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# Moral Distress and Associated Factors among Baccalaureate Nursing Students: A Multi-Site Descriptive Study

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# Moral Distress and Associated Factors among Baccalaureate Nursing Students: A Multi-Site Descriptive Study

Moral distress and its associated negative consequences among post-licensure nurses have been extensively discussed in the literature. Moral distress is defined as knowing the ethically correct action one should take but feeling constrained from acting on one's convictions due to internal and external constraints (Epstein & Delgado, 2010; Hamric, 2014; Jameton, 1984; McCarthy & Gastmans, 2014; Musto, Rodney, & Vanderheide, 2015). The focus in much of the reviewed literature is on measuring and describing moral distress, moral residue (lingering feelings associated with moral distress), and subsequent deleterious consequences (frustration, apathy, compassion fatigue, and turnover) (Grace, Robinson, Jurchak, Zollfrank, & Lee, 2014; Rushton & Kurtz, 2015; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). Less prevalent in the literature is evidence describing moral distress among nursing students who are at risk for developing such distress when they encounter ethical dilemmas during patient care experiences.

Nursing students who develop moral distress prior to licensure may enter the workplace already experiencing apathy and compassion fatigue. These and other consequences of moral distress have been associated with eroded quality care and increased turnover. According to an American Association of Colleges of Nursing (AACN) 2008 public policy statement on moral distress, an estimated one of three nurses will consider leaving their current position or the profession because of moral distress symptoms. Uncovering empirical evidence describing moral distress among student nurses and the associated contributing factors will assist nurse educators to prioritize and implement educational strategies that may prevent the accumulation of moral distress while providing support to students already experiencing distress. This multi-site study

among three baccalaureate nursing programs located in Midwest and Pacific Northwest regions of the United States of America had three aims: first, to assess moral distress among baccalaureate nursing students (BSN) via the Moral Distress Thermometer (MDT) (Wocial & Weaver, 2012); second, to describe clinical situations contributing to moral distress as experienced by students in clinical practica; and third, to describe predominant reasons why nursing students do not take action during distressing situations experienced during clinical practica.

## Literature Review

A comprehensive literature review resulted in locating one empirical study that measured moral distress among BSN students (Range & Rotherham, 2010). This one-site study (n=66) was conducted at a private faith-based institution and used the Moral Distress Scale (Corley, Elswick, Gorman, & Clor, 2001), a 32-item instrument describing common moral problems experienced by post-licensure nurses in hospital settings. Study findings revealed slight to moderate levels of moral distress.

The literature provided qualitative descriptions about student nurse exposure to micro-ethical and biomedical dilemmas that could result in moral distress. Micro-ethical dilemmas, as first defined by Worthley (1997), are every-day, routine ethical decisions that are so common that they may go unnoticed. When students encounter micro-ethical dilemmas, the risk for moral distress is present because they are confronted with making a decision between two choices: (a) speak up and advocate for quality patient care or (b) remain quiet and permit the substandard practice to occur. For example, students reported micro-ethical issues that could cause harm to patients; e.g., breaking infection control practices, violating confidentiality, failing to appropriately implement sterile technique, bypassing medication administration safeguards, and

mocking patients (Grady, 2014; Krautscheid & Brown, 2014; Rees, Monrouxe, & McDonald, 2014). The literature also revealed reasons student nurses felt constrained from taking action; e.g., fear of failing, discomfort with face-to-face confrontation, uncertainty about what to say during conflict, a desire to be liked by superiors, and feeling subordinate (Grady, 2014; Krautscheid & Brown, 2014; Rees, et al., 2014). Students reported experiencing conflict between their obligation to advocate for quality patient care (NSNA, 2009) and constraints inhibiting their ability to take action.

Extending beyond the nursing literature, one study measuring moral distress among fourth-year medical students was located. Wiggleton et al. (2010) used a researcher-developed 55-item survey to report the frequency of both micro-ethical and biomedical dilemmas and the moral distress associated with each dilemma. The authors presented participants with six reasons "for not taking action in the face of distressing situations" (p. 115). Findings revealed mild to moderate levels of distress associated with the 55 ethical dilemmas presented to the participants. The top two reasons for not taking action included "because I played a subordinate role on the team" and "because I felt that my concerns or questions were due to incomplete knowledge and judgement" (p. 115).

Missing from nursing education literature is large-scale, multi-site research that documents student nurse moral distress ratings and associated clinical practica situations. Also missing is quantitative evidence documenting the most frequently reported reasons that nursing students do not act upon their ethical convictions.

## Methods

This study used a descriptive cross-sectional survey design to measure moral distress and to quantify reasons student nurses do not take action during distressing situations. Additionally,

content analysis was used to qualitatively describe clinical situations associated with moral distress.

**Sample**

A purposive, convenience sampling strategy was used to recruit study participants at all three academic institutions. Those who chose to participate received a token appreciation gift card to a local food vendor. All senior-level nursing students who met inclusion criteria (250 or more hours of clinical experience, currently participating in clinical practicum experiences, and at least 18 years of age) were sent an email inviting them to participate. Consent to participate was implied by completing and submitting the anonymous paper survey. The survey contained no identifying information that could connect study participants with findings, thus assuring confidentiality.

**Survey**

The researchers developed a survey (Figure 1) that incorporated the previously tested and validated MDT (Wocial & Weaver, 2012) as well as literature-based recommendations about the reasons individuals do not speak up during distressing situations. The survey was reviewed by three PhD-prepared nurse educators with both quantitative and qualitative research experience to assure content validity. Prior to survey administration, institutional review board approval was obtained from all three academic institutions. The four-part survey asked nursing students to provide the following: 1) demographic data, 2) moral distress rating via the MDT, 3) brief written narrative describing clinical situations contributing to moral distress, and 4) their reasons for not taking action during distressing situations (participants were asked to select all that apply).

Permission to use the MDT was granted by the author, Lucia Wocial (personal communication, July 7, 2015). Psychometric testing of the MDT has "demonstrated acceptable reliability and support for concurrent validity" (Wocial & Weaver, 2012, p. 171). The MDT is simple to use, asking participants to rate the moral distress they experienced in the past week on a scale of zero to 10 with associated verbal anchors. Zero is associated with no moral distress, five is linked with uncomfortable to moderate amounts of moral distress, and 10 is the worst possible distress experienced. The MDT does not propose examples of potentially distressing practice dilemmas; therefore, the survey in this study included a prompt that asked participants to describe clinical situations contributing to their moral distress rating. The paper-and-pen surveys were administered during fall 2015, outside of scheduled class times. Completed surveys were placed into an unlabeled envelope and collected by the on-site researcher. Surveys were scanned into a PDF document and emailed to the primary researcher via password-protected university email servers. The paper versions of the surveys were shredded. Electronic copies were safely secured on a password-protected computer in the primary researcher's locked office.

**Data Analysis**

Surveys were deleted from the study (n=21) if they were incomplete or illegible. Moral distress ratings were entered into a Microsoft Excel spreadsheet. Mean moral distress values were computed for each academic institution and for the aggregate. A between-groups ANOVA of the mean moral distress values was computed using both E-Z Analyze 3.0 and SPSS 22.0. Reasons for not taking action during distressing situations were also entered into an Excel spreadsheet to compute the frequencies of each response.

Narrative responses were analyzed using qualitative content analysis (Elo & Kyngas, 2007; Lambert & Lambert, 2012; Sandelowski, 2010). Hand-written text data were transcribed

verbatim from surveys onto a Microsoft Word document. The researchers read the text data multiple times, seeking commonalities in language and redundancy in thought. Throughout the content analysis process, text segments from the data were classified as belonging to specific codes. A code book (MacQueen, McLellan, Kay, & Milstein, 1998) was utilized throughout the iterative content analysis process to enhance reliability among the findings. Researchers collapsed codes into categories that shared general meanings. To enhance the reliability of findings, the researchers frequently returned to the data, checking text segments against category definitions. Researchers at each study site met via conference call to compare codes and categories, discuss variations, and arrive at final agreement.

## Findings

Demographics are reported in Table 1. Among the participants (n=267), 233 were female (87%), 31 were male (12%), and three declined to denote a gender association (1%). The average participant age was 22.6 years. Ethnicity demographics revealed 213 Caucasian (80%), 26 "other" (10%), 11 Hispanic (4%), six African American (2%), six Pacific Islander (2%), and five selected "decline to reply" (2%).

### Survey Findings: Moral Distress Thermometer

The aggregate mean moral distress rating was 3.12, which was associated with verbal anchors of mild to uncomfortable distress (Wocial & Weaver, 2012). Table 2 presents mean moral distress values among the students at each academic institution and ANOVA statistics. A one-way between-subjects ANOVA showed no significant effect of academic institution on moral distress ratings among students at all three sites [$F(2,264)= 0.746$, $p>.05$]. Forty-four participants (16%) rated their moral distress as "zero."

### Survey Findings: Reasons for Not Taking Action during Distressing Situations

Table 3 presents the four most frequently selected reasons for not taking action during distressing situations. The most common response, "I have a subordinate role in the patient care environment," was selected 187 times (26.3%). The second most common response, "I want to preserve my relationship with my preceptor and/or clinical faculty," was selected 126 times (17.7%). The third most common response, "I felt my concerns were due to incomplete knowledge/judgment," was selected 118 times (16.6%). And finally, "I didn't know how to respectfully speak up to the person(s) involved" was selected 110 times (15.5%).

**Content Analysis: Clinical Situation Contributing to Moral Distress**

Participants provided hand-written narratives describing clinical situations that contributed to their moral distress. Content analysis resulted in the construction of four categories with related subcategories (Figure 2). Categories, subcategories, and exemplar text statements are provided here.

**Compromised best practices**. Moral distress occurred when participants witnessed healthcare providers demonstrating substandard patient care practices. Sixty-five participants (24%) described clinical scenarios where they observed healthcare workers engaged in actions that contradicted evidence-based practice or endangered quality patient care. Three dominant narratives within this category included *infection control breaches*, *substandard medication administration practices*, and *unsafe work-arounds*.

***Infection control breaches***. Twenty-seven participants associated moral distress with witnessing inadequately implemented infection control procedures. Substandard hand hygiene practices were frequently described: (1) "The nurse I was following this week was not 100% compliant with the foam in/out policy"; (2) "at my clinical site, I have witnessed multiple nurses not washing their hands every time they enter/exit patient rooms. This happened almost

constantly in clinical this week and is a major patient safety and infection risk breach." A second dominant narrative described inappropriate use of personal protective equipment (PPE): (3) "Often nurses on my floor do not follow important protocol in regards to PPE. I often had nurses walk into my patients' rooms who were on contact isolation precautions with no PPE" and (4) "the nurse cut off the top of her glove so that her finger was exposed. She was in the process of starting an IV [*sic*]." A final prevalent narrative described sterile technique breaches: (5) "During a bedside sterile procedure – residents/doctors/RN are not keeping a sterile field" and (6) "a nurse was inserting a catheter into a patient and was getting tired of it not getting into the right place. Instead of getting a new kit, she kept inserting the same one."

***Substandard medication administration practices***. Eighteen participants wrote about witnessing medication administration practices that increased the risk of compromised patient outcomes: (1) "When drawing up insulin my RN would leave frequently and not want to verify the dosage. I had to ask her twice to stay with me when drawing it up"; (2) "medications were taken out of the Pyxis and left in the patient room"; (3) "the nurse was to administer pain medicine IV push. Typically done over 2 to 5 minutes. She pushed the whole amount in at once, which was unsafe for this pt."

***Unsafe work-arounds***. Twenty participants described clinical situations involving work-arounds that compromised patient safety: (1) "I felt moral distress when my nurse preceptor was charting on my assigned patient & got to the GI [gastro-intestinal] section and said 'Oh, I didn't listen to his bowel tones' and then charted WDL [within defined limits], which was the previously charted response"; (2) "I felt kind of weird after taking HR ad RR [heart rate and respiratory rate] on infants and I did the most accurate way I was taught, which is listen to each for 1 full minute. My nurse said she only listens for 15 sec. and multiplies by 4 for her vitals so it

doesn't take as long"; and (3) "Even though we are told auscultation is not correct for checking feeding tube placement, I see it all the time, including on a pt who had pulled her tube partially out."

**Disrespect for inherent human dignity**. Fifty-one participants (19%) described experiencing moral distress when they were treated with disrespect or when they saw clients (individuals, families, and populations) treated disrespectfully. Two dominant narratives emerged from the text data: *incivility toward clients* and *incivility toward nursing students.*

***Incivility toward clients***. Thirty-four participants wrote about clinical situations where compassion and respect for the inherent dignity of each person (American Nurses Association, 2015) was not demonstrated. (1) "In several clinical situations I have seen nurses make fun or criticize people for the state they are in"; (2) "there was an incident early in the week in which a nurse, actually a few nurses, poked fun at a patient, which made me pretty uncomfortable"; (3) "the nurse was treating the client as a number, not a person, and I did not like that"; and (4) "an interpreter was not provided to a patient and family whose primary language was Vietnamese. It was clear they were confused and scared."

***Incivility toward nursing students***. Seventeen participants wrote about experiences where they attempted to speak up and advocate for quality patient care. The narratives reveal how the students were ignored or belittled. (1) "Once I told my preceptor an IV [intravenous] was infiltrated and I was not comfortable administering vancomycin as I know it's a powerful vesicant. She told me it was fine and to hang it. I ran saline to prove it was infiltrated and she still refused to evaluate it. I ended up finding a different nurse who confirmed that the IV was indeed infiltrated and commended me on holding the vanc [*sic*]. My preceptor was rude to me the rest of the shift." (2) "My patient's labs came back and there was a clear indication she had

bacteria in her urine. I brought this up with my nurse, but she kept putting me off and the patient was discharged before the possible infection was treated." (3) "I have called a doctor to discuss my concerns about a patient's pain control and the doctor was short with me, and condescending and instructed me to do nothing further regarding the pt's pain and hung up on me." (4) "I attempted to tell a nurse about a set of declining vital signs on a patient and she blew me off. It took the family member to speak up and say something to intervene. I don't know what would've happened if no family was present."

**Perceived constraints**. Thirty-nine participants (14%) reported they experienced moral distress when they knew the ethically correct action to take but felt constrained from taking action due to limited external resources or personal feelings of powerlessness. Subcategories within this category included *external constraints* and *personal internal constraints*.

***External constraints***. Twenty-three participants reported experiencing moral distress due to external resource constraints. Examples of these constraints included lack of human resources, financial resource limitations, systems issues, and time limitations. (1)"Currently in my community health rotation that serves LSE [low socioeconomic] status refugees, there have been many situations in which I wish I could do more for these individuals who do not have equal healthcare." (2) "Many morally distressing things occur here due to lack of resources. People unable to get mental health counseling when needed leading to suicide is a main problem." (3) "Nurse delayed addressing a complication with a patient based on time constraints and her task list." (4) "Nurses have so much to do that they can't spend a lot of time with kids who need to have time spent with them." (5) "Unfortunately, due to funds and potentially burnout, I don't believe the highest quality of care can be given."

***Personal internal constraints***. Sixteen participants described a sense of powerlessness that constrained ethical action. Powerlessness was noted in the narratives when students reported feeling ill-prepared to effectively speak up in an environment where they were also feeling subordinate. (1) "RNs were not washing hands after patient rooms. I felt uncomfortable to speak with them about this since they are superiors." (2) "I have had experiences that cause discomfort based on nurse behavior and not knowing how to speak up." (3) "I had 2 different nurses in my 2 different shifts last week. They both told me very different and sometimes conflicting things about certain ways of doing things. I knew best practice, but I was nervous about standing up for myself." (4) "There was a situation where gossip/bullying was going on and I should have said something but I didn't because I did not feel comfortable speaking up to someone four times my age."

**Navigating personal values and patient-centered care**. Eighteen participants (6%) reported experiencing moral distress as they struggled to navigate between personal values and professional expectations of patient-centered care. Students reported experiencing turmoil during clinical when their personal values conflicted with the patient's values. (1) "During my clinical I had to take care of a drunk driver who hit a family head on. He also has Hep C [*sic*] and is not protected during sexual encounters, putting the partners at risk. I wanted to talk with him about how his sexual activity is extremely risky and about drunk driving." (2) "A patient in hospice wanted to take life-ending medications. It was difficult to determine the level of intervention that should have been required but also struggling with allowing autonomy of care despite personal opinion." (3) "I was uncomfortable when talking to clients diagnosed with STDs who had sex with so many partners it is hard to count. Also it was against my morals when talking to a gay sex addict who was advocating for gay rights."

## Discussion, Limitations and Recommendations

Findings from this study expose the extent of acute moral distress among BSN students. The ANOVA findings indicate that individual academic institution affiliation did not significantly impact the level of moral distress experienced by students. These findings suggest that BSN students, regardless of geographic location or institutional affiliation, are likely to incur moral distress during clinical experiences. Students who acquire such distress during school may experience a heightened susceptibility to crescendo effects (Hamric, 2014), such as burnout and turnover, during the first year of novice, post-licensure practice.

This study also quantified the most frequently selected reasons students do not take action when confronted with distressing situations. Two of the top four aligned with content analysis narratives; e.g., *feeling subordinate* and *not knowing how to respectfully speak up* were illuminated in the subcategory identified as *personal internal constraints*. Feelings of powerlessness due to subordinate roles and inadequate conflict communication skills are likely to persist within hierarchical post-licensure practice environments, further accelerating the risk for moral distress and moral residue.

Finally, while the content analysis findings were disheartening, they brought out of concealment specific clinical situations contributing to moral distress among students. The preponderance of narratives revealed clinical situations that were routine, every-day, and micro-ethical: i.e. compromised patient care, substandard practice, and disrespect for human dignity. One has to wonder if similar narratives could be identified in interviews with post-licensure nurses and physicians. It is conceivable that work-arounds, substandard practice, and negative vocalizations about clients and students are symptoms of existing moral residue, apathy, and powerlessness among nurses supervising students during clinical practica. Nurses and others may

316 exhibit these behaviors as a coping mechanism to survive within clinical practice environments
317 that are plagued with the presence of compassion fatigue. As reported in the classic work of
318 Chambliss (1996), routinization of healthcare activities "inhibits rules of decorum resulting in
319 flattening of emotion and egregious violation of commonsense morality" (p. 21). The research
320 findings from this study, although conducted 20 years after Chambliss's statement, highlight the
321 widespread and embedded nature of ethical problems within healthcare systems. Despite 20
322 years of literature on this topic, little has been accomplished to proactively prevent and address
323 moral distress. Findings from this study identify a critical aspect contributing to the preservation
324 of moral distress. Nursing students are exposed to clinical learning environments in which
325 advocacy is dismissed, belittled, and unrewarded; thus, they begin to embrace practices that are
326 role-modeled and the status quo culture is preserved.

327 According to Deshpande, Joseph, and Prasad (2006), peer behavior has a strong influence
328 on ethical decision making. They observed that "ethical behavior of coworkers was more
329 important than other determinants of ethical behavior" (p. 212). Students who are repeatedly
330 exposed to role models who demonstrate substandard practice and disrespect for human dignity
331 are primed to succumb to external and internal constraints, deterring moral agency. If this
332 supposition is true, then students could enter the workplace already believing that both academia
333 and the ANA Code of Ethics are theoretical and incongruent with the professional practice
334 mental models shared among practicing nurses.

335 Finally, content analysis revealed the students' moral distress associated with learning to
336 navigate between personal values and providing patient-centered care. While only eighteen text
337 statements were related to this category, the narratives highlight the importance of providing
338 educational support that assists students to reflect upon personal values, challenge hidden

assumptions, and work toward person-centered care within the context of the nurse-patient relationship.

A limitation of this study is that student nurses were asked to report acute moral distress; i.e. distress experienced in the past seven to 10 days. A small percentage of participants commented that they had previously experienced moral distress but did not experience such distress in the last 10 days. Additionally, hand-written qualitative text data were brief, providing one or two sentences, which limited the ability to fully capture the context of each clinical situation. Despite these limitations, the findings support recommendations for nursing education and additional nursing research.

Findings from this study validate that nursing students feel vulnerable and require additional educational support to develop requisite knowledge, skills, and affective freedom to thrive as effective moral agents. According to the classical work of Gula (1997), the ability to act on one's convictions requires knowledge and freedom. Gula explained that "it is unreasonable to demand that someone do what is beyond his or her capacity of knowledge, freedom, and emotional moral strength" (p. 30). This is not to say that nursing students and novice post-licensure nurses are victims of hierarchies and are therefore absolved of ethical responsibilities. Instead, nurse educators should use this research in combination with literature-based recommendations to develop, implement, and evaluate educational strategies aimed at addressing moral distress among student nurses. For example, a variety of sources indicate that nurses may reduce moral distress by first identifying the ethical issue and then by speaking up and advocating for the patient (American Association of Critical Care Nurses, 2010; Lachman, 2010; Rushton & Kurtz, 2015). Missing from these resources, however, is a curricular approach for teaching nurses *how* to effectively communicate. Ethical action and effective advocacy require

knowledge of best practices, ethical frameworks, conflict communication strategies, and personal formation of both empowerment and resiliency.

Recommendations for nursing education include critical curriculum evaluation and revision, ensuring a comprehensive, sustainable approach for teaching the future nursing workforce how to prevent and manage moral distress. According to Benner, Sutphen, Leonard, and Day (2010), students emerging from nursing programs are undereducated for the demands they will face in practice. Benner et al. identified that both educators and students described learning "ethics" in terms of biomedical ethical issues, yet findings from this study revealed that the primary causes of moral distress derived from encountering everyday micro-ethical issues. Thus, a pre-licensure nursing program should emphasize micro-ethical clinical examples, such as those identified in the content analysis of the study. We recommend infusing didactic learning experiences with constructivist learning activities such as unfolding case studies, problem-based learning, cognitive rehearsal, and role play scenarios, using both constructivist and behavioral pedagogies.

Ethical dilemmas, both bioethical and micro-ethical, should also be embedded within simulation scenarios in the academic laboratory. The integration of ethical dilemmas within simulation provides explicit, low-risk opportunities to experience and debrief ethical practice, conflict communication strategies, and advocacy. Such experiences will help students develop congruent mental models of professional ethical practice while also enhancing self-efficacy. In addition to simulation, periodic administration of the MDT at pre-determined intervals is recommended for early detection and debriefing of morally distressing situations.

We also propose developing transdisciplinary co-taught ethics, communication, and leadership courses that would explicitly integrate and capitalize upon expertise from non-nursing

disciplines; e.g., communication, philosophy, and business. Such an approach has the potential to empower the future nursing workforce to enact moral agency and ethical decision-making and to promote collaborative work environments, an ethical healthcare milieu, and optimal patient care outcomes.

In addition, the envisioned curriculum should extend beyond the students, providing education for clinical faculty and agency nurses who teach and role model professional nursing practice at the point of care. For example, nurse educators are encouraged to partner with clinical practice agencies, providing either in-person or online education and consultation services that narrow the academic-practice gap. Finally, clinical practicum sites in which students witness pervasive distressing patient care situations should not be used for clinical education until such issues are addressed and resolved.

Recommendations for research include implementing the aforementioned curricular revisions and teaching strategies and then re-evaluating moral distress levels and associated factors. In addition to these recommendations, conducting research that correlates levels of moral distress with clinical specialties could provide data to guide prioritization of educational efforts. A final research recommendation is to conduct a phenomenological study, exploring the meaning of *compromised best practices* from the emic viewpoint of students.

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Table 1.

*Aggregate Participant Demographic Data (n=267)*

| Demographic | Findings |
|---|---|
| Age | $x$=22.6 |
| Gender | Female: 233 (87%)<br>Male: 31 (12%)<br>Declined to reply: 3 (1%) |
| Ethnicity | Caucasian: 213 (80%)<br>Pacific Islander: 6 (2%)<br>Hispanic: 11 (4%)<br>African American: 6 (2%)<br>Other: 26 (10%)<br>Declined to reply: 5 (2%) |

Table 2.

*Mean Moral Distress Rating among Baccalaureate Nursing Students*

| Survey item | Mean (*x*) |
|---|---|
| Moral distress rating combined | 3.12 |
| Academic agency 1 | 3.31 |
| Academic agency 2 | 3.00 |
| Academic agency 3 | 2.98 |

| ANOVA | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 7.970 | 2 | 3.985 | .746 | .475 |
| Within Groups | 1410.880 | 264 | 5.344 | | |
| Total | 1418.850 | 266 | | | |

Table 3.

*Reasons for not taking action during distressing situations – top four responses*

| Survey item | N (*%*) |
|---|---|
| I have a subordinate role in the patient care environment. | 187 (26.3%) |
| I wanted to preserve my relationship with my preceptor and/or clinical faculty. | 126 (17.7%) |
| I felt my concerns or questions were due to incomplete knowledge and judgment. | 118 (16.6%) |
| I didn't know how to respectfully speak up to the person(s) involved. | 110 (15.5%) |