting and unsupportive a different setting. For example, when asked to describe how her supervisor was supportive, Jay stated, "Not blaming. Not accusing,

not making me feel worthless. Giving me positives as well as concerns…. Open door policy, 'Are you sure you talked about this enough?'" However, when describing the formal debriefing process facilitated by her supervisor, she stated the supervisor was ineffective and did not hold anyone accountable for his or her behaviour. Thus, speaking with a supervisor could be considered by participants to be an informal or formal process and participants often described a mixed experience of speaking with their supervisors.

When participants entered the process of **Engaging in Dialogue** they always sought out more than one person for dialogue. After initially speaking with their supervisor, participants then sought out colleagues for dialogue. As with supervisors, participants described mixed experiences and a variety of responses from *them as well.* Except in the cases where participants described team dysfunction as the source of their moral distress, most participants described talking to colleagues as a positive experience. Colleagues provided emotional support because they had an understanding of the participant and the circumstances in which the participant worked. Colleagues did not have to work in the same area as the participant, or be nurses, although being a nurse was identified as being helpful. Certain qualities were integral for the participant in deciding which colleagues they would seek out for dialogue around the incident that initiated the experience of moral distress. These qualities included being trustworthy, being a safe individual, having values similar to those of the participant, being someone who had experience and whose practice the participant respected, being non-judgmental, and having a non-disciplinary role in the participant's work life. These qualities will be discussed further in the category of **Experiencing Dialogue.**

When participants sought out colleagues for dialogue they often stated they were not looking for advise; rather, they were looking to be heard or to create change so the incident would not happen again. Participants looked to colleagues to provide them with guidance or options from their own past experience in dealing with issues that created moral distress. Emma described her colleagues as "Senior nurses who have all experienced it in one way or another… I have to debrief it and come up with a plan about how we're going to avoid this in the future… even if it only happens once in my career, I tell you, it just sticks". Emma described trying to problem solve her incident by speaking to her colleagues from the other departments and disciplines involved in the incident. These colleagues were able to give Emma options from their own experience about how she could deal with the incident.

For participants who experienced moral distress due to team conflict, the feeling of being judged by, and cut off from, their colleagues was a painful experience. Elaine described her relationship with her team prior to the incident as being one in which she was respected by her colleagues. Following the incident, she questioned whether or not she belonged in the agency any longer because she felt cut off from her team members and the decision-making processes of the agency

> I was the senior nurse there… and with all of this it really brought it to the forefront… I don't really feel like I'm part of the thinking in this facility anymore and I had to step back from that senior position… for my own sake really and I'm leaving it 9 months prior to when I'd hoped to … I probably would have stayed except for this scenario. (Elaine)

She identified that she struggles with the loss of her team and felt that the incident hastened her decision to resign from her position..

Some participants sought dialogue with their professional bodies. Dialogue with professional bodies was self-initiated and often rooted in the participant's desire to know that he or she had acted in accordance with the Standards of Practice. Participants talked about their value of acting in accordance with the Standards of Practice in the contexts of **Doing the Best I Can Do** and when they felt their professionalism was being threatened. In some cases, clients or families directly challenged the participant's professionalism. In other cases, co-workers suggested that the participant was incompetent or out of date and threatened the participant's professionalism indirectly. An example of this can be seen in Elaine's comment, "…there was a group of us as the 'older staff'... and were seen as 'old relics that just couldn't change'". She describes that a split had occurred between younger staff and older staff, and when disagreement occurred around the treatment plan for an adolescent, the disagreement was attributed to ageism, indirectly suggesting that the older staff were out of date in their practice.

Some participants contacted their professional body for practice consultation around the incident that created moral distress. Participants who spoke to their professional body described the experience as positive. Joy's experience with her professional body typifies the story related by others who contacted their professional body:

> For me it was really validating and it really allayed some of my fears…. To be able to frame the whole situation in terms of Standards of Practice and had I

> really met them…. I found out through that process that I actually had, that in fact, I'd gone the extra mile.

In the context of being engaged in an iterative process, the act of reviewing their practice against their professional standards helped participants see the incident in the broader context of the unit, the agency or the healthcare system.

A few participants discussed going to family or friends for informal dialogue. When participants spoke with friends or family about a situation, it was to use them as a sounding board and gain emotional support. A few participants had a spouse who was also a nurse. These participants acknowledged that their spouses provided a different kind of support than others because their spouses knew them well and understood their values. They stated that their spouses could be more objective about the situation, and in some cases the spouse could connect the distress the participant was experiencing to other areas of his or her life. Al gave an example of his wife listening to him for the first five minutes and then asking, "'Are you okay, 'cause you're talking about work a lot?' …but then I can look at what's going on at work that's reflecting in my own life…". This kind of discussion helped participants clarify their values, actions, and intentions around the incident.

Engaging in Dialogue is the beginning of an iterative process the participant enters to ameliorate the experience of moral distress. Participants generally sought dialogue from a variety of people as they tried to make sense of the incident. Participants used both formal and informal means for engaging in dialogue, with formal debriefings generally described as not being a safe venue for discussing the incident or situation that created moral distress. For those participants who had experienced clinical supervision,

they described this process as a safe environment for discussing the incident because the people involved in the process understood the intention of the participant, were respected, could be trusted, and worked in the field and therefore, had an understanding of the circumstances the participant faced.

Most often participants sought out their *Supervisor* as the first person they spoke to about the incident that created moral distress for them as they viewed their *Supervisor* as someone in a position to create change. Participants reported a variety of responses from their supervisor that ranged from supportive to invalidating. They also described a mixed experience of their Supervisor, depending on the situation. At times they experienced their supervisor as supportive, and at other times they experienced their supervisor as unsupportive or ineffective. Regardless of the experience participants had when speaking with their supervisor, participants continued to seek out dialogue from other sources, as they wanted to understand the role they played in the incident or situation that initiated their experience of moral distress. Participants remained in this process that began with **Engaging in Dialogue** for varying lengths of time until they were able to move on to **Resolution.**

Experiencing Dialogue

Experiencing Dialogue is the second category of the process and focuses on the participant's perception of dialogue with different people. This category is made up of four dimensions that represent opposite ends of a spectrum, although participants' experiences were varied along the continuum. The dimensions are *supportive/unsupportive, validating/invalidating, heard/silenced, sharing emotional space/being dismissed.* The dimensions identified were a result of participants'

descriptions of the qualities present in the dialogue and the degree that they helped the participant ameliorate the experience of moral distress. Qualities of dialogue that participants experienced as having a negative or positive effect on the dialogue were present in each conversation and overlapped across several dimensions. For the purposes of description, **Experiencing Dialogue** includes negative and positive experiences, though participants describe mixed experiences overall.

The qualities that positively impacted the participant's experience of dialogue included the other person conveying a sense that he or she "gets it", and therefore the participant's experience of moral distress was acknowledged and normalized. If these qualities were absent from the dialogue, participants described a negative experience of dialogue; they felt they were not heard and were therefore unsupported, and their experience of moral distress was invalidated and dismissed. Most participants described a mixed experience of dialogue, however, so long as the overall experience of dialogue was more positive than negative, participants were able to make sense of, and ameliorate their experience of moral distress. **Experiencing Dialogue** was an integral part of answering the question and influenced the outcome of the participant's **Shifting Perspective.** Regardless of the positive or negative experience the participant had of a single conversation, participants continuously sought out further dialogue before they were able to move on to **Resolution.**

As participants engaged in dialogue, they described the experience as being *supportive* or *unsupportive.* Participants identified both qualities of the dialogue and qualities of the other person involved in the dialogue that contributed to their overall experience of the dialogue as being positive or negative. Qualities that participants

perceived as *supportive* were being a nurse, or at least having front-line clinical experience to draw on; being "safe" (non-disciplinary); being non-judgmental; holding similar values to the participant; being a respected practitioner; having the time to listen; respecting the participant's knowledge, skill and experience; listening to the whole story without interrupting; and not offering advice.

Almost all participants identified that speaking to someone who understood their clinical situation was very important. For most participants this meant it was crucial the other person be a nurse. Joy's statement captures the sentiments of most participants when she talked about the qualities of a helpful person "…Who best to know about the struggles or distresses that we are having than another nurse in the field or another nurse whose been there?" A few participants acknowledged that the most important factor was that the other person had an understanding of the types of situations the participant faced, regardless of the profession. The opposite is also true; when participants discussed feeling unsupported, they often made reference to people who didn't understand their clinical situation. This was especially true when participants talked about having a supervisor who was not a nurse and/or who had no clinical experience in the area. Al talked about having to seek help with clinical issues outside of his work area, because he was the only nurse in his area and his supervisors has little or no clinical experience:

> Were their hands are dirty, working with clients? They're management. So that's difficult sometimes to go with -- to them with an issue about what's going on, part -- within the people component of the job and get them to come up with an ability or -- or a way in which they can take in what it is you're saying and -- and share with you in what a suggestion might be. As far as

> nurses go, they [non-nursing coworkers] can't give you anything to do with nursing.

In situations like Al's, participants felt unsupported in their work area, and actively sought out the company of other nurses to tell their story and get support.

Other qualities of listeners who were described as supportive were those of being "safe", having similar values as the participant, and being respected by the participant. When participants spoke about talking to an individual who was safe, they made reference to two different aspects of safety: the listener was not in a position of power over them, and the listener knew the intentions of the participant. Several participants talked about the importance of the listener "honouring their [participants'] ideas". Grace spoke about how difficult the job was and the importance of having a supportive clinical team. She described this team as being a place where "You have to feel that your ideas are honoured. That regardless of how off the wall what you're presenting to them might be, that they're not going to laugh at you. That what you bring to the table is what you bring to the table." Although most participants identified seeking out someone safe for support, more often than not, participants had to go outside of their agency to find someone who could provide that kind of safety.

Other qualities participants perceived as supportive were having the time to listen to the whole story without interrupting, and not offering advice. These qualities are threaded throughout all the dimensions of **Experiencing Dialogue,** and when they were present in the dialogue, participants found the dialogue supportive. Having time to listen, listening without interruption, and not offering advice were woven together and demonstrated to the participant when the listener asked questions seeking clarification,

but listened to the whole story. Although the listener could interrupt the story in this way, when the listener went to problem solving or advice giving too soon, the participants experienced this as being judged or blamed somehow for the situation. Being respectful of the participant's knowledge, skill and experience were conveyed to the participant when the listener acknowledged the complexity of the situation and showed an understanding of why the situation created distress for the participant. Al captures these qualities in the following descriptions of dialogue:

> I should be able to give them the clear data as to why it started out here and why I wound up there at the end. So people jumping before they hear all the facts -- that's not helpful. People who I know have lesser experience than me, who feel like they know what I'm talking about, because they know…. somebody that I know has a lot less experience who comes in and starts telling me how I should have done something, then that doesn't help me at all. So there's -- there's a lack of sensitivity to experience.

And

> …is running a place here right now, she's a social worker … but I did have to go up to her about something a little while ago and say, "How could you make that decision? You're not a nurse. How could you make that judgment? …It's like, "No, you're right, I don't know, and I do rely on you to know this stuff." So that worked -- that seemed to work out quite well where that's concerned.

When the qualities identified as supportive by participants were present in the dialogue, they formed the foundation for a positive experience. When these qualities were not

present, the participant reported a negative experience and walked away feeling frustrated, judged and blamed.

Another important aspect of **Experiencing Dialogue** is that of feeling validated. Participants discussed *validation* from both the perspective of being validated and the perspective of being invalidated by the person whom the participant sought out for dialogue. Participants sought validation from others as a form of perception checking or verification. As participants told their story, they wanted to know that others could understand the reasons for their distress. The unspoken questions being asked by participants included: Is this what I think it is? Do you see what I see? Do you feel what I am feeling? Should I feel this way? Is this reasonable or am I over reacting? Although participants didn't ask these questions directly, the questions were implied in the way they told their story and in the way they described their experience of the dialogue. As participants told their story, they often included their values and the contradictions they saw, and they described their feelings of distress following the incident.

For the participant to experience validation, three elements needed to be present: the other person needed to "get it", the experience of moral distress needed to be acknowledged, and the moral distress needed to be normalized. When asked what advice participants had for nurses who experienced moral distress, the most common response was to "talk to someone who gets it". Grace described finding someone to talk to when experiencing moral distress, as "find somebody incredibly supportive and intelligent to help you through it. And I don't mean intelligent in the sense that 'Wow I have a lot of brains' I mean 'Wow I get what you're talking about' and who can be helpful in supporting you through the pieces". For the other person to "get it" he or she had to

understand the work situation of the participant. Understanding the work situation of the participant meant having an understanding of the work environment, the clientele the participant works with, and the situations and choices the participant faced in day-to-day practice. Emma described what it was like for her to try and explain her work situation to her supervisor, "You have an individual who's running the program… supposed to be your 'go to' person, but doesn't really have an idea of the situations that you find yourself in, right, so when you go to talk to someone who thinks they know what they're talking about and really they don't… it's just, really, it's not helpful". When participants talked with someone who understood their situation, they were able to bring some perspective to the incident. Noelle described the experience as, "I had some sense of making sense of an insane situation right?" Having another person understand the situation contributed to the experience of being validated.

Participants whose experience of moral distress was acknowledged also reported they felt validated. Having the experience of moral distress acknowledged by another was a part of perception checking. When someone else understood why the participant was distressed by the situation, it verified that the participant had an accurate perception of the incident. Acknowledgment was both directly and indirectly given. At times participants heard directly that they were dealing with a difficult situation; more often, acknowledgement was indirect, and people made comments like "I'm glad I'm not the one dealing with this…" Joy reported experiencing a lot of support from people she worked with. When asked to describe how they were helpful, she explained that acknowledgment of her skill and professional judgment, along with ongoing support,

made it possible for her to continue working in her difficult situation and work through her experience of moral distress.

A final part of validation is that of normalization. Normalizing the experience of moral distress helped participant answer the underlying questions of: Should I feel this way? and Is this reasonable or am I overreacting? Many participants accepted that the experience of moral distress was an inevitable part of their professional life and that the important piece was to not to deny the experience; rather it is more important to sort out what to do with the experience. Several participants connected the experience of moral distress to the value of caring, and used these experiences for growth and as a measure of their ongoing investment in their job. Anita captured these sentiments when she explained her thoughts around the experience of moral distress, "I mean, another thing is, I feel it's okay to be distressed. To a certain extent, it's helpful…. And so, like, for me it's quite functional at times and it's just part and parcel of -- of the job." These participants had strategies for managing the experience of moral distress and these strategies included having the experience normalized, and "having some place where you can feel validated… 'Yeah, this is a situation where you should feel moral distress… that's actually the right thing to feel'" (Noelle). When someone normalized the experience of moral distress for the participant, the participant was better able to access the strategies he or she already had in place to manage the moral distress.

Participant experience of *invalidation* also occurred on a spectrum that ranged from simply not being validated to complete invalidation of the participant's experience. Several participants relayed experiences of not being validated that were subtle and *looked like* validation but were not. An example of this is seen in Grace's experience

with her supervisor. She regarded him as supportive in general, however, it was clear that, in the situation she was experiencing, having to prepare a cognitively impaired adolescent for court regardless of her capacity to make decisions that would maintain her safety, his response to her did not respond to the moral distress she was experiencing:

> The conversation had to do with arguing apples and pears. This doesn't necessarily mean that. And it had to do with the court system and mental health and the dichotomies between them. But it's, I don't know, I guess part of it was "this is my job, whether I like it or not, this is part of my job".

In these instances, lack of validation seemed to be about avoiding conflict, either difficult systems issues or interpersonal conflict. In these situations, what was missing was actual acknowledgement that the situation in question was morally distressing for the participant. Instead, the issue of moral distress was skirted by explanations of why the situation had to be that way.

Several participants talked about going to see their supervisor regarding their incident and their supervisor told them to "suck it up". While lack of validation seemed to be a passive process, actual *invalidation* was more intentional and aimed at maintaining the status quo. Emma described her supervisor's response to situations that are brought to her attention, "She doesn't really allow for moral distress… I mean, there just isn't the place or a time for her to allow that… it's like 'suck it up and move on'… so what do you do, you just don't talk to her then". In these discussions, participants' moral distress was acknowledged but not deemed important enough by the supervisor to try and support the participant through the experience. These types of invalidating responses, particularly from supervisors, left the participant feeling like there was no hope that

change was possible, or that the situation could be managed differently or completely avoided in the future. Regardless of whether participants experienced a lack of validation or actual invalidation, the result was that participants no longer sought out dialogue with these people.

Feeling *heard* or being *silenced* was another dimension participants talked about in the context of **Experiencing Dialogue**.. A common phrase used by participants when describing a positive experience of dialogue was that of 'being heard'. When participants were asked to describe what it felt like to be heard, they described the experience in terms of the other dimensions of **Experiencing Dialogue**, feeling supported, validated, and having a shared emotional space. Other elements of feeling heard were that of time and not feeling judged. Participants identified that they felt like they were heard when the other person took the time to hear the whole story without interruption or advice. When someone took the time to listen to the story, the participant experienced it as a supportive action. Participants often recognized there were no easy solutions to their situation, and identified that they felt judged when the other person offered advise without understanding the whole situation. When participants felt like their story was heard, they reported an overall positive experience of dialogue, even when the outcome of the situation that created moral distress did not change.

About half the participants experienced feeling *silenced* when they tried to talk about the incident or situation that created moral distress. Although being heard could only be described in terms of the other dimensions of **Experiencing Dialogue**, participants easily offered a variety of examples when they felt silenced. Participants described being silenced by co-workers and management both directly and indirectly.

Some forms of silencing were subtle and built into the agency culture. In these agencies, participants made a distinction between the *clinical team* and the rest of the staff group. The clinical team was comprised of a psychiatrist, a social worker, a supervisor and a nurse or youth care worker. James described that, in the agency he works in, the clinical team develops the care plan for an adolescent, and if others not on the clinical team had concerns or disagreed with the care plan, there was no formal mechanism for participating in the discussion. Informally, other staff can express concerns but these concerns do not have to be addressed because designated members of the clinical team do not bring these issues forward. James stated, "…nobody was listening to any of the staff. There was [sic] just these three people making the decisions". Another participant working in a different agency described a similar situation, having to follow a treatment plan she did not agree with, but having no voice because she was not on the clinical team.

Another, less subtle, example of formally silencing participants occurred when participants saw co-workers disciplined by management. Several participants spoke about co-workers being disciplined for taking action that did not align with management expectations. Participants reported that, at times, the discipline seemed harsh and reactive. Elaine described several incidents of coworkers being reprimanded and suspended without pay for not using "the best clinical judgment". However, she held the agency partially responsible for two reasons: 1) the agency created the scenario in the first place; and 2) the agency did not intercede and support the individual when it became apparent he was struggling. The discipline was often given during times of chaos and change at the agency, and little support was provided to employees to help them make the shift. The result of the disciplinary action was that employees were afraid to express

concerns or ideas, "and you know people…again that thing where… they want their jobs, they don't want to bring up too much" (Emma). Participants felt that, because the agency was in a time of transition, there was uncertainty about what, exactly, the management expectations were, and they now found themselves in a position of being afraid to act.

Along with formal ways of silencing, participants shared informal ways that they were silenced. Many of the examples they shared were subtle and indirect and included: fear of being labelled by others as a problem, having your practice called into question, or being intimidated by others through yelling, or exclusion from the group. Being labelled by others as "the problem" was identified by one participant as one of the factors that kept her from speaking up when concerns were raised about how to manage adolescent aggression. The difficulty arose because, after management brought in a new model of care, there was a clear division between management and staff. The participant was afraid to state her opinions because she did not want to be seen as being the problem or having a problem with the new model of care, and because she had watched co-workers being disciplined by management for using their clinical judgment.

Lynn: So there were other labels that you were concerned about having.

Kate: Well, labels that . . . of how it had affected other people when they were labelled in those ways, and brought into management's door and -- and been reprimanded….

Other participants had witnessed or experienced being labelled by co-workers as the problem. When this happened, co-workers nullified anything the participant had to say by personalizing the concerns raised by the participant. Co-workers would state that the participant's view was biased by his or her personal feelings and therefore, could be

dismissed. The effect in both these circumstances was that participants felt like they were silenced because they could not have a voice, or would face undesirable consequences if they did use their voice.

The overall effect for the participant of being silenced was they could not directly participate in a problem-solving dialogue. When this happened, participants expressed feelings of anger, powerlessness, and hopelessness, and they could not make sense of the incident that initially created moral distress. However, if participants experienced feeling heard, they reported a positive experience of dialogue, even when the initial situation that created the experience of moral distress was unchanged.

The final dimension of **Experiencing Dialogue** is *sharing emotional space* or *feeling dismissed.* When participants spoke about having a shared emotional space, they were actually talking about the listener connecting with the distress the participant was experiencing related the incident. As has been previously noted, participants recognized the complexity of the situation that created moral distress for them. The purpose of seeking out dialogue in most cases was not to problem solve the situation; instead it was about making sense of the situation. In order to make sense of the situation the participant needed time and dialogue. If the dialogue had qualities participants identified as helpful in ameliorating the experience of moral distress, the dialogue created a space for both the listener and the participant to examine the incident from different perspectives. In the shared emotional space, the participant and the listener could examine the factors that influenced the incident, and the complexity of the situation became evident. Often no tangible resolution or change occurred because of the

dialogue, however; the participant came away feeling supported, heard, and validated and stated that this was all he or she really wanted.

Many of the participants identified that the worst thing that could happen when they experienced moral distress was to have the experience dismissed. Participants spoke about the experience of being dismissed at both a personal and a systems level. On a personal level, having the experience dismissed was identified directly or through the negative qualities of dialogue identified by the participants: being unsupported, invalidated, and/or silenced. When participants had their experience dismissed on a personal level, they expressed feeling frustrated or angry, and powerless to create change. When participants experienced being dismissed on a systems level, they expressed feeling helpless and hopeless. Anita spoke about her experience of being dismissed on both a personal and a systems level

> Well, what's not helpful is to have your feelings dismissed…. I've had that experience with people that don't know me, where it's -- and it's less impactful because of that…. it's much harder to take when people are dismissive when they actually know you and know what makes you tick….

and

> Well . . .the system can seem so overwhelming and here that's what the system feels, is overwhelmingly screwed…. it feels like a huge . . . climb up a mountain, with no ropes or anything to help --

When participants' experience of moral distress was dismissed, they had a negative experience of dialogue. If the overall experience of dialogue was negative, participants expressed feelings of frustration, anger, powerlessness, helplessness and/or hopelessness.

What is interesting to note in this final dimension of **Experiencing Dialogue** is that participants who described having a shared emotional space through dialogue seemed to incorporate this experience into their practice. In the final category, **Resolution**, some participants talk of engaging with adolescents and families in a way that allows then to continue caring. The language they use to describe their engagement is the same language used to describe the experience they had with the listener in having a shared emotional space.

Most participants described a mixed experience of dialogue; it was not all positive or all negative. Participants spoke about different instances of dialogue and were able to identify the qualities of the listener and the dialogue that they found helpful or unhelpful in the process of ameliorating moral distress. One of the important factors is that participants continuously sought out dialogue from a number of sources as they tried to make sense of their experience of moral distress. After each discussion, participants took time to reflect on how this particular dialogue fit with their overall experience of moral distress. Each individual experience of dialogue factored into the participant's ability to make sense of the incident that created moral distress and into the participant's ability to have a **Shifting Perspective.**

Shifting Perspective

The final category of the iterative process participants engage in to ameliorate their experience of moral distress is **Shifting perspective.** For participants, **Shifting Perspective** happened to varying degrees during and after each experience of dialogue. The purpose of engaging in dialogue was to answer the question "Is this the best I can do?" Answering this question was a process and occurred over time as the participant

engaged in dialogue with a variety of sources. Each episode of dialogue was accompanied by an experience of that dialogue and a time of reflection to see how the dialogue fit with, or altered in some way, the participant's perspective of the incident that created moral distress. The participants' experience of dialogue influenced their ability to recognize the factors that played a part in the original safety event. If qualities of the dialogue and the listener were present that allowed the participant to feel safe, the participant had the opportunity to examine the incident beyond the "facts". Participants were able to explore their feelings and values related the experience of moral distress, and eventually, participants were able to examine the factors that impacted on their ability to act in accordance with the values they held personally and professionally. When participants were given the space to examine their own feelings and values surrounding the original incident, they gained insight into their actions. As they gained insight into their actions, they were able to separate their feelings about the incident from the incident itself and examine the contextual factors that impacted on the decision-making that created the incident in the first place.

The listener's response to the participant was integral to this process. As the listener gains understanding of the participant's experience, he or she is able to engage in a process of questioning and dialogue that moves that participant from viewing the incident in the context of that moment to viewing the incident in the context of the system in which the incident occurred. Seeing the incident in the context of the system included examining relationships with co-workers, the unit culture, the agency culture and policies, the other systems involved, and eventually examining the incident in the political context of health care delivery. As the participant is able to recognize the

complexities that surrounded the incident their perspective of the incident shifted. With this shifting perspective participants were able to see the incident and their practice in the broader context of health care delivery. This shift in perspective is seen in Anita's discussion about the experience of moral distress being "dismissed". Anita talked about the experience of being dismissed from a systems level and not from an individual level. Not only was her experience dismissed at a systems level, but also the family's actual health needs were dismissed at systems level because the system didn't have the capacity to meet their needs.

> It was dismissed in the overall picture 'cause he just went home and then back to his drug use and it's all falling apart. And -- but that's the system, that wasn't people. That wasn't any one individual…. Part of my distress in that case was I knew exactly what was going to happen…. in reality, the system didn't allow for anything else to happen.

Within this broader context, participants gained understanding into their actions and the resulting experience of moral distress. When participants moved from speaking about the incident in terms of their own actions to speaking about the incident in the broader context of the team, unit, agency, or healthcare system, they had a more realistic picture of where they could enact change. With growing understanding of the context in which they practiced, participants were able to answer the question "Is this the best I can do?" and move out of the iterative process to **Resolution**.

When participants were unable to consistently engage in dialogue that allowed them to ask questions and explore the incident, they were unable to see their practice in the broader context of the systems that impacted the care they provided. The result was

that the participant could not answer the question "Is this the best I can do?" In these cases, participants did not have consistent avenues to explore their feelings and values surrounding the incident. Because they could not explore their feelings and values around the incident or situation, they were not able to fully examine their actions. These participants continued to talk about the incident with uncertainty and were not able to clarify how they could have acted differently in that situation. Jay captures these sentiments as she struggled to understand if she took the right actions "…because I probably questioned what I ... I wanted to know maybe how I could have done it differently. So I only still have myself to go on at this point…." The complexity of the factors involved could not be explored, even though, in some cases, participants were able to identify factors that contributed to the incident or situation but could not connect how these other factors influenced their own actions. Instead, participants continued to view the incident from the narrow perspective of their own response to it. These participants continued to carry the unresolved question, "Is this the best I can do?" with them.

Participants remained in the iterative process of **Engaging in Dialogue, Experiencing Dialogue,** and **Shifting Perspective** for varying lengths of time. Eventually, when participants had enough experience of dialogue, they exited this process and moved on to **Resolution**. I was not able to determine what triggered each participant to move to **Resolution** however, those who had established supports and an overall positive experience of dialogue moved through this process more quickly than those who did not. Participants who had limited options for dialogue and an overall negative experience remained in the process longer, as they tried unsuccessfully to make

sense of their experience. Elaine's experience of dialogue was generally negative, however, she described finally going to the senior manager of her agency. Elaine described this experience as supportive, and it was only after this experience of dialogue that Elaine moved on to **Resolution.**

Resolution

As noted previously, participants remain in the iterative process for varying lengths of time, trying to make sense of the incident. At some point, the participant has had enough dialogue and is able to move out of this process into **Resolution.** Participants revealed that **Resolution** took one of two forms - *Answering the question* or *Carrying the question with them*. Participants either answer the question, "Is this the best I can do?" incorporate the experience into practice, and engage with clients in a more mindful way; or, they are not able to make sense of the incident and continue to express uncertainty about their actions. When this occurs the participants resolve their distress by removing themselves from the environment in which the incident occurred, and move forward while *Carrying the question with them.* That is, the participant changes practice environment without resolving the moral distress, bringing the unanswered question along with him or her.

Several participants indicated that, through the process of dialogue, they came to believe that, given the circumstances surrounding the incident or situation, they had done the best they could do. For these participants there was a noticeable progression in how they talked about the incident. Much like the zoom lens of a camera, participants kept the incident that created moral distress in focus at the center of the interview. However, they were able to zoom out for a broader picture and see the bigger context in which the

incident occurred. As they looked at the broader picture, they were able to identify and *connect* the factors that impacted, and in some cases, created, the conditions that made the incident possible. When participants looked at the broader picture, they expressed an understanding of why they had acted in the way they did. After taking a broader look at the context of the incident, these participants then zoomed back, holding the adolescent in focus, talked about intentionally engaging with adolescents and families in a way that conveyed caring.

An aspect of **Resolution** that emerged from the data was that the participant's experience of dialogue was later reflected in the language they used to describe the therapeutic relationship. Some of the participants who were able to answer the question, "Is this the best I can do?" talked about the added dimension of intentional practice in the therapeutic relationship. Participants used different language to convey the idea of intentional practice. Some of the phrases used were "mindful practice" (Anita), "I am the intervention" (Grace) and "I made them all know they mattered" (Al). This kind of intentional practice was viewed as an added dimension to "caring" and was used as a possible way to mitigate the limitations of the healthcare system and the participants' experience of helplessness in the face of these limitations. Grace explained it this way

> I have "x" amount of time to work with between now and court. And so, yes I have to do this but I can this other stuff too. And whatever that looks like, teaching cooking skills, teaching social skills, teaching job skills whatever I think I can possibly manage giving them an experience where they feel cared for and nurtured and hopefully that becomes something that they actually want…. so that at some point hopefully that becomes a piece of "oh yeah I

> remember that experience and that was something I really enjoyed and maybe I can create that again for myself" or someone tries to create that for them and it twigs "oh yeah I can, this might be kind of cool" rather than living down on the street with this pseudo freedom or the actual freedom if you really want to look at because you can't go down on the street and scoop them up

Participants who described this type of intentional practice saw the nurse/patient relationship as the place where they could effect change. Focusing on the nurse/patient relationship, at the same time acknowledging the greater context, helped participants move from feeling helpless to having a sense of hope that they could create change for the individual adolescent. These participants continued to try and effect change at a systems level through participation at team rounds and committee work; however, their focus remained on the nurse/patient relationship.

Participants who were not supported through dialogue to see their practice in the broader context were not able to answer the question, “Is this the best I can do?” Although these participants could identify system issues, policies or constraints that surrounded the incident, they were not able to talk about how these factors influenced individual actions and/or the incident. Without the support of dialogue, they were unable to see the incident in the broader context of the health care system. These participants continued to view the incident as an isolated event created by individual actions. Evidence of this experience is found in the following quote from Jay. Throughout the interview Jay had identified team conflict, bullying, and lack of support from her supervisor as contributing to her experience of moral distress, and yet at the end of the

interview Jay continued to view the incident and the moral distress as a result of her own individual actions.

> … It's my dilemma of did I make the right decision cause it could have gone either way, I could have done this way or I could have gone that way and so that's distress. …. I had doubts about it and I don't know that it was morally correct, but that's my moral judgment right, … whatever but I think from a moral standpoint, I didn't do a morally bad thing…. there's some questions so I guess that's the dilemma. So is that something I can really ever get a clear answer?

These participants, unable to see how context influenced their behaviour, carried the question. They also expressed feelings of frustration, isolation, and hopelessness in their ability to effect change, and eventually talked about making a decision to leave the unit or thinking about leaving the unit.

Leaving, or talking about leaving, meant taking a break from the unit they worked on, or leaving the unit or agency altogether. **Resolution** for these participants translated into changing their work environment. At the time of the interview, some participants had already left their position or agency, and others had made the decision to leave and were looking for other work options.

Chapter 5: Discussion

Can't take back those hours
But I won't regret
'Cause you can grow flowers
From where dirt used to be
Kate Nash, 2007

Andrew Jameton first defined moral distress in the literature in 1984, when he noted that nurses had made a moral judgment about a situation but were unable to act on that judgment due to institutional constraints (Jameton, 1993). He later refined his definition to include the experience of initial distress and reactive distress. Initial distress occurred when a nurse made a moral judgment and reactive distress occurred when the nurse was unable to act on that moral judgment. The definition of moral distress was further advanced by Webster and Baylis (2000), when they identified that the original definition was too narrow. They stated that:

> Moral distress may also arise when one fails to pursue what one believes to be the right course of action (or fails to do so to one's satisfaction) for one or more of the following reasons: an error of judgement, some personal failing… or other circumstances truly beyond one's control. (p. 218)

A consequence of unresolved moral distress is that of moral residue, something we may experience when we have "seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Baylis, 2000, p. 318). Moral residue can have a lasting impact on an individual. Webster and Baylis (2000) further delineated the experience of moral distress into positive and negative outcomes for the individual. Unresolved moral distress and the resulting moral residue may move people into a process whereby they clarifiy their values and come to a place of understanding where they will and will not

compromise. A negative outcome of moral distress occurs when an individual manages moral distress by constantly shifting his or her values. When this occurs, an individual may become "desensitized to wrongdoing" (p. 224). This process of trying to clarify one's values was evident in the participants of this research, and engaging in dialogue was the primary means by which participants clarifyied their values. Some of them were able to use the experience of dialogue to clarify their values and discover ways they could take action. Others, who had a negative experience of dialogue, were unable to do this and continued to ask themselves the question, "Is this the best I can do?"

One of the purposes of this research was to explore the process mental health nurses working with adolescents use to ameliorate the experience of moral distress. Nurses in this study identified finding someone to talk to about the experience was a primary means for working through moral distress. This finding is in line with other researchers who point out moral identity and moral action are relational, contextual, and situational (Doane, 2002; Hardingham, 2004; Lindh, 2007; Varcoe et al., 2004) and suggests that ameliorating the experience of moral distress is relational. In Doane and Varcoe's (2005) text on family nursing, they describe a relational nursing practice approach by stating "we view and approach the world through a relational lens, always assuming and looking for how people, situations, contexts, environments, and processes are integrally connected and shaping each other" (p. 51). The stories told by participants in my research project support the need to view moral distress through a "relational lens" as defined by Doane and Varcoe (2005). Participants sought dialogue with others to make sense of the contextual, situational, and environmental factors that contributed to their experience of moral distress and resolution of that distress.

Participants in this study were able to identify qualities of dialogue that were helpful as they attempted to work through their experience of moral distress. These qualities included being trustworthy, being a safe individual, having values similar to those of the participant, being someone who had experience and whose practice the participant respected, being non-judgmental, and having a non-disciplinary role in the participant's work life. Participants also identified that speaking with another nurse was helpful, although speaking to someone from another discipline, who understood their work environment, could also be helpful. When these qualities were present in the discussion, participants were able to engage in a process that allowed them to examine the situational, contextual, and environmental factors that created the situation and made it difficult for participants to act. Hardingham (2004), in her study of student nurses, stated that achieving moral integrity requires that "individuals be thoughtful and reflective as they develop values… it also necessitates thoughtful discourse about the values and theories that guide actions and attitudes, something that cannot be done in isolation" (p. 129). The internal qualities of being thoughtful and reflective were evident in participants of this study. The need for thoughtful discourse to make sense of the experience of moral distress was also evident; however, genuine discourse on moral issues facing the participants seemed to be contingent on external evironmental factors, such as time and the ablity of others to engage in thoughtful dialogue.

As participants talked about their practice and the incident that created their moral distress, it was apparent that they held in mind an image of what they viewed as a "good nurse". The following comments from Elaine reflect this narrative:

> I always wanted to be a good nurse, I always wanted to be professional and the standards are the backbone and they're the framework and I feel professionally supported that way. I feel legally supported if I'm following my standards… and um… I think probably ethically supported… and then, I've done my job and that's what we all want to do at the end of the day

Participants wove comments about what it was to be a good nurse throughout their interview, and answering the question, "Is this the best I can do?" was really about participants trying to discover if they measured up to their personal narrative of being a good nurse.

Doane (2002) referred to this as narrative identity, in her research on ethical practice, and discussed how moral identity is constructed through intra and interpersonal dialogue. Several of the participants in this study seemed to have already constructed a moral identity, and they used dialogue to confirm their reflections that they had either done all they could do, or acted in accordance with their standards of practice and their values. Other participants seemed to be in the process of constructing their moral identity. This was evidenced by the difficulty they had articulating the moral principle(s) that had been violated. While these participants could easily identify moral issues present in their story, they vacillated between believing their distress was due to their own lack of confidence and being unable to identify clearly any violations of moral principles. This uncertainty can be seen in the following comments from Jay:

> [I]t's my dilemma of did I make the right decision cause it could have gone either way [the decision to search a room or not search a room], I

could have done that way or I could have gone that way and so that's distress.

Whereas, at other moments during the interview, Jay was clearly able to connect actions to moral behaviour

Lynn: Can you tell me what makes, what made this incident moral distress as opposed to any other kind of distress that you might have felt?

Jay: because I was undermined by a colleague and it was not directed face to face with that person telling me how she felt and what she thought … it needs to come from that person telling me what I could have done better or what I needed to do differently… no go behind everybody else and just say that we're all incompetent.

For these participants, talking about the incident helped them tease out all the different factors that impacted on the incident. When these factors were illuminated, participants had an easier time speaking about the incident using moral language.

The importance of having time for discussion to developing an ethical practice has been noted by other researchers. Storch et al. (2002), in their research exploring the enactment of ethical practice, identified the importance of dialogue in naming ethical and moral issues in practice. They identified that discussion and the naming of issues had an energizing affect on their participants, and helped them identify "potential solutions and strategies for addressing problems in practice" (p. 12). Using the language of ethics and values to discuss incidents from day-to-day practice has also been recognized as a means of improving the ethical climate of an organization (Rodney, Doane, Storch, & Varcoe, 2006; Storch et al., 2002; Storch, et al., 2009). McDaniel (1998) also identified

involvement in ethical discussions as one of the indicators of a positive ethical environment, and McDaniel et al. (2006) suggested as a means for decreasing or mitigating nurses experience of moral distress. However, increasingly, factors such as lack of time, increasing patient acuity, and lack of human resources make it difficult for nurses to participant in these types of discussions (Storch et al., 2002). Lack of time and resources are instutional constraints that fall outside of the control of front-lines nurses and will be discussed later in the discussion section. What is interesting to note is the reciprocal benefit of creating space for discussion, which is supported in the literature and in this research. In this study, when participants were able to speak about the incident using moral language, they were able see how their actions were congruent, or not congruent, with their own values. They could also identify where they could act to effect change.

Deady and McCarthy (2010) described other strategies identified by nurses to cope with the experience of moral distress. These coping strategies included trying to immunize oneself to moral conflict by adapting/acquiescing to the cultural pressure, denying or trivializing the problem, refusing to work with a particular colleague, moving jobs, or adopting a dual moral code of behaviour: one for home and one for work. They also identified intellectualization as a means of distancing oneself from the situation. Doane (2002) discussed one way nurses maintain an ethical identity is to hold an embedded assumption "that a nurse was not accountable for care (or lack of care), which arose owing to the pressures of systemic forces…" (p. 628). Although these coping strategies are not directly referred to as "negative" coping strategies, Deady and McCarthy (2010) hold them in opposition to "more proactive strategies" that included

reflecting on the problem personally, with family, peers, manager, supervisors, or counselors, further education or training, or working part-time. Participants in this study talked about several of these coping strategies. However, I considered the strategies of intellectualization, and not taking responsibility for care that arose from systemic forces, to be healthy responses to unhealthy situations because participants who used these strategies did not take responsibility for circumstances truly beyond their control.

As participants shared their story with others, and had a positive experience of dialogue that allowed the incident and the actions of other to be explored, their understanding of the situation changed. The participant's perspective shifted from focusing on the actual incident to looking at the environmental and contextual factors that contributed to the incident. As participants were enabled to see their practice in the context of the health care team, the agency, and the health care system, they could examine their actions and measure them against their ideal of a good nurse. As they examined their actions from this standpoint, they were able to answer the question, "Is this the best I can do?" satisfactorily. They could see realistically where they could influence change and where they had limited, if any, power to act. For example, even though Noelle did not receive support from her supervisor, she talked with colleagues and made note of people she could speak to from other systems, such as the outpatient team, to create change. These participants moved beyond viewing their experience of moral distress as a result of a personal failing to viewing the incident as a result of "circumstances truly beyond their control" (Webster & Baylis, 2000, p. 219).

Participants who saw their practice in the broader context did not take responsibility for systemic forces, such as inadequate resources. In this research I didn't

view this as the participant not being accountable for care; rather, I saw it as the participant being able to sort out where his or her responsibility began and ended. Al stated:

> Al: Whereas, sometimes I think -- and I have seen it where people, they -- they don't make those connections [with the adolescent], they don't connect that way, they don't follow that through, or management may say "We're too busy and we can't have you doing it", if they take away the funding which allows me to go play pool or -- or to have hot chocolate with these kids, then they're doing the disservice but I'll wear it.
>
> Lynn: You'll wear it?
>
> Al: Because I can't help them and I know that makes a difference. They [management] know it makes a difference.

In this interchange, Al demonstrates that he was aware of the impact of the lack of resources, but he wasn't willing to take responsibility for it. Al went on to talk about the fact that dwindling resources will make him retire sooner. For participants who could see their practice in the broader context, they often decided the place they could create the most change was in the nurse patient relationship, and that is where they focused their efforts.

Nurses who were able to work through their moral distress talked about it as a learning experience. The incident helped them clarify their values and articulate what they could not live with in practice. This finding has been confirmed elsewhere in the literature (Deady & McCarthy, 2010; Webster & Baylis, 2000). Noelle normalized her

struggling with moral issues in daily practice and acknowledged this struggle as a helpful process

> …you're set up in a situation where you know how potentially dangerous this is [a patient refusing to take medication].. so you try.. because there's no clear and imminent danger, so you try and work with the family, keeping your mind open .. and allowing for people's choices … you do that as long as you can...[the] tight rope is real stressful, walking that tight rope. I wouldn't want to live any other way…. So I think it's always a good thing to wrestle with that.

Struggling with moral issues in a safe environment allowed nurses to develop the moral language to speak to the complex ethical issues that exist in daily practice. Reflective dialogue also made it possible for participants to stay in practice and continue providing ethical care.

One of the questions investigated in the research on moral distress is relates to the impact on patient outcomes. Wilkinson (1987/88) was the first researcher to speculate that the experience of moral distress influenced the way nurses interacted with their patients. Her findings revealed that when nurses are unable to resolve the experience of moral distress, "the nurse may avoid patients and her/his patient care may suffer in various ways" (p. 23). McDaniel et al. (2006) conducted research attempting to measure the connections between ethical environment, healthcare work, and patient outcomes. In their research, patient outcomes were based on two components, a physical summary component and a mental summary component. Their findings led them to "affirm the hypothesized

causal model, linking ethical environment with positive patient outcomes" (2006, p. W27). An underlying assumption of my research was that moral distress would negatively impact the therapeutic relationship. A surprise finding was that there seemed to be a correlation between the participant's experience of dialogue and the subsequent quality of the therapeutic relationship.

One of the findings of this research, which has implications for both healthcare organizations and nursing practice, is that of the impact of dialogue on the nurse/patient relationship. Nurses who had a positive experience of dialogue also integrated that experience into their nurse/patient interactions. Participants seemed unconsciously to integrate their experience of dialogue into the interactions they had with adolescents. During the data analysis phase of this research, it became evident that the language participants used to describe their own experience of dialogue with others was similar to the language they used to describe the interactions they tried to create when they spoke with adolescents. Participants who reported feeling supported, validated, and heard in their experience of dialogue spoke about intentionally trying to create that same experience for the adolescent. For example, Al described how he tried to engage with a family whose teen was having a psychotic break. He use phrases such as "finding a way to connect…", "I don't try to minimize what's going on…", "we just ask a whole lot of questions …", and finally, "You can trust me. What I don't know, I'll find out, but I won't bullshit you…. we'll figure it out together." These phrases reflect the same kind of experience participants were looking for in dialogue, as they struggled to make sense of the incident that created moral

distress, and they echo participant descriptions of how they engage with adolescents.

To a smaller degree, participants who felt unsupported, dismissed, and/or invalidated when they sought dialogue reflected this experience when they talked about working with adolescents. Although these participants did not become unsupportive with their patients, the language they used to describe working with adolescents indicated they needed to protect themselves emotionally from becoming too engaged with the adolescent. The most obvious case was Elaine, who relayed that, after a few months of trying unsuccessfully to discuss the adolescent and the situation that was creating moral distress for her, she was transferred off the unit at her request. On return to the unit, Elaine described putting herself in a position of taking a lesser clinical role on the team in working with the adolescent, "staying more neutral", remaining in the "background", and being available only if the adolescent needed her. Another participant, James, also spoke about the experience of being dismissed when he tried to talk about his safety concerns around agency care plans. The language he used to talk about caring for adolescents in his agency is that they are "just a number". He spoke about putting "a wall up" to protect himself from feeling burned out or too sad when working with his assigned youth. The above findings support the importance of having organizations and management skilled in their ability to respond to ethical situations facing nurses in day-to-day practice. The findings also echo previous research on the need for organizations to establish time and space where ethics can be discussed in the context of daily practice (Storch et al., 2009; Varcoe et al., 2004).

Just as the participants were able to identify qualities of dialogue they found helpful, they were also able to identify the types of dialogue they found most supportive. The people participants sought out for dialogue included supervisors, peers/co-workers, professional bodies, and friends and family, in that order. Supervisors were the most commonly sought out people to talk to after the incident. This echoes other research findings and speaks to the importance of having supervisors and managers skilled in responding to ethical issues and facilitating discussion. (McDaniel et al., 2006; Pendry, 2007; Storch et al., 2002). Participants with previous experience with clinical supervision unanimously stated that it was a helpful forum for working through their experience of moral distress, and activily sought out clinical supervision. The formal debriefing process used in many agencies to discuss issues was described as "not helpful", "superficial", or "the worst experience I ever had" by participants. The debriefing process itself produced no suggestions or course of action. Participants indicated that the formal debriefing process was not a safe place to genuinely discuss issues. I did not determine if the lack of safety was related to the work environment in general or the way the debriefing was conducted. Only one participant stated the debriefing was helpful because it demonstrated that they, management, and staff, were all in it together. A scan of the literature on clinical supervision indicates that it is a relationship that can have a positive effect on helping nurses develop moral decision making skills (Berggren & Severinsson, 2000).

Lastly, participants in this study who were not able to ameliorate their experience of moral distress had either left their position, were actively looking for other work, or talked about looking for other work; this finding mirrors other findings in the literature

(Corley, 2002; Corley et al., 2005; Hart, 2005; Nathaniel, 2006). As noted, resolution for these participants meant changing their work environment.

Implications for Nursing Practice and Organizations

Seeking dialogue was the primary mechanism nurses used to ameliorate the experience of moral distress in this research. Participants also identified there was some personal responsibility involved in seeking out people to talk to about issues that created moral distress. About half the participants in this research reported having positive experiences of dialogue. These participants' stories highlighted the relational, situational, and contextual nature of moral issues. These participants were also able to identify complex environmental factors that impacted on their ability to provide what they perceived as ethical care (Varcoe et al., 2004). This complexity of providing ethical care seemed to be accepted by participants; the difficulty they had was having no place to discuss the issues, and thereby sort out how they would meet their professional obligations. Nurses' feelings of being alone in their decision making has been noted by Pendry (2007), who suggested that agencies be proactive in their efforts to help nurses work through ethical decision making.

Participant descriptions of their efforts to ameliorate the experience of moral distress indicated that they integrated the experience of how they were treated when they sought dialogue into the nurse/patient relationship. As this may affect patient outcomes, it behooves organizations to establish environments that frame clinical discussions in the context of a moral practice (Hardingham, 2004). None of the participants in this study identified speaking to their ethics committees regarding the ethical issues they faced. It is difficult to know if this was because this resource was not available to them, if they were

unaware of this resource, or if there were other reasons for not seeking guidance from members of an ethics committee. Several researchers have suggested that increased involvement with ethics committees may provide nurses with self-confidence when faced with making ethical decisions. Sporrong, Arnetz, Hansson, Westerholm and Höglund (2007) conducted research on the effectivenss in decreasing moral distress by providing ethics education and training. They found that, although participants appreciated the education and training, there was no decrease in participants' levels of moral distress. Sporrong et al's. overall conclusion was that "In the end there are not short cuts to ethical competence" (2007, p.835). Although their research was inconclusive, organizations need to continue offering ethical education and training to develop ongoing competence around ethical decision making. This kind of education and training may help employees decide how to make decisions and take action when faced with competing needs and values. It may also insulate employees from the experience of moral distress and subsequent problematic coping strategies that impact on patient care.

Although it was difficult to ascertain how much dialogue individuals need to ameliorate the experience of moral distress, it is apparent that nurses need a network of support in order to reflect on situations that raise moral issues for them. Aspects of a support network identified in this study that are important are understanding the work situation and the nurse's intention of the nurse to give good care. As well, a support network needs to facilitate the nurse's ability to see his or her practice in the broader context of the health care system. A support network would also help nurses understand how factors in the broader context influence the care they deliver and the nurse's ability to act.

Participants in this study did not explicitly identify a preference for people they would include in their support network; however, when participants were asked to identify people they would go to for support, they most frequently identified supervisors and peers. The influence and importance that supervisors have on ethical discussion has been noted elsewhere in the literature (McDaniel, 1998; Storch et al., 2009). It also seemed that nurses who had an established, formal support network, such as clinical supervision, spent less time struggling with the experience of moral distress. This leads me to the belief that it would be helpful for organizations and nurses to develop ongoing mentoring relationships and/or participate in clinical supervision. Organizations would do well to establish formal mentorship programs or access to clinical supervision that is built into the nurse's work schedule. Doing this would create time and space for nurses to work reflectively through moral issues that create distress. Potentially, these actions would provide support for nurses experiencing moral distress, improve nursing practice, improve patient outcomes, and have a positive impact on recruitment and retention.

Implications for Policy

One significant source of moral distress for participants was that of the conflicting agendas of the different systems involved in the care of adolescents. As previously noted, often when providing care to an adolescent with mental health issues, there can be multiple systems involved. Each agency or system has a different mandate and constraints on the services it can provide. At times the agenda or mandate of the other systems came into conflict with participants' nursing values. One participant identified a situation where lack of funding resources created the opportunity to share staff between

agencies. This opportunity allowed staff in both agencies to gain a greater understanding of the needs and limitations of each system.

Another situation that created moral distress for participants was the inappropriate use of their agency to provide services due to a lack of resources, or gaps in services, for adolescents with specialized needs. When this occurred, participants were forced to provide care for adolescents beyond the nurses' expertise, and felt they were unable to keep the adolescent and/or themselves safe. Another participant discussed that, due to increasing financial pressure, her agency changed the way they delivered services to a specific client group. As a result of this change, they were able to offer more comprehensive support to a larger group of clients. With greater collaboration between systems, the expertise specific to each system could be shared. This could potentially increase the skill level and capacity of staff to provide more comprehensive care. As well, agencies and systems could work together more to fill identified gaps in services effectively. A contributing factor to the experience of moral distress identified in this and other research is that of policy. Lack of policy, binding policy, or ambiguous policy can create situations that lead to moral distress (Storch et al., 2002). It would be helpful for agencies, organizations and systems to work together and develop policy that establishes formal mechanisms for interagency and intersystem collaboration.

Implications for Research

It was beyond the scope of this research to determine how long or how much dialogue was needed for nurses to work through their experience of moral distress. Participants who had clinical supervision, or a forum for clinical discussion built into their practice on a weekly basis, did not spend as much time in the iterative process trying

to answer the question, “Is this the best I can do?” Further, participants who had an established support system seemed to move through the process more quickly. More research is needed to establish whether a formal relationship created around clinical practice, or an informal network of peers, is the most effective forum for working through moral issues. It was also not clear if, or how much, it was the internal characteristics of the participants that made the process of dialogue effective, if effectiveness was related to qualities of listener, or a combination of both the participant and the listener. One final piece that requires more research is that, in cases where participants successfully worked through their experience of moral distress, often there was no obvious change in process or outcome in relation to the original incident that initiated the experience of moral distress. This raises the question of whether genuine dialogue on the moral issues that face front-line nurses on a daily basis is enough support to help them maintain an ethical practice.

Summary

This research adds to the body of knowledge of moral distress by supporting the idea that moral identity is contextually, situationally, relationally and dialogically formed. If this is the case, it makes sense that the resolution of moral distress is also relational and dialogical. Initially the purpose of this research was to: a) identify situations that created moral distress for nurses working with adolescents who struggle with mental health issues; b) identify factors that influenced their experience; c) explore the process nurses used to ameliorate the experience of moral distress; and d) identify barriers and supports to working through the experience. Participants identified a real or perceived inability to keep the adolescent safe as a primary instigator of the experience of moral distress. The

concept of maintaining safety was complex and encompassed both the emotional and physical safety of adolescents and staff. Participants were also able to identify multiple factors that impacted the healthcare environment that both created and influenced the original incident that led to their experience of moral distress. Engaging in dialogue was the most commonly identified, and helpful, strategy nurses used to make sense of moral issues that impacted their day-to-day nursing practice and ability to ethical care. Supervisors were often the person sought out to speak to about moral issues and played an important role in whether or not the participant had a positive or negative experience of dialogue. In order to create healthcare environments where ethical practice can happen, organizations need to create time, space and relationships where front-line nurses can explore how personal and professional values work themselves out in complex practice environments. The act of being allowed to have genuine dialogue on moral issues may be enough in supporting nurses to work through their experience of moral distress.

Bibliography

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., Rankel, M., Kagan, L., & Bergum, V. & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behaviour, 15*(3), 197-212.

Baker, C., Wuest, J., & Stern, P.N. (1992). Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing, 17*, 1355-1360

Berggren, I. & Severinsson, E. (2000). The influence of clinical supervision on nurses' moral decision making. *Nursing Ethics , 7*(2), 124-133.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Englewood Cliffs, New Jersey, USA: Prentice-Hall, Inc.

Breeze, J. A., & Repper, J., (1998). Struggling for control: The care experiences of 'difficult' patients in mental health services. *Journal of Advanced Nursing, 28*(6), 1301-1311. http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=5277868&loginpage=login.asp&site=ehost-live&scope=site

Canadian Nurses Association (2002). *Advanced nursing practice, a national framework,* Canadian Nurses Association, Retrieved September 2005 from http://www.cna-aiic.ca/CNA/documents/pdf/publications/ANP_National_Framework_e.pdf

Committee on Health Human Resources *2002 Our health, our future. Creating quality workplaces for Canadian nurses, FINAL REPORT OF THE CANADIAN NURSING ADVISORY COMMITTEE.* Retrieved April 13, 2008, From http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-cnac-cccsi-final/2002-cnac-cccsi-final_e.pdf

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. *Methodological Issues in Nursing Research, 33*(2), p. 250-256.

Corley, M. C., Ptlene, M., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics, 12*(4), 381-390.

Crestwell, J. W. (1998). *Qualitative Inquiry and Research Design, Choosing among Five Traditions.* Thousand Oaks, CA: Sage Publications.

Deady, R. & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psyciatric nurses experiencing moral distress. *Perspectives in Psychiatric Care, 46*(3), 209-220.

Doane, G.H. (2002). Am I still ethical? The socially mediated process of nurses' moral identity. *Nursing Ethics, 9*(6), 623-635.

Doane, G. H. & Varcoe, C. (2005). *Family nursing as relational inquiry.* Philadelphia, PA: Lippincott Williams & Wilkins.

Erlen, J. A. (2001). Moral distress: A pervasive problem. *Orthopaedic Nursing, 20*(2), 76-80.

Fraser Health Authority (December 2003), *Mental Health & Addictions Strategic Plan 2004 – 2005*. Retrieved March 2004 from http://www.fraserhealth.ca/SERVICES/- MENTALHEALTHANDADDICTIONS

Glaser, B. (1978). *Theoretical Sensitivity.* San Francisco, CA: Sociology Press.

Glaser, B. G. (2003). *The Grounded Theory Perspective II.* Mill Valley, CA: Sociology Press.

Hardingham, L. B. (2004). Integrity and Moral Residue: Nurses as Participants in a Moral Community. *Nursing Philosophy , 5*, 127-134.

Hart, S. E. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship, 37*(2), 173-177.

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues, 4*(4), 542-551.

Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P., & Arnetz, B. (2004). Living with conflicts-ethical dilemmas and moral distress in the health care system. *Social Science & Medicine, 58*(6), 1075.

Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing, 28*(5), 1134-1145. http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=9840887&loginpage=login.asp&site=ehost-live&scope=site

LeFort, S. (2003). Guest editorial and discourse. Nursing care effectiveness: Here to stay. *Canadian Journal of Nursing Research, 35*(3), 7-16. Publisher URL: www.cinahl.com/cgi-bin/refsvc?jid=273&accno=2004016544;

http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2004016544&loginpage=login.asp&site=ehost-live&scope=site

Lindh, I.B., Severinsson E. & Berg, A. (2007). Moral responsibility: A relational way of being. *Nursing Ethics, 14*(2), 129-140.

Lützén, K., & Schreiber, R. (1998). Moral survival in a non-therapeutic environment. *Issues in Mental Health Nursing, 19*(4), 303-315.

Mackey, M. C. (2007). Evaluation of qualitative research. In P. L. Munhall, *Nursing research: A qualitative perspective* (4th Edition ed., pp. 555-568). Sudbury, MA: Jones and Bartlett Publishers.

Marriage, K., Petrie, J., & Worling, D. (2001). Consumer satisfaction with an adolescent inpatient psychiatric unit. *Canadian Journal of Psychiatry, 46*(10), 969. http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=5852692&loginpage=login.asp&site=ehost-live&scope=site

McDaniel, C. (1998). Ethical environment: Reports of practicing nurses. In Nursing Clinics of America, *Ethics for Nursing Practice, 33* (pp. 363-372). USA: Elsevier.

McDaniel, C., Veledar, E., LaConte, S., Peltier, S., & Maciuba, A. &. (2006). Ethical environment, healthcare work, and patient outcomes. *The American Journal of Bioethics, 6*(5), 17-29.

Milliken, P.J. *&* Schreiber, R. S**.** (2001) Can you "do" grounded theory without symbolic interactionism? In R.S. Schreiber *&* P.N. Stern (Eds.) *Using grounded theory in nursing*. (pp.177-191) New York: Springer.

Morse, J. M. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2).

Nathaniel, A. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research, 28*(4), 419-438.

Pauly, B.V., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perception of moral distress and ethical climate. *Nursing Ethics, 16* (5), 561-573.

Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economics , 25*(4), 217-221.

Polit, D. E., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Redman, B. K., & Fry, S. T. (2000). Nurses' ethical conflicts: What is really known about them? *Nursing Ethics, 7*(4), 360-366.

Rodney, P.D., Doane, G.H., Storch, J. & Varcoe, C. (2006). Toward a safer moral climate. *Canadian Nurse, 102*(8), 24-27.

Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber, & P. N. Stern, *Using Grounded Theory in Nursing* (pp. 55-83). New York, NY: Springer Publishing Company.

Sidani, S., & Epstein, D. R. (2003). Enhancing the evaluation of nursing care effectiveness. *Canadian Journal of Nursing Research, 35*(3), 26-38. Publisher URL: www.cinahl.com/cgi-bin/refsvc?jid=273&accno=2004016546; http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2004016546&loginpage=login.asp&site=ehost-live&scope=site

Sporrong, S. K., Arnetz, B., Hansson, M.G., Westerholm, P. & Höglund, A.T. (2007). Developing ethical competence in health care organizations. *Nursing Ethics, 14*(6), 825-837.

Storch, J., Rodney, P., Pauly, B., Fulton, T.R., Stevenson, L., Newton, L., & Makaroff, K. (2009). Enhancing ethical climates in nursing work evironments. *Canadian Nurse, 105*(3), 20 - 25.

Storch, J., Rodney, P., Pauly, B., Brown, H., & Starzomski, R. (2002). Listening to nurses' moral voices: Building a quality health care environment. *Canadian Journal of Nursing Leadership, 15*(4), 7-16.

Varcoe, C. Doane, G., Pauly, B., Rodney, P., Storch, J.L., Mahoney, K., McPherson, G., Brown, H. & Starzomski, R. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing, 45*(3), 316-325.

Webster, G. C. & Baylis, F. E. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of Error: The Ethics of Mistakes in the Practice of Medicine* (pp.???). Hagerstown, MD: University Publishing Group.

Wilkinson, J. M. (1987-1988). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29.

Wuest, J. (2007). Grounded theory: The method. In P. L. Munhall, *Nursing research: A qualitative Perspective* (Forth ed., pp. 239-272). Sudbury, MA: Jones and Bartlett.

Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics , 14*(3), 344-358.

Appendix A

Demographics

Participant	Age	Gender	Education	Length of time in nursing at time of interview	Work setting at time of incident
1	54	F	Diploma	22.6 years	Inpatient
2	56	F	BSN	30 years	Community
3	"Old enough"	M	PhD	30 years	Inpatient
4	41	F	Diploma	9.4 years	Inpatient
5	26	M	Diploma	2 years	Inpatient
6	54	F	Masters	30 years	Community
7	31	F	BSN	7.6 years	Inpatient
8	56	F	BSN CNA Cert	33 years	Inpatient
9	41	M	Diploma	6.6 years	Inpatient
10	43	F	Masters	21 years	Inpatient
11	54	M	BSN CNA Cert	31 years	Community
12	42	F	BSN	18 years	Inpatient
Total/Average	45.3 Years old	8 Female 4 Male	4 Diploma 5 BSN 2 Masters 1 PhD	20.1 Years in Practice	9 Inpatient 3 Community

Appendix B Draft Interview Schedule

Tell me about an experience when you were working with an adolescent and you experienced distress?

Possible follow-up prompts:

And what happened then?

Tell me more about this.

What was it about this situation that you found distressing?

Would you say this was "moral distress"? If so, what makes it "moral' distress"?

How did you respond to this situation? What did you do?

What did you see as your options in this situation? Were there options you felt weren't open to you?

What or who was helpful for you in this situation? What made it/him/her helpful?

What or who was unhelpful for you in this situation? What made it/him/her unhelpful?

What advice would you give a nurse who was experiencing moral distress?

Is there anything else I should know about the experience of moral distress that I didn't ask?