

# Moral Distress Among Long-Term Care Social Workers: Questionnaire Validation

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## Abstract

**Objective:** To describe the quantitative validation of a unique questionnaire to measure moral distress among social workers in long-term care facilities in Israel. **Method:** Overall, 216 long-term care facilities' social workers took part in the pilot study that included psychometric evaluation and construct validation. Moral distress was examined by two scales, measuring the frequency and the intensity of morally loaded events. A third scale was created, representing the product of the frequency and intensity scores for each item separately. **Results:** Two items with high floor effect were removed. The internal reliability of each of the three Moral Distress Scales was .92. An exploratory factor analysis suggested a single-factor solution. The construct validity was approved. In its final version, the questionnaire consisted of 15 items. **Conclusions:** We believe that the questionnaire can contribute by broadening and deepening ethics discourse and research with regard to social workers' moral conflicts and moral distress.

## Keywords

social workers, long-term care facilities, moral distress, questionnaire validation, construct validity

A prominent ethical dilemma in the theoretical literature on social work deals with the conflictual obligations of social workers, when their primary obligation to their clients is challenged by their obligation to the organization for which they work (Dogloff, Harrington, & Loewenberg, 2012; Linzer, 1999). This dilemma has emerged in qualitative studies which describe the difficulties of social workers to act in accordance with their primary obligation to the clients due to rules, regulations, and bureaucratic considerations (Hyde, 2012; Papadaki & Papadaki, 2008; Wilson, 2004) as well as due to commercial and reputational interests (Lev & Ayalon, 2016; Lonne, McDonald, & Fox, 2004).

A theoretical and empirical concept, which is taken from the nursing literature and relates to these dilemmas, is called "moral distress." Accordingly, moral distress occurs in situations where a nurse has difficulty acting in accordance with professional moral due to institutional constraints and restrictions (Jameton, 1984). This concept has been widely discussed and explored in the nursing literature and was more recently expanded in relation to other health professions (Corley, Elswick, Gorman, & Clor, 2001; Hamric & Blackhall, 2007). Nevertheless, very few studies have explored moral distress among social workers as a unique group (Houston et al., 2013; Mänttari-van der Kuip, 2016).

Because it is expected that the experiences of social workers are quite different from those of nurses with regard to moral distress, it is important to develop a measure to assess moral distress among social workers. Such a measure is expected to increase awareness of the topic and potentially result in insights

concerning those workers who experience the highest levels of moral distress and require further assistance in the form of educational interventions or additional supervision. The purpose of the present article is to describe the quantitative validation of a unique questionnaire which examines moral distress among social workers in long-term care facilities (LTCFs) in Israel. The description of the qualitative validation of the measure is detailed elsewhere (Lev & Ayalon, In Press).

## Moral Distress

The definition of moral distress includes two essential elements: the existence of a moral phenomenon and an inconvenient psychological response to this phenomenon (Fourie, 2015). A significant conceptual extension emerged in a study by Kalvemarm et al. (2004), which explored moral distress among health-care professionals. They suggested that moral distress occurs not only in situations where the health-care professional acts against his or her professional judgment but also in situations when he or she acts in accordance with it, but, in doing so, clashes with regulations. This implies that moral distress could be a result of any situation in which the actions of

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the health-care professional lead to a violation of an obligation either to the management or to the clients (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004).

The most widely used instrument to measure moral distress is the Moral Distress Scale (MDS). This scale explores the frequency and intensity of 38 items, which reflect moral problems faced by nurses (Corley et al., 2001; Corley, Minick, Elswick, & Jacobs, 2005). The MDS has been the basis for many studies and was shortened or modified for use with different health-care professions (Hamric & Blackhall, 2007). These studies have indicated that moral distress was associated with organizational–environmental characteristics, such as perceived poor ethical climate (Corley et al., 2005; Hamric & Blackhall, 2007; Pauly, Varcoe, Storch, & Newton, 2009; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014, 2015), low levels of support and leadership, low satisfaction with the possibility to consult with colleagues, high instrumental leadership, and low supportive leadership (de Veer, Francke, Struijs, & Willems, 2013; McAndrew, Leske, & Garcia, 2011). In addition, positive associations have been found between moral distress and professional characteristics like dimensions of burnout (Meltzer & Huckabay, 2004) and intention to leave the job (Karanikola et al., 2014; Papathanassoglou et al., 2012; Piers et al., 2012). Finally, moral distress has been found to be negatively associated with psychological factors like empowerment (Browning, 2013; Ganz et al., 2013) and autonomy (Karanikola et al., 2014; Papathanassoglou et al., 2012).

### *Moral Distress and Social Work*

Only very few studies have identified social workers as a unique group which requires its own scale for the purpose of assessing moral distress (Houston et al., 2013; Mänttari-van der Kuip, 2016). The limited research on moral distress among social workers is unexpected due to the significant ethical component inherent in the social work profession (Openshaw, 2011; Weinberg, 2009). Unlike the nursing profession and other health professions which usually tend to involve life-and-death dilemmas, the ethical dilemmas faced by social workers tend to be less dramatic, tangible, or concrete (Weinberg, 2009). Therefore, ethical dilemmas that relate to the work experience of social workers are not reflected in the existing scales which are mostly intended to measure moral distress among nursing and other health-care professionals (Corley et al., 2001, 2005; Hamric & Blackhall, 2007).

A wider view of ethical dilemmas among social workers and the emotional reactions to them can be found in scales that examine stress and distress reactions to ethical issues. An empirical concept which has a similar meaning to moral distress and has emerged in the nursing literature is “ethical stress” which is experienced when the health-care professional is coping with ethical dilemmas (Raines, 2000). Similarly to moral distress, the measure has been examined among social workers, adapted from a scale developed for nurses (O’Donnell et al., 2008; Ulrich et al., 2007). In another study, a unique scale

was developed to assess ethical stress among criminal justice social workers (Fenton, 2015). An additional empirical concept, which was examined among social workers and is unique to this profession, is termed “disjuncture.” This concept describes a dilemma that results in distress when there is a discrepancy between the social worker’s beliefs and behaviors (DiFranks, 2008).

### *LTCFs*

LTCFs for the older adults in Israel are part of a spectrum of long-term care services for older adults (Brodsky, Shnoor, & Be’er, 2012). In Israel, LTCFs can be divided into two main categories: nursing homes for either individuals who require nursing care or older adults with mental impairments and old-age homes for functionally independent and semidependent frail older adults (Iecovich, 2001). Nursing homes and old-age homes serve about 3% of the individuals aged 65 and older in Israel. A third type of LTCF is the continuing care retirement community (CCRC). CCRCs provide housing and services for mostly functionally independent older adults (Ayalon & Green, 2012).

These three types of LTCFs have been portrayed on a continuum of autonomy versus control, with nursing homes being the most controlled institutions, where older adults have very limited autonomy, whereas CCRCs represent the other side of the spectrum as institutions which provide older adults with choice and self-determination. Nonetheless, LTCFs, especially nursing homes, have been described in the literature as possessing characteristics of total institutions (Lang, Löger, & Amann, 2007). These total features are often expressed by the desire for conformity and obedience (Solomon, 2004) and by a drive toward functional efficiency, which is reflected in a rigid daily routine, a lack of privacy and autonomy, and limited choice opportunities (Angelelli, 2006; Harnett, 2010). These features could potentially weaken the power of the residents when facing the management and staff (Nelson, 2000).

The imbalance in resources between the residents and the management/staff can make it difficult for social workers to act in accordance with their primary obligation to the residents (Allen, Nelson, & Netting, 2007; Fogler, 2009; Lev & Ayalon, 2015, 2016). The total features of LTCFs, on the one hand, and the role of social workers as advocates for the residents, on the other hand, could intensify the difficulties of social workers to act in accordance with their obligation to the residents and could lead to moral distress (Jameton, 1984).

### *A Questionnaire to Assess Moral Distress Among LTCF Social Workers*

The construction of the present questionnaire was based on a secondary analysis of a qualitative study that addressed moral dilemmas of social workers in nursing homes in Israel (Lev & Ayalon, 2015, 2016). The data were analyzed on the basis of a predetermined typology (Given, 2008), which was derived from the theoretical and empirical definitions of moral distress

(Fourie, 2015; Jameton, 1984; Källemark et al., 2004). Based on these definitions, three themes were identified and determined as the organizing framework of the questionnaire. The first theme encompassed respondents' perceptions of the ethical behavior of the management or staff and how this related to their perceived inability to act in accordance with their obligation to the residents. The second theme addressed perceived actions in accordance with the obligation to the management and staff when respondents felt conflicting obligations toward the management versus residents, whereas the third theme addressed perceived actions in accordance with the obligation to the residents in these situations.

Following the definition of moral distress, which emphasizes the existence of a moral phenomenon and a psychological response to this phenomenon (Fourie, 2015; Jameton, 1984), the questionnaire included two scales. The first scale assessed the occurrence of a moral phenomenon and its frequency, and the second scale assessed the occurrence of distress in response to the phenomenon and its intensity.

Content validation included review and evaluation by two experts, a cognitive interview with nursing home social workers and three focus groups with experts and the target population. In its final version, the questionnaire consisted of 17 items which describe perceptions or actions related to possible conflictual situations for social workers in LTCFs. Participants were asked to rate the perceived frequency of moral dilemmas during the past year and to evaluate the intensity of the distress that followed these events. The frequency scale ranged between 0 = *never*, 1 = *seldom*, and 5 = *often*. The intensity scale ranged between 0 = *not at all*, 1 = *low intensity*, and 5 = *high intensity*. The construction and the content validation of the questionnaire are described in detail by Lev and Ayalon (In Press). The Hebrew version of this scale is available from the corresponding author upon request.

## The Present Study

The purpose of the present study is to describe a second stage of validation of the questionnaire designed to examine moral distress among LTCF social workers in Israel. This stage relied on a pilot study of LTCF social workers in Israel in order to establish the psychometric evaluation and construct validation of the questionnaire.

## Method

### Study Sample

To ensure a high participation rate, phone calls were placed by the first author to all LTCFs in Israel: 215 nursing homes, 94 integrated old-age homes (which include nursing departments), 75 old-age homes, and 185 CCRCs (Brodsky et al., 2012). Nursing homes and old-age homes were identified through Israel's Ministries of Health and Social Affairs websites. The CCRCs were located through different private and public websites. The first author introduced herself and the study and asked for permission to contact the social workers employed

in the facility for the purpose of conducting the study. After permission was obtained, the questionnaires were sent via e-mail or post and collected through a Google Drive application, e-mail, fax, or post based on the preference of the participants. In some occasions, the first author came to the facility and provided a lecture on the research topic after the social workers in the facility answered the questionnaire. Additionally, some participants were located through conferences and courses targeting this population. In summary, 216 questionnaires were collected.

No official information was available regarding the exact number of social workers in LTCFs in Israel. However, it can be assumed that there are around 250–300 social workers employed in nursing homes and old-age homes in Israel based on the standard of one social worker to 100 beds (Brodsky et al., 2012). This does not represent an exact number because some of the social workers are employed in more than one facility or work part time. Because there are no standards for social work services in CCRCs, we have no appraisal of the exact number of social workers in these facilities. We do know, however, that of the 343 institutes that were approached, 302 agreed to participate in the study.

The study population included 216 social workers employed in nursing homes (37.7%), old-age homes (12.7%), integrated old-age homes (32.5%), and CCRCs (17%). The majority (91%) were women, 58% of them had a bachelor's degree, 41% had a master's degree, and 1% (two participants) had a PhD. Their ages ranged between 23 and 77.

### Study Procedure and Analysis

The study was approved by the ethics committee of the authors' university. All participants received a comprehensive explanation about the study prior to giving their informed consent to participate in the study. Three scales were assessed. Scales consisted of the frequency with which the event occurred, the intensity of the moral distress associated with it, and a multiplication of these two scales, which reflects the overall moral distress.

The psychometric evaluation of the three scales was established by obtaining floor and ceiling effects, internal reliability, a frequency distribution, and exploratory factor analysis. A floor effect refers to a high percentage of respondents who gave the lowest possible score (*never* or *not at all*), whereas a ceiling effect refers to a high percentage of respondents who marked the highest possible score (often or high intensity; Alexander et al., 2005). Recent studies have distinguished between "significance effect," which indicates a percentage above 20 at floor or at ceiling, and "high effect," which indicates a percentage above 70 at floor or at ceiling. These studies recommended the removal of items with high effects (above 70%) because these items are likely limited in their responsiveness to clinical change (Alexander et al., 2005; Cheng et al., 2007).

The construct validity of the questionnaire was established by examining both convergent validity (strong correlations of the scales with variables that theoretically were expected to be

significantly related to it) and discriminant validity, which corresponds to low correlations of the scales with variables that theoretically were predicted to be less related with moral distress (Collins, Onwuegbuzie, & Sutton, 2006).

Convergent validity was established in relation to two environmental variables which were found to be negatively correlated with moral distress: ethical climate (Hamric & Blackhall, 2007; Pauly et al., 2009) and support in the workplace (de Veer et al., 2013; McAndrew et al., 2011) and two variables, that related to professional attitudes, which were found to be positively correlated with moral distress: emotional exhaustion and depersonalization as part of the burnout scale (Meltzer & Huckabay, 2004; Ohnishi et al., 2010) and intention to leave the job (Karanikola et al., 2014; Papatthanassoglou et al., 2012; Piers et al., 2012).

Discriminant validity was established against constructs which were predicted not to be strongly correlated with moral distress. These constructs relate to the "personal accomplishment" factor in the burnout scale (Maslach, Jackson, & Leiter, 1986), which was found in previous studies to have only a weak correlation or no correlation whatsoever with moral distress (Meltzer & Huckabay, 2004; Ohnishi et al., 2010). An additional construct was the "support from friends and relatives" factor in the support scale (Lindström et al., 2000), which was not tested in previous studies due to the absence of a theoretical rationale for such a relationship.

## Measures

In addition to the moral distress questionnaire, social workers were asked to provide sociodemographic information including gender, age, marital status, religion, strength of religious beliefs, country of origin, education, and seniority as social workers. Additionally, social workers were asked about the type of institution and population they work with. In order to establish convergent validity, the following questionnaires were included in the pilot study.

**Ethical environment.** Ethical environment was measured by the Ethical Environment Questionnaire. The scale consists of 20 items (e.g., "The administration of this organization is concerned with ethical practice"). Participants are asked to rate their level of agreement on a 5-point scale that ranges between "strongly disagree (1) and strongly agree (5; McDaniel, 1997). The scale was translated to Hebrew and then back translated to English by independent translators. Internal consistency in the present study was .95.

**Support.** The support questionnaire was taken from the General Nordic Questionnaire for psychological and social factors at work. The questionnaire consists of 8 items that encompass three sources of support from superiors (3 items, e.g., "If needed, is your immediate superior willing to listen to your work-related problems?"), coworkers (2 items, e.g., "If needed, can you get support and help with your work from your coworkers?"), and friends and relatives (3 items, e.g.,

"If needed, can you talk with your friends about your work-related problems?"). Participants were asked to rate their level of support on a 5-point scale, which ranges between *very seldom or never* (1) and *very often or always* (5; Lindström et al., 2000). The scale was translated to Hebrew and then back translated to English by independent translators. Internal consistency in the present study was .85, .82, and .76, respectively.

**Burnout.** Burnout was measured using the Hebrew version of the Maslach Burden Inventory. The inventory consists of 22 items that encompass three aspects of the job experience: emotional exhaustion (9 items, e.g., "I feel emotionally drained from work"), depersonalization (5 items, e.g., "I become more callous toward people"), and personal accomplishment (8 items, e.g., "I can easily understand patients' feelings"). Participants were asked to rate each statement on a 7-point scale. More burnout is indicated by a higher score on the emotional exhaustion and depersonalization scales and a lower score on the personal accomplishment scale (Maslach & Jackson, 1986). A Hebrew translation of the scale was used (Ayalon, 2008). Internal consistencies in the present study were .90, .76, and .81, respectively.

**Intention to leave the job.** Intention to leave was measured by the turnover intentions questionnaire. The scale consists of 3 items. Participants are asked to rate their level of agreement with several statements on a 5-point scale (e.g., "I think a lot about leaving the organization") with a higher score, indicating greater agreement (Cohen, 1998). The scale was translated to Hebrew and then back translated to English by independent translators. Internal consistency in this study was .90.

## Results

The data were analyzed using SPSS, Version 23, for Windows. Due to the nature of the questionnaire and in accordance with the instructions provided to respondents, we treated items that were ignored with regard to the frequency and intensity scales as irrelevant to the respondent's work experience. Therefore, 43 missing values on the frequency scale and 322 values on the intensity scale were replaced by a 0 score.

Of the 17 items, 14 items on the frequency scale and 15 items on the intensity scale had a significant floor effect (see Table 1). A high floor effect was evident for Item 12 (I felt that there has been an expectation of me to conceal or to give false information in situations where there is suspicion of abuse) and 13 (I acted in a way which was in contradiction with my professional beliefs due to concerns of losing my job) with regard to both the frequency and intensity scales (see Table 1). The high floor effects imply that the phenomenon described by these items can be considered as extreme and do not represent the work experience of LTCF social workers. Therefore, these 2 items were removed. A ceiling effect was not observed for any of the items.

After the removal of the 2 items, a third scale was created consisting of the multiplication of frequency and intensity

**Table 1.** Frequencies and Floor and Ceiling Effects.

Item	Moral Distress Frequency Scale, N = 216								Moral Distress Intensity Scale, N = 216							
	Frequencies						Floor Effect (%)	Ceiling Effect (%)	Frequencies						Floor Effect (%)	Ceiling Effect (%)
	0— Never	1— Seldom	2	3	4	5— Often			0— Never	1— Low intensity	2	3	4	5— High intensity		
1	58	93	36	18	9	2	26.9	0.9	60	38	25	29	46	18	27.8	8.3
2	30	56	38	40	40	12	13.9	5.6	35	34	33	52	49	13	16.2	6.0
3	31	61	37	43	30	14	14.4	6.5	38	47	39	48	35	9	17.6	4.2
4	55	60	32	48	15	6	25.5	2.8	58	54	27	38	29	10	26.9	4.6
5	99	62	22	14	14	5	45.8	2.3	98	31	11	31	26	19	45.4	8.8
6	39	85	35	35	16	6	18.1	2.8	44	54	29	38	39	12	20.4	5.6
7	122	47	19	16	6	6	56.5	2.8	124	20	14	22	21	15	57.4	6.9
8	73	61	31	24	21	6	33.8	2.8	80	38	15	35	33	15	37.0	6.9
9	64	75	23	26	20	8	29.6	3.7	69	26	30	35	39	17	31.9	7.9
10	66	62	28	34	18	8	30.6	3.7	72	33	20	40	32	19	33.3	8.8
11	114	51	22	11	12	6	52.8	2.8	121	26	14	24	19	12	56.0	5.6
12	166	26	7	7	7	3	76.9	1.4	169	9	10	9	12	7	78.2	3.2
13	159	42	6	5	3	1	73.6	0.5	159	22	5	12	9	9	73.6	4.2
14	45	82	28	32	18	11	20.8	5.1	57	54	38	32	22	13	26.4	6.0
15	107	69	16	13	7	4	49.5	1.9	104	45	18	26	13	10	48.1	4.6
16	143	41	14	11	4	3	66.2	1.4	140	13	19	20	14	10	64.8	4.6
17	113	46	12	25	13	7	52.3	3.2	121	19	20	24	22	10	56.0	4.6

items. The means and standard deviations of the items on the three scales are detailed in Table 2. With the possible range of scores between 0 and 6 for each scale, the mean score for the frequency scale was  $1.36 \pm .92$  (range 0.62–2.19) and  $1.69 \pm 1.14$  (range 1.00–2.39) for the intensity scale, indicating moderately low levels of moral distress. The items that received the highest mean score both with regard to the frequency and the intensity scales included Item 2, which describes the social worker’s confrontation with the staff when their behavior was perceived as contradicting the best interests of the residents, and Item 3, which relates to a perceived contradiction between the social worker’s professional obligation to the residents and the financial interests of the institution.

The items which received the lowest mean score on the frequency scale were Items 16 and 7, which correspond to perceived inadequate response of the management to suspected abuse. Similarly to the frequency scale, the items which received the lowest mean score on the intensity scale were Item 16, followed by Items 11 and 15, which had the same mean score. Item 11 addresses the perceived difficulties of the social worker to find an alternate framework for residents due to the opposition of the management, and Item 15 describes the social worker’s feelings that his or her professional work has been driven by the financial considerations of the institution more than by considerations for the best interests of the residents.

An exploratory factor analysis was separately established for each scale. For all three scales, the scree tests indicated that the break between a steep slope and leveling off occurred after a single factor (reflected in the drop of the total eigenvalues from 7.11–7.33 for a single component to 1.3–1.5 for two components). This suggests that each scale can be explained by a single factor that accounts for more than 47% of the

variance (see Table 3). All item loadings were greater than .40 (see Table 3) and, therefore, indicated their adequate association with the respective factor (Costello & Osborne, 2005).

Reliability was assessed by determining Cronbach’s  $\alpha$  coefficient for each of the three MDSs. The Cronbach’s  $\alpha$  coefficients were .92 for all the three scales. The correlations between the three scales resulted in strong positive correlations (see Table 4), which indicating a potential for multicollinearity (Pallant, 2013).

Pearson correlations were computed to assess the construct validity of the questionnaire (see Table 4). The convergent validity indicated high negative correlations of the three MDSs with ethical environment and moderate negative correlations with superior support. The three MDSs had positive moderate correlations with emotional exhaustion and intention to leave the job. Moral distress frequency had a moderate negative correlation with coworker support and a moderate positive correlation with depersonalization, whereas the two other MDSs had weak negative correlations with coworker support and weak positive correlations with depersonalization.

The discriminant validity resulted in weak negative correlations of the three scales with support from friends and relatives. In addition, personal accomplishment had a weak negative correlation with moral distress frequency and no significant correlation with the two other MDSs.

## Discussion and Applications to Practice

The present article describes the second stage of validation of a questionnaire to assess moral distress among social workers in LTCs. The term moral distress includes both a moral phenomenon and an inconvenient psychological response to this

**Table 2.** Means and Standard Deviations.

Items	Moral Distress Frequency Scale, N = 216		Moral Distress Intensity Scale, N = 216		Moral Distress Multiplication Scale, N = 216	
	Mean	SD	Mean	SD	Mean	SD
1. I acted in a way which has been in contradiction to my professional beliefs due to pressures by the institution's management	1.23	1.12	2.08	1.74	3.61	4.47
2. I confronted the staff when I perceived their behavior as being in contradiction with the best interests of the residents	2.19	1.49	2.39	1.53	6.13	5.74
3. There were situations in which I felt that my professional obligation to the residents was in contradiction with the financial interest of the institution	2.10	1.48	2.10	1.47	5.51	5.87
4. I acted in a manner which I perceived as being in the best interests of the residents, even when it was in contradiction with the demands of the institution's management	1.66	1.39	1.80	1.56	4.17	4.80
5. I had difficulty handling, in a professional manner, situations of suspected abuse toward residents due to the lack of cooperation or opposition by the staff	1.06	1.33	1.60	1.80	3.41	5.58
6. There were situations in which I felt that the interest of the institution's management was in contradiction with the interest of the residents	1.64	1.30	2.05	1.57	4.69	5.42
7. I felt that in situations of suspected abuse toward residents, the management acted only superficially and not to purposefully eradicate the violence	0.87	1.28	1.26	1.73	2.84	5.27
8. I felt that my personal and environmental resources have not been adequate in order to protect the residents' rights	1.43	1.44	1.76	1.74	4.35	6.10
9. I confronted the institution's management when I perceived its conduct as being in contradiction with the best interests of the residents	1.48	1.45	2.00	1.73	4.51	5.84
10. I felt that I have not had sufficient capacity to influence the imposition of sanctions on a worker who behaved in an inappropriate way toward residents	1.54	1.46	1.93	1.75	4.85	6.27
11. I felt that I do not have sufficient capacity to work to find an alternate framework for residents, even though in my professional opinion an institutional framework is not suitable for them, due to the opposition of the institution's management	0.95	1.34	1.21	1.65	2.87	5.36
14. I felt criticism from the staff when I advocated on behalf of family members and/or residents	1.67	1.43	1.75	1.53	4.21	5.62
15. I felt that in my professional work, I have been more driven by the financial considerations of the institution than by considerations for the best interests of the residents	0.87	1.18	1.21	1.52	2.26	4.18
16. I had difficulty handling, in a professional manner, situations of suspected abuse toward residents due to lack of cooperation or opposition by the institution's management	0.62	1.09	1.00	1.56	1.91	4.37
17. I acted in a way which I perceived as being in the best interests of the residents, even when it was likely to hurt my future employment	1.07	1.45	1.25	1.65	2.86	4.80
Total score	1.36	.92	1.69	1.14	3.88	3.66

phenomenon (Fourie, 2015; Jameton, 1984). Following this definition, for each item separately, we assessed the frequency of the perceived moral phenomenon and the intensity of the distress that followed it (Corley et al., 2005; Hamric & Blackhall, 2007). In order to assess the level of moral distress, we created a third scale that represents the product of the frequency and intensity scores for each item separately (Hamric & Blackhall, 2007). The strong positive correlation between the three MDSs indicates a potential for multicollinearity (Pallant, 2013). Because of this multicollinearity, the multiplication scale, which is based on the frequency and intensity scales, is recommended for use in future studies.

The findings indicate that the moral phenomena, described by several different items, were relevant to the work experience of most participants and were accompanied by some distress. However, an examination of the distribution of the items with regard to the frequency and intensity scales indicated significant floor effects for most of the items in both scales (above

20% of respondents had the lowest possible score). These significant floor effects could be explained by the unique nature of the present questionnaire. The questionnaire was expected to be positively skewed because the items described negative and even extreme moral phenomena, such as not reporting abuse of older adults.

The moderately low levels of moral distress frequency and intensity in the present questionnaire are consistent with other studies that explored moral distress among nurses. Oh and Gastmans (2013) found in their review of studies exploring moral distress among nurses that seven of the eight studies reported low frequency of moral distress events. However, unlike the present study, most of the studies found moderately high levels of moral distress intensity among nurses, whereas only two studies of nine reported low levels of moral distress intensity (Oh & Gastmans, 2013).

A notable finding is that of the 4 items, which had the greatest floor effect and the lowest mean with regard to

**Table 3.** Component Matrix: Results of a Single-Factor Solution for the Three Scales of Moral Distress: Intensity, Frequency, and the Product of the Two Scales (Intensity × Frequency).

Frequency Scale		Intensity Scale		Product Scale	
Number of Item	Loading	Number of Item	Loading	Number of Item	Loading
7	.82	6	.79	6	.81
5	.80	7	.76	7	.78
3	.79	9	.76	3	.77
6	.78	8	.74	8	.77
8	.77	16	.73	5	.75
16	.76	1	.73	16	.74
10	.69	15	.71	10	.71
14	.68	5	.71	14	.70
15	.65	3	.70	15	.70
1	.65	10	.69	11	.66
11	.63	14	.67	1	.65
9	.62	11	.66	4	.62
4	.59	4	.62	9	.61
17	.54	17	.60	17	.54
2	.46	2	.59	2	.48
Initial eigenvalues for a single component					
Total	7.11	7.33		7.18	
Percentage of variance	47.39	48.84		47.89	

**Table 4.** Correlations.

Variables	Frequency	Intensity	Multiplication
Moral distress			
Frequency	—		
Intensity	.76**	—	
Multiplication	.92**	.87**	—
Ethical environment	-.68**	-.58**	-.68**
Support			
Superiors	-.45**	-.34**	-.42**
Coworkers	-.31**	-.20**	-.27**
Friends and relatives	-.14*	-.16*	-.14*
Burnout			
Emotional exhaustion	.45**	.42**	.45**
Depersonalization	.36**	.24**	.28**
Personal accomplishment	-.17*	-.08	-.12
Intention to leave	.32**	.33**	.36**

\*p < .05. \*\*p < .01. \*\*\*p < .001.

frequency, three addressed the perceived inadequate response of the management to suspected abuse (Items 12, 16, and 7, respectively). The low frequency can be explained by the extreme nature of the events that were described by these items. Although most of the respondents reported not experiencing these events, we decided to remove only Item 12 (due to its high floor effect) and to leave the remaining items. The reason for this is embedded in the severe potential implications of abuse to the residents' confidence and well-being (Castle, Ferguson-Rome, & Teresi, 2015; Lindbloom, Brandt, Hough, & Meadows,

2007). Hence, we believe these events should be addressed even if they occur at a low frequency.

The exploratory factor analysis indicated that each of the three MDSs could be explained by a single factor. These findings are notable due to the different and even opposing themes that were included in the questionnaire. The themes were created based on the moral distress definition by Kalvemmark et al. (2004) and included items which described the difficulty of the social worker to act in accordance with his or her moral and professional obligation to the residents due to institutional restrictions and also items which described actions of the social worker in accordance with his or her moral and professional obligation to the residents, despite institutional restrictions. Thus, the findings of the exploratory analysis support the qualitative findings of Kalvemmark et al. (2004) that moral distress could be a result of any situation in which the actions of the health-care professional lead to a violation of an obligation either to the management or to the clients. Although all of the items belonged to a single factor (Costello & Osborne, 2005), the 4 items with the lowest loadings in the frequency and product scales described actions of the social worker in accordance with his or her obligation to the residents, which could represent somewhat different qualities of moral distress.

Finally, we provided evidence for the construct validity of the present questionnaire. The strong negative correlations of the three scales of moral distress with the ethical environment scale imply that the moral distress questionnaire addresses the environmental aspects present in the LTCF. This is reflected by items that contain explicit and implicit descriptions of the perceived behavior of the management concerning ethical issues. However, unlike scales which measure the ethical environment, most of the items in the moral distress questionnaire also assessed the passive or active reactions of the social worker to that environment.

As noted, the moral distress questionnaire is based on a secondary analysis of a qualitative study that addressed moral dilemmas of social workers in nursing homes in Israel (Lev & Ayalon, 2015, 2016). Based on qualitative content validation (Lev & Ayalon, In Press), psychometric evaluation, and construct validation, the questionnaire has expanded its relevance to LTCFs social workers in Israel. Nevertheless, because the questionnaire was developed and validated in Israel, its adjustment to other cultures or countries requires sensitivity to possible cultural or contextual differences. These differences can be reflected in the structure of the LTCFs, the target population, or the supervision and the role definition of the social workers in these facilities. Hence, future research will benefit from examining the psychometric properties of this measure in different sociocultural contexts.

Another limitation of the present questionnaire is reflected in the fact that all items are long and unidirectional. This might cause a response bias, when early items trigger the response pattern (Tourangeau & Rasinski, 1988). Furthermore, the significant moral component that is embedded in the questionnaire might elicit a social desirability bias, as the respondents might respond in a manner that is viewed favorably by others

(Paulhus, 1991). However, because of the nature of the questionnaire, which examines moral phenomena and the distress that followed them, we could not formulate items in a positive direction. It is important to note that this is similar to other MDSs (Corley et al., 2001; Hamric & Blackhall, 2007). Future research might use social desirability scales for control purposes (Paulhus, 1991).

Finally, the present moral distress questionnaire is based on a self-report, monomethod approach. Exploring the perceptions and attitudes of other professionals in LTCFs or the residents themselves as well as adding other measurement tools, like observations, could enrich our understanding of moral distress among LTCFs social workers.

We believe that the importance of the current questionnaire stems from the fact that distress not only impacts the well-being of social workers in LTCFs but also has severe implications to the well-being and safety of LTCFs' residents (Castle et al., 2015; Lindbloom et al., 2007). The implications of moral distress to the well-being of the residents could be due to the difficulties of the social worker to protect the residents' rights and safety because of institutional constraints and restrictions. The implications could also be indirect, due to emotional exhaustion and depersonalization, which are reflected in negative and cynical attitudes and feelings of the social worker toward the clients (Maslach et al., 1986).

We believe that the questionnaire will contribute by broadening and deepening ethical discourse and research with regard to social workers' obligational dilemmas and conflicts, in an era in which rules, regulations, and bureaucratic considerations as well as commercial and reputation interests of the organization, make it increasingly more challenging for social workers to act in accordance with their obligations to their clients (Abramovitz, 2005; Lev & Ayalon, 2015, 2016; Lonne et al., 2004; Papadaki & Papadaki, 2008; Wilson, 2004). Ethical discourse and research are particularly important in an era where neoliberalism and privatization have spread worldwide and are responsible for a transition of social services from governmental ownership to public and private ownership (Carey, 2008; Liljegren, Dellgran, & Höjer, 2008). Although the questionnaire was built and validated for assessing moral distress among LTCF social workers, it could be adjusted and extended to social workers who work in other institutions characterized by "total" features like boarding schools and institutions for people who suffer from cognitive, physical, or mental disabilities.

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### References

- Abramovitz, M. (2005). The largely untold story of welfare reform and the human services. *Social Work, 50*, 175–186.
- Alexander, M., Berger, W., Buchholz, P., Walt, J., Burk, C., Lee, J., . . . Abetz, L. (2005). The reliability, validity, and preliminary responsiveness of the Eye Allergy Patient Impact Questionnaire (EAPIQ). *Health Qual Life Outcomes, 3*, 1–11.
- Allen, P. D., Nelson, H. W., & Netting, F. E. (2007). Current practice and policy realities revisited: Undertrained nursing home social workers in the US. *Social Work in Health Care, 45*, 1–22.
- Angelelli, J. (2006). Promising models for transforming long-term care. *The Gerontologist, 46*, 428–430.
- Ayalon, L. (2008). Subjective socioeconomic status as a predictor of long-term care staff burnout and positive caregiving experiences. *International Psychogeriatrics, 20*, 521–537.
- Ayalon, L., & Green, V. (2012). Grief in the initial adjustment process to the continuing care retirement community. *Journal of Aging Studies, 26*, 394–400.
- Brodsky, J., Shnoor, Y., & Be'er, S. (2012). *The elderly in Israel: Statistical abstract 2012*. Retrieved from <http://brookdale.jdc.org.il/?CategoryID=192&ArticleID=282>
- Browning, A. M. (2013). CNE article: Moral distress and psychological empowerment in critical care nurses caring for adults at end of life. *American Journal of Critical Care, 22*, 143–151.
- Carey, M. (2008). Everything must go? The privatization of state social work. *British Journal of Social Work, 38*, 918–935.
- Castle, N., Ferguson-Rome, J. C., & Teresi, J. A. (2015). Elder abuse in residential long-term care an update to the 2003 National Research Council Report. *Journal of Applied Gerontology, 34*, 407–443.
- Cheng, K. K., Leung, S., Thompson, D. R., Tai, J. W., Liang, R. H., Kan, A. S., . . . Yeung, R. M. (2007). New measure of health-related quality of life for patients with oropharyngeal mucositis. *Cancer, 109*, 2590–2599.
- Cohen, A. (1998). An examination of the relationship between work commitment and work outcomes among hospital nurses. *Scandinavian Journal of Management, 14*, 1–17.
- Collins, K. M., Onwuegbuzie, A. J., & Sutton, I. L. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning Disabilities: A Contemporary Journal, 4*, 67–100.
- Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33*, 250–256.
- Corley, M. C., Minick, P., Elswick, R., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics, 12*, 381–390.
- Costello, A., & Osborne, J. (2005). Best practices in exploratory factor analysis: four recommendations for getting the most from your analysis. *Practical Assessment Research and Evaluation, 10*, 1–9.
- de Veer, A. J., Francke, A. L., Struijs, A., & Willems, D. L. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies, 50*, 100–108.
- DiFranks, N. N. (2008). Social workers and the NASW Code of Ethics: Belief, behavior, disjuncture. *Social Work, 53*, 167–176.
- Dogloff, R., Harrington, D., & Loewenberg, F. (2012). *Ethical decisions for social work practice*. Belmont, CA: Brooks/Cole.



- Fenton, J. (2015). An analysis of 'ethical stress' in criminal justice social work in Scotland: The place of values. *British Journal of Social Work, 45*, 1415–1432.
- Fogler, S. (2009). Using conflict theory to explore the role of nursing home social workers in home-and community-based service utilization. *Journal of Gerontological Social Work, 52*, 859–869.
- Fourie, C. (2015). Moral distress and moral conflict in clinical ethics. *Bioethics, 29*, 91–97.
- Ganz, F. D., Raanan, O., Khalaila, R., Bennaroch, K., Scherman, S., Bruttin, M., . . . Benbenishty, J. (2013). Moral distress and structural empowerment among a national sample of Israeli intensive care nurses. *Journal of Advanced Nursing, 69*, 415–424.
- Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*. Los Angeles, CA: Sage.
- Hamric, A. B., & Blackhall, L. J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine, 35*, 422–429.
- Harnett, T. (2010). Seeking exemptions from nursing home routines: Residents' everyday influence attempts and institutional order. *Journal of Aging Studies, 24*, 292–301.
- Houston, S., Casanova, M. A., Leveille, M., Schmidt, K. L., Barnes, S. A., Trugale, K. R., & Fine, R. L. (2013). The intensity and frequency of moral distress among different healthcare disciplines. *Journal of Clinical Ethics, 24*, 98–112.
- Hyde, C. A. (2012). Ethical dilemmas in human service management: Identifying and resolving the challenges. *Ethics and Social Welfare, 6*, 351–367.
- Iecovich, E. (2001). An Israeli perspective. *Journal of Social Work in Long-Term Care, 1*, 15–19.
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice Hall.
- Källemark, 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*, 1075–1084.
- Karanikola, M. N., Albarran, J. W., Drigo, E., Giannakopoulou, M., Kalafati, M., Mpouzika, M., . . . Papanthanasoglou, E. D. (2014). Moral distress, autonomy and nurse-physician collaboration among intensive care unit nurses in Italy. *Journal of Nursing Management, 22*, 472–484.
- Lang, G., Löger, B., & Amann, A. (2007). Well-being in the nursing home—a methodological approach towards the quality of life. *Journal of Public Health, 15*, 109–120.
- Lev, S., & Ayalon, L. (In Press). The development and content validation of a questionnaire to assess moral distress among social workers in long term care facilities.
- Lev, S., & Ayalon, L. (2015). Running between the raindrops: The obligation dilemma of the social worker in the nursing home. *Health & Social Work, 40*, 10–18.
- Lev, S., & Ayalon, L. (2016). Coping with the obligation dilemma: Prototypes of social workers in the nursing home. *British Journal of Social Work, 46*, 1318–1335.
- Liljegren, A., Dellgran, P., & Höjer, S. (2008). The heroine and the capitalist: the profession's debate about privatisation of Swedish social work: Hjältinnan och kapitalisten: Den fackliga debatten om privatisering av socialt arbete i Sverige. *European Journal of Social Work, 11*, 195–208.
- Lindbloom, E. J., Brandt, J., Hough, L. D., & Meadows, S. E. (2007). Elder mistreatment in the nursing home: A systematic review. *Journal of the American Medical Directors Association, 8*, 610–616.
- Lindström, K., Elo, A., Skogstad, A., Dallner, M., Gamberale, F., Hottinen, V., . . . Orhede, E. (2000). *QPS Nordic: General Nordic questionnaire for psychological and social factors at work: User's guide*. Copenhagen, Denmark: Nordic Council of Ministers.
- Linzer, N. (1999). *Resolving ethical dilemmas in social work practice*. Boston, MA: Allyn and Bacon.
- Lonne, B., McDonald, C., & Fox, T. (2004). Ethical practice in the contemporary human services. *Journal of Social Work, 4*, 345–367.
- Mänttari-van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International Journal of Social Welfare, 25*, 86–97.
- Maslach, C., Jackson, S. E., & Leiter, M. P. (1986). *Maslach burnout inventory*. Palo Alto, CA: Consulting Psychologists Press.
- McAndrew, N. S., Leske, J. S., & Garcia, A. (2011). Influence of moral distress on the professional practice environment during prognostic conflict in critical care. *Journal of Trauma Nursing, 18*, 221–230.
- McDaniel, C. (1997). Development and psychometric properties of the Ethics Environment Questionnaire. *Medical Care, 35*, 901–914.
- Maslach, C., & Jackson, S. E. (1986). *MBI: Maslach Burnout Inventory: Manual research edition*. Palo Alto: University of California.
- Meltzer, L. S., & Huckabay, L. M. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13*, 202–208.
- Nelson, H. W. (2000). Injustice and conflict in nursing homes: Toward advocacy and exchange. *Journal of Aging Studies, 14*, 39–61.
- O'Donnell, P., Farrar, A., Brintzenhofesoc, K., Conrad, A. P., Danis, M., Grady, C., . . . Ulrich, C. M. (2008). Predictors of ethical stress, moral action and job satisfaction in health care social workers. *Social Work in Health Care, 46*, 29–51.
- Oh, Y., & Gastmans, C. (2013). Moral distress experienced by nurses: A quantitative literature review. *Nursing Ethics, 22*, 15–31.
- Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., . . . Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nursing Ethics, 17*, 726–740.
- Openshaw, L. (2011, October). *Moral distress and the need for moral courage in social work practice*. Paper presented at the North American Association of Christians in Social Work Conference, Pittsburgh, PA. Retrieved from <http://www.nacsw.org/Publications/Proceedings2011/OpenshawLMoralDistressE.pdf>.
- Pallant, J. (2013). *PSS survival manual: A step by step guide to data analysis using IBM SPSS*. Buckingham, England: Open University Press.
- Papadaki, E., & Papadaki, V. (2008). Ethically difficult situations related to organizational conditions social workers' experiences in crete, Greece. *Journal of Social Work, 8*, 163–180.

- Papathanassoglou, E. D., Karanikola, M. N., Kalafati, M., Giannakopoulou, M., Lemonidou, C., & Albarran, J. W. (2012). Professional autonomy, collaboration with physicians, and moral distress among European intensive care nurses. *American Journal of Critical Care, 21*, e41–e52.
- Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (Vol. 1, pp. 17–59). San Diego, CA: Academic Press.
- Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. *Nursing Ethics, 16*, 561–573.
- Piers, R. D., Van den Eynde, M., Steeman, E., Vlerick, P., Benoit, D. D., & Van Den Noortgate, N. J. (2012). End-of-life care of the geriatric patient and nurses' moral distress. *Journal of the American Medical Directors Association, 13*, 80.e7–80.e13.
- Raines, M. (2000). Ethical decision making in nurses. Relationships among moral reasoning, coping style, and ethics stress. *JONAS Health Law Ethics Regul, 2*, 29–41.
- Sauerland, J., Marotta, K., Peinemann, M. A., Berndt, A., & Robichaux, C. (2014). Assessing and addressing moral distress and ethical climate, part 1. *Dimensions of Critical Care Nursing, 33*, 234–245.
- Sauerland, J., Marotta, K., Peinemann, M. A., Berndt, A., & Robichaux, C. (2015). Assessing and addressing moral distress and ethical climate part II: Neonatal and pediatric perspectives. *Dimensions of Critical Care Nursing, 34*, 33–46.
- Solomon, R. (2004). The role of the social worker in long-term care. *Journal of Gerontological Social Work, 43*, 187–202.
- Tourangeau, R., & Rasinski, K. A. (1988). Cognitive processes underlying context effects in attitude measurement. *Psychological Bulletin, 103*, 299–314.
- Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science & Medicine, 65*, 1708–1719.
- Weinberg, M. (2009). Moral distress: A missing but relevant concept for ethics in social work. *Canadian Social Work Review/Revue canadienne de Service Social, 26*, 139–151.
- Wilson, G. (2004). Dilemmas and ethics: Social work practice in the detection and management of abused older women and men. *Journal of Elder Abuse & Neglect, 14*, 79–94.