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Predicting Moral Distress Through the Dimensions of Psychological Empowerment in Nurses

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Abstract

Introduction: Moral distress is an important challenge among critical care nurses. psychological empowerment can pave the ground for proper moral performance and prevention of moral distress among nurses. This study aimed to predicting moral distress through the dimensions of psychological empowerment in nurses.

Methods: This descriptive cross-sectional and analytical study carried out in 2018. For this purpose, 190 nurses were selected by convenience sampling from the critical care units in Southern Khorasan Province, Iran. Data were collected using Corli's Moral Distress Questionnaire and Spreitzer's Psychological Empowerment Questionnaire. Data were analyzed in IBM SPSS ver. 16 using descriptive and inferential statistics.

Results: Finding showed that moral distress intensity was (4.8±0.51) and negatively correlated whit psychological empowerment (P=0.03, r=-0.5). Moral distress frequency was (5.2± 0.56). The psychological empowerment was (4.1± 0.44). The results of the multiple regression indicated that 2 % variation of moral distress intensity explained by psychological empowerment (ADJ.R2:0.238). Among these dimensions, three dimensions meaning, competence and self-determination significantly predict the intensity of moral distress (R2=0.25, P< 0.05). Moral distress correlated with age, working experience, and type of the ward (P<0.05).

Conclusions: Nurses with a greater psychological empowerment showed less intensified symptoms of distress where they were able to perform morally proper action.

INTRODUCTION

Moral distress is defined as a physical and psychological unrest occurring at times when people are unable to perform correct moral action although they are aware of correct performance [1]. In other words, mental and practical limitations act as impeding factors, limiting the fulfillment of moral goals for individuals [2].

When an individual encounters moral distress circumstances, s/he will experience different physical and psychological symptoms [3]. The individual will first feel unhappy and anxious because of failure to perform correct action [4] which may later lead to nightmares, insomnia, and nervous pains [5, 6]. In case moral distress is not relieved of and the individual does not get adapted to it, his/her working quality would be extensively affected [7], where nurses would be unable to provide acceptable care to patients [8]. This can in turn lead to increased hospitalization time and lack of recovery [9].

Nurses who are working in Critical Care Units experience high level of moral distress [7, 10]. Critical Care Units (Intensive Care Unit, Cardiac Care Unit, Neonatal Intensive care Unit, Hemodialysis unit, and Oncology care unit) holds patients in critical conditions [11]. The critical conditions of the patients in these

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wards present moral challenges for keeping and caring of them [12]. A prevalent moral problem is moral distress in these wards.

Lazzarin et al. (2012) and Elprin et al. (2005) studied moral distress in intensive care units and reported high moral distress among nurses. They stated that the conditions caused by moral distress made nurses disinclined to perform their care duties [10, 13]. In a study conducted to assess moral distress in special care units in 2012, moral distress was introduced as a multi-faceted and complex phenomenon with unclear consequences [14]. Joolaee et al. (2012) found moral distress among nurses at medium level and stated that distress can have important effects on nurses [15].

Various issues can bring about moral distress among critical care nurses. Futile care, end-of-life care [16], interaction with the physician or other care team members [11], unnecessary care [17], lack of moral courage [18], and etc. can all contribute to moral distress in nurses.

Among factors contributing to moral distress is psychological disability to perform moral duties [19]. Psychological empowerment is a cognitive state characterized by an individual's perception of the extent to which s/he can control, efficiently manage, and internalize workplace objectives [20-23]. Psychological empowerment can lead to an individual's increased liability, sense of self-efficacy, a change in attitude and judgment concerning personal and organizational issues, and in all has different consequences for nurses [22].

Empowerment on the part of nurses can strengthen their mental power to cope with stressful situations, and help control several stressful factors in the workplace [23]. Empowerment can be an effective factor in quality performance and efficiency of nurses. Increased empowerment can positively affect nurses' recovery and organizational outcomes [21]. Among its significant outcomes are increased motivation and job satisfaction as well as innovative behaviors among nurses which lead to efficiency of their activities [10, 24].

Browning et al (2013) investigated the relationship between moral distress and psychological empowerment among nurses working in the Intensive Care Unit. They reported the empowerment level of nurses as high [19]. Knol and van (2009) also considered psychological and structural empowerment among nurses as medium and introduced empowerment as a predicting factor of innovative behavior among nurses [25].

Evidence reveals that the phenomenon of moral distress is important in nurses and the Psychological inability of nurses in doing moral actions can provide the context for moral distress [20]. Psychologically unable nurses cannot have proper performance, and may undergo moral distress [19].

So, considering the significant effects of distress on nurses and the care provided by them, it may be possible to empower them psychologically with this aim to infuse them with the attitude and power required to deal with distress-producing factors. This is hoped to contribute preventing and reducing distress and its effects in nurses and in turn in patients and health-care systems. Regarding the importance of these in nurses' performance and the quality of care, and the fact that no study has directly considered the relationship between moral distress and psychological empowerment among nurses, the study aimed to examine these phenomena among intensive care units nurses.

The conceptual framework in this study is based on the concepts of moral distress and psychological empowerment. As an ethical challenge, moral distress occurs when an individual has the knowledge and awareness of the right moral performance but is unable to do the right action for some reason including actual or mental limitations [26]. Of these limitations are mental and psychological barriers [26]. Psychological limitations can play an important part in the occurrence of moral distress among people [27]. An individual who is psychologically unable does not have the right ability to do the right action and would undergo moral distress [28].

Since disempowerment of individuals, especially psychologically, is the key concept in the occurrence of moral distress, psychological empowerment may overcome their mental limitations [21]. Psychologically empowered persons acquire the vision to perform the right moral action [19]. Thus, an empowered person with such a vision and belief can manage to encounter moral challenges properly with feeling moral distress [23].

METHODS

The aim of this study was predicting moral distress through the dimensions of psychological empowerment in nurses.

Study Design

This cross-sectional, descriptive and analytical study performed in 2018 in educational and governmental hospitals in Southern Khorasan, Iran.

Study Population and Sampling

The sample size was calculated according to the formula of communication studies $n=\left(\frac{Z_{1-\frac{\alpha}{2}}+Z_{1-\beta}}{\frac{1}{2}\ln\frac{1+r}{1-r}}\right)^2+3$,and based on the following indexes($Z_{1-\beta}$=0/84; $Z_{1-\alpha/2}$=1/96; α=0.05; $\frac{1}{2}\ln\frac{1+r}{1-r}$=0.199; β=0.20; r=0.196). Using convenience sampling, 220 nurses working in critical care units were invited and 190 nurses accept to

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participate in the study. There was 5 educational and governmental hospital in Southern Khorasan, Iran. Intensive care unit (ICU), Cardiac care unit (CCU), neonatal intensive care unit (NICU), Hemodialysis, and Oncology wards were considered for selecting samples.
Including criteria: having at least one year's working experience in clinical wards, holding a minimum degree of bachelor's in nursing, working full-time in study environment, and willing to participate in this study.
Excluding criteria: those of nurses don't have including criteria.

Questionnaires

Demographic and Professional Questionnaire
Data on gender, age, marital status, working experiences as critical care nurse, status of employment, working unit were gathered by specially designed form.

Moral Distress Questionnaire
Moral Distress questionnaire (MDS) consists of 38 items designed by Corley in 1995 and measures moral distress intensity, the level at which the nurse experiences painful feelings related to a given situation (none to great extent), and moral distress frequency, i.e., how often the nurse experiences the painful feeling associated with the distressful situation (never to very frequently) on a Likert type scale from none (1) to great extent (7). The MDS uses 3 subscales to measure moral distress: 1) individual's responsibility (refers to the nurse participating in care not agreed with or ignoring actions one should take), 2) not in patient's best interest (refers to participation in care that the nurse considers inappropriate because of futility for the patient), and 3) deception (refers to the nurse not addressing issues honestly, related to impending death of a patient). The original English tool, which was returned by Back ward-Forward into the Persian version, and was valid and reliable. The validity was calculated using Content Validity Index method (CVI) and reported to be 0.89. The reliability was calculated using internal consistency method (Cronbach's alpha) and reported to be 0.93 [29].

Psychological Empowerment Questionnaire
Psychological Empowerment questionnaire (PEI) consists of 16 items designed by Spreitzer in 1995 [20]. The PEI used 4 domains or subscales, previously defined, to measure psychological empowerment: 1) meaning, 2) competence, 3) self-determination, and 4) impact. Each domain addressed 4 items measuring empowerment. Items were scored on a Likert type scale from very strongly disagree (1) to very strongly agree (7). The original English tool, which was returned by Back ward- Forward into the Persian version, and was valid and reliable. The validity was calculated using Content Validity Index method (CVI) and reported to be 0.87. The reliability was calculated using internal consistency method (Cronbach's alpha) and reported to be 0.79.

Data Collection and Analysis
After obtaining written legal permissions and ethical codes from affiliated hospitals, the self-report questionnaires were given to the nurses and later collected by the researcher after completion. This process took 36 days (From October to November 2018) There were a total number of 220 nurses of whom only 190 agreed to participate; the other 30 nurses refused to participate. Data obtained from the questionnaires were analyzed in IBM SPSS ver.16 using descriptive statistics (Mean, Standard deviation, Frequency, Frequency percentage) and inferential statistics (Pearson's correlation, independent T test, one-way ANOVA, Multiple regression). The statistical significant was ($p < 0.05$).

RESULTS

Demographic and Professional Characteristics
From 220 nurses, 190 completed questionnaires were analyzed. Demographic characteristics of the study units included Age, Gender, years of critical care experience, Status of employment and Working unit. The age of participating nurses ranged from 23 to 47 years, and their mean age was 33 (SD=5.66) years. The highest number of years of critical care experience was 24 years, while the lowest was 1 year, with the mean of 6.54 years (SD=5.44). Table 4 shows the demographic and professional characteristics of the participants.

Moral distress and Psychological Empowerment
The results reveal moral distress intensity was 4.8 (SD=0.51) and mean moral distress frequency was 5.2 (SD=0.56). The mean subscale moral distress intensity and frequency are provided in Table 2 (where total intensity and frequency ranged from 1 to 7). The mean psychological empowerment was 4.1 (SD=0.44). The mean subscale psychological empowerment is shown in Table 1 (Total intensity and frequency ranged from 1 to 7).
There was a negative significant correlation between moral distress intensity and psychological empowerment ($P=0.03$, $r=-0.5$). No significant correlation was found between moral distress frequency and psychological empowerment ($P>0.05$). Correlation between subscale moral distress and subscale psychological empowerment is shown in Table 2.
The results of the regression analysis indicated that the four dimensions of psychological empowerment were significant predictors of moral distress intensity. The results of the regression indicated that 2 % variation of moral distress intensity explained by psychological empowerment (ADJ.R^2:0.238). Among these dimensions, three dimensions meaning, competence and self-determination significantly predict the intensity

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of moral distress. By increasing one standard deviation unit in the score of meaning, the intensity of moral distress will increase by 0.19 standard deviations. Increase one standard deviation unit in score competence, 0.12 standard score will increase the intensity of moral distress. Also, an increase of one standard deviation unit in the self-determination score will add 0.24 units to the standard deviation score of ethical distress intensity (Table 3).

Table 1. Mean and standard deviation of dimensions of moral distress and psychological empowerment in nurses (n=190)

Variable	Mean(SD)
Psychological empowerment	
Meaning	3.12(±0.4)
Competence	5.1(±0.74)
Self-determination	4.2(±0.56)
Impact	4.1(±0.6)
Total	4.1(±0.44)
Moral distress intensity	
Not in patient's best interest	4.8(±0.7)
Individual responsibility	5.5(±0.43)
Deception	4.2(±0.5)
Total moral distress intensity	4.8(±0.51)
Moral distress frequency	
Not in patient's best interest	5.8(±0.6)
Individual responsibility	5.2(±0.44)
Deception	4.66(±0.51)
Total moral distress frequency	5.2(±0.56)

Table 2. Relationship between dimensions of moral distress and psychological empowerment in nurses(n=190)

	Psychological Empowerment				
	Meaning	**Competence**	**Impact**	**Self-Determination**	**Total Empowerment**
Moral distress intensity					
Not in patient's best interest	r:-0.33* P:0.03	r:-0.43 P: 0.03	r:-0.04 P:0.04	r:-0.51 P:0.01	r:-0.35 P:0.01
Individual responsibility	r:-0.5 P:0.04	r:-0.3 P:0.02	r:-0.13 P:0.03	r:-0.4 P:0.05	r:-0.4 P:0.04
Deception	r:-0.53 P:0.01	r:-0.33 P:0.04	r:-0.11 P:0.04	r:-0.45 P:0.03	r:-0.5 P:0.02
Total moral distress intensity	r:-0.4 P:0.03	r:-0.35 P:0.01	r:-0.16 P:0.01	r:-0.25 P:0.01	r:-0.5 P:0.03
Moral distress frequency					
Not in patient's best interest	r:-0.12 P:0.13	r:0.13 P:0.112	r:0.34 P:0.06	r:0.12 P:0.62	r:0.1 P:0.3
Individual responsibility	r:-0.24 P:0.13	r:-0.43 P:0.14	r:0.36 P:0.53	r:0.29 P:0.37	r:0.28 P:0.5
Deception	r:0.48 P:0.23	r:0.13 P:0.27	r:0.5 P:0.16	r:0.03 P:0.33	r: 0.42 P:0.13
Total moral distress frequency	r:0.3 P:0.13	r:-0.6 P:0.52	r:0.03 P:0.23	r:0.35 P:0.34	r:0.43 P:0.1

*: Pearson correlation coefficient

Table 3. Predicting moral distress through dimensions of psychological empowerment

Predictor Variables	B	SE	Beta	T	P
Constant	8.093	2.019	-	2.73	0.05
Meaning	2.654	0.334	0.19	1.07	0.027
Competence	0.043	0.356	0.12	3.114	0.031
Self-determination	1.567	0.24	0.24	1.178	0.033
Impact	0.97	0.507	0.017	0.54	0.067
	R:-0.5	**R^2:**0.25	**ADJ.R^2:**0.238		

Table 4. Mean and standard deviation of moral distress and psychological empowerment according to demographic variables (n=190).

Variables	Frequency (percent)	Moral Distress (M±SD)	Psychological empowerment (M±SD)
Gender			
Female	150(78.8)	5/7±1/1	6/1± 0/5
Male	40(21.2)	4/98± 0/97	4/78± 0/66
Pv		P=0.08 t=1/324*	P=0.12 t=2/004*
Status of employment			
Formal	121(64.1)	3/88±0/56	5/13± 0/7
Informal	69(35.9)	5/11±0/93	4/88± 0/57
Pv		P=0.1 t=1/024*	P=0.09 t=1/134*
Working unit			
ICU	101(53.5)	6/2±0/88	4/11± 0/68
CCU	38(20)	4±0/76	5/9± 0/65
NICU	12(5.9)	3/8±0/7	5/2± 0/47
Oncology	13(6.5)	5/2±0/91	3/8± 1/11
Hemodialysis	26(14.1)	3/4± 0/95	4/7± 0/8
Pv		P=0.04 F=3/931**	P=0.1 F=2/211**

***:** T test
**:
ANOVA

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Moral distress, Psychological empowerment and Demographic characteristics

There was a negative significant correlation between the total score of moral distress and age (P=0.04, r=-0.3) and working experiences as critical care nurse (P=0.03, r=-0.3). There was a significant correlation between the total score of moral distress and type of ward (P=0.04). The highest score of moral distress was observed in the ICU ward and the lowest score was observed in the dialysis ward. No significant correlation was observed between the total score of moral distress and sex and work status (P>0.05), neither was found any significant correlation between psychological empowerment and demographic characteristics (P>0.05). (Table 4)

DISCUSSION

The aim of current study was to investigate the relationships between moral distresses, psychological empowerment of critical care nurses. Results of this study indicate that the nurses with a higher psychological empowerment had a lesser intensity of moral distress. As well as psychological empowerment is a predictor for the intensity of moral distress. The results also confirmed the conceptual framework this study that empowering nurses can to remove one of the obstacles created distress among nurses and the nurses who felt psychological empowerment has characteristics such as competence, self-determination and meaning that it can act as a deterrent to moral distress.

According to Browning (2013), psychological empowerment is a preventive factor from forthcoming moral distress where the distress reduces upon fewer encounter of nurses by this phenomenon [19]. Wagner et al. (2010) studied psychological and structural empowerment mentioning that empowerment of nurses in different domains can play a significant role in gaining job satisfaction and preventing from their stress and moral challenges (24). Knol and Van (2009) also considers structural and psychological empowerment of nurses as important, discussing that when nurses feel empowered, they develop creative behaviors and can achieve their objectives more easily [25].

Also our result indicate that the high psychological empowerment had not coloration whit frequency of moral distress. Browning (2013) in her study the premise that is a significant relationship between psychological empowerment and moral distress and empowering nurses less often with encountered distress [19]. In this context we can say that although the increase in nurses' psychological empowerment, decreases in the intensity of moral distress but cannot prevent the occurrence of moral distress and its effect on patients. This capability can only reduce the severity of nurses compared to ethical challenges. In other words, psychological empowerment as a psychological protection factor between moral condition and nurses.

Moral distress was at an average level in terms of severity and frequency. In most studies, the level of moral distress was medium to high [3, 11, 12]. In previous studies researchers reported that the highest moral distress resulted from items not in the patient's best interest (futile care). These studies showed moral distress an important phenomenon which may have different effects on nurses and patients. Similarly, studies conducted in Iran report it to occur at an average frequency [12, 15, 30].

To investigate moral distress, 38 questions were posed, of which question number 12 [I find myself caring for the emotional needs of patients] was the most relevant and attracted the highest mean intensity and frequency of moral distress in nurses. It was related to concern for patient's feelings and emotions. In the opinion of the study units, emotional involvement with patient's problems and his relatives is an important source of stress. The lowest mean score for distress in terms of intensity and frequency related to question 4 [I have experienced conflicts with supervisors and/or administrators at work]. Previous studies also considered patient's emotional problems and his relatives and conflicts with supervisors and management as important factors in moral distress [28]. The effectiveness of these factors in creating distress depends on the type of workplace and characteristics of individuals.

Nurses' psychological empowerment was at an average level in the present study which is similar to findings of Knol's study [25]. Among the different dimensions of psychological empowerment, competence had the highest average. Browning (2013) reports nurses' psychological empowerment as high in his study, and competence is higher than the other dimensions of psychological empowerment [19]. Mohammadi et al. (2014) in their study reported the average amount of psychological empowerment of nurses in Iran. Also in this study competence is higher than the other dimensions of psychological empowerment [31].

Examining the relationship between moral distress and the parameters of age and working experience as critical care nurse revealed a significant and inverse relationship. These results indicated that as age and the number of service years increase, moral distress decreases. Rice (2008) did not find a significant correlation between moral distress and age, but considered that the intensity of moral distress significantly correlated with work experience [32] Sirilla et al (2017) stated that increasing service years caused increased work experience, and adjusted the person with distressing factors, and hence, the person was less affected by distressing conditions [11]. In another

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study, the relationship between moral distress, age and number of service years was found significant. It was stated that moral distress reduced as age and work experience increased [3-5, 11, 30].
In assessing the relationship between moral distress and type of ward, the highest level of distress was in the ICU [3, 11, 12]. Studies generally consider critical care units as having the highest level of distress for nurses [3, 10, 16, 19]. The height of distress in this ward is due particularly to acute conditions in these treatment settings that in turn are associated with higher challenges in moral terms.

CONCLUSION

The results of this study showed that three dimensions meaning, competence and self-determination significantly predict the intensity of moral distress. The results also confirmed the conceptual framework this study that empowering nurses can to remove one of the obstacles created distress among nurses. Psychological empowerment can increase feel of competency, autonomy and self-worthy among nurses and protect of them against impact severity of moral distress. So, with attention to this relation is recommended by clinical manager create strategies such as self-worthy and autonomy and periodic assessment of moral distress for nurse's psychological empowerment and protect of them.
Our finding has application in nursing education, nursing research, nursing practice, and nursing management. Finding of this study provide evidence for nurse educators and basis for future research. Researcher can use different research approach and design for future study according to this finding. Nursing managers can use finding of this study for planning and implantation interventions to empower nurses psychologically.

LIMITATION

This study has some limitations that should be noted. This study was conducted in a specific region and on nurses of educational and governmental hospitals in Iran. In order to reveal more aspects of this phenomenon, other studies should be conducted in other regions as well as in non-governmental hospital. Sample size and sampling method were the other limitation of the current study which affected the validity of the mentioned results. Using self-reported questionnaire for data gathering is the other limitation.

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CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

AUTHOR'S CONTRIBUTIONS

The first author: study design, data collection and drafting the manuscript. The second author: study design and advisor. Corresponding author: did supervision, Study design, drafting, data analysis, revising the manuscript, and responding to the reviewers.

ETHICAL CONSIDERATIONS

The study was approved by the Medical Ethics and Law Research Center of Shahid Beheshti University of Medical Sciences (Ethical Code: 96:145) and legal permissions were obtained prior to collection of the data. All participants well informed about aim of study, completing questionnaire. Participants were completely free to participate in or refuse from participation in the study. Oral and written informed consent were obtained and they were reassured that their personal information would be confidential and results would be reported anonymously. The participants were allowed to leave the study at any time. No time limit was imposed to complete the questionnaires. It took approximately 10 minutes to complete the questionnaire.

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