Illuminating moral distress in social work:

A grounded theory study informed by critical realism

by

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Abstract

What is it about social work that makes it so ethically challenging? Why do social workers seem to feel moral distress so accurately captures their experiences? And why has there been so much conceptual confusion regarding moral distress? Although well documented in other helping professions, moral distress has not been well represented in the SW literature. Yet, social workers are accustomed to working in ethical challenging conditions.

Building from the seminal work of previous scholars and backed with practical experiences from current practitioners this study applies critical realist methodology to grounded theory methods to reconstruct a conceptual model of moral distress. A mix of qualitative and quantitative studies have established the groundwork for further analysis. Empirical evidence was gathered through interviews with experienced social workers. Data analysis was conducted through an abductive lens intended to integrate all potential theoretical explanations.

Participants described situations that gave rise to significant moral consequences that impacted their mental health and professional career. They described feelings of frustration, anger, resentment, and self-defeat related to an inability to act on their perceived ethical duty.

Ethical challenges were categorized into 5 commonly described themes. 1) Powerlessness 2) Advocacy for Social Justice and its influence on social workers 3) Moral impact of undemocratic work environments 4) Self-determination and barriers preventing participant's efforts to empower clients 5) Moral consequences for social workers working within the medical model.

The 5 major themes have been recognized as the leading factors giving rise to moral distress. This study exposes the interrelated features and underlying mechanisms leading to moral distress in social work and demonstrates that moral distress is more complex and dynamic than scholars have previously specified.

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I would like to thank all the participants who graciously agreed to share their experiences. Only through their genuine willingness to recount challenging moral situations that this study is able to make a contribution to the literature on moral distress. I also would like to thank my advisor Sid Frankel for his knowledge, dedication and invaluable support throughout this project. A special acknowledgement goes to the advisory team, Dr. Laura Taylor, Dr. Merril Pauls and Dr. Bonnycastle for their insight and support.

Dedication

This paper is dedicated to my wife Kathy who was ever so patient and supportive, and all our children Ray, Renee, Matt and beloved son Luke who has left his realm of earthly presence, may you rest in peace. Thank you all for your kind support and sacrifices along the way. I am truly inspired by your love, patience and support. I finally made it!

This paper is dedicated in a special way to my cherished friend, Laura Taylor, who was an inspirational teacher, valued friend, and member of the advisory committee.

Table of Contents

List of Tables

List of Figures

Figure Page

Chapter 1

Chapter one introduces the research topic and provides a basis for the relevance of the topic and contributions this thesis will make to theory, practice, policy, and social work education.

Introduction

Moral distress (MD) has been described as a psychological state that manifests itself through experiences of compromised moral integrity. It can have physiological, emotional, behavioral and spiritual effects on those experiencing it. Given its power to elicit such negative emotional responses, moral distress has been suggested to be a major contributing factor in decreased job satisfaction for nurses and other healthcare professionals; resulting in many withdrawing from their duties, changing positions, or leaving the profession entirely (Hamric, 2012).

Although well documented in nursing and other helping professions social work (SW) scholars are surprised that it is not sufficiently characterized in the social work literature (Weinberg, 2009; Oliver, 2013; Lynch and Ford, 2016; Openshaw, 2011). Social workers share similar ethical responsibilities with nursing and frequently confront similar ethical challenges. Both professions are social agents working to improve the quality of lives, both uphold codes of ethics depicting their profession as moral endeavors, and both are gendered professions with strictures on autonomy and status that contribute to the stress of pursuing their moral and ethical practice (Weinberg, 2009). However, not all SW scholars agree that the contributing factors of moral distress are indistinguishable among social workers, nurses and other health care providers. Some authors suggest there are significant differences and recommend that unique forms of measurement are required to classify MD factors with the SW profession (Oliver, 2011, 2013; Mänttäri-van der Kuip, 2016; Lev & Ayalon, 2016; Lynch & Forde, 2016), while other scholars highlight parallel experiences and denote analogous causal factors of moral distress

within different contexts (Houston, S., Casanova, M., Leveille, M., Schmidt, K., Barnes, S., Trungale, K., and Fine, R., 2013; Kalvemark et al., 2004; Wienberg, 2010; Fantus et al. 2017). This study seeks to illuminate the multifaceted interaction of causal factors related to moral distress in social work by integrating practical social work experiences, values, concepts, definitions and theories with the existing literature and analyzing their relationship with other influential constructs. The data from this study will accentuate moral challenges in everyday SW practice. Social work practitioners commonly encounter ethically challenging circumstances, and it is highly probable that they will experience MD at some point in their career. The need to establish a nuanced understanding of MD in SW has never been greater. Indeed, recommendations from the Honorable Ted Hughes in the Phoenix Sinclair inquiry reveal the 'real-world' challenges of social work. In reference to ethical challenges of front-line social workers, Justice Hughes stated, "I believe that the social workers who testified at this inquiry wanted to do their best for the children and families they served, and that they wanted to protect children, but their actions and resulting failures so often did not reflect those good intentions" (Hughes, 2014, p. 23).

The Sinclair Inquiry revealed several examples of the moral tension experienced as social workers did not act on their moral instincts. In some instances, practitioners were met with limitations that directly restricted their moral agency and conflicted with their individual values and professional obligations. Social work is a discipline with high moral standards that occasionally conflict with organizational policy, or even legal obligations. Subsequently, practitioners may encounter ethical challenges as part of their professional obligation. This highlights the need to conceptualize moral agency within social work practice and advance a

more comprehensive understanding of the interrelated factors leading to moral distress, including contributions from the wider context of social workers' socio-political and cultural environment.

There are several factors to consider when analyzing the complex interaction amid personal, professional, ethical, organizational, and political values and structures associated with moral distress in social work. For example, the impact of thirty years of neo-liberal government agendas has resulted in austerity measures, shrinking public services, increased bureaucracy, proceduralization, managerialism, and the marginalization of social work as a discipline (Mullaly, 2007). As a result, social work responsibilities are mainly focused on gatekeeping of limited government resources, monitoring client behavior, and managing risk. The interaction and impact on individual social workers are not well understood as practice decisions in social work involve multiple subjective, professional, organizational and societal principles, values and accountabilities that are intertwined in a complex manner (Mänttäri-van der Kuip, 2020).

By expanding on the research of previous scholars this study draws upon various theoretical concepts and cycles of events linked with moral distress to demonstrate the causal processes among them. Supported by experienced social work practitioners the data is grounded in the lived experiences and anecdotal accounts of situations that give rise to in moral distress.

This study seeks to enhance our understanding of the factors leading to moral distress in social work, provide evidence for distinguishing moral distress from other closely related concepts, such as burnout and compassion fatigue, and illuminate moral challenges in everyday practice. The emancipatory goal and desired outcome of this study is to enhance and maintain healthy environments for social workers through self-awareness and awareness of the moral challenges inherent in practice. The finding can lead to more resilient social workers that will be better equipped to practice with compassion and empathy, rather than through distress and self-

focused coping in the face of moral experiences. These findings may also be used to enhance theoretical conceptions of moral distress. Through a better understanding of contributory factors, further research will not only lead to the advancement of safe ethical SW practice, but also refine social work specific factors associated with moral distress as a resource for SW educators.

Theoretical foundation

The following section describes the theoretical approach to this study and reason why a critical realist approach is essential to the theoretical framework of this study. There are numerous factors to consider before researching a concept such as moral distress within a social work context. The first is to select a suitable theory; a theory that acknowledges empirical evidence, while at the same time accounts for the impact of contextual features inherent in the social work milieu. Positivist theories are often criticized for their inability to account for the interactions and complexities within the everchanging and unpredictable experience of social work. While on the other extreme, constructivist theory operates within a relativist world that presumes individuals function independently of the determining constraints of social structure (Houston, S., Casanova, M., Leveille, M., Schmidt, K., Barnes, S., Trungale, K., and Fine, R. 2013) and that no real truth exists. Research based on social constructivist theory is not compatible with this researcher's philosophical viewpoint or conducive to researching moral distress.

This study applies critical realist (CR) methodology to uncover the stratified and complex interaction of causal mechanisms associated with moral distress. Looking beyond simple linear causality to explain phenomena is the primary objective of CR. Critical realists pursue vertical explanations linking events and experiences to their underlying generative mechanisms rather than direct antecedent events and experiences. (Oliver, 2011). Roy Bhaskar (1978) coined the

term critical realism (CR) in the 1970's. His theory acknowledges a world of multiple opportunities for intervention and change (Oliver, 2011). Critical realism is well suited for describing social phenomena; its ontology respects the positivist's search for evidence of a reality that exists independent of our thoughts or impressions (Houston, 2012), while also asserting that all meaning to be made of that reality is socially constructed (Oliver, 2011).

The study applies grounded theory (GT) methods of data collection and analysis. GT was always intended to be useful in a broad range of theoretical perspectives (Charmaz, 2014), and is a good fit with CR. The flexible nature of GT makes it useful across the traditional epistemological paradigms spanned by CR (Oliver, 2011). Grounded theory addresses CR's epistemology that understanding is partial, tentative and temporary. Methods of line-by-line coding, constant comparison and interrogating data allow for conceptualization and reconceptualization, intended to push the researcher beyond his or her received understandings (Oliver, 2011). Grounded theory fulfills one of critical realism's major requirements by embracing epistemic relativism (that there are many ways of knowing).

Grounded theory theorists are not only interested in who defines and controls basic social processes, but also under what conditions and for whose benefit (Charmaz, 2014). Rigorously applied grounded theory methods were used to uncover causal factors of moral distress and their potential impact on individual social workers and the profession as a whole; subsequently, this study delves into contextual, political, organizational, individual and societal influences contributing to MD, including personal psychological factors.

Inspired by the work of Michel Foucault (1978; 1988; 1991) the research integrates concepts such as governmentality, subjectivity and technologies of self to demonstrate how public

discourse is used as a means of influencing individual self-identity and social work values that have been fundamentally linked with the development of moral distress.

Previous scholars have defined the consequences of moral distress in behavioral, psychological, emotional and spiritual terms, which manifested into emotional exhaustion, burnout, high staff turnover and retention issues (Ulrich, C., P. O'Donnell, C. Taylor, A. Farrarr, M. Danis, and C. Grady, 2007; Durtson & Tuckett, 2013; Mänttäri-van der Kuip, 2016; Lynch & Forde (2016) identified the following moral challenges as the leading factors in MD; operational differences between social work mission statements and the realities of practice, staff reductions resulting in increased and unmanageable caseloads, time constraints, increased documentation and paperwork demands, inadequate supports, professional development, limited resources, problematic institutional policies and legal requirements.

Arrington (2008) cites research in the United States based on data collected by the National Association of Social Workers that identified lack of time and workload as the two greatest systemic issues negatively impacting social workers; the impact of these factors eventually result in poor quality client care and unsafe practices.

Moral distress not only threatens the integrity of individual social workers and client care, but also of the profession itself. Social workers are leaving their positions at higher rates than other government workers. Between 2002 and 2006 British Columbia's child welfare ministry lost 10 percent of its staff through turnover, while sick leave averaged 12.39 days per employee; an unusually high rate as compared to other government departments was noted by Bennett, D., Sadrehashemi, L., Smith, C., Hehewerth, M., Sienema, L., & Makolewski, J., (2009). Bennett et al. identify systemic and institutional factors that have contributed to these trends.

More recent empirical data on moral distress reveals instances in which social workers experience high rates of MD. Results from Houston et al., (2013) provide quantitative statistics on MD; comparing various healthcare professionals.

The following table demonstrates both intensity and frequency ratings taken from nine scenarios used in their study:

Table 1

Intensity and frequency of MD among Health Care Professionals

Job role	Mean moral distress intensity (0-6)	Mean moral distress frequency (0-6)
Chaplain	3.79	2.64
MD	3.79	2.18
Resident	3.47	2.02
Nurse	3.58	2.33
RX	2.71	2.64
SW	3.79	2.63
Therapist	3.39	2.12

(Houston et al., 2013)

Houston et al. (2013) findings reveal a narrow range of mean MD scores among healthcare professions (nursing, physicians, speech and respiratory therapists, pharmacists, chaplains, and social workers). Social workers report high levels of MD, similar to nurses. The highest indicators of intensity were related to compromised moral integrity due to withholding information from patients because of family requests, issues related to discharging patients before they are ready, or when there are insufficient resources.

The data from this study echoes findings from the literature regarding reasons why they chose a career in social work. Many social workers are inspired by their personal values (CASW, 2015).

Narrators in the article “shared stories” (CASW, 2015) articulate their motives for choosing social work as a profession. Most narrators identified personal values as their primary inspiration and acknowledged that there was a good ‘fit’ between their personal values and social work values. Some even described social work as a ‘calling’ or ‘vocation’ that chose them, which is an important factor in preserving moral integrity (to be in harmony with one’s moral beliefs and values). The collective accounts from the ‘shared stories’ (CASW, 2015) article are reflective of the widespread values and ideological structures taught in universities and maintained in the national social work code of ethics (Marston & McDonald, 2012).

The central feature of moral distress can be characterized by the lack of congruence between ideological, practical and professional values, Marston and McDonald (2012). Martinson and Macdonald posit that there is a distinct gap between social work’s mission statements and ideals learned in universities and the realities of practice. They argue that these articulations may lead to inflated ideas about the worker’s sense of agency and what can realistically be achieved in practice. SW values, when turned into a sense of duty, can lead to overwhelming feelings of helplessness and pose a serious threat to one’s moral integrity. Although the research participants reported congruence between their personal values and professional values, they also stated their experience in the field was frustratingly, unlike the ideals learned in university.

Research on the goodness of fit (D’Aprix et al., 2004) between social work student values and the mission statements and values taught in universities demonstrates this ongoing divergence. Based on Carol Germain’s ecological characterization of goodness of fit, it is the actual degree of precision between an individual or collective group’s needs, rights, goals, and capacities and the qualities and operations of the physical and social environments within particular cultural and historical contexts (Germain, 1991, p. 817). According to this theory, social workers occupy

certain statuses within society, while environments define their role and enforces expectations and demands accordingly.

In the 1950's educators believed social work values could be taught to appropriate candidates and the transformation into the profession is essentially an acculturation process wherein students internalize the social values and behavioral norms of the group (Greenwood, 1957). Social work educators assumed that the instructive process will inspire social work values and that students would come to embrace the objectives of the profession (Abbott, 1981). However, this assertion has not been supported by empirical data (Hayes & Varley, 1965; Pumphrey, 1959).

D'Aprix et al. (2004) reinforced previous findings suggesting that the educational process did very little to change the individual values of SW students; despite years of academic endeavors to indoctrinate historical conceptions of social work based on altruistic values focused on protecting the impoverished and disadvantaged groups. D'Aprix et al. demonstrate that many students entering social work in the United States seek a career in private practice or as counsellors in organizations serving white clients who can afford to pay for their service (D'Aprix et al., 2004).

The above-mentioned concepts are grounded in common themes and factors impacting an individual social worker's self-identity and their level of satisfaction within the profession. Moral integrity can only be maintained when there is congruence between individual and professional values. Moral distress generally occurs when one's moral integrity has been threatened (an experience brought about when one's values or beliefs have been seriously compromised). By illuminating ethical challenges encountered by practicing workers and contributing factors of moral distress we hope to inspire social work educators to find ways of

adapting social work curricula to characterize healthy explorations of workplace expectations, guidelines, policies and professional ideals so the students will be prepared for ethical challenges in the workplace.

For social workers, the inability to implement their professional standards and guidelines can be highly stressful (Canadian Association of Social Workers, 2005). Numerous studies have demonstrated that social workers are struggling in their efforts to meet the needs of their clients within organizational policies while complying with their professional moral code (Conneely & Garrett, 2015; Grootegoed & Smith, 2018). Standards of practice and codes of ethics act as guidelines for professional conduct and represent a measure of fulfillment understood as a professional responsibility. They are rule based ethical guidelines (Weinberg, 2010) and social workers have an ethical duty to abide by them. Social workers are also inspired by their personal conviction to self-impose standards against which to evaluate themselves. In efforts to live up to these standards, social workers often encounter restrictions and incompatible moral obligations. In the face of conflicting obligations social workers experience uncertainty and confusion about precisely what their role is. Amid such dissonance, practitioners may even question the appropriateness of their involvement with a particular client (Siebert & Siebert, 2005). The participants in this study have stated that their personal values aligned with SW values. More specifically, they expressed their obligation toward achieving a level of social justice for their clients and their community.

Values are a significant feature in determining ethical conduct. Social justice is a highly regarded social work value and is the primary objective being pursued by the participants in this study. Respect for client self-determination is another important value in SW. The participants in this study were determined to provide interventions that would be consistent with their clients'

wishes. The participants described the barriers preventing them from moving toward these objectives were associated with systemic issues deriving from the medical model and larger government and organizational barriers by way of restrictions and limitations to resources. When the practitioners were prevented from pursuing SW values, they felt powerless in their pursuit of ethical obligations and were duty-bound to impose undesirable options to their clients which resulted in frustration and distress.

At the center of moral choices, and perhaps the reason why many social workers experience moral distress, is their devotion to multiple and competing normative discourses that they have framed in terms of absolute rights, duties and obligations (Siebert & Siebert, 2005). Even though social workers embrace their professional values and try to maintain them in practice, there remains a wide variety of competing expectations and personal values that influence and shape their overall moral expectations. Moral accountability and self-perception are inextricably linked to MD, "the degree to which a person views herself or himself as individually responsible or as restricted by circumstances" is instrumental in determining MD (Corley et al., 2001, p.251). Moral dilemmas are often at the center of distress and sometimes have lasting personal effects. Philosopher R. Marcus (Marcus, 1980), provides clarity on the influences moral dilemmas can have on personal self-identity. He stated that negative feelings have resulted from a moral dilemma in which the decision-maker, despite feeling he or she has acted correctly, experienced guilt or remorse because, in acting correctly overall, he or she failed to act correctly in some particular manner. Moral residue from this experience leaves them feeling uncertain, questioning, and, in some cases, frustrated and less than satisfied with his or her professional role.

Empirical research on MD among healthcare providers (Houston et al, 2013) found that social workers reported the highest intensity rating of moral distress. Instances such as participating in hiding information, especially bad news, from patients because of family requests were frequently reported. Social workers are client focused and seek to establish trusting relationships with clients. Social workers value veracity. Hiding or withholding information from their client directly violates the clients right to that information and negatively impacts the moral identity of the worker. Professional values are instrumental in shaping one's moral expectations of her or himself and others. It was important to the participants of this study to remain true to their moral identity as a social worker. During the course of interviewing, all participants were invested in rationalizing their intentions and validating their responses so they align with SW standards and/or their personal values.

Personal values are both established and practiced differently across communities. Influences from culture, religion, sex role, occupational role, and changes in lifecycle are but a few of the driving factors formulating ones understanding of what it means to be a moral person (Rokeach, 1979). Values are multi-faceted, and are not concrete rules, but rather constitute interests, pleasures, likes, preferences, duties, moral obligations, desires, wants, needs, goals, aversions and attractions (Rokeach, 1979). They are the result of societal demands and psychological needs that are learned and determined by culture, society, society's institutions, and personal experience. Values govern attitudes, judgments, choices, attributions, and actions. According to Rokeach (1979), values are not fixed states of mind, but rather are susceptible to change often instituted by changes in society, situation, self-conceptions, and self-awareness. Adaptations in personal values represent central transformations that have important consequences for other cognitions and social behavior (Rokeach, 1979). Rokeach's description

of values depict a dynamic ongoing formation of right and wrong that is influenced by multiple factors, many of which occur subconsciously and are inextricably woven into our daily communication and interactions. Therefore, moral identity is indeed shaped and perpetuated through institutional teaching and public discourse.

Foucault's (1978) theory of "subjectification and technologies of self" provides a framework for understanding mechanisms that influence and shape our moral identity. Foucault (1978) described "technologies of self" as methods of providing the means for individuals to enter the realm of knowledge about themselves that enables them to work on themselves as a project for change. Although not always consciously, we compare our lives and adapt according to popular or mainstream discourses; therefore, we construct right and wrong based on popular, mainstream discourses; media reports, psychology, health, diet, pharmaceutical advertising, and countless other forms of discourse (Rose, 1998).

People subconsciously absorb information from many different sources and generally discard notions that are incompatible with their values, while accepting and building on the compatible ones. Social workers, like all other professionals, form professional images of what it means to be a 'good social worker' and use those standards to create a moral benchmark for evaluating themselves. These moral expectations represent our expectation of others and go beyond self-monitoring. They become our moral standards for expected behavior, and often become very challenging to follow. Social workers understand these values as truths within the profession.

The Canadian Association of Social Workers code of ethics demands that social workers do not impose their personal/cultural values onto their clients (CASW, 2005). However, despite well-meaning efforts to remain objective, it is not humanly possible for social workers to dissociate themselves from their own personal values and ideals. For example, when assessing

potential foster or adoptive parents, social workers cannot truly set aside their personal notions of good or bad family life (Clark, 2006). Furthermore, formal organizational procedures and guidelines can also conflict with individual values and expected behavior. This conflict has been identified as one of the leading factors contributing to MD in studies of nurses (Corley 1995; Rushton et al. 2013). Social work as a profession has been highly influenced by social policy and the government of the day.

Governments create welfare policy and eligibility criteria while social workers become the overseers of these guidelines. Not only do social workers provide the public with assistance in accessing the resources, they also become the example through their own lived experience expressed in practical action. “They inevitably become models, transmitting and teaching standards, values and ways of living even if they do not do so deliberately” (Clark, 2006, p.82). Social workers are expected to engage in social and/or political action that seeks to ensure that all people have fair and equitable access to resources, services and opportunities (MCSW, 2018); however, the primary ethical discourse in contemporary social work derives from the liberal individualist tradition (Mullaly, 2007) and directly constrains individual practitioners’ efforts to foster client self-determination. Individual clients and families are believed to be the primary agents of their own social welfare, despite the wide-ranging social, cultural, and environmental factors that have determined their capacity to provide for themselves. However, “the bureaucratic environment of modern welfare practice undermines the pursuit of professional practice” (Clark 2006, P 78). Social work is legitimated by the state and its conception of welfare reflects the priorities and values of the host community and undermines the pursuit of social justice (Clark, 2006).

For the past two decades, neo-liberal ideas and policies have formed government agendas throughout the world (Ferguson & Lavalette, 2007), and the consequences have a direct impact on individual SW practitioners, “Working to achieve change is at the heart of what social workers do. Identifying needs and risks through assessment and developing and implementing action plans to address these will achieve nothing without an effective therapeutic relationship between worker and client…Yet social workers consistently told us that it is this very aspect of their work which has been eroded and devalued in recent years under the pressure of workloads, increased bureaucracy and a more mechanistic and technical approach to delivering services” (Executive, S., 2006, p.28).

Not surprisingly, the growing mismatch between SW values and governmental policy increases the risk of moral distress. Social work managers have become more concerned about numbers and meeting targets than about client needs (Jones & Lavalette, 2004) and justice workers are more concerned with a punitive approach of disciplining children than they are with improving their life circumstances (Ferguson & Lavalette, 2007).

Neo-liberal social work is undermining the more traditional collective approaches to social work; leaving front line workers frustrated and dissatisfied with their efforts. Thirty years of neo-liberal government agendas have led to shrinking public services, increased bureaucracy, proceduralization, and marginalization of social work practice. Subsequently, the worker’s responsibilities are mainly focused on gatekeeping government resources, monitoring client behavior and managing organizational risk (Oliver, 2013).

The seminal work of Adrienne Chambon (Chambon, Irving, and Epstein, 1999) depicts the various interpretations and methodology used in generating ‘a culture of social work’. Her illustrations demonstrate how SW is shaped by wider social movements. Within a Foucauldian

framework Chambon et al. (1999) expose conceptual, philosophical, and methodological challenges facing both the profession and individual social workers. By operationalizing Foucault's term 'technologies of self' Chambon et al. demonstrate the manner in which various forms of discourse and governmental influence have engendered SW values and societal expectations of the profession; including social work's role as public watchdog and gatekeeper to human resources, which conflicts with individual worker's altruistic values.

Social workers formulate identities of themselves as caregivers, often idealized, that are generated through interactive processes based on self-evaluation of their own performance as a personal and professional caregiver and on others' expectations of them in that role (Siebert & Siebert, 2005). Contemporary social work is challenged with adapting to changing societal and cultural conditions and is forced to carve out a new societal niche.

As the profession continues to struggle with unclear and conflicting ideological beliefs, many individual practitioners identify with belonging to a humanitarian group working toward social justice by empowering individuals and impoverished groups to reach their full potential, while others see themselves as 'social scientists' offering professional services such as counselling to help individuals cope with their problems. SW has fulfilled several different societal functions over the years, not all of them congruent with the emancipatory role of SW.

Some describe SW as a major social institution that legitimizes the power contained in modern democratic capitalist states (Chambon et al. 1999). Chambon et al (1999) describe a 'new regime' of social workers referring to the present-day practitioners who identify with 'social scientists', and this introduces motives for revisiting social work's mission, activities, and objectives. A critical reexamination of social work practices, institutional arrangements, and knowledge gives way to alternative social work practices and strategies for social change.

Historical preoccupation with the mechanics of theory, method and technique will not take social work to new levels of understanding or even help it reflect on its historical past. Social work theories and practices have become analytically shallow and increasingly performance oriented by embracing overly instrumentalized responses governed by procedures, competencies and managerialism (Houston, 2001). This study focuses on the interplay between these concepts and workers to reveal potential incongruence between social work ideology and practices as they relate to the moral integrity of individual practitioners.

Chambon et al. (1999) illustrate ways in which contrasting SW roles, values and expectations generate moral impasses that individual workers cannot easily reconcile. For example, personal and professional principles and values do not necessarily translate into practice, and in some cases SW ideology conflicts with larger organizational duties expected of individual workers. Weinberg (2010) depicts SW ethics as a major contributor to moral tension that is inherent in the way it seeks to manage practice. She posits that the SW code of ethics entails rule-based principles implying that lineal application of these principles will help social workers avoid ethical breaches. Weinberg argues that the problem with this ethical imperative is that some solutions are beyond the purview of individual practitioners, motivating them to comfort individual victims of social problems, rather than working toward making critical changes to the fundamental causes of social problems. The social work code of ethics implies that by following the principles and guidelines that social workers will know the ethical action to take. However, that is not always accurate as certain conditions may require practitioners to act on their own moral judgement; yet, the code of ethics is rigidly rule-bound and prohibits independent thinking (Weinberg, 2010).

Empirical research from nursing (Corley, 2005; Rushton & Adams, 2009; Hamric, 2012) documented moral incongruence (acting in ways contrary to ones' moral beliefs) as a primary factor in MD. Social work practitioners are often confronted with divergence between what they would prefer to do ethically and their ability to actualize those preferences in practice (Weinberg, 2007). Examples from child welfare demonstrate that new organizational strategies are not focused on either meeting the needs of children or responding to child abuse; but rather on assessing and managing risk (Chambon, et al., 1999). Chambon et al. (1999) describe how the fundamental theme of managing risk becomes a key point of entry for investigating and understanding contemporary "advanced liberal" strategies for governing conduct in child welfare policy and practice, which is qualitatively different from former SW practices.

The theoretical concepts described above have been contrasted with the practical experiences described by SW practitioners in this study. Participants were encouraged to elaborate on factors that created moral tension. They were invited to share personal values and professional expectations of that situation. From an epistemological perspective, the interview responses reveal the meaning, structure and the essence of the SW experience.

Chapter Two

Literature Review

This chapter is a review and critical analysis of the empirical and theoretical literature on moral distress; including other relevant concepts. The chapter is broken down into ten segments. The first is an introduction illustrating the sources used to obtain the material for this review. The second provides a chronological historical account of MD and varying definitions used to describe it. The third is a review of recent empirical data on MD. The fourth delivers a summary

of inter-related concepts found in the literature, including theoretical distinctions differentiating them from MD. The fifth is a brief summary and critique of recent empirical data on MD in social work. The sixth is a study of theoretical constructs and other relevant terms that have been associated with MD. The seventh is a review the empirical research on MD in social work. The eighth is a review and analysis of conceptual research on MD in social work. The ninth is a summary of the literature review. The tenth and final section is a portrayal of the contributions this proposed study will make to social work literature and of what can be confidently known from the data as well as gaps in knowledge that require further research.

Sources

Combined searches in nursing and social work were completed in the following databases: CINAHL, PubMed, Google Scholar, PsycInfo, and Ebsco Host, Social work Abstracts, and Social Service Abstracts. The searches were limited to publications in English between January 1984 (the year that Jameton (1984) applied the term 'moral distress' to nursing practice) to current research; Attrash-Najjar, A., & Strier, R. (2020); Mänttäri-van der Kuip, M. (2020); Browning & Cruz, (2018); Jaskela, Guichon, Page & Mitchell, (2018); Lev & Ayalon, (2018). The following terms were searched, 'moral integrity', 'moral distress', 'ethical distress', 'moral stress', 'moral development', 'ethical stress', 'moral residue', 'compassion fatigue', and 'burn out'. Books and articles authored by Michel Foucault were searched in the University of Manitoba Libraries data base.

The literature review is narrowed to nursing and social work for three primary reasons. 1) this study aims to develop a grounded theory of MD among social workers. 2) The MD phenomenon originated in the field of nursing and has later been associated with other healthcare professions

such as SW. 3) Researchers have drawn parallels between moral/ethical challenges in social work and nursing (Weinberg, 2009; Openshaw, 2011; Oliver, 2014; Lynch & Forde, 2016). Weinberg (2009) makes the case for similarities between the nursing and social work professions; both applied efforts in dealing with the health and well-being of others, both view themselves as being in the business of helping to improve the quality of lives, both are gendered professions with strictures on autonomy and status that contribute to the stress of pursuing what one views as the right course of action, and both are faced on a daily basis with value conflicts that must be resolved "on the ground" (Weinberg, 2009). Additionally, nursing and social work each have codes of ethics depicting their professions as moral endeavors (Corley, 2002; Reamer, 1999).

The empirical data reviewed for this study has been chronologically incorporated into this segment of textual review, along with the theoretical studies. There are short summary tables provided in Appendix "C"**.** Please refer to Table - 6 for a summary of empirical research in nursing, Table 7 – for a summary of theoretical methodological research in social work, and Table - 8 for empirical research in social work.

Much of the early empirical data on MD derives from studies in nursing and is narrowly focused on small populations, including neonatal intensive care nurses and medical students. Based on Hamric's (2012) empirical research review, there had only been three intervention studies on MD at that time; (Beumer 2008; Rogers et al.2008; Sporrong et al. 2007). All three studies employed educational interventions as a means to address MD. Inspirational new research reveals the benefits of using social work interventions for mitigating the negative effects of moral distress. Browning and Cruz (2018) used pre-test/post-test measures to determine the efficacy of reflective debriefing with ICU nurses. The debriefing was facilitated by social

workers. In summary, Browning & Cruz (2018) emphasize the benefits of reflective debriefing and the importance of interprofessional collaboration as an essential element to combating moral distress. Their study recommends that resolving ethical conflicts between professional values through more effective communication can positively impact the instances of moral distress that stem from those differences. Moreover, learning about moral distress and its effects in addition to taking steps to mitigate it may help to reduce burnout among health care professionals. Social workers can also benefit from similar interventions to alleviate moral distress and play a critical role in helping their colleagues mitigate the negative effects of perceived powerlessness by sharing strategies for personal empowerment and advocacy for systemic change (Browning & Cruz, 2018).

History and Definition

This section will provide a chronological conceptualization of MD and empirical research that evolved in the literature. Moral distress was initially conceptualized in the late 1970s and early 1980s with the bulk of empirical data on MD and research in the nursing profession. Philosopher and professor Andrew Jameton was the first to conceptualize the term moral distress in 1984. Jameton (2013) provides a breakdown of how MD established prominence in nursing ethics. In his account Jameton stated that MD was a highly gendered phenomenon that rose out of feminist ethics. Jameton (2013) recalls that the nursing students in the early 1980's had a tendency to focus on issues of power, inequality, and assertiveness that characterized the feminist literature of the time. Nursing ethics brought bureaucratic and institutional concerns to prominence, and nursing students, some of whom had been clinicians with several years of experience, began to reflect on the clinical moral problems they had encountered. Nurses realized that they expressed little confidence in their own opinions, even though they had relatively strong views on what

needed to be done. A confounding problem was that the nurses expected minimal support from physicians or nursing administrators. Given the structural hierarchy of the time, nurses tended to avoid direct conflict and expressed their views in ways designed to cloak, sometimes unconsciously, their professional disagreement with some medical practices. The concept, moral distress, was thus useful in promoting a more direct discussion of the moral problems that nurses were facing.

Since the concerns of moral distress fit neatly into discussions about gender, the status of women, and participation in decision-making that were appearing in the feminist philosophy, nursing practice had the opportunity to voice a variety of concerns that had not been addressed in the medical ethics literature of the time, particularly the emotive experience of ethical issues. Most early accounts of moral distress arose from nurses regretting not speaking up in times of conflict. Scholars rightly called attention to the somewhat passive character associated with MD and urged nurses to be more vocal on behalf of the values of their profession. The revitalizing answer to the dilemma of moral distress was to speak up and fight for what they see as right. The answer then became activism (Jameton, 2013).

In the 1984 book Nursing Practice: The Ethical Issues Jameton (1984) characterized moral distress as, “painful feelings and psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires but cannot carry out that action due to institutional constraints” (Jameton, 1984, p.6).

Jameton (1984) described moral distress as a reactive psychological response to being constrained from doing what one believes to be the ethically correct thing. The original understanding of moral distress theorized that it was directly associated with one’s moral identity and the institutional constraints preventing one from acting on his or her moral convictions.

Early studies focused on constraints that arose from clinical situations, internal factors (individual/personal), as well as features present in the institutional culture and larger healthcare environment (Jameton, 1995; Corley et al., 2001, 2002, 2005; Hamric, 2012; Nathaniel, 2006; Rushton et al., 2009, 2013, 2016, and others). Building on Jameton's definition, Judith Wilkinson (Wilkinson, 1987) conducted the first empirical research on nurses' experiences of MD. In her mixed methods study she interviewed 24 hospital nurses in an attempt to identify situations that contributed to MD (Wilkinson, 1987).

Based on her findings Wilkinson (1987) developed a Moral Distress Model integrating triggers and responses to morally distressing situations. Wilkinson's conceptual model or algorithm included four parameters; situation, action, cognition, and feelings. The situation refers to a clinical environment with many ethical issues. Nurses, as moral agents, are able to cognize, judge, and act when they face ethical issues in clinical situations. The process initially begins with moral provocation and appraisal in cognition before judging the most ethical response. Moral distress appears because of barriers that inhibit nurses from doing the right thing. Wilkinson's (1987) discovered that nurses who do not receive sufficient support often left their positions and some quit the field of nursing altogether. She concluded that nursing administrators must provide higher levels of support in moral situations. This finding was reiterated in a number of subsequent studies (Corley, Elswick, Gorman, et al., 2001; Pauly, Varcoe, Storch, et al., 2009).

Wilkinson (1987) expanded the definition of moral distress to include a broader range of factors, "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (Wilkinson, 1987, p. 16). Wilkinson's research advanced Jameton's definition

in three ways; 1) clinical situations can give rise to MD, (e.g. providing treatment believed to be futile and lying to patients), 2) nurses can be both externally and internally constrained, (e.g. through being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage), and 3) that moral distress results not only from being constrained from doing what nurses believe to be right, but also from having done the wrong thing. Wilkinson's model (1987) became the cornerstone of research on MD.

Jameton (1993) distinguished initial moral distress from reactive moral distress. He described the initial distress as the frustration, anger, and anxiety that results when a person is faced with institutional obstacles and interpersonal conflicts about values. Whereas reactive distress is 'the distress that people feel when they do not act upon their initial distress' (Jameton, 1993, p.544). Various explanations and empirical tools have been introduced for measuring the frequency, intensity, sources, and impact of MD, including what has become the most widely used instrument for measuring MD. The Moral Distress Scale (MDS) was developed in 2001 by Corely, Elswick, Gorman, and Clor. The theoretical framework guiding the development of the MDS, was influenced by role conflict theory (Rizzo & House, 1972), signifying that nurses are expected to fulfill their obligations to two organizational authorities: the facility's managers, who pay their salaries; and its physicians, who direct their provision of care. The implication is that nurses adhere to a value system based on providing optimal patient care and certain constraints often prevent them from providing that level of care.

Items included in the MDS were developed from existing research on moral problems that nurses encountered in hospitals. Mary Corley became a leading researcher on moral distress and was the first to publish a quantitative measure of moral distress (Corley et al. 2001). Corley's definition expanded on Wilkinson's (1987) view of causal factors by including, "psychological

disequilibrium, negative feeling state, and suffering experienced when nurses make a moral decision when they either do not or feel they cannot follow through with the chosen action because of institutional constraints" (Corley et al., 2002, p.643). These factors included a psychological process that is more in line with personal decision making. Corley noted that nurses are in the challenging position of having more responsibility than authority, thus affecting their ability to fully realize their full scope of practice and confusing their sense of right and wrong. Corley et al. (2001) found MD arose within three main categories: clinical, environmental, and internal factors. The following are the most frequently reported features from each domain; Clinical factors such as unnecessary/futile treatment or testing, inadequate informed consent, aggressive treatment not deemed to be in the patient's best interest, lying to or deceiving patients, and inappropriate use of resources. Environmental factors such as inadequate staffing/resources, incompetent caregivers, interdisciplinary conflict and lack of time. Internal factors that are specific to individuals such as moral development, self-esteem, personal history and feelings of powerlessness. (Corley et al., 2001)

Corley's intention for creating the MDS was to measure the frequency and intensity of MD among nurses working in intensive care unit settings. The inventory originally focused on moral issues and dilemmas that typically arose in critical care settings. Instrument testing included three stages: test-re-test, known groups, and administration of the instrument to a sample of 214 nurses. In the test-retest stage, it was revealed that there was limited variability in responses which led to the scale being expanded from 5 to 7 response categories. (little/almost none 1 to great 7). The second step involved using a contrasting-groups approach whereby occupational health nurses and a group of critical care nurses completed the MDS. An interesting finding was that the occupational health nurses did not report experiencing the situations listed on the MDS

in their practice. However, they did identify other problems that caused them moral distress; for example, the occupational health nurses experienced moral distress when they were asked by their employers for confidential health information about employees. These results did not influence changes to the MDS. The limitations of this scale are that it is confined to a job specific group, namely critical care nurses. In other words, one should be very careful extrapolating these finding onto other groups of health care providers.

Data results demonstrated that critical care nurses reported a high frequency of moral distress resulting in negative emotional responses; over 80% reported medium to high levels of MD and 26 % said they had left a position in the past because of it (Corley et al., 2001). Findings revealed evidence of reliability and validity for the MDS with acknowledgement of further testing required with larger sample sizes to enhance the instrument's validity and reliability, (Corley et al. 2001).

The MDS also measured affective responses to MD; physical, emotional, behavioral, and spiritual changes. Her findings suggested the following symptoms were associated with the experience; physical symptoms included fatigue, headaches, sleep problems and other somatic complaints. Emotional symptoms included anger, fear, guilt, frustration, resentment, feeling overwhelmed, and powerlessness. Behavioral responses were avoidance, withdrawal, sarcasm, blaming/shaming, addictive, crying, controlling and argumentative. The spiritual domain involved an overall loss of meaning/self-worth, crisis of faith, disruption in religious practices, and disconnection with others (Corley et al., 2001).

Quantitative studies such as Corely et al., (2001) have established the groundwork for the measurement and conceptualization of MD. The Moral Distress Scale (MDS) became the standard method of measuring MD in nursing. However, Hamric, Borchers, and Epstein (2012)

have since revised the MDS to include other health care professionals (MDS-R). They shortened the MDS to just 21 items, as the 38-item scale was simply too long for multivariate studies. The revised 21-item instrument used a 0-4 scale (Hamric, Borchers, & Epstein, 2012).
Construct validity was evaluated through hypothesis testing. Each of four hypotheses were supported, although the first hypothesis was only supported for the nurse group. Nurses with more experience demonstrated higher levels of MD. This relationship did not hold for physicians. The other three construct validity tests were significant in the hypothesized directions.

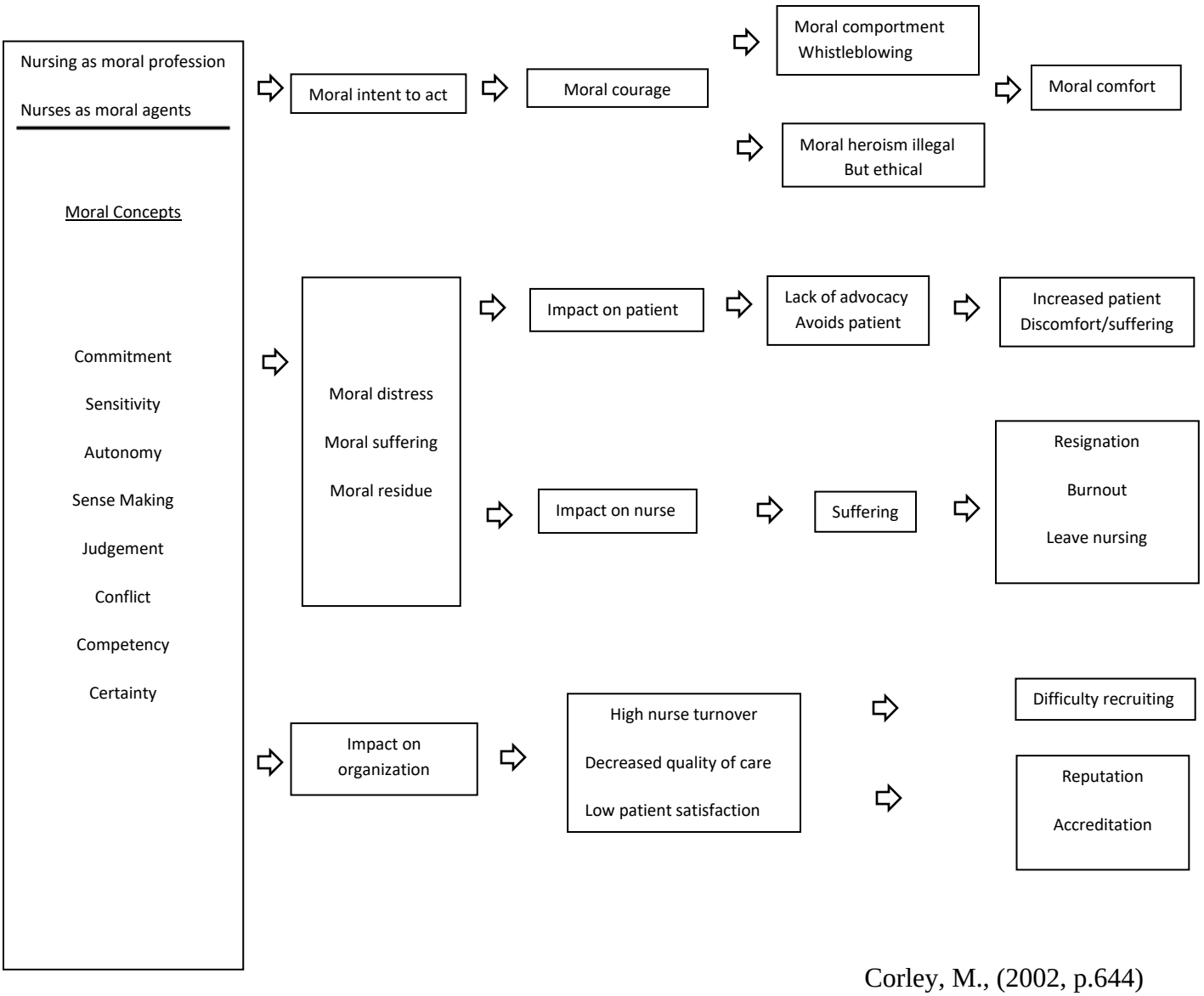
The researchers had three purposes for revising the MDS: to make it more inclusive of root causes of moral distress; to expand its use into non-ICU settings; and to make it useable for multiple healthcare disciplines. Corely (2002) proposed a conceptual model of moral distress to explain what happens when a nurse is unable to advocate for a patient. The conceptual model is rooted in Jameton's (1984) definition that focusses on institutional barriers preventing nurses from their perceived right moral action and included policy constraints preventing nurses from ethical actions, treatment that caused harm to patients through unnecessary pain and suffering, treating patients like objects because of institutional requirements, prolonging dying without informing patient or family about alternative choices, definition of brain death, inadequate staffing, and effects of cost containment (Corley, 2002).

Corley's data also revealed that nurses who experience moral distress behaved differently toward their patients. In particular, nurses either became "over-solicitous" or intense to make up for the perceived transgression, or more frequently noted, avoided the patient; thereby escaping from the frustration, anger and guilt that surrounds the distress (Corley, 2002).

Corley's (2002) theory highlights the moral processes (internal/psychological responses) that constitute MD as well as ways of addressing it. Figure 1. is a reproduced illustration of Corley's theoretical model:

Figure 1.

Model for a theory of Moral Distress



Corley, M., (2002, p.644)

Corley's model theorizes that MD is a determinant of interactions among a variety of psychological processes. She provided definitions for each psychological process and linked them with concepts such as moral integrity, moral sensitivity, moral competence, moral conflict, and others. She added that cultural differences in the nursing role led to varied moral complications based on different moral expectations that shaped individual understandings of correct moral behavior (Corley, 2002). This is of particular interest to our study as we seek to understand the interaction between these experiences.

Corley's (2002) theory summarizes that nurses with a high level of moral sensitivity are more likely to be committed to patients and develop moral competency, and thus experience less moral distress, even under the same conditions. While nurses who have been psychologically injured have lost their caring ability and no longer experience moral sensitivity; therefore, they do not experience moral distress. However, nurses with a strong sense of moral integrity, but who lack moral competency, will experience moral distress. Nurses with higher levels of moral sensitivity will use strategies to solve ethical problems and are more likely to develop moral competency and subsequently, less likely to experience moral distress. Nurses who have high levels of moral sensitivity, moral commitment and moral competence, and moral autonomy, are more likely to experience moral outrage, moral courage, and moral heroism, but less moral distress.

Similar to Wilkinson (1987), Corley concluded that MD is experienced to a lesser extent when collaboration and trusting relationships with physicians are encouraged, and when nurses believe that they are in a more supportive work culture. This was echoed by the participants in this study; social workers expressed feelings of powerlessness and disrespect in their work environment.

Varying Definitions

The complex, dynamic and relative nature of MD makes it a difficult phenomenon to define. Efforts to conceptualize moral distress has been challenging and rather difficult (Mänttäri-van der Kuip, 2020). The following section is a summary of definitions and supporting theories associated with defining moral distress.

Limitations to Jameton's (1984) original definition led to criticisms suggesting factors restricted to institutional constraints do not account for all circumstances in which MD occurs and there is a need to apply broader factors. Kalvemark et al. (2004) argued that Jameton (1984) inappropriately assumes that nurses who act on their moral conviction will not experience moral distress. Kalvemark et al. (2004) hypothesized that moral distress also occurs in situations when practitioners are able to act on their moral instinct. Additionally, professionals cannot always know the right thing to do; they may not have sufficient information to guide their oral decision-making and therefore cannot predict the outcome of their decision (Campbell, Ulrich, and Grady, 2016).

Broader notions of moral distress included the realization that individuals can feel morally controlled by perceived constraints (Webster and Baylis, 2000). Perceived constraints include restrictions to behaving in ways consistent with how one has been socialized. For example, students are socialized to follow the instruction of educators; employees are socialized to follow orders from supervisors, and so on. Feelings of personal moral failure can ensue in the absence of fulfilling these perceived moral obligations.

Ongoing research on moral distress has introduced several variations to Jameton's original definition. Although many scholars work toward broadening the applications to MD, others

argue that the concept has been over-extended and is now at risk of being analytically meaningless (Wocial, 2016). McCarthy and Gastmans (2015) summarized definitions from over fourteen different researchers and found that most authors drew upon Jameton's (1984) original definition. Refer to Appendix B, for a reproduction of definitions for moral distress reproduced from McCarthy & Gastmans (2015, p. 136-141).

It may appear advantageous to have a variety of viewpoints and definitions to define a concept; however, multiple definitions have become a major challenge for MD researchers (McCarthy & Gastmans, 2015). Quantitative researchers have found it difficult to establish internal validity without precisely defining what it is they are measuring, while qualitative researchers struggle with transferability as differing terminology obscures efforts to generalize their results into larger populations; hence the need to recognize the complex interaction among the various factors contributing to moral distress. The most common feature among definitions (Gastmans, 2015) related to the psychological, emotional, and physiological conceptualizations of moral distress. Most authors agree that moral distress is related to the presence of some form of constraint to moral agency and that moral distress is best understood as a two-stage process that can intensify over time. The initial stage was described as the presence of an obstacle/s that prevents one from moral agency and conflict with one's values (involves feelings of frustration, anger and anxiety) and the second stage is regarded as the reactive distress that accompanies one's inaction to alleviate the initial distress (Jameton, 1984; Campbell, S. M., Ulrich, C. M., and Grady, C., 2016). The dual nature of this understanding has some scholars theorizing it as a compound phenonmenon (Fourie 2015, p. 93). However, formalizing the nature of these two elements has been difficult and led to insufficient attention being paid to the relationship between them (Mänttäri-van der Kuip, 2020). Fry, Veatch, and Taylor (2011) identified five factors which

compromise moral integrity; inadequate staffing, lack of administrative support, power imbalances, disrespectful communication, and institutional policy.

Differing conceptualizations of moral distress have also influenced conflicting normative meaning and clarification of the factors contributing to it. The broad and varying definitions have diluted the analytical power of the concept (Wocial, 2016) while making it rather difficult to study empirically (Hamric,2012).

One commonly used definition sufficiently embraces the multiple factors and has become widely accepted by contemporary researchers; Nathanial's (2006) defines moral distress as the pain or anguish affecting mind, body and relationships in response to a situation in which the person is aware of the moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action but as a result of real or perceived constraints, participates in or allows the moral wrong-doing to occur.

Nathaniel (2006) integrates real and perceived powerlessness. Suggesting that instances of perceived powerlessness can derive from ways in which we are socialized to follow orders. As children we learn to respect and obey teachers, coaches, parents, and others perceived to be in a position of power; thus, confining our actions to only those believed to be acceptable to the influential person.

Nathaniel (2006) also implies that moral responsibility originates from one's personal expectations and need to maintain moral integrity. Self-perceived moral responsibility includes the notion that moral distress can be experienced vicariously through association or moral connection with some other party such as one's professional identity. For example, this might include experiences that are not necessarily grounded in one's own action or omission, but through association with another party, or even profession. Situations in which a colleague or

friend acted immorally or negligently can result in moral distress. Additionally, situations in which they acted morally but the action resulted in morally disastrous consequences may also lead to moral distress. This includes instances involving implicit associations with others ascribing to morally condemnable beliefs, attitudes, or motives are included. In summary, compromised moral integrity can result from a complex interaction among a variety of internal and external mechanisms; even in situations when the perceived moral wrong-doing does not fall directly onto the individual. For example, a SW practitioner working in a child welfare agency might experience distress if the agency does not provide adequate care or a good quality of life for its clients.

The literature sourced in this study has established a strong conceptual foundation from which to build. Many different accounts of causal factors have established the need to examine how they interact in contemporary social work. Authors such as Webster and Baylis (2000) have highlighted the importance of looking beyond institutional/environmental constraints to include personal errors in judgement and/or patterns of behavior such as systemic avoidance.
Moral distress is a complex phenomenon that is not easily defined due to the interaction of various factors that impact its development. Interpersonal features of MD have been vastly undervalued in prior studies. Factors related to self-image, professional values, meaning, cultural aspects, religious aspects, gender considerations, societal factors, personality and grit all hold a potential to influence the intensity and frequency of MD. This study seeks to identify the relationship between the above-mentioned aspects in order to establish a more comprehensive understanding of MD within a social work context. A better understanding of the nature MD can lead to healthier, more ethical workplaces, and resilient workers as well as improve the

likelihood of safe and ethical client care. The data from this study can also be used to inspire future research and influence systemic changes across multiple levels.

Related Theoretical Concepts

Moral distress is a complex phenomenon that is primarily associated with individual morality but is also interconnected with a variety of other concepts, several of which appear in the literature. See appendix "F" for a summary of the concepts associated with moral distress that have been identified in this study. This section provides a brief summary of related concepts, including comparison points to distinguish them from moral distress. Moral distress often arises in conflicting values, more precisely, when one is forced to choose between conflicting personal and professional values (Corley, 2001; Hamric, 2012). The Manitoba College of Social Work (MCSW) code of ethics (2015) categorizes six core values for the profession; respect for inherent dignity and worth of persons, pursuit of social justice, service to humanity, integrity of professional practice, confidentiality in professional practice, competence in professional practice (MCSW, 2015). Each ethical guideline in the code of ethics is based on one or more of these values. Thus, social work values are not simply minimum standards for practitioners, but they also represent ideals in which all social workers ought to strive toward (Fantus et al., (2017).

Moral distress can result from ethical situations arising from differing professional perspectives (Corley, 2001; Hamric, 2012). Social workers frequently work in multidisciplinary teams consisting of professionals such as doctors, nurses, psychiatrists etc. Within the context these teams, a hospital environment for example, social workers may be reluctant to confront others due to power differentials that exist among health care professionals. Social workers seldom have power in decision -making within the medical model (Fantus et al. (2017). Social

workers experience a variety of challenges to preserving their personal and professional values while working in the field and often find themselves in grey areas of policy observance. Values are an important consideration in researching moral distress. Not all values hold equal weight and some are malleable while others not as much. Critical events can result in the sudden change or even disappearance of previously held values (Rokeach, 1979). It is helpful to understand the evolution of our own moral values and realize that they have changed with education and life experience. We can also respect that deeply held values rarely change abruptly.

Values represent ideals to which an individual, family, group, organization or community aspires (Barsky, 2010). Personal values are shaped and influenced by a combination of cultural, spiritual, religious, educational, political and other social experiences, and classify what people believe is right, good and valuable. They are important factors in determining what we believe to be right and wrong (Barsky, 2010). People tend to see their own values as morally correct, otherwise they would change them to align with their thoughts. My personal experience has been that values evolve through experience, knowledge, reflection and self-evaluation which replicate the gradual and continuous process of moral development.

Values are prominently demonstrated as an integral component in moral distress (Jameton, 1984; Wilkinson, 1987; Corley et al., 2001), and whether they be personal, professional, or institutional, values form one's moral identity and influence personal expectations and responses to moral challenges. Practitioners in the helping professions are grounded by altruistic values. Corley et al., (2001) claimed that nurses adhere to a value system based on optimal patient care, and when prevented from providing what they perceive to be optimal care, internal conflict leads to them to moral distress. An exploratory survey of social workers' ethical decision-making and value conflicts (Gough and Spencer, 2014) revealed an overwhelming number of ethical issues

arise from value conflicts; 82% of those surveyed claimed to have encountered an ethical situation that resulted from a conflict between their personal values and those of the organization in which they were employed, 53% reported an ethical situation resulted from conflict between their personal values and their professional values, 66% reported situations resulting from a conflict between their values and the school which they attended, and 75% reported ethical issues arising from a conflict between their values and their clients' values (Gough & Spencer, 2014).

Milton Rokeach is a pioneering and foremost researcher on the nature of human values. His groundbreaking work in the late 1970's still stands today as the foundation for understanding and assessing human values. Rokeach (1979) proposes that values are not concrete rules of conduct, nor are they object bound, but they are real concepts characterized by some quality of 'entivity'. He describes a range of values; some are highly explicit and appear as phenomenal entities in which a person can state the value, illustrate its role in making judgements, and identify its boundaries; while other values are not so explicit and a person may even resist making them explicit (Rokeach, 1979). The explicit values are comprised of beliefs or conceptions about ultimate goals or desirable end states worth striving for (happiness, wisdom) and the implicit ones consist of beliefs or conceptions about desirable modes of behavior that are instrumental to the attainment of desirable end states (behaving honestly, being responsible [Rokeach, 1979]). Rokeach (1979) describes a more gradual adaptation to values, usually preceded by a relatively slow withdrawal of affect and commitment to the value as it loses its reason for being. For example; our present view of mental illness as an illness as opposed to historical notions of demonic possession is partly due to developments in biological, psychological, and social knowledge. In the long run altered beliefs profoundly affect our evaluative standards and change

our conception of reality (Rokeach, 1979). Thus, values are simultaneously components of psychological processes and interpretations of social interaction and cultural patterning (Rokeach, 1979).

People differ from one another, not so much on the values they possess, but more so on the way in which they prioritize those values. Even if people everywhere were found to have only a small number of terminal and instrumental values, it would still be possible to account for wide ranging differences in behaviors, attitudes, ideologies, judgements, rationalizations, evaluations, and so on. Only a small number of values can be conceptualized in a trillion different ways, far more than enough to account for variations among individuals, groups, organizations, institutions, societies, and cultures the world over (Rokeach, 1979). Additionally, people change priorities on values across circumstances. A value that was formerly common can rise to become so intensely held and promoted that it becomes the center of one's life, while a value formerly held as central may lose its central intellectual and emotional 'raison d'etre' (Rokeach, 1979).

Rokeach (1979) posits that the greatest value change occurs when two or more central values become inconsistent or incongruent with each other. He provides three examples; when people are induced to behave in a manner incompatible to their values, and when people become exposed to new information, including evaluations from significant others, that are inconsistent with one or more central value, and the third change generally occurs when people are exposed to information revealing inconsistencies already present within their own value system. People strive to remain true to their values, primarily because if they do not believe in them, they would consequentially be forced to change them (Barsky, 2010). Given that people evolve in viewpoints, adapt and change their values suggests that one may experience MD at one stage of their career, while not later, or vis versa.

Rokeach's (1979) predicts that any change resulting from incompatibilities, dissonance, or incongruences will depend on some estimate of the relationship and relevant differences in cognitive beliefs, values, positive or negative evaluation of referenced individuals or groups, positive or negative cathexis of persons, and instrumental interests.

Research on moral distress has primarily focused on the identification of factors that restrict moral agency, with the main feature of moral agency being composed of numerous different beliefs and value prioritizations. More recent research suggests that moral distress results from value conflicts that serve as primary restrictions on moral agency (Fantus et al. 2017). Many of those value conflicts are linked to the values of the workplace or profession. Organizational values are embedded into the policy and practice guidelines. Professional values define how the profession itself views people, its preferred goals for clients and society, as well as its means of achieving those goals (Levy, 1993).

Self-awareness is the vital first step toward understanding our values and moral challenges. Rokeach (1979) created instruments and methods of evaluating individual and organizational values. Barsky (2010) suggests that if and when social workers discover that their values are inconsistent with those of their client, organization, or profession, they will be in a better position to make conscious and deliberate decisions about how to resolve those conflicts. Therefore, to create greater awareness of personal values, Barsky devised a values clarification chart that requires participants to prioritize their values (Barsky, 2010, p.14).

How professionals view their role and themselves in that role has influenced early research (Corley et al., 2001) on moral distress. Role conflict theory was used to evaluate the moral distress scale (MDS). Corley et al. (2001) characterized role conflict as a type of stress that results when nurses are expected to satisfy two organizational authorities (facility manager's and

physicians) who expect conflicting responsibilities. When the dual sources of supervision impose conflicting professional expectations, it leads to role conflict. As described earlier, MD is partially a result of practitioners not being able to fulfill their perceived moral obligation, which is also linked with the values of a profession, group or organization. Social workers perform a wide variety of roles within many different agencies and organizations, and are responsible to varying legal, organizational expectations. Rizzo et al.'s (1970) role conflict theory demonstrates how 'role conflict' and 'role ambiguity' can result in professionals not being able to meet organizational and personal moral expectations. Rizzo and House (1972) provide descriptions and explanations of how stress results when managers of an organization hold competing or conflicting sets of expectations for one's position within the organization.

Rizzo and House (1972) define role conflict in terms of the congruency-incongruency or compatibility-incompatibility in the requirements of that role. Based on the chain of command principle; organizations with a clear single flow of command form structured in hierarchical relationships result in more effective economic performance, and goal achievements than those without. Additionally, the unity of command principle states that in order to prevent employees from being caught in the crossfire of incompatible demands and expectations, employees should receive direction from one supervisor only.

Role theory states that employees faced with inconsistent expectations become stressed, dissatisfied, and perform less effectively than when expectations do not conflict (Rizzo & House, 1972). Role ambiguity theory states that every position should be defined with a specific set of tasks or responsibilities. These duties provide guidance and direction regarding expectations and allow management to hold employees accountable for specific performance. If those expectations are not clear, employees do not know precisely what they are expected to

accomplish, and on what measures they will be judged. Subsequently they will hesitate to make decisions and rely on trial and error to meet expectations.

Results of role ambiguity have negative consequences that influence coping behavior designed to avoid sources of stress by distorting the reality of the situation. Thus, role ambiguity increases the probability that employees will distort reality, become dissatisfied in their role, experience anxiety, and perform less effectively.

Professional organizations frequently experience violations to the chain of command principle resulting from two competing sources of authority; the organizational authority supported by formal sanctions and derived from the legal contract governing employment in the organization, and professional expertise supported by membership in a professional college and enforced by collegial authority (Rizzo, 1970).

Multiple authority figures disrupt individuals' orientation to the organization or profession by requiring them to choose between them. Subsequently, professionals experience the stress of being caught in the middle. This was reflected in the experiences of the participants of this study, specifically within the medical model. Health organizations, such as hospitals, employ various professional disciplines who work together in an administrative hierarchy, and therefore operate in a system of multiple authority (Rizzo, 1970). Social workers are prime examples of professionals caught between lines of authority.

Rizzo and House (1972) categorized four types of role conflicts occurring between personal standards and values, between time resources, or capabilities and defined role, between several different roles for the same person that require different or incompatible behaviors, and also among conflicting expectations and organizational demands in the form of incompatible policies, conflicting requests from others, and incompatible standards of evaluation. The conclusion was

that these conflicts are directly related to role ambiguity and predict individual responses that involve anxiety, stress, dissatisfaction, and avoidance and others (Rizzo & House, 1972). Social workers, as do other professionals, often adopt the identity of their profession, thereby integrating professional values and practice guidelines as personal moral standards by which to measure themselves. Most often these values are congruent. However, given certain circumstances, individual and professional values become incompatible. When that happens, social workers are inclined to bend the rules in search of a middle ground resolution. Individuals primarily oriented to their professional norms are more critical of the organization and more likely to ignore administrative details (Rizzo, 1970).

Siebert and Seibert (2005) describe role identity theory and its influence on social work. The authors provide a framework for understanding how social workers are vulnerable to incompatible moral challenges. Role identity theory suggests that social workers experience overlapping professional and personal identities as helpers of others, which is reinforced by the expectations of clients, friends, and family, as well as their own expectations of themselves (Siebert & Siebert, 2005). As a result, social workers become overwhelmed by attempts to meet unattainable demands that they themselves have created through a commitment to self-perceived conceptualizations of what is expected of them. Due to the nature of social work and practitioners' perceived self-identity, social workers have difficulty recognizing and admitting that they have personal problems that prevent them from seeking help. "Social workers have overlapping professional and personal identities as helpers of others, reinforced by the expectations of their clients, friends, family, and their own expectations of themselves. These multiple reinforcers could make it difficult for them to acknowledge that they have personal problems similar to those of their clients and their idealized self-image would be at odds with the

reality of their personal problems" (Siebert & Siebert, 2005 p. 205). This may explain why social workers are less likely to seek help when experiencing moral dissonance and therefore become increasingly vulnerable to moral distress.

As previously noted (Gough & Spencer, 2014) social work values are a prominent factor in moral equilibrium versus moral distress. Social justice is a foundational value that is woven through the national and provincial code of ethics. One of the problems is that social justice lacks clarity. Social Work education does not define it well and the codes of ethics lack a comprehensive definition, (Bonnycastle, 2011). Furthermore, the concept is used in so many contexts, (sociopolitical, economic, legal, philosophical, practice and academic) that it is a contested concept without a comprehensive, indisputable definition (Bonnycastle, 2011). Within the social work literature authors generally assume that social workers should understand their intended meaning when referring to Social Justice. It is understood to be a normative concept that when operationalized often leads to political advocacy. Bonnycastle (2011) put forward a conceptual model for categorizing the term into four characteristics that can be evaluated along a continuum. Social oppression at one end of the continuum and social equality at the other. Four primary components (distributive justice, identity, human rights, and ideology) are divided into three levels (thin, medium, and thick) used to situate one's beliefs along the continuum. The participants in this study unanimously endorsed a high moral conviction to promoting social justice and described barriers to their efforts as morally distressing.

Individual emotions are also a factor in moral distress. Moral distress has been characterized by feelings of frustration, anger, guilt, and anxiety (Hamric et al., 2012). Can emotional regulation help manage symptoms of moral distress? Prominent sociologist Frank Furedi, (2004) predicts that the Western world has created a culture of emotional vulnerability in which life

experiences once considered a part of normal experience have been redefined as damaging to people's emotions, never more prevalent than since the COVID -19 pandemic. Evidence of that can also be seen in the increased prevalence of counselling emotional breakdowns and suicide rates. This is not only a result of the pandemic, but rather reflective of an ongoing culture of fear. Since the 1980's counselling has become incorporated into the normal routine in personal management (Furedi, 2014).

Over the years, philosophers have debated whether emotions can be moral and whether emotion contributes to higher-level moral judgment and behavior. Some claim that emotions are an obstruction to moral evaluations and disrupt rational, moral thought because they express personal, polarized and biased perspectives. However, modern-day philosophers posit that emotions help people to distinguish moral features within specific contexts, motivate moral behavior, restrain immoral behavior (Eisenberg, 2000). Emotions play an integral role in personal responses and are an important feature in determining how people respond to morally challenging situations.

From a psychological viewpoint MD is described in terms of anxiety and emotional unrest resulting from one's inability to fulfill relevant moral obligations. People are not well situated to make ethical decisions when they are experiencing heightened emotional arousal. Ethically charged situations are often met with increased emotional arousal, and it is during those mental states that emotions become a controlling feature of peoples' response. Emotional regulation, requires self-awareness and practice, but can reduce the negative effects of moral distress. Eisenberg (2000) demonstrated that people who are able to regulate their emotional responses are more likely to respond in a compassionate manner (Eisenberg, 2000). Based on Eisenberg's research we can determine that emotional stability reduces the risk of moral distress. Thus,

emotional regulation techniques such as mindfulness indirectly build resilience to MD and foster more compassionate responses in the face of ethical and moral challenges.

In other-oriented disciplines, such as SW, two concepts are worth mentioning as possible antecedent states leading to MD. Empathic concern includes sympathy, compassion, and tenderness toward others (Batson *et al*, 2007). Empathic arousal is a term that refers to situations when one feels the pain, anguish or fear of another (Chapman et al, 1987). These empathic feelings have been found to be a potent source of motivation to help relieve the aversive state of another (Batson *et al*, 2007). Can we assume that emotional control lessens the risk of MD?

Social workers regularly witness the suffering of others and feel responsible to help. They should be aware that empathy is a double-edged sword. On the one hand, it influences devotion to ethical principles that are fundamental to caring, such as treating others with compassion, respect and dignity. On the other hand, it intensifies empathic arousal, which, if not well regulated, results in attempts to relieve personal distress through means of avoidance or anger, and becomes a significant contributor to MD (Rushton and Adams, 2009). Empathy fosters emotional understanding, and enhances trusting relationships through emotional connections; and is considered an important component of social work practice. It is of vital importance that social workers are able to differentiate themselves and their emotions from those of their client. As Rushton, (2013) has demonstrated, one is more likely to make moral and empathic decisions when their emotions are regulated, thus reducing the chance of making ethical decisions they will come to regret.

Perhaps one of the most closely associated concepts to moral distress is moral residue. Building from the seminal work of George Webster and Francois Baylis (2000) we accept moral residue as an implicit component of moral distress. Philosophers Webster and Baylis (2000)

define moral residue within the context of clinical ethics; “moral residue is that which each of us carries with us from those times in our lives when in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised. These times are usually very painful because they threaten or sometimes betray deeply held and cherished beliefs and values” (Webster & Baylis, 2000 p. 218).

Moral residue is comprised of lingering impressions that remain in our thoughts; hence the term moral residue. Webster and Baylis describe it as a phenomenon that transforms those who have experienced it, “serious moral compromise irreversibly alters the self. One does not experience serious moral compromise and survive as the person one once was” (Webster & Baylis, 2000 p. 224).

Webster and Baylis offer a case example of a medical student instructed by her faculty physician to perform a pelvic examination on an unconscious patient. The student understood this to be a distasteful act which left her feeling as if her very soul had been violated. She described feeling dirty and unclean; analogous to what it would be like to be sexually abused. She felt the deepest reaches of herself had changed and that these new negative feelings would be with her forever.

The power imbalance between the physician and student certainly made it difficult for the student to refuse. Her personal values were to follow orders and academic expectations. This undoubtedly contributed to the pressure to make follow through. In her mind there was really no choice at all. Within this state of perceived helplessness, the student violated her moral conviction and compromised her moral integrity as a person and as a health care provider. She was forced to choose between conflicting moral duties. As a person she felt that she violated the

patient's rights, as a health care provider she also had an obligation to the patient, but as a student the obligation was to follow the instructions of her teacher/physician.

One cannot predict the probability that moral residue will occur simply by evaluating the moral relevance of the distress because it is the internal experiences of the decision-maker that result in moral residue. Therefore, we can only recognize moral residue after it has developed.

Empirical Nursing Research

This section provides a summary of recent empirical research on MD. Refer to table 6 in appendix C for a detailed description of empirical research in nursing that was reviewed for this study.

Previous scholars have made enormous contributions toward the identification and development of conceptual analysis for moral distress which resulted in advocacy for removing institutional constraints; vastly improving the ethical environments for nurses. Corley, (2002), Fry, Veatch, &Taylor, (2011) found that nurses with adequate moral agency demonstrated by strong leadership, management competencies and virtues such as courage, have been acknowledged for taking on their employing institutions and partnering to improve outcomes for all. Other scholars (Rushton, Kaszniak, & Halifax, 2013; Hamric, 2012; Fry, Veatch, & Taylor, 2011; Varcoe, Pauly, Webster, & Storch, 2012) reported similar findings and proposed alternative methods of mitigating the risk of MD. Rushton et al. (2013) developed a conceptual model for building resilience against moral distress. The model moves beyond removing institutional constraints and is built on the principle of enhancing personal attributes to maintain cognitive attunement, moral attunement, well differentiated memory, and empathic attunement.

Some research has theorized that MD is the result of a conflictual moral struggle between an individual and the organizational constraints preventing them from exercising moral agency. Other researchers have refuted that claim, suggesting that the conflict does not exist because the moral agency itself is enabled and constituted by situational, contextual and structural features of the moral terrain (McCarthy and Gastmans, 2015). The theoretical approach of this study does not view those theories as mutually exclusive and delves into the interaction between the seemingly opposing viewpoints.

A review of recent empirical research in nursing demonstrates universal features of MD. For example, Ko, Chin, & Hsu, (2016) used grounded theory methods to reconstruct MD as experienced by nursing staff in Kaohsiung, Taiwan. The aim of their study was to reconstruct a model of MD and increase awareness of the moral values of nurses and the barriers that cause them distress. Its findings contribute to the development of strategies for improving the ethical climate and nursing retention (Ko et al., 2016).

Theoretical sampling was used to recruit twenty-five staff nurses from three teaching hospitals. Each participant was interviewed. Interviews were recorded, transcribed and analyzed using Strauss and Corbin's grounded theory methods (Strauss & Corbin, 1998, 2001).
Six primary categories manifested through analysis of the data are; 1) Moral values – patient-centered care, including honoring patient's rights and providing proper informed consent and accountability refers to nurses' commitment to do what they believed to be the right thing and become their own role model. 2) Moral barriers – environmental barriers such as negligent coworkers, trouble-avoiding nurse managers and arrogant physicians. Systemic barriers included staff shortages that led to lengthy overtime shifts and unmanageable schedules, and large numbers of inappropriate admissions to emergency. Cultural barriers comprised of notorious

diseases stamped with cultural stereotypes (e.g., AIDS) seen as necessary suffering resulting from evil deeds committed in previous life times, peaceful dying at home, filial piety. 3) Moral judgements – framed by the question of what should I do to determine the moral right, within the context of the above-mentioned challenges. 4) Moral efficacy – determined by nurses' self-confidence or conversely self-doubt. Self-confidence is apparent when a nurse is aware of her or his ability and acts on subjective moral considerations to do the right thing. Self-doubt is apparent when nurses do not feel sufficiently confident in their ability to solve the problem, and subsequently do not discuss the problem, or make suggestions, even when they feel right about a solution. 5) Moral actions – Moral actions included creative ways of meeting moral demands. Ko et al. (2016) use the term heterodox skills to define these non-formal methods. An example was begging the doctor to order analgesics when the prescribed dosage did not manage pain, or privately giving the patient advice to ensure his or her best interests are protected. 6) Emotional reactions – Involved instances of both explicit and nonexplicit emotions. Explicit emotions were threats and scolding. Nonexplicit emotions included frustration, anger, self-blame, and tears.

Ko et al., (2016) used grounded theory methods to reconstruct moral distress based on interview data. Comparative analysis compared their findings to existing research findings. During the initial phase of data analysis, open coding was used to identify underlying causes. All data with relevant properties were summarized. The core categories were decided in the axial coding stage with MD used as the axial. The central categories were chronologically compared and integrated into a whole that depicts casual relationships. MD was structured and contextualized on the basis of this comprehensive category.

A selective coding stage was added to the process as a means to integrate, rectify, and refine the theory as well as eliminate concepts with low explanatory power. For example, the origins of nurses' values were eliminated because of low significance for the theory of moral distress.

The comparative analysis yielded both similar and unique findings as compared with previous data. Similar findings indicated that moral distress is dependent on the personal values and beliefs of the individual nurse. Nurses from Taiwan shared moral values such as patient safety, patient rights, and accountability. As in previous studies, moral barriers originated in family intruding on the nursing treatment process and/or providing inappropriate patient care, differing nursing care philosophies among nurses, nurse manager favoritism, physicians disrespecting the nurse role, and systemic issues such as staff shortages, overloading overtime, and inappropriate shift arrangements. Taiwan nurses exhibited similar coping responses, such as the above-mentioned explicit and nonexplicit emotional reactions, which are negatively charged and do not resolve the moral distress.

Unique findings included that policy related to the National Health Insurance system in Taiwan leads to abuse of medical resources from a small number of people, which led to nurses feeling powerless to do anything about this. The other barrier unique to this population of nurses derives from the cultural aspects of nursing in Taiwan. Concepts of family and filial piety are central and sometimes impinge on patient rights. Additionally, cultural stigma focused on certain medical diseases impacts patient care. Heterodox skills are rarely described in previous MD studies yet emerged as an important feature to managing ethical problems in this study.

The heterodox skills described in this study (Ko et al., 2016) are synonymous with findings from Jameton (1993) and Wilkinson (1987), who found that nurses express a variety of strategies for coping with bureaucratic obstacles and/ or disagreeable colleagues; such as trying to influence

physicians, calling in the head nurse, submitting an incident report or discussing the problem with the medical head of the unit. Kalvemark et al. (2004) hypothesize that if these strategies are unsuccessful, reactive distress results.

The researchers findings highlighted the prevalence of moral value conflicts between individual nurses, the nursing profession, organization, and culture. It was surprising to learn Ko et al., (2016) discarded the 'origins of personal values category' from their analysis; stating that it is not important in generating a theory of moral distress. The research literature describes numerous reasons why exploration into the influence and origins of personal values are instrumental in shaping self-identity and defining the meaning that those values have for each individual; a vital component in determining both the frequency and intensity of moral distress. Self-awareness and a healthy understanding of these origins are also aspects of building resilience to moral distress. The researchers themselves suggest that future education should be based on awareness, understanding and accepting their own cultural perspectives that are critical for setting nurses free from moral distress (Ko et al., 2016, p.7).

Missing from the analysis is closer examination into the construction of nursing values and how the health organizations set and enforce policies. Are nurses involved in the development of policies and guidelines within which they must work? A more complete description of the organizational culture and its influence on individual nurse responses would be helpful to uncover potential tensions between personal values, social political and contextual factors in nursing.

Despite the theoretical variations in terminology, there is remarkable consistency in the literature regarding certain levels, causes, effects and sources of moral distress. Some recurring factors include: inadequate staffing, lack of administrative support, power imbalances,

disrespectful communication, institutional policy, lack of resources, and lack of knowledge, lying to patients, causing unnecessary pain (Corley, 2002; Hamric, 2012; Kalvemark, 2004). Effects of moral distress recurring in the literature include: poorer physical and psychological wellbeing, decreased spirituality, decreased self-image, decreased patient care, and an increase in medication errors, fear, frustration, anger guilt, avoidance, and lost interest in the job (Corley, 2002; Elpern, Covert, & Kleinpell, 2005; Maiden, George & Connelly, 2011; Hamric, 2012).

Research findings that denote ways of mitigating and managing MD vary among authors. Some authors found that nurses with adequate moral agency (strong leadership and management competencies and virtues such as moral courage) have been acknowledged for taking on their employing institutions and partnering to improve outcomes for all (Fry, Veatch, &Taylor, 2011). Others have proposed that the risk of moral distress is reduced by increasing moral sensitivity through ethics education (Hamric,2012; Rushton, 2013). Some authors (Weinberg, 2010; Oliver, 2013, Openshaw, 2011; Clark, 2006) have been critical of traditional deontological and consequentialist theories and argue that a move away from those theories would decrease moral distress. The lines between moral constraints, moral conflicts and moral dilemmas are not as straight forward as Jameton's (1984) depicted. There is a need for continued empirical research to distinguish between the competing viewpoints in factors leading to MD and what is defined as moral distress.

This study builds on the seminal work of previous writers and seeks to provide a more comprehensive understanding of the epistemological structure of the moral agent, in this case the social worker, and how well adapted the environment is for individual social workers to achieve their ethical obligations. In other words, we seek to learn more about how social workers arrive at their moral beliefs, values and expectations, how compatible those they are with the profession

and work environment. This knowledge must be understood within the broader context of ethical environment, expectations of social work employers and sociopolitical features.

Philosopher Andrew Jameton coined the term 'moral distress' in the early 80's. He has since expanded its application into a larger environmental sphere.

Jameton (2013), *A reflection on moral distress in nursing together with a current application of the concept.* The notion of moral distress is a world-wide phenomenon that also affects people outside of clinical settings and health care across the globe. Moral distress involves our ethical responsibility to global healthcare with the goal of improving the health industry's current damaging and wasteful practices. Jameton takes an environmental standpoint denouncing contemporary healthcare institutions as primary contributors to ecological destruction that is threatening climate change and global warming.

Although somewhat similar to his earlier definition. Jameton expands the parameters and scope of its application, "Moral distress arises when individuals have clear moral judgements about societal problems but have difficulty in finding an avenue in which to express concerns" (Jameton, 2013, p.297). This revised definition conceptualizes moral distress is associated with environmental issues and the moral choices and actions of the global healthcare industry. His research objective began with a goal to redesign medical technologies and architectures, reset clinical priorities, and reinvent the delivery of healthcare so as to become more environmentally sound and sustainable, less toxic and less intensive in its use of resources (Whitehouse et al. 2010 in Jameton, 2013).

The research findings revealed that massive fundamental changes must occur if the American healthcare system is going to stop the irreversible damage it has been causing to the environment. The data exposed concerns about the toxicity of hospital waste, such as disposal of

products containing mercury, red bag waste, incineration emissions, dioxins, and pharmaceuticals, in fact, the sheer bulk of waste volume going to landfills present ecological concerns. Externally affiliated services, such as laundry services, warehousing, and transporting, also pose a threat, even the hospital building itself is viewed as a massive industrial object; hospitals are complex containers of clinical areas with pipes in the ceilings, basements of fuse boxes, entire floors dedicated to air handling and water processing, loading docks, storage rooms with forests of IV stands, stacks of disposable supplies, and many hospital apparatuses. Even government resources used for healthcare, such as revenues from mining to obtain petroleum, coal, the chemical trade, international trade, and many more must be urgently curtailed (Jameton, 2013).

Hospitals purchase around 85,000 distinct products in addition to pharmaceuticals. The purchasing decisions are made institutionally by committees representing several groups of administrators and professions, many of whom have no clinical background. Commitments to purchase materials and equipment are made outside the hospital by institutions far removed from the bedside.

From an ethics standpoint the clinical gaze has been intently focused on patients and caregivers. However, the patients' choice model does not work here. In the health ethics context this microscopic focus resembles that of science itself; it is "as though like horses with harnesses, ethicists had been wearing blinders" (Jameton, 2013, p.301).

Few health clinicians, like many health consumers, appreciate the potential scale of the climate change catastrophe, nor do they realize how much is needed to mitigate it. So, the climate discussion is generally not only seemingly irrelevant. It is also hardly acceptable within the halls of healthcare. Changes to current practices would increase heath care costs

considerably, and in a world where society is demanding the most resources be provided for patient care, it is inconceivable to consider how and when to make changes (Jameton, 2013). In the case of justice and fairness, climate change is beginning to shift who is the most vulnerable. Indeed, the poorest are already suffering from climate change. No injustices are more important than the future negative impact of climate change. The bottom line is that an ethicist cannot help but be concerned about health care's dependency on high levels of energy consumption, but virtually has no avenue to address the concerns. It is very difficult to champion downscaling in healthcare even as little as 10%, harder still to discuss eliminating approximately one third to one half of the services deemed by many to be either ineffective or even harmful (Jameton, 2013). Jameton states, "Moral distress expresses a decision point, a moment of emotive immobility, where ambivalence needs to be resolved toward a choice. Once the choice is made and action is undertaken, the psychological elements of distress tend to diminish" (Jameton, 2013, p. 303).

This article not only expands MD into a broader perspective, but it also demonstrates that moral distress is related to value differences and their relationship to individuals and their environment. The meaning of those values and one's commitment to realizing them are juxtaposed with the consequences of being prevented from attempting to realize them.

Empirical Social Work Research

This section provides a summary of empirical research on MD in social work. See Table 7 in Appendix C for a summation of the empirical studies referenced in this study. Despite the gains in other areas, MD continues to lack conceptual and theoretical clarity in the social work profession. Some SW researchers (Weinberg, 2009; 2016; Lynch & Forde, 2016; Clark, 2005) hypothesize that the causal factors of MD from nursing data can be used to conceptualize MD in

SW. They theorize that the factors would be analogous due to the nature of the caring profession. Other SW researchers (Lev, and Ayalon, 2016; Maija Manttari-van der Kuip, 2016; Fantus, Greenberg, Muskat, & Katz, 2017; Houston et al. 2013) have itemized differences in the ethical and moral factors endured by nurses and social workers.

There are limited empirical studies on MD in the social work literature, however, the ones reviewed for this study provide rich content and informative analysis for establishing a solid foundation for analysis. Most scholars remarked on the lack of attention MD has received in social work research (Fantus et al., 2017; Weinberg 2009; Oliver 2013; Lev and Ayalon 2016; Maija Manttari-van der Kuip 2015; Lynch & Forde 2016) and all authors emphasized the need to conceptualize MD into the SW context. Please refer to Appendix "C", table 2 for a brief summary of the articles reviewed. The following textual review differentiates empirical research articles from those more descriptive in nature.

Gough, and Spencer (2014) *Ethics in action: An exploratory survey of social worker's ethical decision-making and value conflicts.* The results of this study offer significant empirical contributions toward conceptualizing MD in SW. Although the authors do not claim to explicitly measure moral distress, they have established evidence for the inseparable connection between values, moral distress, and ethical decision making. Gough and Spencer's (2014) results provide crucial information for understanding MD within a SW perspective. Their research is an exploratory survey of Alberta social workers' ethical decision making and value conflicts. The data is provided by social work educators, students, administrators, and practitioners, on survey questions of ethics and values across a variety of circumstances and contexts.

Methods

The survey was designed to be distributed to all the registered social workers in Alberta. Eight hundred (800) began the survey and three hundred (300) completed all questions. The survey consisted of 20 questions. The authors' provided the following report on individual responses and meanings associated with each question. Due to the brevity of this report, not all questions will be discussed in this review. However, they all provide noteworthy data and make significant contributions toward conceptualizing MD in SW. Quantitative data was obtained through responses to Likert scale questions on a percentage basis. The responses to the first two questions asked if participants ever encountered an ethical situation that involved a conflict between their personal and those of the profession (53% gave a positive response); the organization where they are employed (82% gave a positive response), the program or school they attended (66% gave a positive response), and their clients (75% gave a positive response). The second question asked the participants have you ever been aware of, but not directly involved in, an ethical situation that involved conflict their values and those of the organization where they were employed or educational institution you were attending. The positive responses were of the profession (22%), of the organization (34%), of the program or school (11%), of the client (27 %), and not ever been aware of such a situation (6%).

The third question sought out qualitative results by requesting the participants provide a description of the specific nature of the event. All the written responses to this question described a situation in which the organization failed to protect the client's interests and confidentiality and failed to provide access to needed services and information about options. This directly conflicts with the social worker's essential duty and is a central value of the profession. The power imbalance and control within the organization presented challenges for social workers to make changes.

The fourth question obtained quantitative data on specific factors that applied to the conflict. Of the 11 possibilities, between 10-15% identified the following set: organizational ethics, policies and constraints (15%), staffing problems (10%), code of ethics (11%), standards of practice (11%), boundary violations (10%), confidentiality (10%), client lack of regard (10%).
Other questions focused on participant responses to the incident, satisfaction with their response, direction from code of ethics, standards of practice expectations, inspirations from personal values, decision-making processes, support, familiarity with the code of ethics, mechanisms for making ethical decisions, changes and improvements to ethical decision-making, who or what has been the most influential in forming their sense of professional ethics (29% education, 23% self, 18% employment, 17% other).

Throughout the survey participants were encouraged to tell their stories of ethical conflicts and inconsistencies, as well as significant contextual factors that contribute to ethical problems in the performance of their professional ethical responsibilities. All narrative responses were sorted in themes, conflicts and contexts that contributed to difficulties for social workers in making good ethical decisions.

Results

The qualitative data from this study support the contention that ethical decision making is focused on non-formal personal relationships with colleagues, peers and supervisors. This places the practitioner in supportive and caring relationships and not at the discretion of a detached and objective formal process. Findings revealed that the use of a code of ethics/standards of practice was often identified as crucial by those who try to protect the public's interest and in knowing what can be expected from a professional in practice. The education process works well in providing information and familiarity of the code of ethics/standards of practice; however, it

does not do a very good job in teaching the skills required for implementing these formal approaches into actual decision-making. If social workers are getting better at making ethical decisions based on work experience, then we must ask; what is it that they are learning in practice that they did not learn in their formal social work education? Workplaces that structure and, to some extent, determine social work behavior need to be integrated into the community of practice of SW better than it currently is. Personal values can be an obstacle to resolving conflicts. However, having a personal value system is essential to forming personal relationships that are deemed essential to making effective ethical decisions. The issue is how to manage personal values, the professional role, and the necessary personal boundaries that protect the client's and profession's ethos and reputation. As the educational level of the public increases, public services decrease, and access to services decrease, the focus on ethical conflicts involving social work practitioners may increase as a result. There is a need to continue SW education beyond the parameters of formal ethics education, so that the experience that is so valuable to improving ethical decision-making is shared along the spectrum of the social worker's career. Multicultural societies present a context that puts significant pressure on social workers to avoid bias while maintaining personal values consistent with acting on professional values. Boundary crossings and violations are not just an ethical issue of importance to those immediately involved in the situation, but are of ethical importance for the entire profession of SW.

Results from this study (Gough and Spencer, 2014) provide convincing evidence that social workers experience a variety of value conflict including personal/professional, personal/organization, professional/organizational, personal/client, and personal/educational curriculum.

Ethics and value conflicts are central features in MD and the findings from this study (Gough & Spencer, 2014) highlight areas for consideration and improvement. One might also presume that the current model of teaching and promoting ethics is a source of distress in that it encourages institutional/organizational policy and rule following as a means of making ethical decisions. This is also echoed by Weinberg (2010), as she posits that the use of rational cognitive approaches as means of avoiding ethical breaches makes workers feel individually accountable and leads to distress. Ethical dilemmas become private dilemmas rather than a part of broader societal factors. As a result, social work practitioners see ethics as being primarily personal rather than a communal responsibility, supported by codes that place the blame for inadequacy squarely on the shoulders of the individual actors.

An interesting correlation exists between Weinberg's (2010) theory that SW codes of ethics are a means by which social workers govern themselves, which is synonymous with Foucault's notion of governmentality and Gough & Spencer's (2014) findings which accentuates the code of ethics/standards of practice are primarily important to those who protect the public's interest, to establish a formal accountability relationship between a professional and his or her professional association's standards, in order to be able to predict what can be expected from them in practice. The code of ethics thereby establishes self-governance.

Manttara-van der Kuip, (2016). Moral distress among social workers: The role of insufficient resources.

The study examines the role of ever-shrinking resources and its ability to predict reactive MD among social workers in Finland. Maija Manttari-van der Kuip, (2016) concurred that the MDS-R is not a suitable assessment tool for SW; mainly because some items are not relevant to SW. She also states a theoretical objection to its effectiveness, claiming that the MDS-R contains

items that are root causes of MD. Mänttäri-van der Kuip (2016) argues that the phenomenon being measured must be separated from its predictors. While it is possible for nurses or social workers to feel MD because of these factors, it is also plausible that they might not. “neither the MDS nor the Moral Distress Scale-Revised is suitable for measuring moral distress among social workers. Both include items that are not relevant to social work practice. They both contain items that are regarded as so-called root causes of moral distress, such as working with unsafe levels of nurse staffing and providing better care for those who can afford to pay than those who cannot. I consider these items as potential predictors of moral distress, and therefore, in my view, should not have been included in the instrument” (Corely et al., 2001; Hamric, 2012, in Manttari-Van der Kuip, 2016, p.89).

Maiji Manttatri-van der Kuip (2016) stated that their objective was to examine reactive moral distress among Finnish social workers employed in public social welfare services. The premise of the study assumes that social workers hold certain moral values that guide their practice and if they cannot practice according to those values, they may experience MD. The definition of MD used in this study theorizes that both structural and individual barriers constrain moral decision-making, and is supported by research on MD in nursing.

Methods

The data were collected via electronic questionnaire. The target population was social workers employed in public social welfare services. A link to the questionnaire was sent to all persons working as social workers in the public welfare system. The total number of respondents was 817.

Dependent variable - The instrument was formed from three separate variables. The first was a seven-point scale consisting of five items that measured experiences of impaired work-related

mental well-being. The other two variables were statements related to the likelihood that one has to act in accordance with what one considers the right thing to do. The participants were asked first to indicate on a five-point scale if they often had to work in a way that conflicted with their professional values, and second if they often felt that they were not able to do their job as well as they wanted to.

Independent variables – experiences of insufficient resources were measured with the following variables; 1. experiences of work overload (worry that one's caseload will increase insurmountably, experiences of haste, pressures related to unfinished tasks, challenges to finish one's work during the official working day) 2. Changes in budget constraints (whether budget constraints effecting their work had decreased or increased in the past three years, and a scaled evaluation response to the statement; "insufficient resources of collaborating service providers affect my work").

Both parametric and non-parametric methods were used for descriptive analysis. Hierarchic logistic regression was used to estimate the role of different groups of variables; individual, background, organisation-related background, and experiences of insufficient resources.

Results

The individual background variables did not seem to be linked to moral distress. Hierarchical regression revealed no statistical significance in the relationship between them. The organization related background variables did not notably explain MD either. Only 7.7 % of the variance was explained by these variables. However, experiences of insufficient resource variables were all statistically significant predictors of reactive MD. In total, these variables explained 30.2% of the variance, with nearly 11 percent of participants reporting experiencing MD. 77 percent reported they were often unable to do their work as well as they would like and 36 percent felt that they

were often forced to work in a manner that conflicted with their personal values. The social workers that reported having MD were less willing to continue in their positions and were more frequently on sick leave, and had less positive work experiences than their colleagues who did not have MD.

Results from Van der Kuip (2016) demonstrates there are similarities in responses to MD between social workers and nurses; the high turnover rate experienced among social workers, and desire to leave their positions (11%) as a result of MD. Her findings parallel Corley's results; however, there is a significant difference in numbers. For example, Corely et al. (2001) found 25 percent of nurses experienced moral distress to the point of wanting to leave their position, and 15 percent resigned from their position as a result of MD. This may be a result of the direct consequences associated with the incidents. For example, life and death consequences in nursing are more dramatic.

The research findings establish strong empirical evidence for the author's claim that insufficient resources are contributing factors leading to reactive MD. The author mentions the influence of SW values as a primary variable; however, the individual background variables: gender, age, formal social work education, length of experience as a social worker, living in the same household with underage children, experiences of major changes in one's personal life, or having a chronic disease, disability, or some ailment that affects one's ability to work, revealed no statistically significant association with MD. This variable might have yielded a different result if individual values were included as an independent variable in this group. I am curious to learn if other individual background variables may have impacted the results. For example, personal coping mechanisms and perseverance/grit to obtain long-term goals.

Lev and Aylon, (2016) Moral distress among long term care social workers: questionnaire validation.

Lev and Aylon anticipated the experiences of MD to be quite different between nursing and SW. Subsequently, they developed a unique measurement for assessing MD in SW. The authors cite Weinberg's (2009) research to validate the primary differences, which are that MD in nursing primarily derives from dilemmas involving life and death consequences, whereas in social work ethical dilemmas tend to be less tangible or dramatic. Consequentially, ethical dilemmas found in social worker are not reflected in the existing scales (Lev & Aylon, 2016).

The most widely used MD assessment questionnaire in nursing has been the MDS, and for other healthcare providers it has been the MDS-R (Corley, 2001). Lev and Aylon (2016) critiqued the MDS on its ability to measure MD in SW and found it unsuitable, mostly because it is predominantly nursing focused, and thus, relies mostly on nursing specific examples. The authors also advise against using the MDSR (revised version to include physicians and other health care professionals) as it is not reflective of the wider view of moral challenges in SW.

Thus, the objective of this study is to construct and describe the quantitative validation of a unique questionnaire to measure MD among social workers in long term care facilities in Israel. The construction of the questionnaire was based on a secondary analysis of a qualitative study by the same authors.

Methods

The participants were social workers working in long term care facilities (LTCF), which is further comprised of nursing homes, old age homes, and continuing care retirement communities (CCRC). 343 institutions were approached and 302 agreed to participate in the study. The total number of participants was 216.

The questionnaire was based on a secondary analysis of a qualitative study that addresses moral dilemmas of social workers in nursing homes in Israel (Lev & Ayalon, 2015, 2016). Based on definitions from Jameton, (1984); Kalvemark et al, (2004); Fourie, (2015), three themes were identified and determined the content of the framework of the questionnaire. The first theme encompassed respondents' perceptions of 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. The third theme addressed perceived actions in accordance with the obligation to the residents in these situations.

In addition to the questionnaire participants provided sociodemographic information consisting of gender, age, marital status, religion, strength of religious belief, country of origin, education, and seniority among social workers. Additionally, they described the type of institution and population they worked with, and completed specific questionnaires on ethical environment, support, burnout, and intention to leave the job.

In order to establish convergent validity questionnaires from a previous pilot study (Lev and Ayalon, 2015, 2016) were tested for correlations with ethical environment, support, burnout, and intention to leave the job. Two scales were used, one assessed occurrence and frequency of MD and the other measured the occurrence of distress and its intensity. Evaluation of scales; the first measure (frequency), the second (intensity), multiplication of the two scales as a measure of overall MD.

Results

The highest mean score, both with regard to frequency and intensity, was item 2; which describes social workers' confrontations with other staff when their behavior was perceived to be contradicting the best interests of the residents, and item 3 which assessed the perceived contradiction between social workers' professional obligation to the residents and the financial interests of the institution.

The items with the lowest mean score on the frequency scale were items 16 and 17, which correspond to perceived inadequate response to management regarding suspected abuse. Reliability was assessed by determining Chronbach's coefficient for each of the three MD scales. The Chronbach's alpha coefficients were .92 for all three scales.

Convergent validity was established in two environmental variables which were found to be negatively corelated with MD; (ethical climate, and support in the workplace), and three variables related to professional attitudes, which were found to be positively correlated to MD; (emotional exhaustion, and depersonalization, and intention to leave the job).

The results indicated high negative correlations of the three MDS sub-scales with ethical environment and moderate negative correlations with superior support. The three MDS's had moderate positive correlations with emotional exhaustion and intent to leave the job. MD frequency had a moderate negative correlation with coworker support and a moderate positive correlation with depersonalization, whereas the two other MDS's had weak negative correlations with coworker support and weak positive correlations with depersonalization. In this writer's opinion, this does not provide strong evidence of construct validity.

Discriminant validity was established in the case that constructs predicted not to have a relationship with MD. These were "personal accomplishment" and "support from friends and relatives". Early definitions of MD (Jameton,1984; Fourie, 2015, and Kalvemark et al., 2004)

provided the foundation for this study. The focus is on ethical conflicts arising from conflictual obligations. Specifically, conflictual obligations that prevented social workers from acting within their moral principles. Based on previous definitions of MD this study demonstrates variations in MD between nursing and SW, however, it fails to account for manifestations of MD that arise for reasons other than ethical obligations. MD also results from situations in which the individual was able to act in accordance to their moral conviction (Kalvemark et al., 2004), or situations in which distress derived vicariously as a result of being associated with unethical behavior. For example, when colleagues do things that directly conflict with ones' moral values, or as in the example provided by Jameton (2013) in which the organization is inadvertently damaging the environment.

The conceptualization of MD used in this study is not comprehensive enough to account for the complexity of social work and social work values. It doesn't account for the different levels of interaction between various factors. Although the researchers account for specific differences between SW and nursing and propose alternative forms to measure MD should be used in each. The authors focus on dilemmas as the only contributing factor, thereby dismissing a variety of causal factors. Dilemmas are described as situations in which practitioners know the ethically correct action, but due to forces beyond their control are not able to act on their moral conviction. It is not a dilemma simply because one knows the correct action but is constrained from taking it. In a genuine dilemma, neither of the two or more conflicting requirements, accountabilities, or obligations overrides the other(s) (Sinnott-Armstrong, 1988) thus there is no clear reason to choose one over the other.

The data results are reflective of the author's findings that MD results from a conflict between the practitioner's perceived response toward ethical client care and the rules, regulations, and

bureaucratic considerations of the organization. Further research in this area would help to expose the complex interaction between multi-level factors leading to MD in social workers including areas such as; educational theory, organizational and professional values, sociopolitical influence, systemic power dynamics and role expectations within long term care organizations, as well as personal values/influences of the practitioner.

Sagit Lev & Liat Ayalon (2018): Development and content validation of a questionnaire to assess moral distress among social workers in long-term care facilities.

The objective of this recent study is to describe the development and content validation of the previous questionnaire (Lev & Ayalon 2016) used to measure moral distress among social workers in long-term care facilities for older adults in Israel.

Methods

The construction of the questionnaire was based on a secondary analysis of a qualitative study that addressed the moral dilemma of social workers in nursing homes in Israel. Content validation included three stages; the first was a review and evaluation by two experts, the second stage was a cognitive interview with a nursing home social worker with a master's degree and two and a half years of experience, the third stage included a review of the revised questionnaire with focus group discussions. The focus groups consisted of 21 social workers who had practical and experimental experience. The first focus group consisted of 16 research students, twelve of whom were doctoral students, and the remainder graduate students. The two following focus groups consisted of the target population of social workers in long term care facilities (LTCF).

Results

The initial questionnaire consisted of 25 items. The items on the questionnaire were extracted from a qualitative study on the obligation dilemma of nursing home social workers (Lev & Ayalon, (2015, 2016). They were adapted based on the theoretical and empirical definitions of moral distress by measuring both the frequency of morally loaded events and the intensity of distress that followed them (Corley, Minick, Elswick, & Jacobs, 2005; Fourie, 2015). After the content validation process the questionnaire in its final version, consisted of 17 items and included two scales, measuring the frequency of morally loaded events and the intensity of distress that followed them.

Discussion

Study 1 - (Lev & Ayalon, 2015, 2016) described the development of the questionnaire, based on secondary analysis of a qualitative study, whereas study 2 - (Lev & Ayalon, 2018) is a description of the content validation of the questionnaire. The uniqueness of the term “moral distress” is reflected in the fact that it does not describe an abstract feeling, but a feeling which is embedded within a specific occasion (Jameton, 1984). Thus, it is assumed that the more a moral distress questionnaire is focused on a specific profession and a specific work environment, the higher its validity will be. Following this assumption, the uniqueness of the current questionnaire is reflected by the fact that instead of adjusting available questionnaires to a specific target population, the new questionnaire was built and validated based on qualitative interviews and focus groups with the target population. The use of qualitative methods promoted the creation of a questionnaire which can authentically reflect the unique dilemmas and conflicts of the target population, such as handling cases of suspected abuse and advocating for the residents. The unique content of the present questionnaire distinguishes itself from other moral distress questionnaires, which tend to focus mostly on dilemmas related to

medical issues like lifesaving actions for dying patient, patients' informed consent to medical interventions and nurse-physician relationships (Corley et al., 2005; Hamric & Blackhall, 2007). This uniqueness of content also highlights the importance and necessity of a questionnaire intended specifically to assess MD among social workers.

Limitations

The present questionnaire focuses on obligation dilemmas, expressed in conflicting obligations of social workers to their clients and to their management and staff. Yet, obligation dilemmas can be wider and include other kinds of conflicting obligations that are not reflected in the present questionnaire, such as obligations to different family members (Dolgoff et al., 2011; Feng, Chen, Fetzer, Feng, & Lin, 2012; Lev & Ayalon, 2015). In addition to obligation dilemmas, there are two main groups of moral dilemmas that were described in the theoretical and empirical literature in social work that are not reflected in the present questionnaire. These are: dilemmas arising from conflicting values (Dolgoff et al., 2011), like individualism versus paternalism (Wu, Tang, Lin, & Chang, 2013) or beneficence versus nonmaleficence (Feng et al., 2012), and dilemmas arising from cultural diversity which are reflected in differences in values between the social worker and the clients (Dolgoff et al., 2011; Katiuzhinsky & Okech, 2014). Therefore, the present questionnaire does not reflect the whole range of moral dilemmas that may be relevant to the work experience of LTCF social workers, but rather is focused on a unique part of these dilemmas.

Additionally, MD can result from situations that are not directly associated with a dilemma of any kind, such as witnessing or taking part in an egregious moral wrong doing.
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, the researchers could not formulate items in a positive direction. Which is similar to other moral distress scales (Corley et al., 2001; Hamric & Blackhall, 2007).

In addition, the present questionnaire is based on a self-report, mono-method approach. Adding other measurement tools, including direct observations, could enrich our understanding of moral distress among LTCFs social workers.

Applications to research and practice

The questionnaire could potentially be adjusted to social workers employed in institutions that are characterized as having "total" features, like boarding schools and institutions for people who suffer from cognitive, physical or mental disabilities. However, the questionnaire will be less suitable for the assessment of moral distress among social workers who work in facilities like welfare departments and hospitals. Because of the wide diversity of settings in which social workers work, it is necessary to develop and validate specific scales to assess ethical stress among social workers (Fenton, 2015). In contrast, the nursing profession is characterized by less diversity in employment settings and, therefore, moral distress questionnaires tend to be general and relevant to the varied forms of employment settings of nurses (Corley et al., 2001).

The researchers intention is for the questionnaire to contribute by broadening and deepening ethics discourse and research with regard to social workers' obligation 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 obligation to their clients (Lev & Ayalon, 2015, 2016; Lonne et al., 2004; Papadaki & Papadaki, 2008). Ethics discourse and research are important in an era where neo-liberalism and privatization have spread globally and are responsible for a transition of social services from governmental ownership to public and private ownership (Carey, 2008; Liljegren, Dellgran, & Höjer, 2008).

Baker Collins & Cranmer-Byng (2018). Things I Cannot Change.

This research study is specific to moral distress among social workers who worked as case managers in southern Ontario. The focus was particularly on the role of structural constraints, such as policy restrictions as contributors of moral distress. The researchers distinguish three main approaches toward MD definitions in the literature.

First, moral distress refers to situations where there is an awareness of the right course of action and a sense of moral responsibility to take the right course (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005; Corley et al., 2001; see also Jameton, 1984, 2013). The concept is distinguished from a classic moral dilemma (choosing between two or more right courses of action), and from situations of moral ambiguity (Weinberg, 2009, 2016).

Second, the concept includes references to barriers to enacting the ethical course of action. While some authors suggest internal barriers (e.g., Carse, 2013; Hamric, 2012; McCarthy & Deady, 2008) others emphasize institutional constraints (Jameton, 1984) or “factors outside of the self” (Weinberg, 2016, p. 17). These institutional constraints come in the form of the decisions of others in charge (Carse, 2013; Davis, Schrader, & Belcheir, 2012; Goethals et al., 2010; Jameton, 2013), and/or institutional structures that include lack of time for clients/patients, lack of resources, and conflicts between values and regulations (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). The important role of policy as an institutional constraint is noted

by some scholars (Lynch & Forde, 2016; Pauly, Varcoe & Storch, 2012) and Weinberg (2009) points to the struggle between rules and how one wants to act.

Third, the term moral distress is distinguished from other kinds of distress. The term refers to a "serious moral compromise" (Varcoe et al., 2012) that impacts one's moral integrity (Davis et al., 2012; Hamric, 2012; Peter & Liaschenko, 2013) through a failure to live up to one's fundamental convictions and values (Carse, 2013; Goethals et al., 2010). Davis et al. (2012) posit that long term exposure to moral distress can permanently alter one's moral integrity leading one to trivialize or deny wrong-doing so that moral compromise is no longer seen as impacting a sense of right and wrong.

The researchers also imply that SW ethics has a role to play in moral distress. Citing Weinberg, (2014, 2016) they make the case for how rule-based ethics in the form of narrow codes of conduct and general rules are being used as a tool of new public management which is particularly relevant for SW case managers who must navigate these narrow codes and rules or risk discipline.

Methods

Interviews with SW case-mangers (N=15) in southern Ontario. Participants were recruited formally and informally via local service agency personnel who were asked to share information about the study and a recruitment letter was emailed to those who were potentially interested. The case managers were representative of experience and case management roles. They varied from income eligibility and employment counselling to community outreach, training, and working with particular populations including the homeless, youth, and those with addictions and mental health issues. They all worked in regional offices in southern Ontario.

Interviews were audio recorded, transcribed and analyzed using the MAXQDA qualitative data analysis program. Aspects which related to the nature of the job were coded and analyzed, including the rewarding and challenging aspects of the job, workload, and supervision. Interviews were analyzed inductively for moral distress and codes of moral distress and 'not social working' emerged. The findings revealed two broad themes; the first included systemic and contextual factors that contributed to case managers' moral distress, and the second was resistance demonstrated in strategies used by case managers to cope with and respond to moral distress

The barriers under systemic and contextual factors reflected rule-bound constraints on the managers ability to establish relationships with clients and offer holistic services, resulting in practices that have the potential to do harm. Barriers to moral agency included lack of time for clients, heavy caseloads- "crazy overworked". Limited time to get the job done let alone time to have a relationship with clients that makes room for understanding the challenges in their life. Large caseloads meant increased record keeping. Technology reorganizes institutional practices and replaces conversations with clients and limits their ability to respond to clients' needs. Other factors included oppressive policy resulted in the inability to meet very visible and pressing needs of the client due to restrictive legislation and inadequate welfare incomes. These are the "things we cannot change" trying to work within these restrictive policies requires creativity, but the difficulty is not being able to find or implement a loophole to benefit clients. The worst cases are when they are unable to bend the rules to meet pressing needs.

However, case managers made it clear that the inability to act in the clients' best interest is not always the case of moral distress. In some instance rules and eligibility criterion demand the

worker to sanction clients and cut them off assistance. Likewise, managers take “fraudulent letters” from landlords as a means to sanction clients.

Another important feature of moral distress manifests in the avoidance of moral distress, through professional distancing and disinterest. One case manager described colleagues feeling little empathy and concern toward clients and worry about heading down the path of cynicism and restrictive case management. Others performed their job in a detached and bureaucratized manner. The strategy of detachment is to avoid moral distress.

The second theme described a form of resistance depicting situations in which case mangers demonstrated an ability to work in the “grey areas”. The demands of bureaucratic accountability coupled with complex rules required case managers to spend a great deal of time on determining and managing eligibility. This often shadows the implicit directive that a “good” case manager is “not a social worker”. Case managers are reminded by supervisors that they are case managers first and not hired as social workers, that somehow being a part of management somehow precludes responsibility to social work values.

Case-mangers were also instructed not to counsel in their job. They are not paid to counsel in their job. The system actually required them to ignore human suffering and adapt their skills to working with technology and focus narrowly on eligibility. Conceptual insights on moral distress explained in the summary highlight that the contradictory nature of moral distress points to the limitations of the concept.

> On its own, moral distress is unable to clarify or provide the means for understanding how taking the right course of action is determined. Thus, moral distress lacks the conceptual and theoretical tools to critique current moral practice and the underlying assumptions that perpetuate moral decision-making. The rule-based iteration of moral distress, for example,

> underscores case managers' ongoing attachment to liberal conceptions of fairness and rule-based morality. Without these conceptual tools, and an alternate framework for understanding moral and ethical decision-making, it may be difficult to use moral distress to build and sustain a comprehensive social justice critique. (Baker & Cranmer, 2018, p.19).

Recommendations from Baker Collins et al. are significant in advancing moral distress in social work literature and provide a basis of validation for the experiences reported by the participants of this study. Aligning social work education and ethics within a feminist framework can help to reclaim the ethical by problematizing social work ethics as merely professional rule-based ethics. The data delivers examples of constrained work environments that result in a restricted social work voice and is the cause of the powerlessness experienced by SW in government organizations, healthcare, schools, and other institutions. The case managers reveal the moral challenges experienced by social workers in the contradictory practice of being both a helper and agent of the state.

The data from this study exemplifies true complexity of moral distress in social work. What's missing from the analysis is an exploration into the methods in which individual practitioners become influenced into the tension between helper and agent of the state. For example, using Foucault's concepts of governmentality, surveillance, technologies of self. A deeper understanding of how these concepts impact SW can help to conceptualize MD from the not so visible constructs that are present on multiple levels. Never-the-less the evidence-based data provided in this study provides a considerable contribution towards conceptualizing MD in SW.

Jaskela, Guichon, Page & Mitchell (2018). Social workers' experience of moral distress. This is a qualitative descriptive study on health care social workers' experience of MD. The study is based on situations that resulted in MD, the personal impact of MD, coping strategies

that SW's used to deal with the experience, and recommendations from the participants for decreasing the negative effects of MD. The authors operationalize Andrew Jameton's (1984) definition by focusing on institutional constraints that prevent one from pursuing the right course of action. Jaskela et al. highlight the dearth of research on MD in SW literature. Examples taken from nursing literature form the basis to articulate the effects MD (Corley, Minick, Elswick & Jacobs, 2005; Kalvemark et al., 2015; Hoglund, Hansson, Westerholm & Arnetz, 2004; Spenceley et al., 2015; Wilkinson, 1988). For example, nurses reported symptoms of "frustration, sadness, psychological exhaustion, helplessness, suffering, distress, disappointment, depression and physical exhaustion" (Wiegand & Funk, 2012 p. 483) and "they lose their capacity for caring, avoid patient contact, and fail to give good physical care" (Rushton, 2006, p. 2) as a result of moral distress. The negative effects of MD culminated in several nurses leaving their positions.

Within a SW context the Jaskela et al. (2018) accentuate the relationship between MD and altruistic values. The authors cite The Canadian Association of Social Workers Code of Ethics, emphasizing social workers' primary concern being the "social well-being of all people equally with attention to their physical, mental, and spiritual well-being" (CASW, 2008, p. 1). The authors theorize that social workers are commonly blocked from fulfilling this value because of institutional constraints within their workplace and the organizations to which they refer people. Furthermore, these constraints conflict with social workers' code of ethics and their professional goals of helping people attain what they really need. It is at these times of perceived inability to "do the right thing" for their patients that social workers may experience moral distress. Jaskela et al distinguish between nurses and social workers by isolating MD into a personal experience that differs among individuals; what causes moral distress for one health care

provider might not be the same for another. As Epstein and Delgado (2010) wrote, “Because values and obligations are perceived differently by various members of the health care team, moral distress is an experience of the individual rather than an experience of the situation” (p. 4). Therefore, even though nurses and social workers share a common goal of helping people, their experiences of moral distress may be different, making it inappropriate to assume that what nurses report as causes and effects of moral distress in their work would be the same for social workers. However, the causal factors reported in their findings are very similar to Corley’s (2001) findings among nurses (insufficient resources, time constraints, short staffed, organizational policies, incompetent care providers, and power differentials within health care teams).

Methods

Qualitative Description (QD) is used to explore the causes of moral distress for health care social workers and how the distress affected them. The aim of QD is to report the findings directly and provide a description of the participants’ experiences in their own language. Data were collected through semi-structured interviews, which were conducted in private, one-on-one settings. Interviews commenced with participants being provided with Andrew Jameton’s (1984) definitions of moral distress (mentioned previously in this paper). Participants were asked to speak freely about their experience with moral distress. Prompts were used when participants were unable to think of experiences of moral distress, and to assist in participants’ reports of the effects of distress and the supports they used to deal with moral distress.

Participants

Social workers representing a variety of health care departments with extensive experience working in health care were intentionally selected in order to provide a diversity of perspectives.

Ten social workers were sent a recruitment email message from the Social Work Professional Practice Leader describing the purpose of the study and all ten agreed to participate in the study. The participants (nine females and one male) worked in a variety of health care departments, including Home Care, Supportive Living, Community Health, as well as inpatient and outpatient units in Calgary's four hospitals, including the Alberta Children's Hospital.

Data Analysis

Specific quotes (data) from each interview were coded into three pre-determined research themes: causes of moral distress; effects of moral distress; and supports for moral distress. The terminology and codes were then examined to create the sub-themes for each main research theme. Consistent with the methods Sandelowski (2000), the number of times a sub-theme was mentioned was statistically recorded to determine the most frequently reported sub-theme.

Findings

While all participants acknowledged experiencing moral distress, they reported its frequency as varying from rarely to daily, with most participants stating they experienced it a couple of times per month. Causes of moral distress generally fell into one of four participant-generated sub-themes; other health care professionals; caseloads; external resources; and internal rules.

Other health care professionals – the most frequently reported cause of MD was linked with members of the multidisciplinary teams in which the social workers were a part of. The two main issues included unrealistic expectations of the SW's ability to see all patients referred to them and the SW's ability to resolve all their problems before they go home. The other was issue was frequently being asked to do things out of the SW scope of practice, and in many situations being asked to do things that were not in the patients' best interest.

Caseloads - the second sub-theme identified was unmanageably high caseloads and inadequate number of social workers.

External resources – the third sub-theme included constraints imposed by community agencies and programs to which participants referred their patients. Lack of resources and strict eligibility criteria was a common problem. Some agencies out and out refused to accept their referrals.

Internal rules – the fourth sub-theme was directly linked with their own workplace. Complaints of patients being discharged because they were medically cleared, despite having egregious social issues such as housing, income and general emotional support. Other rules prevented SW's from assisting and communicating with family members.

In discussion with the participants about what coping strategies they used the most common theme was 'pushing the rules', or 'going in through the back door' which essentially meant that the SW found creative ways to work in the best interest of their patient. For example, when they were met with some type of constraint to get their patients the assistance and/or resources they needed. Participants reported doing this even if they were told not to assist a patient, either overtly by another health care professional or because of internal rules. They also "bent rules" or withheld information so their patients would meet eligibility criteria for resources. This high level of advocacy was the participants' attempts to *combat* the constraints that caused them moral distress. The participants said they were mindful they would get reprimanded for "pushing the rules," however, they felt they were doing "the right thing" for their patients and they could justify this belief if they indeed were reprimanded. They did not express that "pushing the rules" caused them moral distress but that it allowed them to get around constraints that caused them moral distress. They did however, question themselves as to why they would 'push the rules' for some patients over others.

Effects of moral distress – the most frequently reported effects included exhaustion and sleep disturbances. Other commonly reported symptoms included; emotional responses such as anger, frustration, disappointment, and sadness. Some participants also suggested MD negatively affected their self-esteem and they experienced self-doubt when unable to secure resources for patients. Most participants reported they had difficulty falling or staying asleep because they could not stop thinking about specific instances that had caused them moral distress. All participants reported experiencing MD multiple times throughout their careers, and that MD not only affected them but also their patients and the organizations they represented.

Recommendations – social workers should educate other health care professionals on the role of SW and their guiding code of ethics. Organizations should also ensure that managers are informed of the causes and effects of moral distress so they are better able to support their staff members who experience moral distress. Health care departments should advocate to their upper management for funding to ensure a sufficient ratio of social workers to patients. This would allow social workers to fulfill their professional role effectively and also allow patients to have equitable access to the specialized services provided by social workers. Social work education programs should include training on the causes and effects of moral distress to help social workers learn to recognize when they, and their colleagues, are experiencing moral distress. Such recognition could prepare social workers to take the necessary steps in addressing the effects of moral distress before such effects become detrimental to the individual and the profession as a whole. Finally, managers should encourage social workers to participate in regularly scheduled, peer support meetings and recognize that such time "away from the job" is time well spent as it may prevent social workers who are unable to cope with their moral distress on their own from taking sick leave or leaving their jobs.

Limitations of this study as described by the author of this proposal; this study aims to identify causes and effects of moral distress among social workers in health care. The findings are similar to previous research among nurses. Although the authors set out to distinguish the MD experience between SW and prior research in nursing the methods used do not provide sufficient content and discriminant validity. Many concepts and terminology have been transposed from nursing literature into a SW context which may have established a bias in responses. By providing Jameton's (1984) definition, each participant understood MD as a result of being constrained from doing what they believed to be the ethically correct thing. Some examples provided by the participants may simply be employee disagreement or personality conflict or values conflict and not moral distress, per se. Moral correctness involves self-reflection and critical thinking. There may have been instances of unethical behavior in their 'pushing or bending the rules". In reality the SW's perception of the right thing may not be consistent with the health care team, the mission or values of the organization, or in some cases inconsistent with the wishes of their patient/family.

Other related problems with restricting MD to Jameton's early definition is that it inappropriately assumes that those who act on their moral conviction will not experience moral distress. Based on research with nurses and other healthcare providers Kalvemark et al. (2004) discovered that moral distress also occurs in situations when the practitioner acted in the best interest of what they deemed to be the right thing to do. In many cases moral distress was a by-product of that action.

Olcon and Gulbas (2020). "Their needs are higher than what I can do": Moral distress in providers working with Latino immigrant families.

The findings of this study found similar value conflicts in workers supporting Latino immigrant families in metropolitan Texas. Building from a description of burnout, pointing to the emotional exhaustion that stems from overwhelming work demands (Marek & Maslach, 2017), the authors describe moral distress as an extension to burnout by considering providers' requisite responsibility to uphold professional values and ethics and the organizational, institutional, and political barriers that preclude them from doing so (Jameton, 1984; Weinberg, 2009). In essence the authors state that moral distress recognizes the political dimension of social work practice by shifting away from the capacity of individual providers to the structures which fail both, them and their clients (Lynch and Forde, 2016; Weinberg, 2009). This data for this study was drawn from a larger study that explored the experiences, perspectives, and needs of community leaders, stakeholders, and social service providers who worked predominantly with Latino immigrant families. The goals of the larger study were to identify: (1) community mental health concerns and service barriers and (2) avenues to promote health among Latino immigrant families. The participants (N=24) were recruited from non-profit agencies, school-based services, primary care and behavioral health clinics, churches, and after school programs. The majority of participants held a master's degree in social work or related degree. Findings from this larger study were that behavioral health providers, including social workers, mental health counsellors, and healthcare outreach coordinators, described feeling helpless in their capacity to assist their clients. Olcon and Gulbas (2020) implemented an instrumental case study design that selected only those interviews of participants providing mental and behavioral health services in order to uncover deeper insights into this preliminary observation,

Analysis proceeded in three stages. First authors generated preliminary themes through a comprehensive reading half of the instrumental readings. Then they defined and arranged

preliminary themes into a codebook which was revised by reading the remaining cases. Saturation was reached after the analysis of 15 cases. During the second phase the authors developed the properties of emerging themes by comparing and contrasting dimensions of the themes with existing literature on burnout. Efforts to capture empirical realities of burnout led them to the concept of moral distress as elaborated by Weinberg (2009). Drawing on this framework moral distress was operationalized in two dimensions; (1) structural barriers limiting workers from delivering services in ways they deem ethical and (2) the emotional ramifications of experiencing those barriers. In the third phase each author coded the interviews independently to compare, revise, and contextualize the theme and dimensions of moral distress within the interviews.

Four main themes identified in the findings were: (1) the system had failed them (poverty, inadequate housing, isolation, inaccessible healthcare services, deportations) , (2) compromised service quality (limited services, lack of resources, long waitlists, large caseloads, shortage of bilingual providers), (3) who really can help (helplessness, stress, frustration, self-doubt, disempowerment), (4) individual solutions to structural problems (counselling, psychosocial education, support groups).

Although providers were keenly aware of the structural limitations placed on them and their clients, the majority suggested solutions aimed at client behavioral change such as coping skills and education. Few called for advocacy and community development to improve the quality of life and mental health outcomes of their clients. Some participants mentioned the most salient issue was poverty, housing shortages, and undocumented legal status. However, the focus on changing individuals rather than systems was evident throughout. The findings illustrate how moral distress comes from these experiences. They are expected to help clients address their

needs to improve their lives, yet they are severely limited in their capacity to enact authentic change due to structural barriers. The interaction of the systemic failures and compromised service quality creates an environment within which feelings of helplessness, dissatisfaction, and disempowerment emerge. This emotional toll in turn creates a cycle where providers' capacity to envision authentic, systemic change becomes limited. Most notably, the tension found between structural problems and individual solutions. Although providers usually situated their clients' problems within broader social and institutional systems, their vision for what was needed seemed somewhat decontextualized. Consequentially, responsibility for improving clients' lives was placed solely on the individuals-providers and clients alike. Structural problems thus continue to be addressed with predominantly individual-level solutions.

The authors posit that MD needs to be viewed as a problem for the SW profession, not just for individual providers or even their settings. SW education needs to include discussions on MD to prepare students for ethical and moral challenges they will face in contemporary field settings (Lynch and Forde, 2016; Oliver, 2013). Social Work education must also incorporate more content on macro-level interventions, especially advocacy and social action to address the tremendous social injustices affecting thousands of immigrants, including advocacy against anti-immigrant policies. In conclusion the authors suggest that there needs to be more attention and acknowledgement to the various systemic constraints placed on providers and their clients. Understanding organizational and structural barriers from the perspectives of the providers-and the ways in which the barriers shape moral distress-can yield important contextual information on the quality of the providers interactions and ways to improve social service delivery. In closing they state that a shift toward a social action model would show an authentic commitment to equity and social justice and to empowering both providers and the marginalized populations

they serve. Other contemporary scholars focus on the negative impact neo-liberal policies have on the social work environment.

Attrash-Najjar, A., & Strier, R. (2020). Moral Distress and Privatisation: Lost in Neoliberal Transition. Based on a qualitative study of social workers (N=15) in Israel, Attrash-Najjar and Strier determine the impact of privatization in long-term nursing home care agencies. The data links four main sources reportedly linked to moral distress: illegal actions, violation of caregivers' employment rights and benefits, clashes between professional principles and profit considerations, and harm to elder's wellbeing. The study focused on three main research objectives: identifying experiences of MD, explaining MD and examining patterns of coping with moral stress. The research design was based on a critical constructionist qualitative paradigm and analyzed with grounded theory methods. Data was gathered with semi-structured, in-depth, face to face interviews. The inductive approach intended to explore how interviewees identify and respond to MD, as well as build descriptive and theoretical knowledge. Rigor and reliability were enhanced through three methods. The first, triangulation was accomplished by involving multiple people in examining the analysis of the data to reduce bias. Secondly, the data was compared with data from other studies on the topic. Thirdly, findings and conclusions were discussed with long term care insurance experts from the fields of gerontology and nursing to confirm reliability (Attrash-Najjar and Strier, 2020).

Findings the findings have been identified in three main themes: expressions of moral distress, sources of moral distress, and coping with moral distress. Expressions of moral distress consisted of illegal actions, violations to the caregiver's employment rights and benefits, conflict between professional standards and agency profit considerations, and harm to the elderly.

Illegal actions included filling missing caregiver logs, reporting caregivers for not providing services, lying to elders or their families to enroll more elders in the agency, reporting services that were not provided, false reporting of caregiver hours, and incorrect reporting of total hourly payment to the caregivers. The most frequent of illegal actions was the completion of missing hours in the caregivers work logs, denial of caregiver employment rights and benefits included paying them salaries below minimum wage, unpaid overtime, unpaid holidays, delayed wages, and signing a waiver of their rights without informing them.

Conflicts between professional values and agency profits included values of promoting the wellbeing of the elderly verses the agencies economic considerations such as lowering costs by saving on care expenditures impacting the quality of care. High caseloads and demands to reduce travel expenses for caregivers were also reported to be a problem. Harm to the elderly included pressure from family members and the agency to keep the elderly in their homes and under the responsibility of the agency even when the home care could not meet their needs and their health was deteriorating. Some workers described situations in which clear examples of neglect and abuse had occurred, yet the agency has incentives to retain clients.

The most common patterns of coping included compliance and denial with a few instances of resistance, mostly covert resistance, mostly afraid to lose their jobs. Rationalization and denial were used to reduce the participants level of discomfort. Participants reportedly assimilated into the organizational culture and justified their decisions as part of their commitment to the agency and accept it as it is. The participants used denial by framing the issues in organizational terms and not identifying the ethical viewpoint. The participants that resisted did so on a macro level by advocating for the rights of the elderly and increasing public awareness about issues of ageism. In some instances, participants chose to oppose corporate policy covertly and overtly.

The most common instances of resistance occurred in cases that involved issues of elderly neglect and abuse.

This study portrayed alarming examples of ethical challenges deriving from unethical and illegal expectations placed on social workers. Yet despite the moral distress most participants complied with agency policy. Participants offered multiple explanations for their acceptance of unethical environment such as fear of speaking out, lack of courage, loyalty to the agency, difficulty in identifying the ethical issues, sense of helplessness, fear of losing a job, and self-doubt. Over-all the study establishes legitimacy to caution that adopting neo-liberal and neo-managerial policies that embrace the implementation of market principles on social services may generate high levels of stress for social workers" (Attrash-Najjar and Strier, 2020 p. 35).

The authors did not conceptualize moral distress and referred to previous scholars (Austin, Bergum and Goldberg 2003; Bruce, Miller, and Zimmerman 2015; Epstein and Delgado 2010; Fourie 2015; Kondrat 2014; Ulrich, Hamric & Grady 2010; Varcoe, Pauly, and Webster 2012) to summarize moral distress by way of a shared assumption that it occurs when professionals are unable to do what they believe is the right thing. The examples provided were examples of workplace constraints which can be linked with prior research data on MD (Jameton, 1984). The constraints specifically derived from neo-liberal policies and business-economic methods designed to optimize financial dividends of the agency and resulted in direct conflict of values with the social workers and caregivers.

Conceptual Social Work Research

The following is a review of the Summary of theoretical methodological literature in social work. See table 8 in Appendix C for a brief summary of the studies listed in this section.

Weinberg (2009). Moral distress: A missing but relevant concept for ethics in social work.

The objective of this study is to conceptualize MD from a social work perspective. Weinberg embraces data results from nursing research that focuses on institutional constraints as the primary factor preventing social workers from moral action. Weinberg (2009) provides data to support why social workers leave their position. She cites a 2009 study (Bennett et al., 2009) highlighting retention issues in child welfare agencies. The report describes the four main reasons that social workers left their positions were; unmanageable caseloads, lack of confidence in all levels of leadership and management, high stress levels, and a lack of preventative and supportive resources for children and families (Bennett et al., 2009).

Weinberg (2009) hypothesizes that the root of these problems stem from neo-liberalism and the shrinking welfare state, which has resulted in increasingly limited resources and a market driven system that places the bottom line before client needs (Cohen, 1997), inevitably compelling social workers to practice in ways contrary to social work principles. She draws similarities between SW and nursing asserting that they are both applied sciences dealing with health and well-being, view professionalism as helping to improve the quality of lives of others, are gendered professions with strictures on autonomy and status, have codes of ethics and perceive their professions as moral endeavors, and both are frequently confronted with value conflicts that must be resolved on the ground. In conclusion Weinberg posits that social workers experience MD for reasons similar reasons found in nursing data.

Weinberg explains that the social work literature accentuates concepts such as ethical dilemmas and burnout; yet has little to say about MD (Weinberg, 2009) and she emphasizes the need to distinguish between these concepts and MD; ethical dilemmas concern two or more courses of action that are in conflict, each having positive and negative consequences. Whereas MD arises when one action is preferred and seen as morally superior, but the actor feels blocked

from pursuing it by factors outside the self (Weinberg, 2009). The actor does not view it as a choice, but rather a constraint to an ethical choice. Weinberg further explains the interpersonal conflict of MD occurs when social workers cannot reconcile conflicts between the idealized and the actualized self (Weinberg, 2009), instances in which they do not fulfill their perceived ethical duty. Weinberg goes on to predict that by focusing on the dichotomy and perceived helplessness of an ethical dilemma social workers lose track of their political responsibility to be agents of change and subsequently maintain the marginalization of their client. MD is associated with ones' perception of accountability and the "degree to which a person views himself or herself as individually responsible or as restricted by circumstance" (Corley et al., 2001, p.251). Weinberg also suggests reasons that MD is missing from the SW literature can be attributed to consequences of the circumstances are less tangible than the consequences in nursing. Furthermore, the overall social construction of ethics in social work, and constructed silos of knowledge are factors affecting the dearth of data on MD in the SW literature (Weinberg, 2009). Weinberg theorizes that additional features such as professional self-reflexivity is crucial understanding MD. She posits that moral distress provides a vehicle for identifying the gap between best intentions and what was actualized on the job. Constraints leading to MD in SW develop within the neo-liberal environment.

> The erosion of the safety net, reductions in resources, and increasing restrictions on the autonomy of professionals, making it very difficult for them to fulfill that desire for goodness. Consequentially, professionals fail in doing what they perceive of as their best, most ethical practice, and the theoretical tool of moral distress allows for recognition of both that failure and the emotional price that workers pay. (Weinberg, 2009, p. 149).

Weinberg advocates for adopting MD in social work by proposing the following benefits, MD is an adjunctive analytical tool for highlighting the discrepancy between supposed autonomy and the structural strictures that impede ethical behavior. It demonstrates self-reflexivity of the profession by incorporating an idea that squarely acknowledges the divergence between preferred and actualized selves, and it recognizes the importance of context in ethical action, as social workers are part of a web of relationships that are regulated by policies, laws, and organizations that both enable and constrain ethical behavior. Weinberg (2009) projects flaws in MD as a concept. She describes that though MD assumes the dichotomy of human agency and structure it can lead workers to sustain a stance of victimization by the system. Practitioners are not separate from their environment and social institutions are the creation of human beings; hence, every time a social worker enacts practice in a particular way, it establishes how SW is constructed at that moment. The notion of MD assumes that an appropriate way of behaving exists.

That is not a shared theory of this study. From a critical realist approach, we surmise that individual constructs such as morally correct behavior exist within the confines of each and every one of us, although not universally accepted, but nevertheless real constructs that are recognized by cultures, religions, societies, organizations, and professional bodies.

Moving beyond workplace constraints and structural barriers, Weinberg (2010) provides a theoretical exploration into the social construction of social work ethics. With a critical examination into SW ethics, she illuminates internal mechanisms that influence moral values in SW. Weinberg acknowledges the structural barriers preventing social workers from ethical action, and offers a theory describing the evolution and construction of SW ethics, as well as what interests are served in contemporary SW ethics, and complications inherent in the current

ethics paradigm. She hypothesizes that the social work code of ethics is the means by which values are indoctrinated into SW practice; it embodies the SW values and recommends guidelines for ethical behavior.

Weinberg, (2010). The social construction of social work ethics: Politicizing and broadening the lens.

Weinberg (2010) opines that the social construction of SW has evolved within the context of conservatization and professionalization. Fundamentally, social work has embraced a psychoanalytic approach to casework as a means to gain respectability as a profession. The implications of this model result in increased emphasis on the dyadic relationship between client and worker rather than the broader societal problems as the explanation of why individuals need help.

Fundamentally, ethics in social work is the means by which individual workers govern themselves. Under its current devices, each practitioner is individually responsible for following the principles. The ethics of social work is established and maintained through dominant discourses attached to a juridicial-theoretical model which encourages individual social workers to conduct one to one relationship with clients through the lens of codes of universal abstract principles such as confidentiality, and to regulate themselves by ensuring they are constantly abiding by those tenets. This is similar to Foucault's notions of 'governmentality' and 'institutional technologies' (Chambon et al. 1999, p. 275).

Weinberg (2010) states that the outcome of these trends has shaped societal expectations of the SW role itself as well as individual workers' self-identity. Weinberg's findings offer a solid foundation for understanding how ethics influence socialization and individual values. Her data reveal incongruent value systems that have emerged within the profession. Based on Weinberg's

theory, we can also envision the impact individual self-reflection has on this process and recognize how these mechanisms have shaped SW ethics, values and individual moral identity, as well as various compatibilities/incompatibilities between social worker's professional image and expected duties.

Weinberg (2010) findings are valuable contributions in MD research for social workers. One important feature of her work that is not found in the literature is the social construction of ethics as a regulatory tool for self-directing social workers. However, as SW's seek to emulate the values within their code of ethics but when they are prevented from actualizing their goals they are at risk of developing MD. For example, the practitioner's primary value of self-determination becomes constricted by social work practice which indirectly blames the individual for social problems and practitioners work to provide them with the resources for managing in a dysfunctional society; inadvertently restricting their autonomy and perpetuating societal problems like poverty and homelessness.

Weinberg, (2009) places emphasis on institutional constraints as a primary contributing factor to MD. She (Weinberg, 2010) does not specifically imply that the social construction of ethics in SW leads to MD. However, her findings are conceptually significant to theorizing its contribution to MD, and opens the door to challenge the notion that institutional factors are the only contributors to MD. Furthermore, that there is a relationship between the social construction ethics in SW and the manner in which social workers conceptualize moral behavior. Therefore, ethics are instrumental in determining the intensity and frequency of MD in SW.

Carolyn Oliver (2013). Including moral distress in the new language of social work ethics. Continuing our theme of SW, ethics and MD, we review Oliver's theory that conventional approaches to ethical problems such as deontology and consequentialism have created

dissonance between social workers and their sense of moral responsibility, and lead to MD. More precisely, those traditional approaches to ethics frame the act as moral (or not), rather than the actor, and both deontology and consequentialism can lead to MD (p.207). For example, a social worker following the deontological rules to arrive at the logically correct ethical choice may find the dictates of her professional code of ethics contradicting those of her own conscience. Similar to Weinberg, (2009) Oliver (2013) associates formalized rules and decision-making with neo-liberal policies that have seen social work agencies become more likely to engage in risk aversive, procedural, and top-down decision-making (p.205).

Social work students are increasingly being exposed to relational ethics but will often work in settings that continue to use traditional ethical frameworks, formalized in agency rules and decision-making algorithms. Furthermore, it is not just rules, outcomes, decision-making frameworks and logic that determine whether social workers will do the right thing. It is the social workers themselves who possess virtue and are disposed to acting morally.

Social workers claiming to be "just following the rules," or making "objective calculations of maximal benefit", can lose themselves as being personally implicated as moral agents. Decisions made under such theoretical frameworks are understood to be a matter of technical procedure rather than an individual moral judgement; thus, the political identity of social workers has been overshadowed by a drive to establish a distinct body of technical expertise (Oliver, 2013, p. 208). Such dissonance has the potential to create MD.

Oliver argues that the change to relational approaches to SW practice has increased moral sensitivity and subsequently increased the risk to MD. She maintains that relational theories foster an increase in moral sensitivity among social workers, which correlates with instances of MD. In other words, the more they know about the ethical and moral issues the more distress

they will have. Oliver hypothesizes that by integrating the language of MD into ethics education, social workers will be provided with a means to define and address the emotional consequences that arise from blocked moral agency. Increased knowledge of MD may also facilitate cross-disciplinary discussion on the negative effects of moral engagement, opening the door to further research and potential solutions.

Overall, Oliver's account of ethics and MD objectifies Weinberg's description of the social construction of ethics in SW. That said, there is a noteworthy incongruency between nursing literature on moral sensitivity and Oliver's account. Oliver's assertion that moral sensitivity increases the likelihood of MD is juxtaposed by previous scholars (Corley et al., 2002; Rushton, 2013, 2016; Hamric et al, 2012) that posit that moral sensitivity reduces the risk of MD because through increased moral sensitivity one better understands the ethical parameters of the situation, including alternative ways of resolving ethical problems.

Lynch & Forde (2016). Moral distress and the beginning practitioner: preparing social work students for ethical and moral challenges in contemporary contexts.

The stated goal of this study is to examine how beginning practitioners work through challenges, risks, and moral dilemmas of social change practices across different organizational and policy contexts. Lynch and Forde have applied MD in a context of social work students, teaching practices and student learning experiences, including field placements, associated with social justice ideals, activism, and challenges found in practical SW (field placements). They highlight three recurring themes that emerged as important ways of mitigating MD; to the first being associated with recognizing risks that come along with social work practice, the second recurring theme was being able to acknowledge moral dissonance and the third the realization

that all SW takes place in a policy context and therefore engaging with policy is a fundamental element of practice.

This article implements definitions of MD from Weinberg, (2009), which is essentially Jameton's (1984) definition of MD, pinpointing institutional constraints to moral agency as the primary feature. Lynch and Forde (2016) list similarities with a host of complex ethical problems inherent in both SW and nursing. They refer to ethical stress associated with value laden decisions related to end-of-life care, patient autonomy, and rights; as well as broader systemic issues such as staffing levels, lack of resources, and issues of procedural justice.

Lynch and Forde state that the social justice values of social work make it imperative that workers rock the boat and make waves if that is what is needed for compassionate and just practice. However, students expressed fears about rocking the boat in field placements as it might impact their potential job opportunities, and immediate relationships with their supervisor and the organization, particularly in government organizations.

Suggestions for change include making political involvement a part of the job, the need for reflexivity (critical self-awareness and analysis of knowledge/power relations, and critical self-awareness in the context of social change practices). Reflective journals, narratives, case studies, storytelling, dialogue and peer mentoring or role modeling were used to enhance the process of reflexivity within the context of organizational policy.

Social work programs should encourage students to learn the ethical and moral foundations of practice and develop their understanding of ethical concerns as well as the professional responsibility for making ethical decisions. It's imperative that students develop skills and understanding of critical analysis and dialogue as tools of ethical decision-making. The education process should not attempt to provide right and wrong answers, but rather, assist

practitioners to think systematically about moral problems and come to informed decisions in circumstances of uncertainty, “we cannot encourage students to be political without helping them to develop skills and collective practices to sustain themselves in the work. We argue for more nuanced and creative forms of activism to address social justice concerns. Scaffolding these more critical practices offers ways of addressing moral distress”, (Lynch & Forde, 2016, p.104). Lynch and Forde, (2016) have emphasized ways in which social work education can adopt new approaches to prepare students for moral challenges in the work place regarding social justice. They also propose practical theoretical changes to social work curricula, including field placements that can reduce the potential for MD.

Fantus et al., (2017). Exploring moral distress for hospital social workers.

The expressed aim of this study is to describe the concept of MD and theorize how it transpires within hospital social work. Factors such as hospital policy and institutional structure, and ethical dilemmas were highlighted as predicting factors. Building on McCarthy’s & Gastman’s (2015) conceptualization of MD in nursing, Fantus et al. (2017) correlate occurrences to: (i) clinical situations; (ii) working condition and limited resources; (iii) structural conditions; (iv) moral sources.

Fantus et al. (2017), operationalize the definition of MD from the nursing literature (Jameton, 1984; Corely, 2001; McCarthy and Gastman, 2015). The foundation of this definition theorizes that MD occurs when ‘when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action’.

Fantus et al. (2017) posit that MD must be preceded by a moral dilemma brought on by value conflicts that threaten the moral integrity of the worker. Their theory is supported by referencing

various clinical situations, and structural/systemic conditions endured by hospital social workers in two case vignettes.

The first example depicts a social worker being pressured by her manager to discharge a patient into what is perceived to be an unsafe environment and the power dynamics within the health care team are such that the social worker feels powerless to advocate for the patient's needs. The second vignette describes a pediatric example in which a 3-year-old child with a complex metabolic disorder is recommended for a tracheotomy. The social worker is uncertain about the impact the proposed intervention will have on the quality of life of the child and does not believe it is in the child's best interest to have the procedure done. The SW also believes that the demands associated with caring for this child will completely overwhelm his mother who is already depressed and exhausted. Yet, the health care team is pressuring the social worker to help the mother accept the intervention. The SW is torn between his responsibility to the request of the medical team and its impact on both the child and mother.

The case examples used in this study typify SW specific situations in which practitioners are confronted by institutional constraints preventing them from doing what they believe to be the ethically correct thing to do. The causal factors of distress are fundamentally similar to previous studies in nursing such as; lack of resources, power differentials, and hierarchies within the healthcare system, unnecessary/futile treatment or testing, inadequate informed consent, aggressive treatment not deemed to be in the patient's best interest, lying to or deceiving patients, inappropriate use of resources, inadequate staffing/resources, incompetent caregivers, interdisciplinary conflict and feelings of powerlessness (Jameton, 1984; Wilkinson, 1987; Corley et al., 2001, 2002; Hamric et al., 2013; Rushton, 2013).

The methodology and research methods of this study have transposed definitions and causal factors from the nursing literature and directly applied them into the social workers' experience, and do not account for theoretical differences between social work and nursing. Factors such as, social workers conceptualization of client problems versus nursing patient view which is more individualistic and biological in nature. The moral dilemmas exemplified in this study provide social work examples however, the analysis fails to recognize fundament differences between the professions that might have also influenced MD. Never-the-less, Fantus et al. have effectively demonstrated that hospital social workers are exposed to similar ethical dilemmas as their professional colleagues in nursing, and the constraints to moral agency exemplified in their vignettes result from power differentials within a bureaucratic institution and conflicting policies, rules, regulations, and other organizational/systemic limitations preventing hospital social workers from acting on their moral judgement, similar to the constraints to moral agency articulated in the nursing literature.

The theoretical framework of this study is based on the supposition that MD must be preceded by a value laden moral dilemma, and that hospital social workers are exposed to value-laden, medically and emotionally complex cases that may trigger such dilemmas. As previously noted, ethical dilemmas may be a contributing factor; however, they do not always lead to MD and are not the only factor in MD. Varcoe et al. (2012) claim that MD results not only from ethical dilemmas and institutional constraints, but from a variety of interrelated factors. They propose that if we are to understand MD, we must also understand how it is constructed and experienced, both emotionally and physically. Such inquiry will move us beyond understanding MD as solely an individual experience that practitioners and students will either endure or develop individual coping skills to overcome.

The findings of this study highlight moral challenges for social workers in a bureaucratic medical model. However, further research is needed to uncover the influence from SW values, beliefs, educations, sociopolitical factors, and personal expectations of social worker practitioners. Further research may reveal the meaning attached to moral constraints and their impact on the social workers' self-identity as well as provide opportunities for self-reflection and exploration into the complex interplay of factors culminating into MD.

Social work literature continues to recognize ethical dilemmas facing front line workers, yet little attention is given to the development of moral agency or potential root causes of ethical compromise. Extended research in needed on the originations of Canadian SW values, socio-political influences, and role expectations to enhance our ability to fully comprehend expectations and limitations to individual moral agency.

Mänttäri-van der Kuip, (2020). Conceptualising work-related moral suffering: Exploring and refining the concept of moral distress in the context of social work.

The goal of this study is to enhance conceptual clarity to the conceptualizations of moral distress as it has been applied in nursing and social work literature. The author theorizes that there are two interconnected components of moral distress, 1. the existence of some sort of event that is characterized by the person as having restricted moral agency and 2. the psychological and physiological suffering, i.e. distress this induces. Jameton's (1984) definition provides the foundation for describing causal factors arising from institutional constraints.

Mänttäri-van der Kuip differentiates between moral uncertainty and moral dilemmas in their association with MD. Moral uncertainty frequently occurs when a person is uncertain about the right course of action in a highly complex and ethically challenging situation, or they may not have sufficient information to guide their moral decision. In the case of moral dilemma, the

person is sure about the morally correct action, but is prevented from doing it. Moral dilemmas often occur when a person is forced to choose between two or more mutually exclusive courses of action and neither of the conflicting variables ethically overrides the other. According to Jameton (1984), moral distress is not a dilemma, per se, because again the person knows the morally appropriate action but is prevented from doing it. Thus, even if moral uncertainty and moral dilemmas create distress, it's not enough to define them as moral distress.

Influencing factors leading to distress have been inconsistently supported in the literature on MD. Jameton (1984) highlighted institutional constraints as the primary factor, Judith Wilkinson (1987/1988) emphasized the psychological process and defined the distress as a psychological equilibrium and negative feeling state that occurs when a person makes a moral decision but does not follow through by performing the moral act indicative of the decision. Other authors Campbell et al. (2016) included negative self-directed emotions and attitudes', such as guilt, shame, self-criticism that arise when a person professionally perceives themselves in a morally undesirable situation. Definitions for moral distress provided by Dudzinski (2016) and Hutchinson (2015) theorize that intensified emotional responses are a direct result of moral distress.

Mänttäri-van der Kuip (2016) describes a two-stage model of moral distress similar to Jameton (2013) and the empirical and Fourie (2015). Stage one directly follows one's inability to act, the second stage is a reactive distress to that inability to act which then becomes a lingering state that impairs well-being over a longer period of time Jameton (1983). This reactive stage has also been termed moral residue Hamric (2009), Webster & Baylis (2000).

The following description, supported in literature, is provided by the author, constraints to ethical practice originate from external barriers (institutional), Jameton (1984), and internal

predisposition (self-doubt, socialization), Wilkinson (1987/1988). These also factors included in the Moral Distress Scale measurement (MDS) (Corely et al. (2001) that were later revised MDS-R Corley, Hamric, 2012). The MDS and MDSR included questionnaires designed to measure the frequency and intensity of moral distress and are based on the previously mentioned factors. The measurement included two scales, 1) the frequency of the predefined moral phenomena that is acting on the professional beliefs and 2) the existence and intensity of distress as a response to the first factors.

The author argues that if the root causes (predefined moral phenomena) in the first measurement are specified as predetermined causes of moral distress, then the phenomenon is being conceptualized from the relatively narrow perspective of readily defined constraints, leaving little space for subjective judgements and evaluations. Mänttäri-van der Kuip (2020) proposes that influencing factors of moral distress vary considerably among social workers and a more subjective, relational and contextual approach to constraints would be more fruitful. Therefore, in might be beneficial to different the phenomenon itself from its antecedents or predictors (root causes).

Moreover, there are additional influential factors to consider in social work that cannot be directly defined as institutional constraints. For example, a social worker might experience moral distress when she becomes aware that she does not have the requisite skills or necessary knowledge to perform a given task in an ethically appropriate way, yet she feels an obligation or duty to act. The social worker might also notice the existence of oppressive practices in her employing organization but fails to challenge them for fear of losing her job. The author adds that internal constraints also influence moral distress. For example, working with a lack of resources can make social workers less sensitive, and that moral insensitivity can serve as a

coping mechanism for moral distress. Christen and Katsarov (2016) argue that an increase in moral sensitivity might temporarily increase the experience of moral distress, which could motivate professionals to change their behavior or to challenge constraints that they find morally questionable. Additional factors are that some constraints are not real but perceived. There are perceptual barriers that seemingly can be eliminated through good works.

To conclude the author is suggesting the existing understanding of MD is not sufficient to measure. MDS and MDS-R are too restrictively focused on institutional/organizational constraints and must be expanded to include internal sources and subjectivity. Existing studies have suffered from an oversimplified idea of the role of constraints to moral action and MD is a more complex and dynamic phenomena. A new conceptual understanding must also include the interaction between external and internal constraints, and to respond to questions such as, what does it mean to pursue the right course of action, or how does one know if they are pursuing the morally correct action?

This writer concurs that an expanded interactional version of moral distress is needed, as reflected in the purpose of this study. Maija Manttari van der Kuip (2020) puts forward an innovative approach to understanding factors related to MD. Specifically, that the constraints on moral action should be understood more broadly and the interaction between them should be acknowledged. Her central claim is that constraints on moral action should not be included in the definition or amongst instruments to measure MD. Instead, theses root causes should be understood as antecedents of MD, not as components of it.

Erin Sugrue (2019). Understanding the effect of moral transgressions in the helping profession: In search of conceptual clarity.

This article compares contextual features of three constructs related to moral transgressions in helping professions and the ensuing psychological, emotional, and social effects. The author proposes a synthesis of contributing factors to put forward a new construct “moral suffering”. The term “helping professions” encompasses all professions involved in caring for and aiding the physical, mental, emotional, or spiritual well-being of others, including teaching, social work, counselling, nursing, medicine and ministry. Sugrue posits that all helping professions are shaped in moral terms and share a common value of altruism. They are all guided by formal codes of ethics outlining expectations of professional behavior and establishing core beliefs and principles to which all practitioners are expected to abide by (Sugrue, 2019).

The study contrasts three constructs to demonstrate competing factors used to conceptualize moral transgressions and their impact on helping professionals. *Moral injury* (Shay 1994, 2014; Litz et al. 2009; Santoro 2011), *moral distress* (Jameton 1984, 1993) and *demoralization* (Gabel 2011, 2012, 2013; Santoro 2011).

Moral injury – was briefly defined as lasting emotional, psychological, and existential harm that occurs when an individual “perpetuates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and expectations” (Litz et al. 2009). Moral injury occurs when individuals experience deeply troubling cognitive dissonance between their internal moral code and the actions that they engage or witness. (Litz et al. 2009).

Moral distress – described as “painful feelings and/or psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action” (Corley, 2002 pp 636-37) because of either internal constraints (e.g. fear) or external constraints (e.g. lack of time, lack of resources, legal limits, hierarchical decision

making; Corley 2002; McCarthy and Deady 2008). Sugrue referred to Jameton (1993) revised version of MD distinguishing between initial and reactive moral distress. Initial moral distress refers to emotional reaction (frustration, anger, anxiety) experienced when one is confronted with a conflict between one's moral values and available actions, and reactive moral distress refers to the lasting distress after not acting in a way that is consistent with their moral values (Jameton, 1993). Jameton (1984) made a distinction between moral distress and moral uncertainty; moral uncertainty occurs when the person is unsure of the moral action whereas moral distress occurs when the person knows the correct moral action but is unable to do it. Sugrue also cites Weinberg (2009) to distinguish moral distress from an ethical dilemma; ethical dilemmas are conceptualized at the individual level, moral distress recognizes the role of larger systems including "political dimensions of practices, thereby enabling structural issues to be recast as ethical problems" (Lynch & Forde 2016, 96).

The author posits that moral distress has received significant attention in the nursing literature, both conceptually and empirically. Despite the substantial research there remains uncertainty over the specifics of its definition. Dudzinski (2016) posits that the exact definition and meaning of moral distress is "famously nebulous". Some scholars choose to focus on the role of external social and institutional constraints (e.g., Jameton, 1984, 1993; Corley, 2002), while others include the role of internal constraints (Webster & Baylis 2000). Hanna (2004) argues that some scholars (e.g., Jameton 1984, 1993; Wilkinson, 1988) focus too much on psychological aspects of moral distress and are conflating psychological distress with moral distress while ignoring the more salient ethical components. McCarthy and Deady (2008) propose that moral distress should be considered "a cluster concept or umbrella concept" (p. 259) capturing a range of symptoms and experiences of individuals who are morally constrained.

Some scholars have pushed back against Jameton's (1984,1993) assertion that moral distress must involve a situation of moral constraint (Johnstone and Hutchinson 2015; Campbell et al. 2016; Fourie 2017). Johnstone and Hutchinson (2015) argue that the dominant conceptualization of moral distress is based on a flawed assumption that nurses always know the right thing to do and the only reason they are not doing it is because of internal or external constraints. Fourie (2017) proposes that moral distress is composed of multiple categories, including the constraint-based moral distress as defined by Jameton (1984, 1993) and the uncertainty-based moral distress as identified by Campbell et al (2016). Campbell and colleagues point out that "life as a moral agent is complex" and it is difficult if not impossible for nurses to know the correct moral action to take. In contrast to Jameton (1984), who distinguishes between moral dilemmas (which are a source of moral distress) and moral uncertainty (which is not), Campbell and colleagues (2016) assert that both moral dilemmas and moral uncertainty can lead to moral distress. Fourie (2017) proposes that moral distress is composed of multiple categories, including the constraint-based moral distress as defined by Jameton (1984, 1993) and the uncertainty-based moral distress as identified by Campbell and colleagues (2016).

Demoralization- is defined as "feelings of impotence, isolation, and despair" (Clarke and Kissane 2002, 734). The feelings are in response to a perceived inability to deal effectively with a stressful experience (Clarke & Kissane 2002). Demoralization is related to both an individual's moral beliefs and actions and with a loss of morale when important beliefs and values are lost (Gabel 2013). When individuals are demoralized, they feel trapped, helpless, and unable to respond to a stressful situation in a way that feels appropriate to them, all of which results in feelings of anxiety, depression, and "a sense of meaninglessness of life" (Clarke & Kissane 2002, p. 734). Stewart Gabel (2011, 2012, 2013) has examined demoralization in the context of

health care professionals and defines demoralization as “a condition of diminished morale or hopelessness that occurs when one’s principles, values, or standards are threatened” (Gabel 2011, 892).

Gabel (2013) argues that medicine and health care are rooted in moral beliefs and practices and their obligation to help. Demoralization can occur when their obligation is threatened by a lack of resources, increasing commercialization of health care, or policy changes that limit their ability to provide the type of care that they feel morally obligated to provide.

Conceptual similarities – Sugrue summarizes that all three constructs describe emotional, psychological, and existential distress related to a violation of moral expectations and deeply held values by takin from definitions provided in the literature (Jameton, 1984; Webster & Baylis, 2000; Litz et al. 2009; Gabel, 2011; Shay, 2014).

Sugrue adds that Clarke and Kissane (2019) have linked demoralization to interpersonal loss critical to one’s sense of self, which coincides with Dombo and colleagues’ (2013) assertion that the core of moral injury derives from the threat to self-identity. Webster and Baylis’s (2000) have also revealed that permanent changes in self-identity can result from moral distress.

Conceptual differences – The author posits that concepts of demoralization and moral distress focus one’s inability to change their circumstances (Jameton, 1984,1993; Clarke & Kissane 2002; Santoro, 2011). Although internal or external constraints may be present, they are not required for a person to experience moral injury. Moral injury encompasses all circumstances in which a person has mistakenly or freely transgressed their moral expectations. Thus, the action and one’s interpretation of the action as being morally transgressive are primary factors leading to moral injury, regardless of constraints being placed on the actor. The role of the individual also varies among concepts. Moral injury can result from a person perpetrating a moral

transgression, witnessing a moral transgression, or being the victim of someone else's moral transgression. Thus, moral injury may follow if the person has evaluated the action be a violation of deeply held moral beliefs and expectations (Litz et al 2009; Shay, 2014).

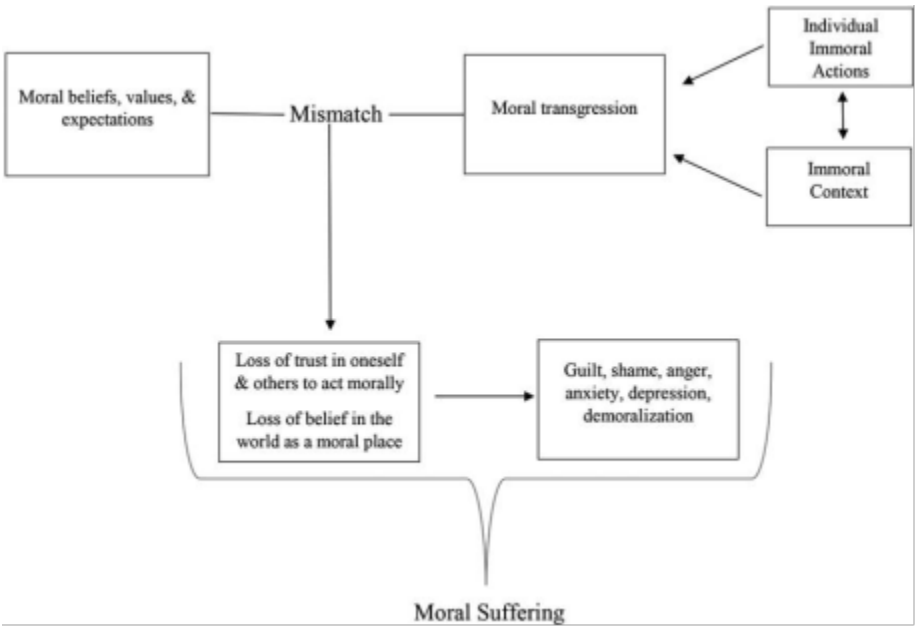
Both moral distress and demoralization are based on the individual's own immoral actions or inactions, including their inability to act in a manner consistent with their moral beliefs (Clarke and Kissane, 2002; Gabel, 2011; Santoro, 2011).

Some scholars (Campbell & Colleagues, 2016; Fourie, 2017) have supported broadening the conceptualization of moral distress by expanding contributing factors and their impact. Scholars have also supported the broadening of moral injury factors. McAnich, (2016) states the Shay's (1994) original definition was centered around a person's response to a betrayal by a person in authority in a high-stakes context. Litz et al. (2009) expanded it to include peers and the service member himself. More recently Mcdonald (2017) argued for a revised definition to include instances that shatter one's moral beliefs of the world. Santoro (2011) writing on teacher demoralization cited Mcdonald in his assertion that it's not individual characteristics or even individual actions that are the source of demoralization, but it is the teaching itself that has become morally irreconcilable.

Sugrue (2019) posits that broader conceptualizations have resulted in even more overlap among moral distress, moral injury, and demoralization. Sugrue offers a new concept "moral suffering" to encompass the collective similarities among these concepts and proposes a conceptual model that better articulates the experiences of helping professionals.

Figure 2

Moral suffering – conceptual model



Surgue, (2019, p. 17)

Sugrue's conceptual model begins with dissonance between moral beliefs, values, and expectations and some form of moral transgression. The model illustrates the relationship between individual immoral actions and an immoral context is circular and reciprocal meaning individual immoral actions collectively produce an immoral context or environment and the immoral context also influences individuals' immoral actions.

Moral suffering moves beyond situations of moral constraint to include instances of moral uncertainty. Individuals are unsure of what to do because they committed an action and only later understood its moral implications, or because they accidentally committed a moral transgression. In this conceptual model the reason of how or why a person experiences a moral transgression is much less important than the resulting moral cognitive dissonance and accompanying existential and psychological outcomes of this dissonance.

The dissonance resulting from incongruity between moral beliefs and morally transgressive experiences leads to loss of faith in oneself and others to act morally and belief that the world is

moral place. This leads to feelings of guilt, shame, anxiety, anger, and depression. Thus, moral loss is at the core of moral suffering.

Drawing from Weinberg (2009) Sugrue posits that moral suffering is a critical construct for social work. Sugrue's rational is that the concept of moral suffering could support the well-being, effectiveness, and professional retention of social workers and play a role in drawing attention to the sources of injustice and immorality inherent in the workplace.

Sugrue offers significant contribution to this study by focusing on a concept (moral suffering) that emphasizes the moral connection between individual social workers and the larger social, political, and economic structures in which they work. In addition to revealing sources of moral injustice, Sugrue claims the concept of moral suffering can contribute to the development of effective strategies for responding to similar sources of injustice in social work practice. As many organizations that employ social workers have become increasingly dominated by neo-liberal and market-driven approaches to social welfare, social workers are increasingly finding themselves in situations in which their actions are being shaped by immoral systems and structures.

This writer's summary – The author, Erin Sugrue (2019) states that the primary motivation for this study as inspired by the lack of clarity within three concepts (moral distress, moral injury, and demoralization), and this lack of clarity is due to similarities and overlapping constructs among the concepts. Sugrue then assumes that clarity would result by amalgamating the main features of these constructs into one single construct "moral suffering", and that this new construct would generalize across professional contexts in a much more precise manner. It may be suggested that a more complete definition of moral distress would satisfy Sugrue's objective. A comprehensive literature review on moral distress demonstrates that it can be used

to explain the instances of moral suffering referenced in this study. However, moral suffering can not be used to explain all cases of moral distress.

Surgue (2019) argues for the need to establish an integrated model for all the helping professions, and these can be evidenced in the fact that moral distress, moral injury, and demoralization have been researched almost exclusively within one academic discipline or professional field. Sugrue goes on to list the overarching motive for this thesis topic is to illuminate moral distress within social work because the social work context/experience is different than that of nursing, in which most of the research has taken place. What is missing are the differences in ethical and moral expectations among the helping professions. Social workers understand client problems with a different lens than nurses, teachers or military personnel. Social workers hold different values, beliefs and theoretical approaches than other professions. Nurses focus on individual health and biology, while social workers adopt a more holistic/societal viewpoint. As a result, professional role expectations and self-evaluation would be perceived much differently as they have much different roles and functions in society. Furthermore, the military worldview in which much of moral injury research has been conducted can be considered contrary to social work values. Likewise, social work values and beliefs differ greatly from the teaching constructs used to conceptualize demoralization. It is for those reasons that this writer disagrees with lumping the professions into one singular rubric “helping professions” and then setting out to conceptualize moral transgressions and distress. Nor will it bring clarity to the specific factors associated with moral suffering, or moral distress in social work. What is needed to bring clarity to moral distress in social work is a better understanding of the complex and interactive nature of various contributing factors, including how they manifest into professional dissonance and individual moral distress.

Sugrue's inferences for replacing MD with moral suffering into social work literature does not differ significantly from Weinberg's (2009) theoretical advantages of conceptualizing moral distress into social work literature. Sugrue embraces similar values, concepts and contextual features as previous SW scholars (Weinberg 2009, Hamric et al 2013, Oliver 2013) on MD. What Sugrue's theoretical model also lacks is empirical support. For example, Sugrue hypothesises that dissonance resulting from the mismatch between one's moral beliefs and morally transgressive experiences leads to the loss of faith in oneself and others to act morally and the rejection of the belief in the world as moral place. Sugrue also posits that ensuing sense of moral confusion and betrayal leads to feelings of guilt, shame, anxiety, anger, and depression. The experience of moral loss is at the core of moral suffering. The supporting literature in Sugrue's study does not verify these claims.

In conclusion Sugrue (2019) argues that an integrated concept, moral suffering, to identify the structural and systemic sources of injustice and oppression that all social workers by the nature of their professional code of ethics (National Association of Social Worker 2017) and historical mandate, have a responsibility to address. The author does not provide specific reasons explaining how or why the concept of moral suffering will provide more concise data to identify structural and systemic sources of injustice and oppression faced by social workers. It may very well be that Jameton's original definition would sufficiently serve that purpose, as long as the constraints preventing social workers from promoting social justice can be described as institutional constraints. Depending on the methodological approach and research methods many such constraints have already been identified. What's also needed is critical exploration into by what means these constraints come about, why they are perpetuated, and in what manner they

impact private practitioners. It is expected that the responses to those research questions will differ among professional disciplines within the specified “helping professions”.

Contributions from Adrienne Chambon (1999). Reading Foucault for social work.

For a more comprehensive understanding of the socio-political context and the shaping of professional social work values, we turn to the groundbreaking work of Adrienne Chambon and her colleagues (Chambon, Irving, and Epstein, 1999). Chambon et al. apply Foucault’s methodology to the social work profession. Her book is a group of essays that provide invaluable insight and understanding into the conception of social work values. This is of particular importance to this study as it reveals the hidden realm of reality that impacts individual social worker’s expectations and their role in society. As a profession, social work has struggled to establish a consistent philosophical viewpoint. In earlier years social workers pursued altruistic measures to support societies’ most vulnerable groups. As such, social workers were regarded as “social helpers”. The workers themselves identified with their altruistic role in society. Altruism continues to be an intrinsic motivator attracting people to social work and it exists in many social work agencies and university programs today (Clark, 2006). However, researchers such as Weinberg (2009) and Clark (2006) argue that modern social work has aligned itself more with clinical and scientific approaches. Some theorists suggest contemporary social work has become a mechanism for governments to implicitly maintain the capitalist order (Chambon et al., 1999). Maintaining the capitalist order goes against intrinsic social work values and when put into practice may very well result in moral distress.

Laura Epstein’s (1994) seminal work on the ‘culture of social work’ provides a foundation for understanding the complex nature of modern social work. Among other social functions, she described social work as a major social institution that legitimates the power contained in

modern democratic capitalist states (Chambon et al, 1999). The implication is that SW takes a primary role in normalizing citizens into workforces that can staff the public and private enterprises that maintain the performance of the economy and preserve civil order. The term normalization in this context refers to instruments of power by which healthy and pathological behaviors are established. This aligns with Foucault's (1978) use of governmentality where beliefs and rules are learned and modeled in behavior and become established norms that are the vehicle for bureaucracies to enact power. Through these technologies the individual is transformed and in social work practice these norms are 'taken in' as truth by both the clients and the worker themselves (Rose & Miller, 1999).

Chambon maintains that this is not assumed to be an intentional process instituted by the colleges and professional bodies; quite the contrary. The power relations between government and social work are not so obvious. The relationship is best explained through Foucault's notion that the success of power relations is proportionate to their ability to hide their own mechanisms (Foucault, 1978). Therefore, SW's purpose is successful only if workers can influence people through the client's own pursuits. Subsequently the principle of 'self-determination' becomes social work's key mechanism, professing to empower clients in making their own choices while at the same time voluntarily adopting the normative views inherent in the intentions of the practice. "In social work noninfluential influencing is its communicative art, its specialty. It has evolved complex rationales and methods for appearing to sew together influencing and not influencing without the seams showing too much" (Chambon et al., 1999, p.8).

It is important to remember that it is not the mechanisms of the profession or its workers that motivated this action, but rather processes of governmentality and technologies of the self (Foucault 1988). The evolution of social work and its societal function has been highly swayed

by public discourse, social movements, and societal expectations, “social work is inscribed within a larger function that has been taking on new dimensions for centuries, the function of surveillance-and-correction. Its place in governance prohibits social workers from prevailing at a collective more general level” (Chambon et al., 1999, p.92).

Sociologist Jean Rene Treanton (in Chambon et al., 1999) adds his interpretation of the dichotomous relationship between social workers and their function in society, “the social work role does not afford them the power to influence at a collective or political level, therefore many of them come to realize that to intervene at the individual level is totally illusory unless political problems are addressed” (Chambon et al., 1999, p.92).

Therefore, social workers are likely to experience professional dissonance arising from the value conflict between their job task and personal/professional values. Professional dissonance refers to a feeling of discomfort arising from conflict between professional values and job tasks (Taylor, 2005). Moral distress may then result as social workers core identity becomes threatened. Many social workers enter the profession with high altruistic expectations of themselves and later find themselves in the role of gatekeepers for government resources and agents of social control. This is not an accidental coincidence as mechanisms beyond everyday thinking reveal a more insidious role for social work, “Social work collaborates with other occupations, mainly the helping disciplines, all of which together manage the population” (Chambon et al., 1999, p.8). The recognition of themselves as agents of social control may leave social workers feeling frustrated and powerless to effect real change within the system. To complicate matters, in order to be effective social worker must not appear authoritative in its public persona. Social workers then, control clients without force, without command, and indirectly so as to have the clients want to be transformed, consent to it, and do so on their own

free will (Chambon et al., 1999). This is the social work principle of client self-determination and noninfluential influencing becomes social workers' communicative art.

Summary of Literature review:

Overall, the social work literature highlights the need for a stratified approach to conceptualizing MD within the SW context. Collectively, the data reveals the complex interactions that occur between personal values, professional values, sociopolitical environment, and personality and the meaning these factors have on social work practice must be considered before one can understand MD and its development. Based on the analyses and literature reviewed for this study it is evident that the negative effects MD include the following; Physical symptoms - fatigue, headaches, sleep problems and other somatic complaints. Emotional symptoms - frustration, anger, fear, guilt, resentment, feeling overwhelmed, and powerlessness. Behavioral responses – crying, avoidance, withdrawal, sarcasm, blaming/shaming, addictive, controlling and argumentative (Corley, 2001, 2002, Wilkinson, 1987; Hamric et al, 2013; Rushton et al., 2013; Webster & Baylis, 2000; McCarthy & Gastmans, 2015) and others. The literature unanimously demonstrates the negative impact of MD on practitioners, the organizations in which they work, their clients and the larger community.

One common feature in the literature is posits that MD originates from some form of constraint to moral agency that it is best understood as a two-stage process that can intensify over time. The initial distress occurs when a practitioner is faced with some form of obstacle to moral agency. Many scholars identified institutional obstacles and conflicting values leading to feelings of frustration, anger and anxiety. The second stage is specifically described as the reactive distress that accompanies one's inability to rectify the initial distress.

Studies that highlighted positive effects of MD referred the experience as an opportunity for self-reflection and change, both individually and systemically (Webster and Baylis, 2000; Rushton et al., 2013; Corley, 2001, 2002; Hamric et al, 2013). An operative feature for further study is to identify factors to elucidate factors to support why a morally distressing experience is debilitating to one yet, acts as a form of motivation to another.

My personal experience has provided examples of MD resulting in positive responses. Change often comes about when there was a collective voice. For example; health care workers were reluctant to report instances of unethical behavior by their colleagues or instances that they themselves took part in. The hospital developed a process for reporting critical incidents and near misses which provided nurses and other staff with a safe way to come forward with concerns. The process came about to resolve individual cases of moral distress. The main objective was toward improvement of organizational procedures. The primary tenant of this process emphasized a safe environment focused on awareness and improvement for the future rather than blame and retribution, this is process is referred to as “critical incident reporting”.
The literature also revealed instances in which MD led to positive changes in organizational policies, practices, guidelines, education, and emotional awareness. Weinberg (2009), and Oliver, (2013) demonstrate how the negative effects of MD facilitated a need for changes in ethics education and management. Maiji Manttatri-van der Kuip (2016) illustrates how MD prompts practitioners to advocate for additional resources, Lynch & Forde, (2016) findings establish the benefits for SW education.

Chambon et al (1999) provides noteworthy data toward the conceptual analysis of MD in SW. Their seminal work exposes how social workers may unwittingly work against their very own altruistic values. Chambon described social work as a major social institution that legitimates the

power contained in modern democratic capitalist states. The implication is that SW takes a primary role in normalizing citizens into workforces that can staff the public and private enterprises that maintain the performance of the economy and preserve civil order. This is not what is taught in social work schools. Social workers would feel manipulated to learn of their role as government agents for social control. This might also explain incongruence between SW values and their expected workplace duties/responsibilities. Social workers devoted to values of social justice and client self-determination find themselves practicing within constrictive organizational policies and bureaucracies preventing them from working toward their goals.

The literature reveals that MD is associated with multiple factors such as, institutional constraints - policy and practice guidelines, neo-liberal policies resulting in lack of resources, lack of time, power differentials, hierarchies within the healthcare system, managerial decision-making, unnecessary/futile treatment or testing, inadequate informed consent, aggressive treatment not deemed to be in the patient's best interest, lying to or deceiving clients and/or families, inappropriate use of resources, inadequate staffing/resources, incompetent caregivers, and interdisciplinary conflict (Jameton, 1984; Wilkinson, 1987: Corley et al., 2001, 2002, Hamric et al., 2013, Rushton, 2013; Fantus et al. 2017; Lev and Ayalon, 2016; Mänttäri-van der Kuip, 2016; Fantus et al., 2017, and others).

The overarching theme among both nursing and SW literature is that MD ensues from the practitioner's restricted moral agency. In other words, nurses and social workers are at risk of MD when they are unable to act within their moral expectations. Most examples come by way of the organizational restrictions to moral agency listed above. Although not all researchers agree on how and why restricted moral agency contributes to MD or what kind of restrictions result in MD. Yet, a variety of reasons are hypothesized. For example, unmanageable caseloads,

insufficient resources, lack of education and personal/professional values conflicts (Corley, 2002; Hamric, 2012; Epstien & Hamric, 2009).

Many scholars assume that professional (SW) values are consistent with individual moral agency and hypothesize that those value conflicts are at the heart of MD when practitioners are unable to act on them. Conflicting theories are put forward to explain the origins of MD, some scholars insist that MD occurs by way of a dilemma (having to choose between two or more mutually exclusive courses of action), while others theorize that MD can arise in situations where practitioners assume moral responsibility simply by way of association with the moral wrong doer and thus experience distress vicariously.

Primarily, the theoretical approaches to research have resulted in binary viewpoints of factors leading to MD. For example, institutional constraints vs. psychological processes. However, MD is a complex phenomenon that involves the culmination of several factors. Thus, a more comprehensive understanding of MD must include ongoing interactions with contextual features. Through the theoretical lens of critical realism, this study unpacks the development of influential factors and their relationship to the above-mentioned factors. Informed by prior research this paper sets out to hypothesize with some degree of certainty that MD, in part, results from interactions between external constraints (austerity measures, lack of time, managerial decision-making, insufficient resources, organizational policies) and internal constraints (being socialized to follow orders, the futility of past actions, the fear of losing a job, governmental processes, self-doubt, and lack of courage, decreased moral sensitivity, lack of understanding of the full situation, and lack of education, perceived powerlessness, and value systems (Wilkinson, 1987; Corley, 2002; Rushton, Kaszniak, and Halifax, 2013; Hamric, 2012; Fry, Veatch, & Taylor,

2011; Varcoe, Pauly, Webster, Storch, 2012; Weinberg 2009; Oliver, 2013, Fantus et al., 2017, Gough and Spencer, 2014, and others).

More recent studies by Lev and Aylone (2016), and Ko et al. (2016) have included cultural components to the list of internal factors to demonstrate its influence and explanatory power in building morality within each individual person. Although not mentioned in the nursing literature, many SW authors have emphasized the effects of worldwide neo-liberalism and privatization as being responsible for the transition of social services from government to private ownership (Mullaly, 2007). As a result, social welfare agencies have experienced ever-increasing budget constraints and pressures to be more efficient in a world of shrinking resources thereby constraining the resources and services social workers can offer to their clients and families. Austerity measures have also resulted in bureaucracy and managerial-type decision-making (Lev & Ayalon, 2016; Weinberg, 2009; Clark, 2006; Oliver, 2014; Lynch & Forde, 2016; Mänttäri-van der Kuip, 2016; Chambon et al, 1999).

Baker Collins et al (2015) provide detailed examples of the effects of neo-liberal effects on SW practice. Chambon et al, (1999), Weinberg, (2010) and Clark, (2006) take a closer look at the governmental and societal influences shaping both professional and societal expectations through education and other forms of discourse. Opportunities for future research include the impact of sociopolitical changes. For a more complete view of causal factors leading to MD one must understand the meaning associated with these factors including, how practitioners internalize and respond to them. Government influences on social work do not happen in a vacuum and are dependent on organizations and individual practitioners to enforce certain objectives. It is for those reasons that moral distress can only be understood within and interactional model that accentuates the relationship between the above-mentioned factors.

One overarching theme from the literature supports the need for research that explores constraints on moral action more broadly and the interaction between influential factors must be understood and acknowledged. The central goal of this study is to explore preexisting factors in relation to constraints on moral action. Including how these factors are linked with the social work profession.

Chapter Three

Methods

This chapter describes the methods used to achieve the primary goal of this paper, including a reflexive account of the researcher's viewpoint, realizations, setbacks and changes made along the way. The chapter also expands on supporting theories, methodology, research methods, sampling strategy and rationale for the thesis. The theoretical construction put forward follows grounded theory methodology as described later.

Informed by the critical realist (CR) ideology of philosopher Roy Bhaskar, (1986), the goal of this study is to develop a theory of MD that is grounded in the data and reflective of the experiences from within a social work context. Grounded theory methods proposed for this study have been taken from various authors including; Glaser (1992, 1999); Glaser & Strauss (1999); Corbin & Strauss (2008); Charmaz, (2014); Birks & Mills, (2015); Glesne, (2016); Oliver, (2011).

In search of a paradigm

Social work practitioners work in a variety of settings and it requires more than one analytic perspective to understand the complexity of ethical challenges within social work practice, particularly when analyzing a certain context to find underlying mechanisms related to moral distress. Factors such as diverse policy implementation processes and their consequences on

practitioners, or government influence on program development. It is for those reasons that the research approach must accommodate a systematic investigation into the interaction between what is observable and what goes beyond the apparent factors. The theoretical approach to this study was originally going to be based on a constructivist theoretical approach to grounded theory. However, considering the limitations of both social constructionism (relativism) and positive research methods (doesn't account for context or change) the researcher concluded that the most appropriate theoretical paradigm for this study was through the lens of critical realism. Critical realism provides an inclusive theoretical approach that can support its methods with theory, and through rigorous data analysis contribute to research in social sciences (Patton, 2015). One of the strengths of a critical realist methodology is that it is an addition to, rather than instead of, other types of research perspectives. Critical realism goes beyond the limitations of traditional positivist and classic social constructionist theories that have been used to study MD. CR implements a more stratified ontology that offers a solid philosophical base, while at the same time satisfies the emancipatory expectation of SW research. Archer (1995, 2007) argues that critical realism provides more than just breadth, depth, and a focus on structure, but critical realism also advances our human capacity to influence structure, conditions that construct suffering, and difficult life situations.

The researcher reviewed the literature and theoretical approaches for a paradigm that is most suited for this study and compatible with the researcher's worldview. The following table is a summary of theoretical data reviewed in consideration search of a research paradigm for this study. (Patton, 2015; Charmez, 2014; Glesne, 2016; Payne, 2014; Tuffin, 2005).

Table 2

Summary of Paradigms

Paradigm	Positivism	Critical Realism	Constructivism
Ontology (worldview)	A single objective reality exists	There is a reality independent of our knowledge of it	Multiple realities constructed through interpretation & understanding
Epistemology (Nature of Knowledge)	Reality is absolute and fixed	Knowledge is fallible and subject to modification and refutation at any time	Knowledge is co-constructed and developed through relationships. "we" created meaning.
Research Focus	Uncover single truths	Provide an explanatory account (causal but not successionist) of what works for whom under what conditions	Gain an insight into the lives of people, their thoughts and feelings, to understand their reality
Data Collection Methods	Quantitative statistical analysis. Systemic observation questionnaires	No specified methods. Realist interviews, analysis of grey literature. Insight comes from anywhere	Qualitative, unstructured, semi structured interviews. Participant observation Personal documents
Data Analysis	Deductive, theory testing	Retroduction, theory inspired by data/adaptive theory	Inductive, theory generating

In summary, the object of positivist research is to provide explanations about causes and make predictions about social phenomena. Positivism views individuals as a separate entity, independent of the social world that surrounds them (Patton, 2015). One problem for social sciences research has been that social phenomena can be very difficult to predict and real-world

problems are complex and are subject to change given any number of circumstances. As Tuffin (2005) pointed out, the problem with accepting explanations purely based on assumptions of individualism and reductionism is that these explanations fail to take account of the wider social and cultural forces at play, and, in fact, work to divert attention away from issues of politics, power and control in society.

Limitations of positivist research in the social sciences have been well documented in recent years (Charmaz, 2014), and provide evidence for not embracing traditionalist positivist principles in this thesis. For example, the intent of this paper is to demonstrate the complex interrelated concepts related to MD. That goal cannot be achieved through standardized questionnaires designed to verify a hypothesis put forward by the researcher.

The researcher accepts the existence of objective and knowable truths and has chosen more tempered approaches to the standard positivist principles. Barney Glasser's (1992) grounded theory methods and Bhaskar's (1986) critical realism methodology both entail constructs of positivist reality. Positivism is predicated on a knowable world that can be understood through objective observations, measurements, and carefully designed experiments (Glesne, 2016). Social work practitioners are interconnected with the clients, communities and social structures in which they service. For those reasons the research methodology must allow for a critical investigation into various contexts and their impact on individual practitioners. For example, there is a need to know more about socio-political factors and why certain coping strategies are used to deal with them, when they are used, and when/why they work or not (Collins et al., 2010), and also how they work. Because of this broad focus, social work research must be viewed with an interdisciplinary approach, focusing on the relationship between the individual and the environment, and between structure (living reality of the agent) and actor/agent, and

these practices must be understood as process-oriented and systemic. Critical realism builds upon the assumption that reality is external and independent, at the same time as being socially and historically constructed.

Social constructionism has advanced significantly in social science research as a result of its response to the limitations of positivist theory (Charmaz, 2014). However, it adopts a limiting worldview that does not account for external realities and objective truth. Social constructionism envisions a world in which reality is socially constructed, complex, and ever changing; a world in which humans inevitably influence the world around them and in turn are influenced by it (Payne, 2014). What is important to SC is how people interpret and make meaning of events, objects, actions, or perceptions. Those interpretations become constructed realities that exist only in the mind of the individual (Glesne, 2016). Social constructionism has become a widely accepted theory among social sciences and social work in particular. However, this researcher does not align with SC's premise that reality exists only in the mind of the individual. I believe that there are universally accepted truths, concepts and realities in which most humans conceptualize in similar fashion, comparatively speaking. Thus, reality exist in such a way that we can make generalized but accurate claims about it and social science research must reflect those truths while also acknowledging that we live in a multi-layered reality that is not linear but rather interacts on various interrelated levels of understanding. "Critical realism emphasizes interdisciplinarity and methodological pluralism in research, because of its focus on complex interplay between phenomena in social practices" (Kjorstad & Solem, 2017 p 8).

The epistemological construction of this thesis is predicated on my personal experience as a social worker and knowledge derived from readings, textbooks and class discussions within the Faculty of Social Work at the University of Manitoba. My educational experience of SW theory

is referenced for two reasons; 1. as a means of relating my own personal journey in choosing a theoretical paradigm for this study, and 2. to offer a current example of social constructionism as the prevailing theory championed by the Faculty of Social Work at the University of Manitoba. This is particularly important for this study as social constructionism may have been a factor influencing moral distress during this researcher's social work education. A textbook required for a graduate course on theoretical perspectives, '*Modern social work theory'*, (Payne, 2014) characterized SC as the most plausible SW theory. In his introduction, the author describes social work theory in general and practice as essentially a socially constructed activity. Payne (2014) hypothesizes that SW theory and knowledge is comprised of socially constructed interactions between clients and practitioners in their agencies and in wider political, social, and cultural arenas resulting in the construction of SW through practice and theory. In summary Payne (2014) posits that reality is constructed.

The ontological foundation of social constructionism (SC) is that the world cannot exist independently of human understanding (Glesne, 2016). It is a world in which reality is socially constructed and is complex and ever changing. Notably, reality is how people interpret, and make meaning of some object, action, or perception. Thus, the goal of researchers is to assess others' interpretations of social phenomenon as well as interpreting themselves, their intentions and interactions with others (Glesne, 2016). In this manner constructed realities exist only in the mind of individuals and develop into socially constructed realities that represent that social world from the perspectives of those actors in that world (Glesne, 2016). This concept, despite having flourished as a research theory in social sciences, is not without its critics.

Some scholars argue that social constructionism eventually leads to relativistic omission of real concepts. Hammersley (1992) proposes that social constructionism should be rejected

because it ultimately leads to a relativistic dead end. In other words, there is no possibility of knowing a real world exists separately from language. If reality does not exist outside of ones' mind and all things are socially constructed, two people would not be able to share understandings and constructs. In fact, one could not even qualify research as it would be unmeasurable. In the extreme people would not even have the ability for effective communication. Hammersley (1992) goes on to claim all theories that account only for constraining social structures (theories adhering to naïve realism) should be rejected for their failure to account for the role which individuals play in defining their experience. Thus, Hammersley (1992) states, the influence of human agency must be acknowledged whilst at the same time being aware of the real structure of action. This researcher wholeheartedly agrees. If social work is going to be successful in dealing with issues of poverty and the like, it must be able to acknowledge these as real and existing constructs with distinct qualities.
Houston (2012) concurs and posits that social work theory cannot advance models of empowerment and active citizenship when their descriptions of events and everything else, including the self, is reducible to text or the language game. Houston also proposed that the problems surrounding the inherent relativism of postmodernism have never been adequately dealt with by those SW theorists who champion the cause.

Overall, this researcher agrees with the foundation of theoretical principles of SC; for example, individual interpretation is the only way for individuals to make meaning of objects, actions and perceptions. However, it is illogical to assume that objective reality does not exist outside of human understanding. I am not alone in this claim; similar support for this ontology is evidenced in the writings of several authors (Bhaskar, 1986, 1989; Glasser, 1989; Fletcher, 2017; Hammersley, 1992; Oliver, 2011; Houston, 2014).

Informed by Critical realism

Critical realism (CR) responds to the criticisms of positivism while at the same time addressing the relativist challenges of social constructionism (Houston, 2014). CR theory offers a solid philosophical base to overcome the shortcomings of social constructionism, while at the same time fulfilling the emancipatory expectation of SW research (Archer, 2014).

Fletcher (2017) takes a quote from Bhaskar (1979) to highlight an important ontological and epistemological distinction of CR, "all explanations of reality are treated as fallible, including the explanations provided by research participants, theorists, and scientists. This ontological departure of CR from interpretivism becomes particularly useful for change-oriented research in which participants offer competing explanations of a phenomenon and some must be taken as more accurate than others" (Fletcher, 2017, p. 188).

Critical realism presumes the existence of an external world in which events and experiences are triggered by underlying (and often observable) mechanisms and structures. Its theoretical approach moves us beyond thick description and into explanation (Patton, 2015). CR researchers accept that causal mechanisms exist independent of their human conceptualization, and that they can speak for themselves, "realists have no problem treating human thoughts, feelings, attitudes, intentions, and mental states as real even though they are not directly observable, a position denied by positivism" (Patton, 2015, p.112).

Critical realism also accepts that all understanding and meaning of that reality is individually interpreted (Oliver, 2011). In that manner, CR bridges the divide between positivism and social constructionism by adopting the positivist search for evidence of an external reality; while at the same time accepting that all meaning originating from that reality is socially constructed (Oliver, 2011). This is a very helpful approach for social workers trying to balance competing demands.

For example, individual social workers often struggle to harmonize the cognitive dissonance that occurs when they are focused on honoring client self-determination and individual meaning-making, particularly when external reality suggests that the client's decision is not helpful, or even potentially harmful (Houston, 2012).

Therefore, critical realism offers the nuanced understanding that social workers often seek as their ultimate goal; which is not only to identify generalizable laws (positivism) or to recognize the lived experience or beliefs of social actors (interpretivism); but to develop deeper levels of explanation and understanding (McEvoy & Richards, 2006; in Oliver, 2011). As an example, critical realism would see poverty, disability and violence not merely as a function of individual beliefs, but also as an objective reality that exists independently of whether we or our clients choose to acknowledge it (Oliver, 2011). In that manner social workers can advance models of empowerment against real social constructs such as poverty.

Critical realism goes beyond previous approaches by adopting a more stratified ontology which entails a multi-level understanding (Fletcher, 2017); an empirical level (experienced and observed events understood through human interpretation), an actual level (events occur, whether observed or not), and a real level (causal mechanisms within objects or structures that cause events at the empirical level to occur). The first domain, the empirical domain, consists of our experiences and observations. The second domain is the actual domain which consists of all the phenomena and situations that appear, regardless of whether we are aware of them or not. Those two domains represent the traditional empirical level, which is far from sufficient for understanding social phenomena and is definitely not adequate for understanding why and how social problems appear (Kjørstad & Solem, 2017). This is why the third domain is particularly important. The third domain is the real domain that consists of all the structurers and

mechanisms that are not always observable. These structures and mechanisms, under certain circumstances, support and sometimes cause the situations and practical events within the factual domain (Kjørstad & Solem, 2017). The three domains cannot be reduced according to each other; this represents an understanding of causality that is very different from causality based on empirical regularities. A critical realist understanding is that reality consists of open systems, which means that your understanding is based on a multi-causal view of the world.

In that manner CR ontology posits that reality is not reducible to epistemology (Fletcher, 2017). In other words, CR adopts a realist approach to ontology and a relativist approach to epistemology; reality exists but cannot be perfectly detected. CR views reality to be a complex, multilayered, and multi-causal web of interacting forces in which all phenomena can be explained in part by, but not reduced to its underlying generative mechanisms (Oliver, 2011). Within a CR lens we can break down MD into more basic stratified layers to expose its inner composition. While concurrently understanding that MD is not reduced to any single contributing factor. In this manner, MD is constructed through the interaction of multiple mechanisms; generative mechanisms that are neither determinative nor all-explaining, and individual practitioners may interpret and experience them very differently. Critical realism examines how human agency (meanings, understandings, reasons, and intentions) interacts with the effects of social structures (social rules, norms, and laws), (Houston, 2012).

The CR approach is predicated on a thorough review of existing theoretical and empirical data, but avoids commitment to any preceding theoretical paradigm (Fletcher, 2017). Initial theories are viewed as just that, ‘initial’. Never-the-less previous data facilitate understanding and support new, more accurate explanations of reality (Fletcher, 2017).

Critical realism also embraces emancipatory goals that correspond with social work research values. For example, clarification on the distinction between individual/professional beliefs and structural causes found in organizational settings establishes evidence for programs of action aimed at eliminating those structural barriers to ethical action.

Because the social world is an open system, more than one mechanism will operate at any one time. Therefore, causal mechanisms must be analyzed as the "tendencies" of processes (Kjorstad & Solem, 2017). The ontological approach to this study uses CR methodology to provide a framework for challenging the empirical domain (surface appearances) through rigorous examination of the structures that generate them. Bhaskar (1986) explains the benefits of using an 'explanatory critique' as a means of revealing hidden factors. In this fashion, we expose the current disjuncture between notions that social workers experience moral distress because of internal pathology, structural causes, and organizational factors such as unmanageable caseloads and inadequate staff support (Maslach et al., 2001).

There are many unseen influences that result in individual practitioners experiencing cognitive dissonance. An explanatory critique used in CR necessitates the combination of a cognitive critique that confirms the falsity of a social or personal belief and explanation of why, despite its falsity, the belief is held (Oliver, 2011). This study has revealed examples of this, for example; Chambon et al. (1999) use Foucauldian methods to illustrate ways in which social workers inadvertently act as social police of sorts, by setting the standards of social behavior in families and in society. In this example the explanatory critique reveals that a cognitive critique establishes evidence to confirm the falsity of social worker's belief that they are endorsing individual autonomy in their interventions with clients when their overall actions are essentially

monitoring, determining and controlling their clients' behavior. As can be evidenced in one of the primary SW values of self-determination. One can see how this can lead to moral distress. Chambon et al., (1999) provide theoretical explanations for this phenomenon. Values surrounding client autonomy characterize the foremost beliefs embedded in the SW code of ethics and standards of practice. Furthermore, social workers would not be successful in applying coercive methods; not only are paternalistic methods ethically unacceptable, but individual social workers would not be motivated to work with clients under such pretenses, as social workers are driven by a sense of altruism and well-being that comes from helping others to help themselves. Certain value judgments that Bhaskar seeks to eliminate are allegedly consequences of explanatory critique being carried out in a theory about beliefs concerning a specific social structure. In this manner difficulties arising from social/structural problems will be falsely understood as individual pathology (Oliver, 2011) which is inadvertently perpetuated in SW values.

CR research goes beyond surface tinkering (mindfulness workshops and healthy living advice) to tackle the more complex interaction of needs and false beliefs (Oliver, 2011). Research from within a realist paradigm is grounded in critical analysis of all possible theoretical explanations for phenomena. Rigorous empirical testing of all potential theories is based on comparing theories to other data and data to data; pursuing the most plausible explanation (Charmaz, 2014). This form of inquiry, also known as abduction, is not restricted to immediate and observable factors, but includes wide ranging constructs, such as larger structural issues and other contextual features.

Grounded Theory

Selecting a method of data collection and analysis must provide conceptual support that carries from the actual data. Although critical realism demands stratified exploration, it does not suggest a particular method of research. However, grounded theory (GT) provides the most suitable research methods for this study because: its design is intended to be useful within a broad range of theoretical perspectives, it is well-suited for critical realist methodology, and GT compliments the emancipatory values of social work research (Oliver, 2011). GT has evolved under different epistemological paradigms, some more positivist than constructionist, and others purely constructionist. However, all approaches share core characteristics that focus on the development of new theory through an inductive process of concurrent data collection and analysis (Oliver, 2011). While the battle between positivist and constructivist methodologies offers conflicting theoretical analysis, the reality is that both have a role to play (Oliver, 2011). Within the theoretical confines of CR theory, this study incorporates grounded theory methods from both sides in order to construct theory.

The researcher has collected dated from previous research, actual interviews, and used utilized basic GT methods such as: memo writing, theoretical sampling, coding and categorizing data, constant comparison, and reflexive analysis (Birks & Mills, 2015, Glaser, 1992, Charmaz, 2014, Corbin & Strauss, 2008 and others). In contrast to quantitative research methods (theory developed purely by logical deduction from a priori assumptions), GT is a qualitative method that securely incorporates and applies inductive strategies of theory development, (Patton, 2014). GT emphasizes steps and procedures for connecting induction, deduction, and abduction through constant comparative methods, comparing findings and carrying out theoretical sampling (Morse, 2010).

Existing empirical research on MD and other related concepts and theories inform this study and provide a starting point from which to begin our conceptualization. CR theory moves our analysis beyond the empirical level and away from grounded theory's reliance on pure induction. (Houston, 2001). Careful analysis of related concepts, whether experienced or not, will be a major part of this study. A breakdown of factors will require the more flexible approach of abductive analysis; rigorously contemplating all possible theoretical explanations for the data, framing hypotheses for each possible explanation, checking them empirically by examining data and pursuing the most plausible explanation (Charmaz, 2014). Abduction analysis also accommodates the researchers' pre-existing theoretical knowledge, hunches and hypotheses as necessary points of departure (Charmaz, 2014).

Through retroduction (abduction with a specific question in mind) researchers seek further understanding, "A critical realist grounded theory would ask of the data 'what must be true for this to be the case?' or 'what makes this possible?' and seek an explanation in generative mechanisms at a deeper ontological level. This is no stretch from a methodology that already encourages researchers to ask 'what are the larger structural issues here and how do these events play into or effect what I am seeing?' (Oliver, 2011, p.10)

Critical realism theory seeks all possible vertical explanations for a phenomenon (Oliver, 2011). All phenomena become broken down into progressively more basic stratified layers and structure is then established. Structure is 'the inner composition making each object what it is and that it is not something else (Danermark et al., 2002). Through the identification and deconstruction of specific concepts such as governmentality, values, moral development, role conflict, and role identity theory we establish a starting point for this study that moves beyond

the epistemological assumptions that narrowly define MD as a personal response to restricted moral agency.

Previous empirical research on MD in nursing (Jameton, 1985, Corely, 1995, Corely et al, 2001, 2002, 2005, Epstein and Hamric, 2009, and others) have established clear-cut associations between moral distress as a phenomenon (combination of features) and individual perceptions of it (vary across individuals and situations). Given theoretical, philosophical and epistemological differences between SW and nursing, any attempt to conceptualize MD in SW based exclusively on findings from nursing will lack conclusive evidence and will not have explanatory power in hypothesizing causal factors.

Grounded theory methods have proven to be effective in capturing and interpreting specific social constructs and individual construals (how people perceive, comprehend, and interpret the world around them, particularly the behavior or action of others towards themselves). CR places and interprets those constructs and construals within a specific theoretical and particular real-world context that unifies *causality* (Patton, 2014).

Other theoretical contributions

A primary feature of CR is using multiple theoretical approaches to analyze a phenomenon. According to Bhaskar, (1978), all phenomena can be explained in part by, but not reduced to, their underlying generative mechanisms. Current research on MD label preexisting factors such as; institutional policies, time constraints, lack of education, cultural beliefs, moral development, social discourse, values, principles, and socio-political realities as generative mechanisms of MD. This study theorizes that reality is created when the combined effects of the countervailing (and sometimes complimentary) mechanisms come together (Houston, 2012). Thus, a thorough examination of the combined effects of various heterogeneous factors; each with its own distinct

mechanisms is an essential part of understanding MD but not as individual causal factors within themselves. This includes phenomena that influence the moral development of individual social workers and shape the culture and values of the profession as well as any political socio-political factors. Theoretical ideologies embodied in SW education, public discourse, societal expectations of the SW profession, individual role expectations all come together in shaping the moral identity of individual practitioners.

Bhaskar does not regard people as mere subjects at the mercy of social mechanisms; rather he proposes that people can actively transform their social world and are, in turn, transformed by it. Thus, individuals make their own history, but not naturally under conditions they have chosen for themselves, but rather on terms immediately existing, given and handed to them (Houston, 2012). Philosopher Michel Foucault provides a framework for understanding ways in which various social mechanisms actively transform people, as well as professions. The basis for Foucault's work must be conceptualized within a critical realist worldview. One that accepts social influences, but also one that recognizes individual autonomy within mechanisms. Foucault (1978, 1988, 1982, 1984, 1991) emphasizes the influential role of public discourse, and theorizes the relationship of power, among government, society and ones' ability to shape their own worldview. This study incorporates Foucault's concepts into real world implications for social work practitioners and conceptualizes his theories through a critical realist mindset.

Foucault - Discourse, knowledge & power

Michel Foucault put forward concepts such as 'governmentality', 'technologies of self', and 'power' to reveal the influential power and purpose of government/social mechanisms. This study explores how these concepts may be directly linked to societal expectations of SW, SW

education, SW values, role expectations, and even the moral identity of individual social workers.

Foucault's definition of 'discourse' moves beyond language to include ways of thinking, speaking and acting, which culminate into what we understand to be knowledge. In this fashion all manner of discourse come together in ways that essentially bring things into being and give them meaning (Foucault, 1982). Based on this knowledge we create ideals of who we are and how we and others ought to think and behave.

Foucault claimed that conceptualized forms of knowledge are intrinsically linked to power and establish norms for acting certain ways while marginalizing other ways. Over the years there have been numerous conflicting philosophical ideologies underpinning SW, some more likely to be accepted in society than others (Chambon et al., 1999), and it is these competing ideologies that govern SW values and expected behavior. Educators, team leaders, and others possessing such knowledge, perpetuate the culture and expected norms of the profession. Thus, power is dependent on these hegemonic 'knowledges', and afforded to those who poses it.

Foucault's description of power differs from traditional notions that perceive power to be a possession of the privileged used to dominate and control the underprivileged. Foucault theorizes a relationship between power and knowledge, "We should admit … that power produces knowledge … that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations", Foucault (1977, p.27)

Foucault's work was not intended to be an analysis of power, but rather of how individuals, as subjects, are being formed by cultural practices. He stated that his goal was to expose the mechanisms used in the objectification of the subject (Foucault, 1982).

Foucault's work has been the inspiration of many authors writing about the use of discourse to create so called 'truth'. Burr (2005) posits that power is demonstrated when people draw on various discourses to validate and support their actions. McHoul and Grace (1993) state, that the 'truth' as we know it is produced through power relations, and it is our shared understanding, or accepted knowledges that officially function as tools for normalization.

Various discourses engender thoughts and actions that perpetuate certain ideas and behaviors that are deemed 'right and proper' or 'normal'. In that manner, discourse dictates one's version of morally correct ways of responding. Subsequently, SW as any other profession, establishes and maintain power through knowledge, education and values put forward in its standards of practice and code of ethics. Social work practitioners also adopt the moral values espoused in wider society, also highly regulated by public discourse. MD frequently results from incongruence within these moral principles. Foucault's terminology provides us with a breakdown that also suggests a connection and purpose in public discourse.

Governmentality

Foucault (1991) expanded the notion of government beyond the common references to politics. He described it as a process in which governments shape and guide the conduct of citizens. However, their means of managing conduct are not only through overt rules and laws, but are primarily in mechanisms that influence people to govern themselves. Foucault defines how discourse and technologies are used to promote and normalize acceptable behavior so people self-govern accordingly. "Government" did not refer only to political structures or to the management of states: rather it designated the way in which the conduct of individuals or of groups might be directed: the government of children, of souls, of communities, of families, of the sick. It did not only cover the legitimately constituted form of political or economic

subjection, but also modes of action, more or less considered and calculated which were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others" (Foucault 1982, p. 221)

According to Foucault, discourse used to manage the conduct of society is broad and all encompassing, and the means range everywhere from formal education, informal discussions, media and advertising to the much more inconspicuous technologies used in the physical and social sciences. Such a wide range of mechanisms provides the tools necessary for methods of normalization and are the central component in governmentality (Rabinow & Rose, 1994). In this manner SW becomes a conduit for perpetuating behavioral norms both within the profession and with their clients and the greater public.

Technologies of self (Social Work & The 'Psy' disciplines)

Sociologist Nikolas Rose provides explicit examples of how SW and other therapeutic disciplines act as mechanisms of governmentality. Rose suggests that social workers have been included in a growing number of professional disciplines that exert power over individuals and play an instrumental role in 'social control'(Rose, 1998).

Rose (1998) clarifies methods in which psychiatry, psychology, and social work act as tools of normalization for societal behavior. He argues that psychology, psychiatry, and psychotherapy and other 'Psy' disciplines play a key role through shaping and normalizing personal self-image around certain expected behaviors (Rose, 1998). The 'psy' disciplines espouse proper behavior and also determine how and when individuals need help to correct so called maladaptive behavior. Rose (1998) describes helping disciplines as 'government surveillance tools' or 'technologies for controlling the masses'. He theorizes that social control is covertly achieved under the cloak of autonomy and self-governance, as it would not be successfully achieved

coercively. People would never become complicit in their own subjugation. Distortion of their own self-knowledge through the process of internalized psychiatric symptoms and labels provides the tools for self-governance. In that manner, the 'helping disciplines' legitimize and normalize accepted knowledge (truths about who we are and how we should behave) associated with those labels, and people strive toward those ideologies.

Behavioral surveillance and control go much further than psychiatric symptoms and labels, they fundamentally define the normal family, the healthy child, the perfect wife, and the proper man (Chambon, Irving, and Epstein, 1999). Helping professions create a regime of invisible power to transform and control people. For example, psychotherapy overtly becomes a technology of self-governance in its depiction of correct or acceptable behavior. People who fall outside those norms seek out professional help to adapt. Foucault describes this form of control as 'technologies of the self' which are can be perpetuated through various discourses and institutions. Foucault (1988) described 'therapy' as a technology of control, stating that therapy, "Permits individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988, p. 18).

In this fashion individuals form ideas of health, happiness, wisdom, etc., and strive toward those ideals, often seeking professional helps if and when they find themselves outside of the boundaries of 'normal'. Therapy, then, becomes a process of instilling dominant discourse that uphold and/or discourage certain conduct while endorsing and encouraging other conduct. In that manner, psychology has invented the 'normal individual' and reshaped the practices of those who exercise authority over others – social work managers, teachers, and nurses are all examples

of those who nurture and direct others in the most appropriate and productive fashion (Rose, 1998).

However, it is not the intentions of those in the helping professions to control others; quite the opposite is true. These mechanisms function under the principle of individual freedom and autonomy and could not be accomplished coercively. Nikolas Rose claims that control is best achieved under the forms of freedom bound to a regime of subjectification. In such a worldview subjects are not merely 'free to choose', but 'obliged to be free' to understand and enact their lives in terms of choice; the problem is that they can only do so under conditions that systematically limit their capacity to shape their own destiny (Rose 1998).

Therefore, helping professions (social work) maintain the dominant discourse and wield the power to facilitate technologies of the self, and thereby shape individual value systems. Herein lies the connection to moral distress which emanates from the cognitive dissonance created between the emancipatory function of social work and the social control role implicitly inherent in social work duties.

Social work values include respect for client's individual self-determination; yet practitioners often find themselves at philosophical odds with neo-liberal policies in their workplaces that are designed for controlling people (Chambon, 1999). The ideologies are built into organizational structures and sometimes demand social workers go against their better judgement or even client requests. These policies involve organizational sanctions and even legal implications in the event that they are breached.

A more expansive look into larger societal trends demonstrates how larger communities have collectively become more susceptible to MD. Prominent medical sociologist Frank Furedi (2004) claims that modern society has become increasingly drawn to 'emotionalism', and has

become hypersensitive to even the slightest emotional dysregulation. Through this emotional hypersensitivity individuals are distinctly fragile and feeble, looking to counsellors for resolving their perceived individual inefficiencies. He describes a 'therapeutic culture' that has replaced the religious custodians of the old moral order (Christianity). Beliefs stemming from this cultural mindset creates a society that is not to blame for ethical problems; rather, individuals construct their own personal inadequacies based on 'normal' functioning created through a variety of discourses fed to them through media and other sources. The result is that life management requires continuous intervention of therapeutic expertise (Furedi, 2004). Subsequently, society is dependent on the 'PSY' disciplines to establish correct behavior and also correct individual modifications to fit with expected norms.

Furedi's description of 'emotionalism' depicts a vulnerable and fragile self-image that increases the potential of MD. People have become vulnerable and helpless to manage common ethical and moral challenges yet see them as personal inefficiencies. Everyday moral challenges become internalized as people feel inadequate to manage them. Subsequently individuals are disempowered from working through ethical challenges by other more traditional means. This societal change may have an impact on the incidence of MD, as SW's are more likely to internalize their ethical challenges.

Furedi (2004) recognizes specific discourses as responsible for promoting the culture of therapy and he provides context for this cultural shift in societal coping. He refutes the widely accepted notions that the therapeutic experience represents an enlightened shift toward the human condition. Rather, Furedi claims therapeutic culture is primarily about imposing a new conformity through managing peoples' emotions (Furedi,2004).

The Researcher

In keeping with grounded theory methodology, it is important to retain a conscious awareness of the researcher's experience, thoughts and involvement in the social and interpersonal process of research, as well as his or her impact on the process and results. Birks & Mills (2015) accentuate the importance of positioning the researcher within their own historical socio-cultural background as a means to develop an understanding of its impact on the research process. Despite my agreement and support for this approach, I am reluctant to share my personal story, to some extent because of its private nature, but more importantly because of the assumptions it will project onto the readers. In spite of this, I admit that my involvement represents a vital component of the research methodology and therefore will share my experiences and self-reflection. I also feel that a self-reflective approach symbolizes a spirit of kinship and reciprocity with the participants who share their own experiences.

I begin by declaring and celebrating my relationship with the topic, the profession, and the data. The research topic of moral distress in social work has been intuitively inspired through my own personal journey in social work, both as a student and practitioner. My journey in social work has come with its own moral challenges, many of which emerged from value conflicts. I enrolled onto the Faculty of Social Work as a mature student. I was/am a married, middle aged, heterosexual, Caucasian male and father of four children. I was an outlier among other students who were mostly female, Indigenous or other ethnic background younger, and younger.

Our family was raised in a small conservative-minded rural Manitoba town of predominantly English-speaking Protestants of German and Norwegian descent. Our family heritage is French Canadian and rooted in the Catholic faith. Both my parents worked outside the home and struggled to meet the financial demands of our large family. I am the first and only member of our nuclear family to acquire a university degree.

I have always empathized with and supported underprivileged people, whether in school or out in the community. I felt a certain connection to them and understood their feelings of being an “outsider” and not financially well to do. It is for those reasons that it came as a surprise to me when the social work educators and students looked at me as a privileged person. I was extremely proud of putting myself through University. Yet, according to SW academia I belonged to an especially privileged group because of my sexual orientation, skin color, gender, and age. This places me at the top of their depiction of social location. It was particularly difficult to buy into the notion that I am a colonial oppressor, a gender privileged person with power over most other people. I was often bullied as a child for my own cultural/religious background. I knew my family and ancestors and they all struggled to survive. Having to internalize the theory was a moral challenge, but it was a requirement of social work education. I often felt guilty, almost like I had to repent for being who I was. Classroom discussions, emotional check-ins and reflexive activities were all intended to encourage students to reflect on their social location and there was an internal form of self-hatred expected from me. It was like I would demonstrate understanding if I expressed distain for my social location because of what the colonizers had done in the past. As a result, my input into class discussions was limited as the cognitive dissonance was great. If I expressed my true feelings they would be misinterpreted as racist and that my white privilege doesn’t allow for me to understand, but perhaps one day I might evolve to a higher level of understanding through self-reflection, awareness and the practice of decolonization.

SW discourse is primarily informed by left leaning ideology that is commonly conceptualized through the lens of power and privilege. As a symbol of societal power, I often felt

misunderstood by classmates and somewhat self-protective over my opinions but was aware that my academic success was contingent on adopting these theories.

My conservative Christian ideals also became a factor. Those values primarily inspired to social work as I wanted to help others in need. An internal moral struggle ensued in attempt to reconcile these conflicting viewpoints. After much soul-searching I arrived at moral acceptance of my path in life and was inspired to work as a SW practitioner. I am truly thankful for that challenging experience from which I have grown in self-awareness and moral development. As a result I now have a more mature understanding of previously held beliefs and values. Some previously held values have changed entirely while others have transformed into a new understanding of the old values. There also remains deeply rooted values that are integral to my self-identity.

The transition from student to healthcare provider presented new ethical challenges. My personally adopted social work values were abruptly met with real-world barriers that prevented me from doing what I believed to be my ethical duty as a social worker. For example, I was working on a psychiatric unit of a hospital and upholding a client's right to self-determination when they are deemed incompetent was an issue. The model was a paternalistic one and many patients were admitted and treated against their will. Other ethical difficulties included placing so called 'incompetent seniors' into personal care homes against their will. These real world practices directly conflicted with the values I had learned and come to adopt as my own.
I was motivated to work within the system and advocate for clients whenever the opportunity arose and with the help of a supportive supervisor was able to challenge and bend some rules to overcome ethical barriers. I truly believe those experiences have enhanced my skills and ability to become a more effective social worker and subconsciously inspired this research topic.

Following thirteen years as a social work practitioner, I pursued a new path in teaching health ethics to various healthcare providers, including social workers, nurses, doctors, healthcare aids, occupational therapists and others. Whilst facilitating workshops I discovered other healthcare professionals shared similar moral challenges and I was inspired to study MD and increase public awareness about its contributing factors. My hope is to build resilience to MD.

I am currently working for the Manitoba College of Social Work and have been there for three years. I am currently working on an ethical decision-making framework to help social workers navigate challenging ethical decisions and facilitate ethical discussions with stakeholders.

In preparation for this research I have reflected on my personal experience of moral distress and have summarized those thoughts in this section of the thesis. The process has helped me understand why this research topic is important to me, and ways in which my understanding might bias data analysis. In hindsight I appreciate how my personal journey has inspired this study, which is, in part, articulated in the research questions. I am thankful for dialogue with other health care providers which has provided insight into their own moral challenges which has enhanced my appreciation for the complex nature of everyday moral challenges.

Graduate level studies have incited new questions about and I look forward to learning about the relationship between moral distress and the hidden mechanisms that lead to it. I believe that there are real concepts that impact people; such as poverty, mental illness and countless others that exist outside of our conscious awareness. I also believe that they are experienced and conceptualized differently among people. It is for those reasons that I used critical realist theory as it provides a first-rate methodological fit with my worldview.

Participants

The primary goal for data collection was to gather authentic information from experienced social workers related to their ethical challenges in social work. The researcher's intention was to seek out the most likely participants that will provide examples of potential causal mechanisms of MD, "Sampling choices are purposefully selected to seek out examples of mechanisms in action, or in action to be able to say something about the causal powers. Sampling is both pre-specified and emergent. It is driven forward through an engagement with what is already known about a given concept" (Patton 2014, p. 269).

Experienced social workers were selected from various SW programs in which MD is most likely to occur. Hypothetically, recruiting practitioners from every sector of SW would establish a wealth of cross discipline data; however, that was not within the scope of this study as it would be an onerous task to obtain information from all the various organizations and intuitions. The primary objective was to gather first hand experiences that can provide rich data from the sectors of social work with a high propensity of MD. It is acknowledged that all areas of SW practice can be morally challenging; however, careful consideration was placed on soliciting participants with a potentially higher risk of experiencing ethical challenges.

Designated specific agencies were chosen based on the researcher's experience and understanding of SW roles within those organizations. The chosen areas of practice were also deemed to be higher risk agencies based upon knowledge gathered from group discussions and self-reported occurrences disclosed in MD workshops facilitated by the researcher. That is not to say that practitioners in other sectors do not experience moral challenges, or even that they may not have a higher than average propensity for moral challenges; only that the chosen agencies are likely to present moral challenges for SW practitioners.

The decision to choose a variety of sectors over one specific area of social work was considered. Following a discussion with the advisor it was agreed that multiple sectors would provide more representative data. The data analysis is not intended to provide cross-sectional analysis between sectors, but rather to explore more general themes experienced by social workers and if a definitive difference between sectors emerges that further research would be proposed. The findings across sectors are presented in table 4. The chosen sectors included, child and family services, mental health services and older adult services. Prior to the selection of participants it was decided that two social workers from each sector would be chosen. However, responses for potential volunteers revealed that one was from Indigenous health and was also one of the early volunteers. This provided an opportunity to include another sector with potentially additional-factors. Upon reviewing the social work experience it was revealed that a participant currently working in health also had several years-experience in child and family services as a front-line worker. As a result, the participant's in this study represented 6 sectors of social work, mental health, child protection, medical/hospital, geriatrics, and Indigenous health. The participant with experience in two sectors was asked to identify any areas in which she felt should be noted as they pertain to MD. The questions were focused on social work practice in general, as it is not within the scope of this study to compare ethical challenges across sectors. The experiences and stories provided by the participants make up the empirical basis to form categories, compare factors, and build theoretical concepts of MD.

Recruitment Process

The selection of participants included those who had previously expressed interest in the study through workshops and conversations as well as volunteers responding to an advertisement listed on an e-bulletin from the Manitoba College of Social Workers, (Appendix "G"). The

researcher was familiar with numerous interested social workers while facilitating workshops; many of whom learned of this study and expressed their desire to participate. Six participants were accepted on a first come first serve basis with an additional participant chosen in case of any withdrawals. All seven participants were interviewed. Following consultation with the advisor it was determined that a second interview would be necessary to clarify information and expand on conceptual data provided, and a second interview was held. In total, eight interviews were held with seven different participants.

A written invitation was sent to all registered social workers on the Manitoba College of Social Workers data base. The invitation informed volunteers of the basic idea of the research, the purpose of the study and what was included in their participation.

After volunteers responded to the invitation, it became apparent that there were a limited number of volunteers from child welfare (CW) agencies. The researcher became curious and asked participants from that sector for potential explanations on the lack of interest from CW. The responses were enlightening and worthy of further research. One participant suggested, "*personal acknowledgement to moral distress is a sign of weakness that indicates the worker may not be able to handle the work. It is a coping measure of sorts, you know, through avoidance and denial."*

This concept is not new and has been well explained in "The Professional Accommodation Syndrome" (Morrison, 2017). Morrison's model describes how the failure of organizations to combat the alienating environment of social work will result in defense mechanisms of denial and minimization. He posits that staff who are feeling helpless, or are affected by dealing with child abuse, feel ashamed because adults and agencies despise helplessness. The participant also described these as common feelings within the culture of child welfare; in fact, she explained

"I can feel it as soon as I walk into a child welfare agency, it's like a visceral response." Another participant stated that child welfare workers are kept too busy to think of anything but work and their clients' problems.

After the volunteers came forward, a consent form was sent to them. The consent form provided a basic written explanation of the study, its purpose, and what their involvement will entail, including a caution informing them that if the disclosed information reveals abuse or potential harm to others that information must be reported to the appropriate bodies. Consent was understood to be an ongoing process and participants were welcome to drop out at any time. The consent form was presented on Faculty letterhead. A copy can be seen in Appendix "C". Participants were not involved in this study without first signing the voluntary consent form. Upon agreeing to participate each participant was provided with an instruction letter inviting her or him to review the MCSW code of ethics and standards of practice and reflect on their relationship to each interview question.

Data collection

In preparation, all potential participants were provided instructions, a copy of the interview guide, and a link to the MCSW Code of Ethics and Standards of Practice to be reviewed prior to the interviews, see Appendix "F" for an illustration of instructions**.** Participants were asked to review the material as it relates to their own experiences. This self-reflective activity invited them to consider the ethical nature of the questions prior to the interview and apprise them of what is expected of them in the interview. The interview questions were inspired by previous research on MD and the researcher's knowledge of MD in the SW profession. The interview questions were refined and approved by the research committee in the proposal defense of this thesis. In general, participants were asked to describe experiences in which they felt an intrusion

on their own moral identity. They were encouraged to elaborate on the personal values that influenced their career choice, their interpretation of events and consequences, suggestions for educators and future social workers.

Some interview questions assumed a symbolic interactionist approach to elicit meaning, while others were specifically designed to elicit description. The interview guide approach was used for the interview format (Patton, 2015). The primary reason for selecting this method was to enhance the interviewer's ability to create an open environment allowing the flexibility for participants to introduce topics, issues and impressions; while at the same time providing enough structure for the researcher to direct the discussion. The format also helps the researcher remain objective in his approach. The outline was based on predetermined topic areas and questions that have been itemized in advance. The interviewer along with the Thesis Committee and Advisor agreed on the sequence and wording of questions. Questions were asked in an open-ended format. Strengths of this type of interview are that the outline increases the comprehensiveness of the data and makes data collection somewhat systematic for each participant. Logical gaps in data can be anticipated and closed. Interviews remain fairly conversational and situational (Patton, 2015).

Weakness of this type of interview, include the possibility that important and salient topics may be inadvertently omitted. Interviewer flexibility in sequencing and wording questions can result in substantially different responses from different perspectives; thus, reducing the comparability of responses (Patton, 2015).

Interviews were scheduled to be 60 to 90 minutes in length. The shortest was 56 minutes and the longest interview was 180 minutes in duration. The mean time for interviews was $\mu = 79.38$ minutes with a variance of 1604 and standard deviation $\sigma = 40.05$. All participants were

emotionally engaged. Emotions ranged from crying when describing their personal experiences to frustration and resentment when describing constraints. All emotional expressions occurred within appropriate context being discussed and were well within the regulation of the participant. Most participants felt the need to explain their rational and one participant went into great detail both describing the context as well as rationalizing her duties and responses in relation to the incident(S) the resulted in moral distress. All participants were provided with a list of resources for support however, they all expressed their resolve to cope with these matters on their own. In addition, the participants had established their own support network that have been helpful.

The interviews took place in a private agreed upon space. Two interviews took place in a neutral meeting room, two interviews were held in the participant's home and three were held in the participant's office. It was difficult to stay on track during the 180-minute interview. The participant provided a lot of extra details but the information was insightful and pertinent to this study. The first interview was a higher-level conversation using academic terminology to describe her circumstances and I was required to clarify details and context. There were interesting developments as I had expected all participants to be demoralized from their experience and was surprised when one used the ethical challenges as motivation. She demonstrated a certain personality that can best be described as grit. She had courage and moral conviction in her actions. I seem to have gained rapport with participants in healthcare, as I have worked in healthcare for numerous years and could identify with their situation. All participants presented with confidence and a sense of certainty in their opinions.

Interview guideline was a helpful tool to structure the process and provide the participants with an idea of the content prior to the interview. Questions four and five seemed a bit redundant. Most participants provided a wholesome description to question 4, "Have you

experienced organizational guidelines that prevent you from practicing according to SW values? And the response to question 5, “Describe a common occurrence that occurs quite often, that is quite unethical to you?” often resulted in the participants referencing the previous experience. Although P-1 and P-7 provided a different example to question five. Additionally, the wording to question six “How would you describe the implicit rules that are expected to be followed at your workplace”, frequently required clarification from the researcher. The interviews were structured but participant engagement and researcher prompting led to moments of conversation that also help establish rapport. See Appendix “A” for a detailed list of interview topics and issues discussed.

The interviews were audio-recorded on a handheld device and transcribed verbatim. After removing all identifying details, the transcripts were sent to the participant for review. They were provided with the opportunity to verify the data and provide additional comments. No additional information provided by the participants, two commented on how differently their spoken words are from a written version of events.

The participants were asked questions regarding their values, reason for choosing a career in SW, a description of a morally challenging experience, and suggestions for educators and future social workers. The data was established through rigorous testing and refining of factors that have reportedly been associated with MD. Together with the existing literature on MD they will demonstrate how the interaction and culmination of events, concepts, theories and institutional structures come together to synthesize what is known as MD within a SW context.

The researcher is confident that the central elements expressed by the participants have been captured in the data. Even though there are other elements, the researcher is confident that they will not alter the data claimed. In other words, saturation is the point in a critical realist study is

that point in which the theory arising from inquiry has, for the time being, greater explanatory power than its rivals (Oliver, 2011). The five prominent themes are listed in tables 3 and 4.

Data Analysis

In keeping with grounded theory methodology (Birks & Mills, 2015; Charmaz, 2014; Glasser, 1992; Glaser & Strauss, 1999; Patton, 2015; Strauss & Corbin, 1997), the researcher begins by acknowledging his own philosophical position. The methodologies adopted for this study follow a critical realist approach to the grounded theory methods initially introduced by Glaser and Strauss (Birks & Mills, 2015), and are congruent with the researchers' ontological and epistemological beliefs. As stated by Glaser and Strauss, 'the researcher does not approach reality as a *tablu rasa*, (Birks & Mills, 2015). Moral distress is not a new term to the researcher, so careful consideration and ongoing consultation with the advisor helped to prevent presumptuous theoretical assumptions by the researcher. The researcher has assumed a reflexive perspective toward selecting and analyzing relevant data to protect against unconscious bias while categorizing and interpreting meaning/themes.

Data analysis followed and informed ongoing theoretical propositions. Initially, the data was collected during interviews with a mean of 79.38 minutes in length. The audio taped interviews were then transcribed verbatim onto written transcripts. Analysis of the data began with recording the data from the transcript on a line-by-line basis. The next step was open coding. In this phase the researcher tried to keep an open mind while analyzing specific word phrases regarding the potential underlying causes of moral distress (Charmaz, 2014). During this phase coding was conceptualized into categories. For example, a quote such as "it's the social justice aspect of social work that has been the driving force for me throughout my life. I want things to be fair and equitable and I've always wanted things to be fair and equitable, even as a kid, I was

the kid saying it's not fair." This segment of the data was conceptualized as "social justice". Additionally, the relevant conceptual groups were then classified into a subcategory named "values'. The comparative analysis proceeded until all of the data with relevant properties were summed up and those with different properties were selected as the precursor to theorizing.

Comparisons were also made among participants as common themes became apparent. Careful consideration was given to the meaning each experience had for the participant.
Constant comparative analysis helped form categories and properties that linked to the data and formulate new categories. For example, the fourth participant told a unique story that demonstrated courage and resolve in the face of ethical challenges. Thus, the theme Grit was added to the list of concepts to be analyzed.

Axial coding as defined by Strauss and Corbin (1997) was used as a means of putting the data back together in new ways, by making connections between and within categories, while elevating the level of conceptual analysis. The core categories were decided at the axial coding stage with moral distress as the axial. Taking the above example, 'social justice' is grouped into the central category of 'moral values'. The central categories were then subjected to chronological comparison and summed up into themes that highlight causal relations. On the basis of these themes questions including 'how does this influence moral distress,' 'what are the results of these interactions,' 'what larger, less obvious factors are at play,' 'what are the results of these interactions,' were answered.

The contributing themes were then analyzed within a critical realist theory and categorized into three levels of reality, 'empirical,' 'actual,' and 'real,'. Critical realism examines how human agency (meanings, understandings, reasons, and intentions) interacts with the effects of social structures (social rules, norms, and laws) (Houston, 2012). Examples of human agency

were listed in the empirical domain. To formulate an outline of the causal interactions or processes we explored the organizational, governmental and social structures that explain how the original experience and listed them in the 'actual' and 'real' domains with the larger and hidden mechanisms in the 'real'. There are *emergent properties* at each level of reality, where new properties and causal powers develop (by emergence) at each level, compared with the level below. Questions used to generate emerging constructs included, 'what must exist for this to happen,' 'what are the hidden drivers,' 'who is behind these hidden drivers,' 'how and why are these mechanisms implemented'. The causal powers from the lower levels also exist in the higher levels. The division into different levels is a social construction and belongs to the transitive dimension of the reality. However, the phenomenon emerges that new causal powers develop depending on whether the levels below belong to the intransitive dimension of the reality.

The conclusions were also analyzed and compared with other concepts in the literature. Moral distress was structured and contextualized in this manner. The complexity of this phenomenon is thus represented as theoretical structures categorized in the critical realist domains to illuminate where, when and how moral conflicts occur.

The primary objective of the selective coding stage was to integrate, rectify, and refine the theory as well as to eliminate the concepts with low explanatory power. For example, after reflection by the researcher, the concept of 'dealing with difficult clients' was later eliminated because of its low significance to the theory of moral distress.

Memos were created throughout the process, which included an ongoing analysis of the researcher's interpretations and commentary. These methods provided a combination of inductive and abductive reasoning used in formulating the comparative analysis.

During the data analysis both inductive and deductive reasoning was used (Charmaz, 2014) whereas abductive analysis was used when examining and scrutinizing the data, exploring all possible explanations for the data, and then establishing hypotheses to be confirmed or denied, until the researcher arrives at the most plausible interpretation (Charmaz, 2014).

Consideration was made along the way to recognize emergent conceptualizations. When selecting data for establishing memos and new categories, the researcher worked to avoid imposing theories from previously established categories onto new data (Glasser & Strauss, 1999). Similarities and convergences with previous research were established only after the analytical core of categories emerged. The final result was a logical, systematic, and explanatory model for moral distress that corresponded with the experiences of front-line social workers.

CHAPTER 4

Findings

This chapter provides a description of the participants, report of the results, including the common themes in table 3, explanatory excerpts from the interviews that highlight the participants experiences and their relationship to moral distress conceptualized in critical realist theory in table 4, and a description of grounded theory methods used and data analysis including the theoretical conception of moral distress as established in this study.

Overall, the participants had extensive social work practice experience. Participant one was a regional manager for a CFS agency with over 20 years of experience in child welfare. Her responsibilities as a regional manager were to the local agencies and she reported to the Deputy Minister of Families. She has a master's degree in social work. Participant two worked as a hospital social worker for the past seven years and has a bachelor's degree in social work. Duties in that role included psychosocial assessments, family meetings, resource procurement, ongoing

case management, and interdisciplinary team meetings. The function of that role was described as “discharge facilitation”. Participant three worked for the past six years in health care, specifically with the Indigenous People of Manitoba. Her duties included advocacy in all areas of health involving Indigenous Peoples. Her duties included but are not limited to education of healthcare teams and resource procurement that is suitable for meeting the needs of her clients. She has a master’s degree in social work. Participant four worked as a manager in a personal care home for 5 years and has an extensive background in forensics and front-line work in child and family services. She had a master’s degree in social work. Participant five worked on a forensic ward of a mental health centre and previously as a community mental health worker, she had a bachelor’s degree in social work and a master’s degree in marriage and family counselling. Participant six worked several years in the mental health field and worked for community agency. She had a master’s degree in social work. Participant seven worked for a specialized mental health team with a master’s degree in social work.

Applying the critical realist lens – The prominent themes that emerged from axial coding were further analyzed within three levels of reality. Critical realism posits that reality is stratified into three domains: empirical, actual and real. For example, the actual domain consists of events and their effects that have been caused by the activation of mechanisms from real and empirical levels. In that manner the events in the “empirical” level are considered as factors or entities of moral distress contingent of the activation/influence of various other levels. For example,

Empirical—Actual events or events that can be or have been observed or experienced i.e., social justice may be observable at the empirical level through asking people about their beliefs and attitudes towards social justice or actual experiences related to social justice.

Actual— Mechanisms whether visible or not. This level of events is determined by

mechanisms or events that can be explained with reference to the real level.

Real— The real domain is the domain of mechanisms that consist of entities or structures with properties that give them the power to activate and affect other structures.

Findings

Six of the seven participants reported that moral distress gave rise to significant personal consequences that impacted their mental health and professional career. Two were advised by their physician to take a medical leave from practice, three have changed areas of practice as a direct result of the incident/s, while one participant continues to work and is experiencing ongoing frustration and stress. The seventh participant persists in her role and uses ethical challenges as a source of motivation for improving life circumstances for Indigenous peoples interacting with health services across the province.

The participants identified similar ethical challenges that have been categorized into five broad themes. Findings will be delineated within the following themes:1) Powerlessness, 2) Advocacy for Social Justice and its influence on social workers, 3) Moral impact of undemocratic work environments, 4) Self-determination and barriers preventing participants' efforts to empower clients 5) Moral consequences for social workers working within the medical model.

The five major themes reported by participants have been acknowledged as leading factors associated with moral distress. Although not in a direct cause effect manner but in an interconnected way. The themes are analyzed within three stratified levels of reality and displayed in table 4. The two primary categories represented within these themes can be described as values (social justice, self-determination) that when are not shared or validated by the work environment resulted in moral distress. The instances prohibiting social workers from

working toward these values fall into the critical realist (empirical level) domain as they are visible experiences, barriers of the first order preventing the actualization of moral agency. Other themes (powerlessness, medical model, undemocratic workplaces) fall into the actual level. These mechanisms can be visible or not. The constructs in this domain are determined by mechanisms or events that can be explained with reference to the real level. Table four lists the factors and examples within all levels of reality as understood in critical realism. The participants reported feelings of frustration, anger, resentment, and self-defeat in response to the incidents and the negative effect of these feelings were severe enough that most either had to leave the workplace or change positions. The following table lists the five most frequently reported themes along with the corresponding normative meaning to practitioners and how they constituted barriers to fulfillment of moral agency. The conceptualization of moral distress in relation to these themes can also be seen in table 3. Participants have described the prominent themes that have led them to experience moral distress. Table 3 lists the common theme in one column and in another column, the normative meaning associated with those themes. In this manner table 3 demonstrates the moral and ethical importance of each reported theme to the participants. The third column lists the barriers to moral agency. See table 4 for a conceptualization of these concepts and how they are interrelated and become factors in developing moral distress.

Table 3

Five Most Common themes

Common Theme	Normative Meaning	Barriers to Fulfillment
Powerlessness- relationship to moral distress-whether real or perceived, practitioner did not feel they could act on their ethical convictions	Authority to enact decision-making and moral agency in the workplace. Results in empowerment and feelings of acceptance.	Focus on financial commitments and scientific measures, SW are the least respected in multidisciplinary teams and health institutions and least able to enact political change

Common Theme	Normative Meaning	Barriers to Fulfillment
Social Justice-relationship to moral distress-a primary value of social work that when unsupported or unrealized leads to moral distress	Commitment to fairness, equitable distribution of resources and reduction of barriers and expansion of choices for disadvantaged populations. Equity in affairs of distributive justice, human rights, social welfare, and personal identity.	The pursuit of social justice is political in nature and often conflicts with institutional goals, purposes, and structures. Health teams focused on individual healing are not interested in challenging government policies or even workplace culture. Researchers such as Weinberg (2009) and Clark (2006) argue that modern social work has aligned itself more with clinical and scientific approaches than with advocacy for social justice
Democratic Workplaces-relationship to moral distress- when structured in bureaucracy and managerialism social workers are forced to act on values that conflict with their personal and professional values	Safe environments to share in decision-making and environments which are collaborative & respectful. Supportive supervision by a supervisor who knows and lives by the SW code of ethics	Barrier to democratic workplaces include; bureaucracy, capitalism, culture of ladder climbing, bullying, managerialism, gaslighting, competitiveness, neo- liberal policies, unequal opportunities for advancement, legislation, institutional policy, low SW occupational status
Client Self-determination-relationship to moral distress- a primary value of social work. when social workers are not able to honor client-self-determination, they go against several values leading to moral distress	A shared SW identity that is based on social workers' ability to empower clients to make their own informed decisions	Involuntary clients and forced treatment go directly against this value and often make it unachievable. Client autonomy is a fallacy used as means of self-control and often contradicts with the policies and procedures in the medical model, the criminal justice system and the law (Chambon et al., 1999)
Medical Model-relationship to moral distress, medical model is structured on values that prevent social workers from acting on other values such as social justice, client self-determination and others, leading to moral distress	SW's view client care from a relational perspective that includes the environmental and social factors impacting the client. They envision themselves as an equal partner in multidisciplinary teams working together to make good health care? Decisions	The medical model is focused on medicine and illness, uses labels and prescribes pills to manage social problems. Health care institutions are often mired in a Corporatist structure of bureaucracy, lack of resources, and time constraints. SW's have the least power in team decision-making. Territorialism often accompanies difficult decisions
Grit-relationship to moral distress, when social workers have grit they possess an increased capacity to respond morally, despite barriers.	The concept of grit is generally described as perseverance and passion toward long-term goals and describes sustained commitment toward completing a specific endeavor despite episodes of failure setbacks and adversity.	Contrary to reacting with grit, some practitioners view ethical problems with a negative/fixed mindset that includes thoughts of failure and setbacks and opt to avoid action and therefore are more likely to experience moral distress.

Other important factors were internal factors that were not overtly reported. The literature on moral distress (Corley, 2001, Hamric et al, 2012) recognized intrinsic factors implicated in preventing practitioners from pursuing moral agency. These factors may or may not be

intrinsically associated with any particular individual, but present themselves in certain circumstances. However, internal factors were evident in this study. These factors are described as “internal constraints”. They include lack of education, knowledge and skills, or background history that negatively biased the social worker’s view of the situation. An example of internal constraints reported by participants in this study included instances in which participants maintained personal meta-narratives that negatively biased their view of the situation. For example, some participants believed that as a social worker, they must always alleviate suffering, never make mistakes, have all the answers, not show weakness or be fearful, and fall into line when expected to. Although this was not a reoccurring theme, it was prevalent enough to record and the impacts significant enough to list as a factor. The instances were categorized as “helperholism” because of their association with research (Morrison, 1990) that resulted in coining the term. Helperholism was used to describe a professional’s addictive drive to help others which leads to emotional and psychological harm arising from repetitive sets of negative behaviors derived from unsatisfied or unresolved personal pain and unsupportive irrational beliefs such as the ones mentioned above. Morrison (1990) described that peoples’ choice to work in a helping profession is often rooted in aspirations to in some way assist those less fortunate and improve their quality of life. At the heart of the nature of helping is the strong feeling of helplessness within the helper which diminishes temporarily when he or she helps someone else. However, when not able to fulfill her self-image of professional helper, the social worker becomes distressed.

Another theme that emerged from the data but not frequently enough to designate it as a theme included instances of teams, colleagues, mangers or supervisors who were pontificating their theoretical/political viewpoint onto the participants. These viewpoints were often

conflicting with either the social worker or social work values (often within multidisciplinary teams) and resulted in the social worker feeling powerless to challenge the ethical issue. It was part of the workplace culture as a mechanism to demonstrate or establish power and authority. The consequence of conforming to these ideas and behaviours meant that social workers became bullied or sanctioned by the group to follow along. These instances were labelled as "territorialism" and were often present in the themes labelled powerlessness and medical model. These instances often conflicted with personal or SW values and created moral distress. Critical realism methodology provided a framework for challenging surface appearances through rigorous examination of the structures that generate them. This was helpful for the researcher to establish a more comprehensive understanding of the interacting mechanisms that lead to moral distress in social work. Bhaskar (1986) explains the benefits of using an 'explanatory critique' as a means of revealing hidden factors. In this fashion, we illuminate the disjuncture between notions that suggest social workers experience moral distress because of internal pathology and the structural causes and organizational factors such as unmanageable caseloads and inadequate staff support (Maslach et al., 2001). Within the critical realist viewpoint these would fall within the empirical domain.

Many contributing factors to moral distress described by the participants are understood on an experiential or empirical level. However, the conceptualization of causal mechanisms of that event are only partially apparent. For a more comprehensive understanding one must uncover the interconnected workings between all potential factors. For example, socio-political mechanisms, social trends and the status and social location of the actor, which are invisible factors to the empirical experience and have the potential of adding to the understanding of moral distress. We will unpack the influences of these concepts with the knowledge gained by the research of

Chambon, Irving, and Epstein, (1999) and the seminal work of Michael Foucault (1978, 1982, 1984, 1988, 1991) as well as other scholars on the topic of social work, Mänttäri-van der Kuip, M. (2020), and Olcon, & Gulbas, (2020). By introducing concepts of governmentality and technologies of self we inform our critique of the empirical account reported by the participants. For example, Empirical Experience: *"I was going nowhere, I could go to the media, but that wasn't for me, for a variety of reasons, confidentiality, and I had no trust in the media. I was in a terrible situation, so for me the only stone I had left unturned was to become a whistleblower* - Actual Event: Social workers that are employed in government agencies administering government policies, in healthcare, in child protection, personal care homes, and community programs are restricted to working within government guidelines and budgets.
Real Mechanisms: Thirty years of neo-liberal government agendas have led to shrinking public services, increased bureaucracy, proceduralization, and marginalization of SW. Subsequently, SW responsibilities are mainly focused on gatekeeping government resources, monitoring client behavior, and managing organizational risk.

The interaction among the three levels of reality describe how moral distress comes about. In the example above the social worker described dire circumstances that were taking place within an agency and she was seeking to secure measurable improvements to the resources provided. Despite trying all the prescribed methods/avenues for change, she was unsuccessful. The moral distress she felt inspired her to become a whistleblower. The process was laborious and time consuming and at the end did not yield long term changes. One of the direct mechanisms impacting this case of moral distress can be described as the long time neo-liberal government agendas that resulted in shrinking public services, increased bureaucracy, proceduralization, and marginalization of SW in which social workers are mainly responsible for gatekeeping

government resources, monitoring client behavior and managing organizational risk, all of which are included in this experience. This example also highlights a conflict between SW values and their prescribed role as government agents. All the mechanisms are interrelated and in flux, meaning that they can change given variable circumstances.

The following table lists the primary themes reported by participants and uses a critical realist analysis to demonstrate how these instances have created ethical challenges for the social workers involved. The "empirical" column reflects comments and experiences as recounted by the social workers, the "actual" column represents preceding events associated with the empirical domain, whether seen or unseen, the "real" column represents the many mechanisms at work, most often unseen. This is not an exhaustive list, rather the most prominent examples from the most reported themes. Some of the less prominent themes included personality conflicts with colleagues and supervisors, workplace gossip that breaches client confidentiality and ethical standards, for example coffee and lunch discussions about client situations, overall disregard for the social work perspective amongst healthcare professionals, lack of support from the regulatory body when participants reported situations in which they were advocating for SW values that conflicted with organizational policy, the social work educators do not teach clinical skills to prepare students for frontline work. Although not articulated as the predominant factor in the more commonly reported themes, the previously mentioned factors were described as highly influential in the development of moral distress as specified by the participants.

The order in which the themes are listed are not reflective of any particular rank of frequency or severity and the corresponding columns of events and mechanisms listed in the "real" and "actual" can be used to describe numerous empirical experiences. The primary feature of these mechanisms is that they were commonly associated with the morally distressing experience

described by the participants.

Table 4

Critical Realist conceptualization

Common theme	Empirical	Actual	Real
<u>Powerlessness</u> Meaning: To not have a voice in decision-making nor the ability to act on ones' moral intentions. Relationship to moral distress- workers who work in conditions that combine high demands, low control and low support are at high risk for moral distress. Whether real or perceived, practitioners did not feel they could act on their ethical convictions. Supported in prior research, literature (Corley, 2001; Fantus et al., 2017; Hamric & Blackall, 2007; Hamric et al., 2012; Hansung & Stoner, 2008; Openshaw, 2011; Webster & Baylis, 2000).	The following quotations are taken from the interviews and represent visible examples of instances in which the participants felt powerless to act on their moral judgement. Some quotations reflect the profession's status within the participant's workplace. P-1 describes her desperation as she was ineffective in securing government resources for destitute organizations, *"I was going nowhere, I could go to the media, but that wasn't for me, for a variety of reasons, confidentiality, and I had no trust in the media. I was in a terrible situation, so for me the only stone I had left unturned was to become a whistleblower."* P-3 describes how social work lacks professional status to influence administrative support *"It's difficult, you don't have the power to have people go along with what you're attempting to do"* The following participants reflect on the powerlessness and status of social workers among other helping professions, P-2 "*I think that the SW profession is not valued as much as it should be"* P-7*"The social worker is the one that is least imbedded in the medical model. And it*	The following statements are representations of the quotations in the empirical domain and are determined by mechanisms or events that can be explained with reference to the "real" level. When applied to moral distress the actual level consists of events and constructs that may or may not be observed. Social workers that are employed in government agencies administering government policies, in healthcare, in child protection, personal care homes, and community programs are restricted to working within government guidelines and budgets that often prevent them from realizing their social work objectives P-7*"it's so hierarchical. Multidisciplinary teams are the façade of undemocratic workplaces, and the hierarchy just keeps getting repeated at different levels. It's the political realities of people vying for power and control. In the end there are people who are ladder-climbers who are thinking strategically in terms of what's best for them, not what's best for the program. And they are more than happy to play that game"* P-7*"we're creating mentally ill workers, you know. How this giant monolith of an*	The following are examples of the often-hidden mechanism responsible for the experiences listed in the Actual and Empirical columns. The real domain is the mechanisms that consist of entities or structures with properties that give them the power to activate and affect other structures. Upper-level politicians delegate considerable discretion to the local level. In doing so they buffer themselves from the controversies that surround the symbols they espouse, and they need not be concerned with the difficult issues of implementing the programs that must do moral work, Hasenfeld, (2000) Thirty years of neo-liberal government agendas have led to shrinking public services, increased bureaucracy, proceduralization, and marginalization of SW. Subsequently, SW responsibilities are mainly focused on gatekeeping government resources, monitoring client behavior and managing organizational risk. (Chambon et al., 1999) *"the social work role does not afford them the power to influence at a collective or political level, therefore many of them come to realize that to intervene at the individual level is totally illusory unless political*

Common theme	Empirical	Actual	Real
	seems like it's also in my experience, that they're the least respected." P-2 "*SW's treated like pizza crust. Used and discarded"* P-7 feels powerless to support her clients in an environment of austerity measures, "*The housing market is just insane and with the [1]rates so low and the continuing [2]clawbacks, this is going to make it impossible. How can we find people housing?"* P-7 feels defeated in her efforts and does not see any hope for the future *"I just felt like, well, if we continue with these [3]austerity measures in health. There is just no way that, even these programs can be effective in helping people in any kind of meaningful way."* The following are quotes from participants in healthcare, P-3 "*But the system is big and other people have more of the power, physicians have most of the power in healthcare."* P-2 "*Doctor has all the power, everyone goes along with the doctor or team manager"* P-4 "*Team managers that are not social workers don't respect SW values"*	*organization has taken over the nonprofits. It's so enormous and people just go from one revolving door to the next. You can move constantly, so there's less accountability. And the way this corporate giant deals with all this moral distress is by putting on workshops on moral distress that personalize the stress you feel. You know, so it's like mindfulness workshops to deal with the stress created by the workplace. Like it always has to do with your interior mind as opposed to the exterior world where we have this structure that's so hierarchical"*, (the top-down decision-making) Non-social work mangers more likely to focus on managerialism and fiscal responsibility. Social workers have become "resource gatekeepers"	*problems are addressed"*. (Chambon et al., 1999, p.92). Legislators would not leave the decision of assessments of actual or potential high risk to the health and welfare experts alone. The decisions and the accountability for making them must be lodged with the court and based on forensic evidence. (Chambon et al, 1999)
<u>Social Justice</u> Meaning: Advocate for equal treatment & protection, challenge injustices,	The following quotes are examples to reveal the participants commitment towards social justice as well as their feelings when they are not able to act on this	The following statements are representations of the quotations in the empirical domain and are determined by mechanisms or events that can be explained with	The following are examples of the often-hidden mechanism responsible for the experiences listed in the Actual and Empirical columns. The real domain is

[1] Employment and Income Assistance rates not high enough to meeting basic housing market

[2] New government introduced austerity measures resulting in program cutbacks in community health programs

[3] New government introduced austerity measure resulting in program cutbacks in community health programs

Common theme	Empirical	Actual	Real
advocate for fair & equitable access to public services & benefits Relationship to moral distress-a primary value of social work that when unsupported or unrealized often leads to moral distress.	value or that the work environment does not validate this value. P-7 states two important distinctions; one that social justice is the one thing that separates social work from all other professions, and two that it is highly political, implying that it is seldom achievable "*what is the one thing that social workers contribute most? What is the distinguishing feature that sets us apart from other disciplines? To me it's the advocacy and social justice piece, and that's inherently political"* P-6 expresses her commitment to social justice, "*the biggest reason for me being in social work is my commitment to being an agent for social change, and for improving things beyond the individual level, so I always work from all levels. Fairness and ethics have been both a gift and a curse to me, being an ethical person and working toward fairness for all gives me satisfaction but has also been the cause of grief and anxiety when it conflicts with the agenda of those more powerful".* P-6 describes how her self-image is shaped through social justice. P-6"*I'm known as an advocate. I've always been an advocate, it's part of my story from the time I was a kid, it's just something that's been part of me."* P-1 expresses a deep lifelong commitment to social justice P-1"*the social justice aspect of social work has been the driving force for me throughout my life. I want to be fair and equitable and*	reference to the real level. When applied to moral distress the actual level consists of both events and constructs that may or may not be observed. Social workers work in government agencies administering government policies, in healthcare, in child protection, personal care homes & community programs. Restricted to working within guidelines and budgets Researchers such as Weinberg (2009) and Clark (2006) argue that modern social work has aligned itself more with clinical and scientific approaches than philanthropy models taught in social work schools. P-3 "*Well, when you're advocating for social justice, you're going to be speaking up against powerful figures and that's just the unfortunate nature of doing advocacy work"* (in effort to improve circumstances involving Indigenous Peoples, one sometimes climbs the ladder of authority and eventually go against powerful figures) Rationing resources to clients within restrictive guidelines involves a moral categorization of deservingness which goes against the equity for all philosophy of social justice. Social justice is a political venture that cannot be achieved at a clinical level. The participants in this study struggled to achieve a measure of social justice. How social workers understand social justice has implications for how they	the mechanisms that consist of entities or structures with properties that give them the power to activate and affect other structures. Social workers cannot actualize moral agency because of their role and status in workplace. Unable to act on their moral conviction social workers become conflicted as they challenge agency policy in pursuit of social justice. Based on participant's experience it may be that critical anti-oppressive social work is not compatible with capitalistic goals of the agency and can potentially lead to moral distress as social workers in clinical roles push to change organizational policy. New cohort of social workers seeking careers in healthcare as counsellors must be aware of the ideological conflict between activism, social justice and clinical teamwork. Racism, gender bias and other forms of unconscious bias and discrimination present undercurrents that permeate the delivery of health services. Unconscious bias makes it nearly impossible to establish equality in distributive justice. For example, when a client is accorded with high social worth, staff are motivated to mobilize all the necessary resources to affirm such a status (Hasenfeld (2000). As noted by one participant, when Indigenous Peoples seek medical assistance, stereotypical thinking makes staff less motivated to

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	I've always wanted things to be fair and equitable, even as a kid, I was the kid saying that's not fair" P-5 contrasts system constraints with supporting clients, *"my role is very social worky, so I'm constantly balancing trying to support people that are fairly marginalized within system constraints"* P-2 obtained a social work degree overseas and compares the social work values with those from his homeland *"In my home country social workers are not trained to challenge the status quo and are not expected to. It is less focused on social justice. Whereas Canadian social work is more focused on social justice. You know, like how much Canadian social work teaches about feminist perspectives challenging patriarchal values and gender-based studies. That's the main focus"* P-5 also identifies social justice as a distinguishing feature of social work, *"You know what the one thing that sets social work apart from all the other disciplines? It's the social justice piece."* P-6 expresses her commitment to social justice, *"Things in society need to be fair and it's my role to advocate for equal access to resources"* P-3 described a barrier to social justice, *"There is an unconscious bias toward Indigenous People"* P-7 reiterates society's reluctance to resolve social justice issues,*" I can tell you*	view their roles in promoting it (Mullaly, 2001). Moral distress can arise from not being able to incorporate a measure of social justice in practice. Moral distress can easily result from instances in which social workers are forced to go against workplace standards in order to honor their code of ethics. One participant was sanctioned by the workplace for upholding her duty as stated in the code of ethics. As stated in the code of ethics, If there is a conflict between the standards of practice and a member's employing environment, the member's primary obligation is the Manitoba College of Social Work code of ethics and standards of practice (MCSW 2015, p.8) Social workers take all reasonable steps to uphold their ethical values, principles and responsibilities even though employers' policies or official orders may not be compatible with its provisions (MCSW 2015, p.23) Social justice is not clearly defined in social work education and various conceptualizations lead to confusion and unrealistic ethical commitments.	mobilize all necessary resources. Social workers have very little control over political processes. The Participants in this study reported moral distress resulted from their inability to affect real change toward equitable distributive justice in organizational and governmental policies or even practice guidelines within their organization. The insurmountable ineffectiveness of their attempts may have also resulted in professional dissonance (Taylor, 2005)

Common theme	Empirical	Actual	Real
	what I struggle with is social equity. It's not something that can be decreed, right? Like our whole society would have to change, and who wants to give up the things they already have? As far as I can tell, the answer is a lack of will to establish social equity. Like that's a really complex thing that would require entire the entire reorganization of our society as we know it. Well, that's huge. You keep thinking that can happen right? Like, wouldn't that be great, but really, come on, we got day to day stuff to do. And so, it's like futile" P-4"*referencing power dynamics or increasing social justice overall, that doesn't work in professional conversations. Not when you're talking to managers, doctors, or systems people. I feel like it actually, it's, it's a little bit embarrassing to just come from that place, it's like rah rah kumbaya."* P-1 describes the moral struggle with social justice issues, "*social equity is really a political thing that can't be resolved easily"*		
<u>Democratic Workplace</u> Meaning: Shared decision-making, supportive environment, transparent processes, integrity, and accountability Relationship to moral distress- When the work	The following quotations represent instances in which the work environment prohibits social workers from ethical practice. P-7 described common behaviors in her workplace that kept her from ethical practice," *bureaucracy, territorialism, ladder*	The following statements are representations of the quotations in the empirical domain but are determined by mechanisms that can be explained with reference to the real level. Bureaucracy shields the administrators and decision-makers from the impact of	The following are examples of the often-hidden mechanisms responsible for the experiences listed in the Actual and Empirical columns. The real domain is the mechanisms that consist of entities or structures with properties that give them the

Common theme	Empirical	Actual	Real
environment is structured based on bureaucracy, managerialism and restrictive policies, social workers are forced to act on values that conflict with their personal and professional values. A worker can feel distressed if she is experiencing workplace pressure and bullying, but only experiences moral distress if she feels obligated to compromise her ethical principles due to those experiences. On several occasions the participants reported frustration with the top-down decision-making process which often forced them to go against social work values. Social workers are not fully autonomous decision makers when practicing in large organizational and institutional settings and are seldom included in organizational decision-making. The lack of autonomy and limited control in their daily tasks and personal scheduling have an immediate impact on their ability to provide ethical services. Value conflicts between social workers and undemocratic workplace culture have been documented in previous literature (Baker & Collins, 2019; Gough & Spencer, 2014; Hansung & Stoner, 2008; Manttara-van der Kuip, 2016; Fantus et al., 2017)	*climbing, corporatist thinking, bullying, gaslighting, not transparent and unsupportive managers"* *P-6* expressed her emotions regarding the bureaucracy of her workplace, *"So, all of this[4] stuff was really stressful"* P-7 describes how her attempts to advocate for changes in a community health program were met with apathy and disregard *"I started to realize that as I questioned systems, that people looked at me differently, you know, the higher ups, with shock, as if speaking it was some sort of sin, some trespass, you know. To make any kind of complaint, like it's just, you had to be quiet after that. I realized even though some coworkers would be supportive, supervisors were not interested in that. I think one of the reasons was because my comments were more troublesome for them because I'm pointing out the system deficiencies"* P-6 described similar experiences, *"There was a manager that was problematic and I saw really good people around me get hurt. The work environment had become toxic"*. P-7 describes her experience with supervisors that pushed unrealistic workloads and reduced available resources forcing her to take away resources she was already providing her clients, *"You know, nobody wants to*	their decisions have on others. Social repercussions for not following team consensus. Shunning, avoidance, not being included in discussions Real consequences for sanctions, in a manner that cannot be challenged, such as a non-disciplinary letter. (which really is a disciplinary letter without punishment). That means it cannot be challenged or appealed because there was no formal disciplinary measure to refute; however, the letter remains on file having negative consequences) Organizational culture determines and perpetuates the power alignment & old ways of doing things through key role models and informal rules. For example, "so and so is a great worker because…." rituals such as work parties perpetuate a form of ideology through unwritten rules (Boyle et al., 2004). Constant reorganization is a wonderful method for creating the illusion of progress while producing confusion, inefficiency, and demoralization (Morrison, 1990) Effective teamwork and mutual support are not the norm among senior management with the result	power to activate and affect other structures. Institutions use social workers to enforce a means to control the public in a manner that is not obvious to their clients. Large government organizations and institutions use undemocratic processes and bureaucracy as means of maintaining this function and preventing social workers from making real change to those mechanisms. Foucault's technologies of self are used to discipline social workers through cultural values in the workplace that shape and maintain the role of government agents and gatekeepers of resources. Social work codes of ethics and standards of practice are a restrictive means of self-governance for social workers. (Chambon et al., 1999) Principles of the panopticon is that power should itself be visible, but at the same time unverifiable (Chambon et al., 1999) Large organizations uphold dominant values about desired behavior, they enforce these values through laws, rules, and regulations; and they provide typification schemes to categorize and classify people (Hasenfeld (2000).

[4] Stuff- referring to a combination of disrespectful efforts by her supervisor to make her feel bad

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	challenge a dictator. So for me, you know, the most important thing we talk about is democratic workplaces." P-6 expressed her frustration that led to moral distress because she was frequently prevented from fulfilling ethical social work values because of a non-social work supervisor, *"We lost an executive director who was a seasoned social worker. So, we lost a social worker who was very clear about the code of ethics and standards of practice and was very committed and dedicated to the profession and very knowledgeable. I always thought that in the child protection services, social workers needed to be supervised by social workers. That's not the case here, and that's part of the problem; when you have non social worker as part of the management structure for social workers and social work programs"*. P-7 reveals that a toxic workplace resulted in high staff turnover, many of those who left could no longer cope in the dysfunctional work environment, *"I was the last of 17 people to leave within a span of a three-year period."* P-7 emphasized how bureaucratic workplaces can result in moral distress for social workers. *"Something about this corporatist setting that is sooo not conducive to social work values."* She went on to describe the impact it has had on her colleagues who went on stress leave, *"When I left, I was the fourth person to be on disability in that office*	that managers are left abandoned and isolated. The predictable result of such stress leads to territorialism, aggression, poor decision-making and crucially reduced sensitivity towards staff. It's the culture of self-defensiveness. (Morrison 1990) Supervisors in welfare agencies are not only largely abandoned but are often untrained, certainly as far as first-line managers are concerned (Morrison, 1990) If there is a conflict between the standards of practice and a member's employing environment, the member's primary obligation is the MCSW Standards of Practice (MCSW 2015, p.8) Social workers are expected to take all reasonable steps to uphold their values. This can cause moral distress when those values require action that is not in the best interest of the client. As stated in the code of ethics, "social workers take all reasonable steps to uphold their ethical values, principles and responsibilities even though employers' policies or official orders may not be compatible with its provisions" (MCSW 2015, p.23)	

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	alone. All at the same time. Four people on stress leave!" P-6 described the workplace behavior of the management team and typical response she received when she voiced suggestions for improvement. *"It's not sustainable, it's CRAZY MAKING. and then to be told at various times, if you don't like it, leave! Because we're all expendable."* P-6 expressed the implicit message she received from her workplace. *"Social workers are just like Kleenex, you know, you're expendable, they use you up and throw you out"* Workplace culture and management teams feel threatened when employees speak out about unethical practice, P-7*"Because in the end you always have to shut up and make do. You can't discuss because they find everything threatening."* Large corporations reward workers that do not rock the boat, P-7"*and that is another thing that's distressing about the working there, it doesn't matter how hard you work, how effective you are with participants and clients"*		
<u>Client Self-determination</u> Meaning: Primary social work value to respect and support clients' right to self-direction and freedom of choice without interference from others. Relationship to moral distress - a primary value of social work. When social	The following quotations represent instances in which social workers were unable to promote the autonomous right of their client. P-2 was asked to disregard her clients wishes, P-2"*my supervisor was asking me to disregard the right to self-determination of my client"*. P-2 provided examples of frequent occurrences related	The following statements are representations of the quotations in the empirical domain but are determined by mechanisms that can be explained with reference to the "real" level of reality. Social workers would not be successful in applying coercive methods of client intervention; not only are paternalistic methods	To accomplish its purpose social work must dominate its clients. However, to be effective it must influence people, motivate them to adopt normative views inherent in SW practice. This must be done without force. Clients must be transformed voluntarily through the notion of autonomy. Non-influential influencing is its communicative art, SW's specialty. A person being

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workers are not able to honor client-self-determination, they go against several values leading to moral distress. This construct is also associated with the concept of informed consent, or mor specifically, lack thereof. Support from prior research demonstrates how health professionals experience moral distress in workplaces that restrict client self-determination and inhibit adequate informed consent (Fantus et al., 2017; Hamric et al., 2012; Webster & Baylis, 2000)	to ignoring the client's desires and best interest when discharging them P-2*"we discharge vulnerable people to shelters that can be potentially harmful and this can be morally painful, but there are lots of pressures to do it. Bed pressures, makes doctors choose to get people out"* P-2*"People don't have any say about discharge they go when and where we discharge them to"* P-5 describes the importance of honoring client's wishes and building a therapeutic relationship P-5*"It took a lot longer to build trust with involuntary patients"* P-7 was uncomfortable with forced medications as part of the program, *"They can't go off medications even if they want to"* P-4 had made strong statements regarding informed consent and transparency in the healthcare system, *"So, it's a really unforgiving system that doesn't give clients a lot of direction and they need someone to help them navigate it."* Some participants expressed a sense of satisfaction when they could honor client's autonomous choices, P-6*"Something I feel proud of is the multiple different aspects that are incorporated into the wellness program. The participants are able to choose whatever they wanted to do."* P-4*"Helping people to navigate resources and achieve their goals. So, supporting and cheerleading*	ethically unacceptable, but individual social workers would not be motivated to work with clients under such pretenses (Chambon et al., 1999) this can lead to moral distress as social workers actions are not congruent with their altruistic values and sense of well-being that comes from helping others to help themselves. An example of a social norm regarding public resources is exemplified in the following comment by Hasenfeld (2000), Clients must undergo "repentance" or publicly profess their moral deficiencies to qualify for services. This social norm is represented in healthcare staff and is in direct conflict with social work value of respect for client self-determination. Of course, there are occasions in which SW must override a client's autonomous choice. The ethical issue is when and how to go about it. (MCSW, 2015)	transformed should want this, should consent to it, and do it on their own free will. This is the principle of self-determination. (Chambon et al., 1999) Social sciences are the backbone of the technologies that have emerged as instruments by which the state can govern with minimal coercion (Chambon, et al, 1999; Rose, 1998)) Criminal justice dictates who gets the resources and treatment plan. Doctors and team managers. Are the authors of it (Chambon et al., 1999)

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	people to tap into their own stuff was always part of my practice"		
<u>Medical model</u> The medical model represents both practical and theoretical approaches to healthcare with a focus on curing illness and individual treatment. Problems are symptoms viewed in biomedical terms under science-based evidence. The social work profession is dedicated to the welfare and self-realization of all people with a particular focus on the needs and empowerment of vulnerable, oppressed people. Workers uphold diversity and the democratic rights of others. Relationship to moral distress - Medical model is structured on values that sometimes prevent social workers form acting on other values such as social justice and client self-determination which can lead to moral distress.	The following quotations represent instances in which social work values were prohibited do to what is referred to as the medical model which is predicated on values of short-term treatment of individuals versus longer term intervention strategies that include the clients larger social support system. P-2 describes the power dynamics and hierarchy of the medical model, *"I try my best to follow what I think is the right thing to do. But the system is big and other people have more power. Physicians have the most power in healthcare."* The following quotations describe a social worker's experience in a hospital, P-2*"Pressure from unit Mgr. and team to discharge vulnerable patients, goes against values and code of ethics"* P-2"*Hospital is run like military model. Can't question the doctor."* P-7*"They won't let them go off medications."* P-5 defines how the medical model conflicts with social work's values, "*the medical model only sees the pathology within the person, so that's the lens through which we view people."* P-5"*And so it's hopeless because the person is viewed through an illness lens rather than a personhood lens."*	The following statements are representations of the quotations in the empirical domain but are determined by mechanisms that can be explained with reference to the real level. A participant that was forced to choose between social work values and the medical team described being viewed as a member of the health care team and not as a social worker. The assumption is that team members comply with the consensus of their colleagues. Yet social workers as a discipline do not hold the respect of other health care professionals such as doctors, nurses, psychologist and physiotherapist. *P-2, "Social workers are least respected in the medical model"* As supported in the literature (Fantus et al, 2016) social workers do not hold status and decision-making power within medical institutions/organizations. Those statements were echoed throughout the participants from health-related organizations. Team managers are often more focused on managing their unit case-load and resource allocations than actual client care. P-7 *"unit/team managers are just focused on numbers"*. The medical model is also prevalent in community programs and can create	Thirty years of neo-liberal government agendas have led to shrinking public services, increased bureaucracy, proceduralization, and marginalization of social work. Subsequently, social work responsibilities are mainly focused on gatekeeping government resources, monitoring client behavior and managing organizational risk (Chambon et al, 1999) Medicine and healthcare is run like a business and is very much focused on managing its resources and meeting it financial commitments as well as maintaining a caring image (Boyle et al. 2004). This approach to patient/client care has direct consequences for social workers working within it. Historically, social workers placed the person (not subject) at center stage. Recent trends depart from that as they now define the person on the cultural and institutional arrangements they are in (Chambon et al., 1999) Medicine is no longer confined to techniques for curing ills, it embraces the model of the healthy which authorizes it to not only distribute advice on healthy living, but also dictate the standards for physical and moral relations of the individual and of society in which he lives (Rose, 1998) The process of normalizing behavior is inherent in the

Common theme	Empirical	Actual	Real
	The following quotations describe how the medical model doesn't respond to individual needs and thus conflicts with social work values, P-7*"Corporatist setting in health care is run like a business"* P-2*"The entire focus is on discharge planning"* (in other words how to get them out quickly) P-3 expresses frustration with the dominance of managerialism in medicine, *"Too much bureaucracy in healthcare"* P-5 was describing how staff on a mental health ward focused on clients' behavior, *"It was a hospital but we treated people like prisoners when they didn't act like they are supposed to"* If social workers don't follow along, they get no respect, P-2*"The social worker is the one that is least imbedded in the medical model. And it seems like it's also in my experience, that they're the least respected."* This participant described her experience as she challenged medical dominance in treating clients. P-7*"In the end I was seen as a threat… because it's my values, and how I practice them that was a threat to a system that seems to be hardening. I see it as an institutional hardening."* This participant felt everyday experiences as subtle forms of moral distress when vulnerable patients are discharged to unsafe environments. P-2	similar ethical problems for social workers. P-7 describes her experience with a supervisor that was focused on meeting the numbers, *"It is difficult for us to do our work with people. The housing market is just insane and with EIA rates so low. The continuing clawbacks just make it impossible. How can we find people housing? So, all this stuff was really stressful. I just felt like, well, if we continue with these austerity measures there is just no way that, even these programs can be effective in helping in any kind of meaningful way."* If there is a conflict between the standards of practice and a member's employing environment, the member's primary obligation is the MCSW code of ethics, standards of practice (MCSW 2015, p.8) Social workers take all reasonable steps to uphold their ethical values, principles and responsibilities even though employers' policies or official orders may not be compatible with its provisions (MCSW 2015, p.23) One participant reflected on a pervasive attitude by health care staff toward Indigenous Peoples and described it as a systemic bias that pervades all levels of healthcare and is in direct conflict with social work principles. *"In health care there is always this elephant in the room. It's the unconscious bias toward indigenous patients"*.	social work assessment (Rose, 1998) SW's have developed a mastery of details through the activity of data collection. They sift through the client's information to assess, weigh and discard sets of information. As they collect facts they simultaneously draw inferences and interpret their findings within a lens provided to them about truth, right and wrong (Chambon et al., 1999) Social workers are frequently hired in health organizations and institutions such as hospitals. Their role, however, is a contested one as they become assimilated into the norms of the medical model. Social work uses terms like client self-determination, equity and social justice to deceive public of their role in surveillance and gatekeeping for the government resources (Chambon et al., 1999). To accomplish its purpose social work must dominate its clients in a manner of interpersonal relations appearing to work in a democratic egalitarian manner (Chambon et al., 1999). As described by the participants, their values and intentions are client focused and working within the medical model can lead to moral distress. .

Common theme	Empirical	Actual	Real
	"We discharge vulnerable people to unsafe shelters without the resources they need to manage."		
Lack of Resources Meaning; Social workers to bring to the attention of their employers, policy makers, politicians, and general public situations where resources are inadequate or where distribution of resources, policies and practices are oppressive, unfair or harmful (IFSW &IASSW, 2012) Relationship to moral distress - In situations where resources are no longer adequate for the goals of their work, social workers are compelled to choose strategies that negatively impact their quality of practice. Evidence for lack of resources as a contributing factor to moral distress is well represented in the literature (Manttara-van der Kuip, 2016; Corley, 1995; Corley et al., 2005. Hamric, 2012; Houston et al., 2013).	The following quotations represent instances in which lack of resources can result in moral distress. P-1 describes the reality of living conditions in northern communities *"So the reasons why kids living, indigenous kids, living in isolated communities are living in third world conditions, including, not even available drinking water. Not even water to wash, are fundamental social inequity, and a lack of will to properly share our money as Canadians... So it's... it's a, it's a great, I think a classic social justice issue"* She elaborates to reveal how this can be a morally distressing factor P-1*"I can see, because I worked in government for a long time. I saw lots of money flowing...Lots of money flowing, and from my point of view, it didn't make a lot of sense but spending was to serve that particular um, optic, to look good to the public. Do you know what I mean? Look good to the voters."* P-2 experiences ongoing stress when there are inadequate resources available on discharge, *"you know, certain times when you have to prepare resources for discharge say for instance, the weather is bad, really bad, and you are told to discharge her to the shelter, which is on a first come first serve basis. So there are limited shelters, and limited spaces. If the*	The following statements are representations of the quotations in the empirical domain but are determined by mechanisms that can be explained with reference to the real level. This worker describes how she was impacted by the Child Welfare Agency's rigidity and miserly approach to their funds. *"So, it left me cynical. Yeah, the SW role is also gate keeping right. People who work in health and mental health and addictions. Would privately tell me that if there is a whiff of Child Welfare that the kids would be denied or put on an endlessly long waitlist with the expectation that child"* The research findings establish strong empirical evidence for the author's claim that insufficient resources are contributing factors leading to reactive MD. The author posits the influence of SW values as a primary variable; (Manttara-van der Kuip, 2016); P-1 describes attitudes from health care teams when it came to providing resources to children belonging to the Child Welfare Program, *"Welfare would pay privately for something, and that's fine, but when you pay privately for something, for a service for example, then there's no capacity to refer out within the healthcare system and that's harmful. In that manner the system keeps people on welfare from its full range of services."*	Thirty years of neo-liberal government agendas have led to shrinking public services, increased bureaucracy, proceduralization, and marginalization of social work (Manttara-van der Kuip, 2016; Mullaly, 2007) Government austerity measures directly impact front-line social workers as they have professional personal relationships with the clients and cannot help them access the resources they so desperately need.

Common theme	Empirical	Actual	Real
	shelters we have no more group homes to put him in." P-3 describes how clients have to earn available resources through good behavior, *"Sometimes people come at resources with like a punishment oriented approach, like you have to earn your way out of these situations, if you're not being a nice person like smiling and nodding and everything, then you kind of get a reward, if not, the team doesn't like that and they believe you should continue to live in that situation"* she goes on to describe the consequences, *"so, he's stuck there because of a system constraints issue right, we run out a group homes And now it's actually infringing on his human rights because he shouldn't be in a hospital setting…Grp homes get full, then what?"* P-7 describes the impact of community cutbacks have on the social worker's ability to connect with clients as well as provide for them *"that whole experience meant a lot more suffering for participants, these cutbacks, this change in informal policy where you don't have the time to spend an hour with people. If you can only spend 20 minutes or 10 minutes with them so be it. But that's those are all informal changes… and some of us would donate a lot of things that they don't have, cutlery and cups, pots, pans whatever, just donate so that you know when people lose their housing and gotta start up again, we can we can grab sheets and stuff like that. And sometimes we would just*	Moral distress can result in when an ethical response follows organizational guidelines but goes against social work guidelines. The Manitoba College of Social Work code of ethics states when there is a conflict between the standards of practice and a member's employing environment, the member's primary obligation is the code of ethics and standards of practice (MCSW 2015, p.8) Social workers take all reasonable steps to uphold their ethical values, principles and responsibilities even though employers' policies or official orders may not be compatible with its provisions (MCSW 2015, p.23) P-7 described that community programs for mental health have not been provided with the resources to effectively support their clients and are not well respected within the larger regional initiatives of health.	

Common theme	Empirical	Actual	Real
	give directly. That was also discouraged." P-7 described losing her expense account to purchase small items like a cup of coffee for clients, "*These are precious benefits and we have a few that are allotted to us."* P-7 described how important the current programs are to clients and how difficult it will be without even the existing programs, "*portable housing benefits are really helpful because the housing market is just insane and with the vacancy rates so low with the continuing clawbacks, it is going to make it impossible to find people housing. So, all of this stuff was really stressful just felt like, well, if we continue with these austerity measures in health. There is just no way that, even these programs can be effective in helping people with mental illness in any kind of meaningful way."*		
<u>Internal Factors</u> Prior research documenting internal factors that lead to moral distress have included, lack of knowledge and influences from negative experiences impacting current conceptualization of the problem, Hamric et al., (2012); Corley, M., Elswick, R., Gorman, M., & Clor, T. (2001), Rushton et al. (2013), Wienberg (2009). Relationship to moral distress - One does not always see things for what they are. Under certain situations on may misperceive something as a moral dilemma as a result of simply not being properly	The following quotations represent value statements highlighting social workers' commitment to help, or how past negative experiences have impacted their current choices This participant had witnessed great suffering in a community and was morally distressed by the lack of results in her efforts P-1 "*CFS workers trying to be a positive impact and keep kids safe and families together and I don't know how you can. It's not even reasonable" I think that I would still say that it's important to, for me it's all about being able to look myself in the, in the mirror, so it's still important to be*	The following statements are representations of the quotations in the empirical domain but are determined by mechanisms which explain them with reference to the "real" domain. P-5 explains that people with negative experiences may be more likely to become social workers and need to differentiate between their issues and those of their client,"*social workers aren't necessarily all therapists but like everybody is probably drawn to that field because of their own baggage and need to be sort of aware of that, and what to do with that"* Negative impact from viewing social work practice	The mechanisms in this domain influence those in the actual and empirical domain but are not obvious. Society in general is more susceptible to moral distress because therapy culture has changed the cultural imagination of trauma. Today individuals lack the resilience to deal with feelings of guilt, disappointment and failure. There is a decreased ability to cope with emotional and psychological stress. Contemporary culture unwittingly encourages people to feel traumatized and depressed by experiences previously

Common theme	Empirical	Actual	Real
prepared or missing a vital piece of information to the problem (lack of knowledge). In other instances a negative memory may lead to negative emotions and an inaccurate understanding of the facts, or that one's self perception of what it means to be a social worker does not permit one to be less than perfect and moral distress results because one cannot live up to her own standards.	*able to say that you've done all that you can",* Negative experiences with the media prevented this participant from making her story public to put political pressure on the Minister with the hope the Minister would provide extra funding to the Agency- P-1. "*no confidence in the media and no willingness on my part to breach confidentiality to do that, so for me the only real other... The only stone I had left unturned was becoming a whistleblower"* Code of ethics as absolute rule P-2 "*Yes, and what I'm saying is in my code of ethics, we have that duty to warn, there is no choice".* This participant felt moral distress from being placed into ethically charged situations without the proper training. P-3 "*So, yeah, it was distressing, I felt like I came out of school with, not as many skills as I would have hoped or what I needed to do my job."* P-1 describes what she would have like to have included in her undergraduate education. "*The things I wish I had known are to be more about savvy advocacy. I also wish that I had known about cumulative and vicarious trauma and how to work through it. I wish that would have been part of my curriculum and maybe it is now because that was so long ago, but these are predictable normal reactions that you're going to have when sitting and talking or witnessing the trauma of others. I wish I had known about that and how to get*	from a rule-based ethic does not account for all situations. Metanarratives that negatively impact one's view of the situation, (must have all the answers, must relieve suffering) Morrison (1990) In the previous column the social worker's past experiences told her that the media cannot be trusted, and she did not see that as an option to resolving her problem, although it was an option. In the case of P-2, he was going against the treatment team's advice in order to follow MCSW code of ethics. High caseloads and lack of training are responsible for unethical social work practice. There are simply not enough social workers to fill work demands. (Hughes, 2013). Morrison (1990), on unresolved issues from the past - "one social worker had been hospitalized for long periods of her childhood and had painful memories of helplessness, isolation and abandonment". She had guilt because she could only cope with children in pain by becoming emotionally distant and unavailable (p.235). Based on the reports in this study, social work education is not providing the clinical skills required to prepare workers for practical work responsibilities.	regarded as routine. (Furedi, 2004). As noted by participants, People that have been socialized to believe that helping others is important are inclined to choose a career in social work. The social work code of ethics becomes internalized into what social workers believe to be ethically and morally correct. The social work code of ethics – "social workers uphold the right of every person to be free from violence and threat of violence" (MCSW, 2015) Healthcare institutions follow practice guidelines that at times allow for flexibility when it comes to issues of consent and confidentiality whereas the social work code of ethics does not. Manitoba College of Social Work code of ethics and standards of practice are rigid rule-based guidelines that do not accommodate for exceptional circumstances. Manitoba College of Social Workers code of ethics demands that social workers are responsible for being aware of the extent and parameters of their competence and shall limit the scope of their practice accordingly. (MCSW, 2015)

Common theme	Empirical	Actual	Real
	supports around it. I had to figure it out for myself and when I became a supervisor I had to on my own for myself figure out how to develop a safe climate. So we have a great gap in the program".		

Social workers do not easily admit to feelings of distress (Morrison, 1990). Based on Morrison's (1990) 'professional accommodation syndrome' some social workers adopt a form of denial against admitting to moral distress. Morrison described this as a maladaptive form of coping to prevent from appearing incompetent or emotionally fragile. As so eloquently spoken by one of the participants in this study, "*admitting to moral distress is a sign of weakness that indicates workers might not be able to handle the work, so not thinking about it or admitting to moral distress is a coping measure of sorts, you know, through avoidance and denial."*

Although denial may help in the short term it may also increase the likelihood of moral distress. This was evident in the participants of this study. Two participants continued working while silently struggling with emotional distress associated with ethical trespass which eventually resulted in medical leaves of absence. As confirmed by the participants, social workers' commitment to helping others is a primary factor in their career choice, and all participants reported that their personal values were congruent with social work values. This reveals congruent overlapping of personal and professional identities as professional helpers.

A unique discovery emerged during the analysis of the data. Various levels of moral distress were reported however, some participants did not perceive ethical challenges as a self-defeating event resulting in moral distress. Even though they described morally distressing experiences,

their responses where much different. One described a sense of motivation to overcome the ethical challenge. Her disposition can be associated with fundamental personality characteristics stemming from childhood experiences which left her with determination and courage to go forward in the face of challenges. She was also inspired to become a social worker through her mother's mental illness and a desire to improve access to resources for those suffering from mental illness. This intrinsic motivation helped her to push through ethical challenges with resolve. Another participant demonstrated similar fortitude. She is devoted to improving health care for Indigenous People. As an Indigenous Person herself she has a passion to make a difference and demonstrated grit, courage and resolve when faced with ethical challenges. From her perspective ethical obstacles are just that, an obstacle to overcome. Current research on "Grit" best describes these experiences. Grit is defined as "perseverance and passion toward long-term goals with sustained commitment toward completing a specific endeavor despite episodes of failure, setbacks & adversity" (Stoffel & Cain, 2018). The researcher expected all the participants to be negatively impacted by the effects of moral distress and was pleasantly surprised to learn that that these participants did not experience the severity of negative symptoms and demonstrated courage and determination in the face of ethical challenges. Grit was included into the major themes following participant articulation of perseverance to follow through with their long-term goals despite ethical challenges. Grit is an influential factor in determining if a person will experience moral distress in the face of ethical setbacks and should be considered for future research.

The most significant factor of moral distress revealed in this study involved the moral values of the social worker which guided the participants in their appraisal of thoughts and judgements about the ethical issues. These moral values conflicted with the mechanisms operating on the

work environment, consequently producing moral barriers that in some participants caused moral distress and others it did not. During the participant's evaluation of what to do, some decided that the correct response was within their ability and they pursued moral action, and others in their judgement learned that the consequences for their perceived right action was too high, or that they lacked the required courage or ability to act, which triggered emotional reactions. Whether the participant actually took moral action depended on their perceived success and consequences of the proposed action and their courage/ability to act.

Chapter five

Discussion

This chapter provides a brief summary of how the thesis responds to research questions and its relationship with prior research on moral distress. The discussion section contrasts the findings from this research with the seminal concepts previously recognized in the literature, implications for social work education, practice and theory, as well as further research suggested by the findings. In conclusion the researcher describes the limitations of this study and how they were minimized.

Comparison with prior research

There are similar findings to this study to support the descriptions of previously published studies. The categories used to in the model of moral distress for this study such as moral values, moral barriers, moral judgements, and emotional reactions are similar to categories described in the literature. Moral distress does not happen spontaneously but rather depends on a complex interaction of values and beliefs (Wilkinson, 1987; Mänttäri-van der Kuip, 2016, 2020). This study builds off the prior research as a foundation of knowledge. The moral barriers originating

from the participants are similar to those in previous studies (Hamric, 2012; Ko, H.K., Chin, C.C., & Hsu, M.T., 2016; Varcoe Pauly, Storch, Newton, & Makaroff, 2012; Corley, 2012). The critical realist theory illuminates the causal mechanisms that create barriers to ethical practice in social work. A summary of the literature proposes that moral distress is determined by the presence of two interconnected constructs. One is the presence of an event that is understood to restrict moral agency (Moral Barriers) and the other being the resulting psychological and physiological suffering, i.e., moral distress (Jameton, 1984; Campbell et al., 2016). Research data suggest that these two constructs can be defined in multiple ways (McCarthy and Gastmans, 2015; Corely, 2012; Hamric, 2012; Mänttäri-van der Kuip, 2020). Jameton (1984), defined moral distress occurs 'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action' (p. 6). Some authors added to Jameton's definition by proposing that moral distress also results from internal constraints (Hamric, 2012, McCarthy & Deady, 2008), while other authors described it as a failure to live up to one's moral convictions and values (Carse, 2013). Oliver (2013) included influences from the internalization of social work ethics in relation to moral distress. Oliver (2013) hypothesized that conventional approaches to ethical problems such as deontology and consequentialism have created dissonance between social workers and their sense of moral responsibility, which can ultimately result in moral distress. Weinberg (2009) and Oliver (2013) attribute formalized rules and decision-making to neo-liberal policies that have seen social work agencies become more likely to engage in risk aversive, procedural, and top-down decision-making. This phenomenon was reported by the participants in this study described as identified under the theme of undemocratic work environments.

Social work practice is predicated on formal values and codes of ethics that outline standards expected to be followed. In a survey of value differences among social workers, Gough and Spencer (2014) demonstrated that moral distress often arises from conflicted values. Gough and Spencer (2014) revealed 82% of social workers encountered an ethical conflict between personal values and organizational values. Findings from their survey (Gough & Spencer, 2014) discovered that moral distress arose when government austerity measures resulted in a reduction of services and fiscally driven approaches to client services gave rise to situations in which social workers failed to protect the client's interests and confidentiality, and organizations failed to provide access to needed services or information about options. Similarly, the participants in this study reported a new conservative government ushered in austerity measures that resulted in paralleled outcomes.

Restrictions and barriers to moral agency have been hypothesized in various forms throughout the literature. Versions of moral distress often give the impression that it is born out of a single dramatic, life-altering episode. In reality, moral distress more frequently occurs in repeated, common everyday experiences, or in a culmination of events known as the crescendo effect (Hamric, 2012). The findings of this study suggest that the constraints on moral action could be understood more dynamically. In addition to external and internal constraints, more attention should be placed on the interaction between the two (Varcoe et al., 2012). It is plausible that constraints on moral action are not only objective constraints that are subjectively perceived (Wilkinson 1987/1988) but rather, moral distress can be explained as a response to a fluctuating and complex interaction of mechanisms which seriously restrict moral agency. Mänttäri-van der Kuip (2020) recommends that constraints to moral distress should not be included in the

definition of moral distress or amongst the instruments to measure it. Instead, the root causes should be understood as antecedents of moral distress.

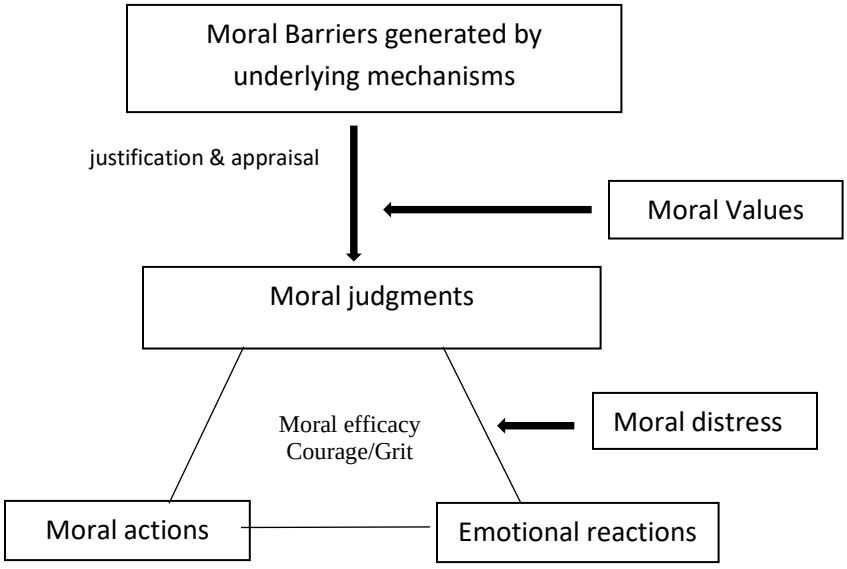
In summary, the data from this study has both confirm previous findings postulate a more complex description of moral distress.

Implications for theory

Grounded theory allows for the reconstruction of a logical and comprehensive model of moral distress in social work and a critical realist theoretical approach helps to establish explanatory power attributable to mechanisms from other domains of reality. Figure 3 illustrates the moral distress model that was developed based on grounded theory used in this study. The most significant factors of moral distress involve the moral values of the individual social worker (social justice, client-self-determination) which guide social workers toward justification and appraisal of moral reasoning and moral judgement, which arises later. These moral values are brought into the social worker's daily practice and may contradict the mechanisms operating in the work environment, hence causing moral barriers to moral agency. Those barriers may subsequently induce moral distress. In the face of moral barriers, the social workers may continue making moral judgements that are based on their personal values with the intention of "defining the moral right". After making moral judgements, social workers may discover the possible moral actions within their abilities or may find that they lack the required courage to act, triggering emotional reactions. Whether the worker actually takes moral action depends on the perceived efficacy of their proposed action.

Figure 3

Grounded theory model of moral distress



Grounded theory analysis (Glaser & Strauss, 1999) was used to reconstruct the model of moral distress. Critical realist methodology exposes the interconnected mechanisms that advance our understanding of moral distress by illuminating interactions among various factors/mechanisms within a social work context. The findings replicate prior research results linking moral distress with barriers to moral agency. The primary themes established in the data can be described in the model above in the following categories: 1) Moral values – Social justice and client self-determination, including social advocacy and honoring patient's rights and providing proper informed consent and accountability refers to social workers' commitment to their moral values. 2) Moral barriers – interacting mechanisms both seen and unseen. Environmental barriers including excessive amounts of bureaucracy and paperwork takes time away from client work and restrict clients' access to resources. Theoretical differences in client care (wholistic versus individual/medical), lack of professional status/power to impact organizational decisions and non-social work supervisors/mangers who do not abide by social work values also operate at the

environmental level. Systemic barriers include lack of resources that led to inability to adequately meet the basic needs of clients, austerity measures leading to higher caseloads resulting from neo-liberal government agendas (Mullaly, 2007). Cultural barriers comprised of implicit bias toward Indigenous Peoples leads to poor patient care and unnecessary suffering. 3) Moral judgements were framed by responses to the questions: What is your impression of the ethical problem? and What if anything should have been done differently within the context of the above-mentioned challenges? 4) Moral efficacy was determined by social workers' ability, grit, self-confidence or, conversely, self-doubt. Self-confidence is apparent when a social worker is aware of her or his ability and acts on subjective moral considerations to do the right thing. Self-doubt is apparent when social workers do not feel sufficiently confident in their ability to solve the problem, and subsequently do not discuss the problem, or make suggestions, even when they feel right about a solution. 5) Moral actions – Moral actions included creative ways of meeting moral demands. These have been describe as working in the grey areas by some participants and included informal methods. An example was privately giving the client advice to ensure his or her best interests are protected. 6) Emotional reactions – Involved instances of both explicit and nonexplicit emotions. Explicit emotions included challenging others in meetings, bullying, threats, and scolding. Nonexplicit emotions included frustration, anger, self-blame, and tears.

Concepts identified in this study such as social justice, and undemocratic work environments and powerlessness are not viewed as unfettered causal mechanisms of moral distress. Rather, they are latent entities because their activation is contingent upon the mechanisms of another factor being activated. Thus, the properties of these entities provide the power to activate mechanisms that cause various effects culminating in moral distress.

The often-hidden mechanisms exemplified in the ‘real’ domain include, but are not limited to, political structures (methods of maintaining power and control over the public and professionals, bureaucratic systems, and autocratic decision-making), instruments of self-control (workplace culture, codes of ethics) and internal and personality factors (moral self-image, professional image, sense of belonging, personality, statuses and social location, and grit). Personality characteristics are influential in determining how individuals internalize ethical challenges. Despite their commitment to follow ethical guidelines and standards of practice social workers conceptualize and respond to ethical challenges in unique ways, and it is the complex interaction among these entities that govern the frequency and severity of moral distress.

A broader understanding of moral distress makes it possible to identify and tackle the issues on the political and organizational levels and shift the focus from the individual practitioner. Research on moral distress has suffered from an oversimplification around the role of direct constraints (Mänttäri-van der Kuip, 2020) and much of the empirical data on moral distress are focused directly on institutional constraints (systemic/environmental factors) preventing practitioners from exercising moral agency. If research on MD continues to focus merely on constraints as a necessary condition of MD, there is the risk of neglecting interactions among all contributing mechanisms. Constraints alone are unable to clarify or provide sufficient means for understanding how and why moral distress occurs. Influences from various mechanisms must be considered in establishing a comprehensive understanding of moral distress, including, reactions and responses to moral distress (Varcoe et al. (2012).

The intent of this study is not an attempt to eradicate moral distress; as long as people have morals there will be moral distress, and moral distress can have a positive influence that inspires people to oppose injustices. Everyone faces moral challenges at some point in their life. Even

people who are morally corrupt can have rare moments of moral conscientiousness and experience distress when they are kept from acting rightly. The difference between strong and mild moral distress is a difference only in degree, not in kind. There are occasions of moral distress that result from an instance of serious moral failure, while other occasions are only mildly distressing but occur on a regular basis, thus having an adverse cumulative effect on those who experience them, previously defined as moral residue (Webster & Baylis, 2000).

This study is not designed to measure the frequency or the degree of negative effects, but rather to acknowledge the existence of and the influential power within mechanisms leading to moral distress, including personal variables such as courage, grit and one's ability to work through moral adversity.

Implications for practice and education

The data from this study adds to the literature on moral distress by integrating the relationship between external constraints and internal characteristics of the workers. Internal characteristics include the development of self-identity and moral reasoning based on social work values, and value-based practices (e.g., living according to ones' moral code). The findings are essential in moving moral distress beyond an individual experience for practitioners who need to endure the distress or develop individual coping skills to overcome it. It is the hope that workplaces and social work educators will use the data to improve work environments and enhance educational opportunities in a way that social workers can be more resilient to moral distress. The data identifies areas in which social workers can build resilience to moral distress and affect positive change within their work environment to decrease structural mechanisms implicated in moral distress. Examples include identifying and reporting instances in which organizational policies conflict with the social work code of ethics, advocating for government reaction to insufficient

resources, reducing unnecessary bureaucracy that impedes their ability to meet the client's needs. Whether individually or as part of an organizational effort social workers can take moral action through public policy advocacy beyond the workplace. As indicated in the data, increased moral sensitivity may also help to reduce moral distress. Thus, social workers can learn about various ethical theories and approaches to solving ethical dilemmas. Other ways to build resilience may include, remaining open-minded and curious about ethical challenges and resisting conclusions that there is only one way to conceptualize moral obligations, humbly acknowledging what is within their limits and capabilities.

The data provides support for increased workplace initiatives promoting shared decision-making, establishing supportive environments regarding ethical problem solving, transparent processes, integrity and accountability in management, and including social workers in policy development. Organizations that employ social workers should understand the social work standards of practice and work toward eliminating value conflicts or at least have a mechanism for dealing with them. Organizations can revise practice guidelines and policies around workplace harassment to include a more comprehensive description of workplace bullying and abuse, develop and maintain effective training for managers, and hire social workers in leadership positions over social workers. The data also supports changes to social work education can reduce moral distress. Specific education on moral distress would be helpful. Modifications to educational curriculum at the undergrad level would include skill training on the core competencies of social work. Specific training might involve competency in mediation skills, assessment skills, trauma informed practice, and successful advocacy. Additional training may also include social work within various theoretical approaches such as the medical model, forensics, and child welfare. The data revealed ethical challenges that arose due to incompatible

demands between organizational policies and the social work code of ethics, which reportedly resulted in moral distress. Regulatory bodies and the Canadian Association of Social Workers can use the findings from this study to minimize value conflicts by reaching out to health institutions, government agencies and social work educators with the intention of minimizing value conflicts.

Recommendations for future research

The data from this study has highlighted the need for future research to elucidate some relevant factors. Social justice was the common theme reported by social workers in relation to their refuted attempts to achieve it. Further research into individual social worker's interpretation of social justice and its relationship to moral distress is needed. Hypothetically, social workers with a higher commitment to social justice may experience increased moral conflict. Another variable for further research is grounded in the personality characteristics of individual practitioners. Grit is an independent variable worthy of future study as a determinant of the frequency and severity of moral distress one experiences given similar ethical challenges. It was not included in the theme's because it presented separately. However, Grit is a factor that, along with other factors, can determine whether or not moral distress will result. from Similarly, one might do empirical research on social workers' denial of moral distress as a means of coping. The data from this study suggest that some people have greater resolve in meeting ethical challenges and do not internalize them negatively, but rather see the challenge as motivation to dig a little deeper. The findings of this study also endorse further research into the prevalence of incompatible guidelines between the Social Work Code of Ethics and various organizational policies with the goal of eliminated major discrepancies.

Limitations –

The data for this thesis was obtained through interviews about participants' experience. This researcher believes that a person's moral experiences are best known and communicated through conversation. Other studies on moral distress in social work have been helpful in establishing a source of knowledge for comparison. An attempt to include various social work sectors was made (tables 7 & 8). Further data collection focusing on sector-specific data may help to explore differences among organizations across different service fields. The sampling process was intended to seek out practitioners working in areas most likely to experience moral distress. Participants interested in moral distress who attended a workshop offered by the student were also invited to participate. Therefore, the participants may not constitute a representative sample of all social workers. Probability sampling of a larger number of social workers may provide more precise findings on social workers that exhibit grit and resilience to ethical challenges as well as more representative findings on moral distress.

The four criteria of trustworthiness: *credibility, dependability, transferability, confirmability* as outlined in Lincoln and Guba (1985, pp. 301-318) will be used to evaluate the limitations of this study.

Credibility – The credibility criterion mirrors internal validity; ensuring that the study is measuring what it is intended to measure. Methods for establishing credibility are: prolonged engagement, persistent observation, triangulation, peer debriefing, referential adequacy, and member checks. In qualitative research credibility deals with the question, "how congruent are the findings with what has been reported; are the results of the study credible or believable from the perspective of the research participants?

Prolonged engagement - Refers to spending sufficient time in the field to learn or understand the culture, social setting, or phenomenon of interest. This includes observing various aspects of

a setting, speaking with a range of people, and developing relationships and rapport with members of the culture.

The researcher has worked as a social worker for several years in health-related settings. Although each individual setting has its own workplace culture and differs from the researcher's experiences, the social work viewpoint is well understood by the researcher. It would be ideal to spend time observing each participant in his or her work environment; however, due to time constraints data collection is restricted to interview sessions.

The researcher had in-person meetings with Dr. Rushton, a leading scholar on moral distress to discuss methods of building resilience. The discussions were informative and clarified the researcher's conceptual knowledge of moral distress. Additionally, the researcher met on several occasions with Dr. George Webster to discuss his research on moral distress and moral residue. Conversations with Dr. Webster were inspirational toward further study of moral distress. The researcher also has facilitated numerous ethics workshops intended to create awareness on contributing factors and negative effects of MD. The workshops were well attended by a variety of healthcare providers, including social workers. Workshop discussions revealed an abundance of moral and ethical problems related to policies, codes of ethics and cultural practices in healthcare and other social work settings. The workshops were safe places for participants to share stories; as a result, group discussions revealed personal experiences of moral challenges within social work environments.

As a social worker, the researcher shares social work values and practice guidelines with the participants. Trust and rapport with the participants were enhanced through a shared understanding that comes from common professional values. Eight interviews were held with an average of 90 minutes in duration. Following a discussion with the supervisor an additional

interview was scheduled to clarify details and strengthen the validity of the data. The researcher also established a level of comfort through pre-interview contact and well-defined processes. The process also included an extensive review of the literature.

Persistent Observation - Involves the researcher's extended time spent in the environment and in interaction with situations and characteristics of the phenomenon being studied. The purpose is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. "If prolonged engagement provides scope, persistent observation provides depth" (Lincoln & Guba, 1985, p. 304).

Due to time restrictions associated with persistent observation and limitations of this study, persistent observation was not a part of data collection. However, as previously mentioned, conversations with well-known scholars and years of workshop facilitation on moral distress combined with several years working in social work environments augment the researcher's understanding of characteristic related to MD. Additionally, prior research data and grounded theory methods inform this study to develop the conceptualization of moral distress in social work.

Systemic and environmental factors have been identified as major factors leading to MD in nursing (Jameton, 1984; Corley, 2001,2002; Hamric, 2012). The interview questions have been informed by existing data and prior knowledge gathered through workshops.
Furthermore, a critical realist approach encompasses a thorough exploration of all potential characteristics and causal factors. In that manner the methodology itself establishes credibility in the absence of persistent observation.

Grounded theory methods of coding and constant comparison were used to identify and ensure that the characteristics and elements are relevant to the problem or issue being pursued. Data were grounded in each participant's description of factors and compared to other participants' descriptions as well as compared with all other data. Thus, processes of constant comparison and abduction, with as many theoretical explanations as possible were used to explain influences from larger structural issues and how they impact the social worker's experience. Prior research was the starting point for identifying and creating a list of characteristics and elements that commonly contribute to moral distress.

Throughout the interviews the researcher was observing the participants' non-verbal communication and noting moments of discomfort or emotional reactions. In all instances the participants' affect was congruent with their expressed statements. Some, cried, and some showed frustration as they told their stories.

Triangulation – Involves the use of multiple types of data, and/or theoretical frameworks and/or data collection methods and/or sources to produce understanding. Some see triangulation as a method for corroborating findings and as a test for validity. Rather than seeing triangulation as a method for validation or verification, qualitative researchers generally use this technique to ensure that an account is rich, robust, comprehensive and well-developed. This study used four types of triangulation as per Denzin (1978) and Patton (1999):

Methods – Grounded theory, allowed for the reconstruction of a logical and comprehensive model of moral distress in social work and the application of critical realist theory established explanatory power to mechanisms from other levels of reality. Critical realism bridges the gap between logical positivism and constructivist views, insisting that all facts are theory-laden (Oliver, 2011). This study uses multiple data sources that combine interviews, observation, and

textual analysis. Grounded theory was intended to be useful with a broad range of theoretical perspectives and provides an opportunity for a variety of different methods (Charmaz, 2014). Quantitative findings from previous research were used to check for consistency and identification of divergence across the varying factors. Empirical data that identified commonly reported causal factors and emotional responses were compared with emerging data. Constant comparison was also used to check for consistency and identification of variation across factors. Relationships among conceptual categories and their impacts on the social worker helped to describe MD in greater detail. Therefore, critical realist grounded theory addresses both the event itself and the meanings made of it. Methods in this study have allowed for new ideas to emerge from the data. Through open coding, constant comparison and abductive questioning the data moved the researcher beyond the received understandings (Oliver, 2011). The data analysis accounted for comparison across different sources and methods. For example, at different points in time historical conceptualizations of MD differed from Jameton, (1984) to current. Comparisons across settings, four different sectors, and across professions, with results from nursing and other helping professions compared to social work. Comparisons were also made across seven participants and their experiences as well as empirical data obtained from experienced social workers being analyzed with grounded theory methods and compared to theoretical constructs.

Analyst - The primary researcher was the only observer of individual participants. Observations were predominantly obtained through the interview process. This study is under the direct supervision of an advisor and advisory committee who provide critical review of the findings and interpretations drawn from it. The advisor has been in constant contact with the researcher throughout the process, has examined the observations generated by the researcher

and provided feedback identifying blind spots in the interpretive analysis. As a result, differing viewpoints are provided through multiple reviews, analysis, and feedback critiquing the data.

Theory/perspective – Multiple theoretical perspectives have informed this study. In order to complete a comprehensive analysis, the data includes theories from differing viewpoints. For example, critical realism theory, (Bhaskar, R. 1978, 1986, 1989), role conflict theory (Rizzo, J. R., House, R. J., & Lirtzman, S.I. 1970), values theory (Rokeach, M., 1979), moral development theory, (Eisenberg, N., 2000), ethics theories (Wienberg, 2010; Webster & Baylis, 2000), caregiver role identity theory (Siebert & Siebert, 2005), and postmodern theories, (Fouault, M. 1978, 1982, 1984, 1988, 1991). An application and comparison of these different theories provides multiple understandings and acts as a form of triangulation to support the findings. The correspondence among these theories were considered in the analysis and culminated into the final analysis to establish the conceptual theory.

Critical realist grounded theory draws inspiration from the hermeneutical bent and fluidity of the constructivist approach (Oliver, 2011) and demands the exploration of and appreciation of the relationships among a variety of theoretical perspectives. CR researchers approach data with preconceived analytical concepts of emergence and generative mechanisms and pursue emancipatory goals, rather than merely descriptive observations. In that manner, the theory itself demands triangulation through its processes.

Peer debriefing - "It is a process of exposing oneself to a disinterested peer in a manner paralleling an analytical session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308).

Peer debriefing was not a source of securing credibility in this study. The advisory committee offered multiple viewpoints and professional feedback to the researcher. The hope is that the process pushed him beyond his own personal viewpoint and analysis. Although peer debriefing provides for multiple viewpoints, it also introduces a risk of making assumptions and injecting biases into the results. Advisory committee reviews delivered an opportunity to test and defend emerging hypotheses. Analytical examination from the advisory committee revealed some of the researcher's taken for granted biases and moved beyond his personal assumptions to a more comprehensive understanding of MD. Additionally, the researcher developed insight into his preconceived notions on MD and epistemological approaches; thereby providing an opportunity to distinguish between preconceived assumptions and participant reports. The researcher has attempted to keep an open mind in discussions with other social workers on the topic.

Member checks - This is when data, analytic categories, interpretations and conclusions are tested with members of those groups from whom the data were originally obtained. This can be done both formally and informally as opportunities for member checks may arise during the normal course of observation and conversation (Lincoln and Guba, 1985).

Participants had an opportunity to provide feedback throughout the process, including follow-up conversations. One particular participant was interviewed a second time for additional information and clarification of various experiences. Transcriptions were sent to the participants, providing them with an opportunity to assess and verify their authentic nature and ensure they reflect their intended message. Summaries of the analysis will be sent to participants when available. Participants were welcomed to evaluate categories, interpretations, or conclusions. All comments and suggestions were noted. Two participants provided written responses. The

responses were summaries of the dialogue with comments about wording changes as they thought the conversational version was not professional. There were no requests to delete or add content to the transcripts.

Dependability – The dependability criterion establishes reliability. If the study were to be repeated in the same context, with the same methods, and with the same participants, similar results should be obtained. From a qualitative approach the researcher must account for the ever-changing context within which research occurs. The researcher is responsible for describing changes that occur in the setting and how the changes affected the way the researcher approached the study. The method used to establish dependability is through external audits, to demonstrate that the findings are consistent and could be repeated. To maintain dependability the processes of the study has been reported in detail, thereby enabling future researchers to repeat the work, if not necessarily gain the same results.

External audits - involve having a researcher not involved in the research process examine both the process and product of the research study. The purpose is to evaluate the accuracy and the degree to which the findings, interpretations and conclusions are supported by the data. External audits are conducted to foster the accuracy or validity of a research study. This study will not use external audits. However, it is under the supervision of an advisor and advisory committee who served similar functions. They provided an opportunity to summarize preliminary findings, assess the adequacy of the data and preliminary results, provide important feedback that can lead to additional data gathering and the development of stronger and better articulated findings. In this context, the primary researcher is a student undertaking research for a thesis, and took advice from the advisory committee on matters of interpretation. During the

interviews the Researcher put aside all personal opinions and assumptions. The audit trail is supported through memos and described in the methods section of the thesis.

Transferability - The criterion of transferability establishes external validity. How well do the conclusions generalize or transfer onto other contexts or settings and or persons? From a qualitative perspective transferability is primarily the responsibility of the one doing the generalizing. The qualitative researcher enhances transferability by thoroughly describing the context, the research participants' experience and the assumptions that were central to the research. The person who wishes to "transfer" the results to a different context is then responsible for making the judgment as to how sensible the transfer is. Methods include: using thick description and reflexivity to demonstrate that the findings have applicability in other contexts.

Thick description - Thick description is described by Lincoln and Guba (1985) as a way of achieving a type of external validity. By describing a phenomenon in sufficient detail, one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people. This description includes a detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context.

Thick descriptive data provided comparisons between the context and participants and other social work settings. Four different social work sectors were represented in this study and compared in the analysis. Based on the tenets of critical realism, this study was not limited to any particular theory put forward by other researchers, but rather applies many theoretical approaches to seek out as many plausible mechanisms and explanations as possible to define the subject matter. One of the most important features of CR is that ontology (nature of reality)

is not reducible to epistemology (our knowledge of reality). In this respect, critical realism deviates from both positivism and constructivism (Fletcher, 2017). The primary goal of CR is to explain social events through a stratified layer of causal mechanisms. Results provide a description of the relationships among conceptual categories and their synthesis into theory. CR methodology moves the researcher beyond the ‘rich description’ and ‘giving voice’ typical of constructivist methodologies that only hold up a mirror to the experiences of others (Oliver, 2011). The methodology of this study demands a thorough and rich description of contextual features and phenomena; thus, enhancing the transferability of data onto other settings.

Reflexivity - Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. Because the researcher is often constructed as the 'human research instrument’, and the one responsible for transferring the data onto other contexts, understanding something about the position, perspective, beliefs and values of the researcher enhances the criterion of transferability. "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions", (Malterud, 2001, p. 483-484).

Steps to foster reflexivity included a reflexive journal in which the researcher maintained a diary in the form of memos. These memos were ongoing throughout the research process and included the researcher’s thoughts about the process, ideas about change, comments on unexpected findings, methodological decisions and the reasons for them, the logistics of the study, and reflections upon what is happening in terms of the researchers’ own values and interests.

Memos - and journal reports are included in the methods section of the thesis. The thesis is part of a master's degree program and takes place within the roles of an advisor and advisory committee. The advisor and advisory committee are a means to foster dialogue, leading to the development of complementary as well as divergent understandings of the circumstances, and provided a context in which the researcher's, thoughts, beliefs, values, and assumptions were revealed and contested. As part of the research findings and summary the researcher will briefly report, as best as possible, how his own preconceptions, beliefs, values, assumptions and position may have come into play during the research process.

Prior to the interviews the researcher conceptualized moral distress from a nursing perspective. The hope was to merely confirm the literature and adapt it to a social work context (work environment). This viewpoint shifted after learning that the theoretical and environmental differences between nursing and social work make a substantial difference to the way moral distress develops and is understood. In particular, participants were morally motivated in their commitment toward social justice. Participants repeatedly described social justice as an influential value that inspired them to the profession and how workplace managers, supervisors and administrators were not supportive and often opposed their efforts toward social justice issues.

Critical realism theory helped to formalize patterns and mechanisms leading the researcher to a more complex understanding of moral distress. Several new concepts emerged that required critical thinking and comparison. There are many interrelated factors to analyze and the three domains of critical realism helped to formulate a clear understanding into how and why mechanisms influence each other and are factors in moral distress.

The researcher was careful to remain objective and avoid leading participants on during the interviews and all went well when the participants provided their examples however, when participants did not divulge personal negative effects related to the experience the researcher pursued with additional probe questions in attempt to uncover versions of distress that may have been unrecognized and acceptable to the participant. This was a result of the researcher's preconceived notion that moral distress has various negative physical, emotional and psychological effects. Fortunately, this occurred early in the data collection phase and the researcher was prepared for such a response and also asked for more specifies about how the experienced affected the participants. This became a turning point that indicated there are personal characteristics to consider that may alter the frequency and duration of moral distress. Only after entering the first round of axial coding did that become evident. Features such as personality, culture, commitment, epistemology, government agendas and mechanisms emerged as factors to consider.

Prior to the interviews the researcher was concerned about conducting an investigative style interview while remaining empathic and understanding of the participant's circumstances, or that information related to one's personal moral experiences would not be as openly offered in that style of questioning. Other concerns were related to asking the questions in a standardized manner to establish continuity among participants. Following a discussion with his advisor it was decided to use presupposition questions that through their content and grammatical structure create rapport by assuming shared knowledge and assumptions (Patton, 2015). This also help the researcher remain objective in his approach. After the first interview the researcher was alerted to his presentation as in efforts to maintain report interjected additional information into the question that resulted in double barrel questions. The researcher noted the instances and made a

commitment to be clear and ask only one at a time. A copy of the research questions was used as a guide to prevent extra words added to the question and prevent double barrel questions. Prior to the interviews, the researcher had preconceived notions of how participants might respond based on their sector of social work. Concerted efforts were made not to allow self-directed thoughts affect the interview process. For example, power imbalances in hospitals or unconscious bias toward Indigenous People. Despite well intentioned efforts instances of preconceived notions did alter the interview process. The primary result being increased probe questions about situations to clarify or expel the researcher's belief.

The memos enabled the researcher maintain reflexivity during the entire study and also helped itemize patterns in the data and define links between them. Memos mapped out the epistemological progress revealing emerging ideas, developments and changes to the researcher's understanding of moral distress.

Confirmability – The criterion, confirmability, establishes objectivity. Qualitative research accepts that each researcher brings a unique perspective to the study. Confirmability refers to the degree to which the results could be confirmed or corroborated by others. Methods to enhance confirmability include; external audits and audit trials to maximize the extent to which the findings of the study are shaped by the participants and not the researcher's bias, motivation, or personal interests; thereby attaining a degree of neutrality.

As previously mentioned under the 'dependability' criterion, external audits were facilitated through the ongoing involvement of an experienced advisor and advisory committee, who, as independent coders l analyzed transcriptions and reviewed raw data, tape recorded data, written field notes, documents, and results, independently. Advisory committee meetings and feedback from presentations helped to establish authenticity of the data and determine whether or not the

findings, interpretations and conclusions are supported by the data. The advisor provided important feedback that resulted in additional data gathering to develop stronger data to support the conclusions made by the researcher.

Audit trail - An audit trail is a transparent description of the research steps taken from the start of a research project to the development and reporting of findings. These are records that are kept regarding what was done in an investigation (Lincoln and Guba, 1985; Halpern 1983).

Memos have been kept from the beginning of the process and contain information that provides a clear description of the research path. The steps have been described in the methods section of this paper. This includes the research design and data collection decisions made along the way; as well as steps taken to manage, analyze and report data.

Discussing factors leading to moral distress includes disclosing workplace incidents that may have been unethical. Some social workers may have been reluctant to come forward and reveal these incidents for fear of reprisal. In the invitation to participate the researcher emphasized measures that will be taken toward protection of information. However, it may be possible that some participants did not disclose details of the circumstance that created MD for fear of breaching confidentiality.

The researcher has experienced numerous stories of moral distress prior to the study. In an attempt to prevent bias from entering into the analysis of the data the researcher constructed cognitive inventories of potential interpretive bias as the data were being gathered and analyzed. Critical realist methodology moves the researcher beyond perceived notions through constant comparison and multiple viewpoints.

Appendix A

Interview Questions

1. Describe the social work duties in your position.
2. What inspired you to choose a career in Social Work?
3. During your social work experience, can you describe an instance in which you felt the most ethical action was not carried out, and it caused you to feel distress?
   a.) *What was your perception of the ethical problems?*
   b.) *What barriers prevented you from acting on your moral instinct?*
   c.) *What did you do?*
   d.) *What if anything could have been done differently?*
   e.) *Describe the emotions associated with that experience.*
   f.) *Are there any personal changes resulting from this incident?*
   g.) *How has this incident affected your outlook on your professional practice?*
4. Have you experienced organizational guidelines that prevent you from practicing according to SW values?
5. Describe a common occurrence that occurs quite often, that is quite unethical to you?
6. How would you describe the implicit rules that are expected to be followed at your workplace.
7. If you were a social worker educator, what would you change or add to the social work curriculum to better prepare students for frontline social work?
8. Out of all the things we talked about today – or maybe things we missed – what should I think about most when I read your interview?

Appendix B

Table 5

Summary of definitions of MD included in the literature review (ed by date)

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
Jameton, United States	'A nurse experiences moral distress when the nurse makes a moral judgment about a case in which he or she is involved and the institution or coworkers make it difficult or impossible for the nurse to act on that judgement' (p.542)	Initial distress, reactive distress	Moral judgement sees nurses as, ideally, 'responsible actors' (as distinct from wholly free or wholly oppressed)	Inadequate patient consent; overtreatment; cost cuts; economic efficiencies; prioritizing technological interventions; hierarchal structures; power imbalance; focus on measurable outcomes; attribution of emotional labor to nurses; unequal status of pay and power relations between nurses and doctors	*Negative:* burnout; decision to leave nursing
Corley, United States	'Moral distress is the psychological disequilibrium, negative feeling state, and suffering experienced when nurses make a moral decision and then either do not or feel they cannot follow through with the chosen action because of institutional constraints' (p.643)	Initial distress, reactive distress, moral residue	Moral judgement, moral integrity; moral certainty; moral courage; moral sensitivity; moral comportment; moral competency; moral imagination	Harm to patients; treating patients as objects; institutional constraints; aggressive care; inadequate informed consent; poor staffing; cost cuts; poor pain management; incompetent care; grim choices with unpredictable outcomes; risk of unpleasantness/more work following action; need to obtain cooperation from others	*Negative:* high staff turnover; burnout; resignations; leaving nursing; inadequate care; denying responsibility; detachment; avoiding patients; longer hospital stays; *Positive:* learning from failure; greater resolve; personal and professional growth; compassionate care; coping strategies
Lützén et al. Sweden	'Moral stress is experienced when nurses are aware of what ethical principles are at stake in a specific situation and external factors prevent them from making a decision that would reduce the conflict between contradicting principles' (p. 314)	Stress with a moral concept	Moral decision; moral sensitivity; caring as an ethical activity; doing good	Sensitivity to patients; vulnerability and lack of autonomy; experience of external factors preventing them from doing what they think is best for patients; no control over the specific situation	*Negative:* coercion of patients; long-term health problems *Positive:* feeling of accomplishment of professional goals (p.315)

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
Hana United States	An "umbrella category" that could include the experience of anguish or suffering associated with facing a moral dilemma, moral uncertainty as well as certainty accompanied by constraint 'Not exclusively an external constraint or right action…. It involves a perceived violation of the person that can produce a disconnection from self and others' (p.76)	Conscience	Right action; role morality (what nurses do to meet the goals of nursing), moral integrity; whistle-blowing and advocacy; universal objective moral norms; perceived violation of the person	Harming the purpose of another person; role morality- whistle-blowing; patient advocacy; truth-telling; clinical conflicts	*Negative:* disconnection from personal values and beliefs; burnout; blunting affect *Positive:* develops moral character; personal transformation and growth
Peter and Liaschenko, Canada and	'On the one hand, in order to experience moral distress, an agent is required to possess at least some autonomy in recognizing and reflecting upon moral concerns. Yet on the other hand, an agent's autonomy must be at least somewhat constrained in acting upon the very moral responsibilities he/she understands him/herself to have. This apparently irreversible contradiction is experienced as moral distress' (p.221)	Not stated	Moral agency; integrity; responsiveness; sustained proximity (to patients); moral agency as situated-enabled and disabled by social context; interpersonal morality	Difficult working conditions; corporatization of healthcare; proximity to patients and acute awareness of moral responsibility	*Negative:* the urge to flee and abandon the patient
Kopala and Burkhart, United States	'Moral distress is a response experienced when a decision-maker's ability to carry out a chosen ethical or moral action is thwarted by some barrier. Barriers or constraints have been identified as internal, external, institutional and situational' (p.8)	Not stated	Moral judgement; universal moral norms; ideals and virtues to avoid ethical harms and maximize good	Lack of support; security; time constraints; distance from hospital; exercise of medical power; futility in past actions; self-doubt or lack of courage; legal concerns; administrative and institutional policies	*Positive:* addressing causes of MD by confronting barriers to patient choice and empowering patients through educational interventions

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
McCarthy and Deady, Ireland	'An umbrella concept that captures the range of experiences of individuals who are morally constrained. Generally speaking, when individuals make moral judgements about the right course of action to take in a situation, and they are unable to carry it out, they may experience MD' (p.254)	Initial distress; reactive distress	Moral judgement; personal integrity; moral values; moral sensitivity; occupational role	Personal failing; hierarchical decision-making; lack of resources; aggressive treatment; unnecessary tests; deception; incompetent or inadequate treatment; power imbalances; lack of institutional support	*Negative:* negative coping strategies; for example, leaving the unit, blaming nursing and hospital administration, excusing one's actions, avoiding patients *Positive:* positive coping strategies, for example, self-care, working part-time, assertiveness, collective action, greater self-awareness and resolve
Epstein and |Hamric, United States	'A hallmark of MD is the presence of constraints, either internal (personal) or external (institutional)…that prevent one from taking actions that one perceives to be morally right' (p.330)	Initial distress; reactive distress; moral residue; crescendo effect	Acting on one's ethical obligations; damaged moral integrity; perceived violation of core values and duties	Aggressive treatment; lack of resources; inability to provide necessary treatments; problems with team; poor communication; poor team leadership; lack of policies	*Negative:* self-blame; powerlessness; passivity; conscientious objection; burnout; withdrawal form position/profession
Repenshek United States	'The current definition is not moral distress as defined by Jameton, but rather, in large part, nursing's discomfort with moral subjectivity in end-of-life decision-making' (p.734)	Not stated	Right action; moral subjectivity; role morality; personal and professional integrity	Aggressive and/or futile care; whistle-blowing and advocacy	*Negative:* inability to act on patient's behalf; professional integrity at risk; not invested in professional role; burnout
Walsh, United States	'The feelings and experiences that result from a moral conflict, where one knows the correct action to take but constraints lead to an inability to implement this action' (p.746)	Not stated	Moral knowledge; integrity; sense of responsibility; misplaced guilt	Futile medical care	*Negative|:*flight from patients

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
Cribb, United Kingdom	'I am interested in how we can work with the routine and constant tensions and dilemmas that professional role occupancy thus generates; and also in the implications the recognition of these routine tensions has for role construction' (p.124)	Stress that has a moral burden	Ethical judgement; moral integrity; professional role; moral burden; role construction; professional ethical identity; moral compass; professional autonomy; authenticity; institutional and personal values	Gap between the normative expectations attached to a professional role and the personal moral compass of the healthcare professional (p.120). (e.g. funding pressures and the colonizing of the subjectivities of health professionals with institutional norms for institutional ends)	Not stated
Austin, Canada	'Experiences of frustration and not stated failure arising from struggles to fulfill their moral obligations to patients, families, and the public' (p.28)	Not stated	Moral agency; professional identity; fiduciary duty; moral responsibility; situated and relational; moral agency as diminished; ethical clarity	Healthcare reform; cuts to services; efficiency measures; technological advances; unable to fulfill one's perceived responsibilities; unrealistic expectations; aggressive treatment; inability to advocate for patients; lack of recognition of one's expertise; professional and interprofessional relationships; poor care	*Negative:* leaving positions *Positive:* carrying out acts of resistance; advocating for patients
Hamric, United States	Refers to Jameton's definition as well as several others that refer to situations when nurses are unable to practice ethically because of internal and external constraints	Reactive distress; moral residue; crescendo effect	Moral judgement; moral integrity; occupational role; erosion and compromise of core moral values; desensitization	Internal factors, for example, perceived powerlessness, external factors, for example, inadequate staffing; clinical situations, for example unnecessary/futile treatment, inadequate informed consent	*Negative:* desensitization; withdrawal; conscientious objection; leaving the position/profession

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
Lützén and Kvist Sweeden	'A person's experiences of external factors preventing him/her from doing what he or she thinks is the right thing to do, at the same time as being aware of his or her inability to take action according to internalized moral guidelines' (pp. 16-17)	Stress; stress of conscience; initial stress; reactive distress; moral residue	Doing the right thing; judgement; occupational role; moral guidelines; moral sensitivity; moral knowledge; moral climate; moral responsibility	Technological advances; scarce resources; economic and political structures; absence of guidelines, value conflicts; unhealthy ethical climate	*Positive:* positive catalyst (p.13); prevents moral blindness; reflection on moral duties
Pauley et al. Canada	'Associated with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties' (p.2)	Initial distress; reactive distress; moral residue	Moral agency; personal integrity; professional values; responsibilities; duties; structural conditions that give rise to moral distress	Professional position; policies; workload; efficiency measures	*Negative:* withdrawal from patients; unsafe/poor patient care; decreasing job satisfaction; leaving nursing
Varcoe et al., Canada	'The experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple context, including the socio-political and cultural context of the workplace environment' (p.59)	Moral residue	Moral agency; personal integrity and identity; serious compromise of deeply held personal/professional values; context; relational; interpersonal; structural	Social and health inequities; discrimination; scarce resources; individual and structural factors; for example, deception, non-disclosure; inability to enact standards	*Negative:* desensitization; disengagement; moral silence; deafness, blindness *Positive:* clarifies ethical commitments and strengthens resolve
Jameton, United States	'Moral distress… arises when individuals have clear moral judgements about societal practices, but have difficulty in finding a venue in which to express	Not stated	Moral judgement; moral choice; moral actions; involvement in moral wrong-doing; lacking authority; constrained agency; constrained advocacy	Aggressive treatment; contributing to patients' suffering; proximity to patients; power imbalances; nurse-physician conflicts; lack of support; lack	*Negative:* ambivalence; passivity *Positive:* energizing response-activism

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
	Concerns (p.297) Moral distress expresses a decision point, a moment of emotive immobility, where ambivalence needs to be resolved toward a choice' (p.303)			of opportunity to voice concerns	
Johnstone and Hutchinson, Australia	The main tenet of moral distress is the idea that nurses know what is the right think to do but are unable to carry it out (p.4) Considers the standard definition of MD but argues that it is conceptually and empirically problematic	Initial distress; reactive distress; moral residue	Moral judgement; moral integrity; moral competency; moral intuition; moral imposition; moral disagreement	Nurses' own perceptions; lack of moral competency; external environments; disagreement/conflict about ethical values; views not respected	*Negative:* threat to quality of patient care; job dissatisfaction; burnout; leaving positions/profession; harm to patients' and families' significant moral interests
Peter and Liaschenko, Canada and United States	MD is an umbrella concept; the response to constraints experienced by nurses to their moral identities, responsibilities, and relationships (p.337)	Not stated	Moral response; damaged moral identity; relational; moral responsibility; moral habitability; morality is a socially embodied accomplishment (p.339)	Damage to moral identity; breakdown in trust; recognition that values and expectations are not shared; devaluation of nursing perspectives; power imbalances; focus on cost containment and efficiency; proximity to patients; perceived responsibility to relieve suffering; aggressive treatment; morally uninhabitable workplaces	*Positive:* critical questioning; open up dialogue and communication about values, assumptions and expectations; nurses can create counter stories; can evaluate the moral habitability of environments
Rushton et al., United States	'Moral distress is defined as the pain or anguish affecting the mind, body or relationships in response to a situation I which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action; yet, as a result of real or	Conscience; secondary stress; crescendo effect (repeated experiences of moral stress culminate into moral distress)	Moral judgement; individual and professional integrity; moral sensitivity; principled compassion; empathy; resilience	Pain and suffering of dying patients; conflicting moral demands and value conflicts; perceived inappropriate or burdensome use of technology	*Negative:* unregulated action; burnout; avoidance and/or abandonment of the patient and family; self-focused behaviours; desensitization *Positive:* empathy or positive regard; compassionate action; advocacy; requests for ethics consultation; integrity; resilience

Author, Country	Definition	Related Terms	Normative meaning	Sources	Impact
	perceived constraints, participates in perceived moral wrong-doing' (p.1074; cited from Nathaniel A: moral distress among nurses. American Nurses Association Ethics and Human Rights Issues Updates 2002; 1(3a)				

Note. Adapted from a journal article: A review of the argument-based nursing ethics literature (131-152), J. McCarthy & C. Gastmans. Nursing ethics, *22*(1), 131-152.

Appendix C

Table 6

Empirical nursing research cited in this study

Researcher	Title	Goal & Design of study	Methods	Findings
Corley M., Elswick, R., Gorman, M., Clor., T 2001	Development and evaluation of a moral distress scale	This methodological research developed and evaluated the moral distress scale from 1994 to 1997.	Instrument testing included three stages: test-re-test reliability, known groups validity, and administration of the instrument to a sample of 214 nurses. In the test-retest stage, it was revealed that there was limited variability in responses, which led to the scale being expanded from 5 to 7 response categories (little/almost none 1 to great 7). The second step involved using a contrasting groups approach whereby occupational health nurses and a group of critical care nurses completed the MDS. The occupational health nurses did not identify items on the scale as causing MD although they identified themselves as experiencing MD related to other problems. The critical care nurses identified moderate to high levels of MD related to the situations identified in the MDS (Corley, 1995). In the third stage, five groups, three of them from critical care areas, completed the instrument as a random sample with both descriptive and factor analysis conducted on the data. The possible	Mean scores on each item ranged from 3-9 to 5.5, indicating moderately high levels of moral distress. The item with the highest mean score (M=5.47) was working where the number of staff is so low that care is inadequate. Factor analysis yielded three factors: individual responsibility, not in the patient's best interest, and deception. No demographic or professional variables were related to moral distress. Fifteen percent of the nurses had resigned a position in the past because of moral distress. Conclusions: The results support the reliability and validity of the MDS

Researcher	Title	Goal & Design of study	Methods	Findings
			range for scores was 1 to 7 with a higher score indicating a greater level of MD. The mean scores by item ranged from 3.9 to 5.5, indicating moderately high levels of MD.	
Hamric, A.B., & Blackhall, 2007	Development and evaluation of a moral distress scale	This methodological research developed and evaluated the moral distress scale from 1994 to 1997.	Questionnaires included MDS reduced to 19 items (MDSR) to measure intensity (level of disturbance) and frequency of MD; Intensity multiplied by Frequency was used for a measure of MD; Ethical Environment/Climate was measured in the first site sample with 11 items from McDaniel's (50) 20-item Ethics Environment Questionnaire (EEQ). The Cronbach's of the shortened EEQ in this pilot was .89. For reasons of cost, this scale could not be used with the second sample. Olson's (48) Hospital Ethical Climate Survey (HECS) addresses this same concept but uses the word climate instead of environment. The HECS was shortened to 14 items with a Cronbach's alpha score of .88; Descriptive analysis was used to measure End-of-Life Communication and Satisfaction with quality of care; SPSS version 11.0 was used to analyze the other data (one-way ANOVA, Spearman's rank order correlation coefficients.)	Mean scores on each item ranged from 3-9 to 5.5, indicating moderately high levels of moral distress. The item with the highest mean score (M=5.47) was working where the number of staff is so low that care is inadequate. Factor analysis yielded three factors: individual responsibility, not in the patient's best interest, and deception. No demographic or professional variables were related to moral distress. Fifteen percent of the nurses had resigned a position in the past because of moral distress. Conclusions: The results support the reliability and validity of the MDS.

Researcher	Title	Goal & Design of study	Methods	Findings
Kalvermark, S., Hoglund, T., Hansson, M. G., Westerholm, P., Arnetz, B. 2004	Living with conflicts-ethical dilemmas and moral distress in the healthcare system	To measure MD among healthcare professionals in a broader perspective, including nurses, doctors, and pharmacy staff. To answer three main questions: 1. what kind of situations do healthcare professionals consider to be ethical dilemmas? 2. Do they experience stress in connection with those dilemmas? 3. Is MD limited to situations where the professional knows what is ethically correct but is prevented from acting on it?	Focus groups comprised of 5 to 7 members, each, where selected from the dept. of cardiology, hematology, and pharmacy. The participants included physicians, nurses, auxiliary nurses, pharmacists, dispensers, secretaries, and pharmacy assistants.[5] Participants were chosen by a contact person in the clinic/pharmacy. Interviews followed a question guide format, and were recorded, and transcribed. Statements were analyzed and categorized based on stress related comments.	Four main categories evolved from the data. 1. Lack of resources. 2. Rules vs. praxis. 3. Conflicts of interest. 4. Lack of supporting structures. Each of these categories were further broken down into sub-categories including specific examples. Conclusions are threefold- 1. All professionals reported MD. Therefore, it is not exclusive to nursing. 2. MD is not restricted to instances of not acting on moral convictions due to institutional constraints. Many acted on their moral convictions, and still had MD. 3. Heath organizations must provide better support resources.
Hamric, A.B., Borchers, C.T., Epstein, E.G., 2012	Development and testing of an instrument to measure moral distress in healthcare professionals	Descriptive study; The three purposes for revising the MDS: to make it more inclusive of root causes of moral distress; to expand its use into non-ICU settings; and to make it useable for multiple healthcare disciplines.	With Corley's authorization, items were removed from original MDS, remaining items were reworded to enhance clarity and broaden applicability to include a broader array of healthcare professionals. New items were added to include additional root causes of MD. This study was administered to Registered nurses (n=169) and physicians (n=37) only. Statistical analysis SPSS, Descriptive statistics, Pearson	Initial testing revealed evidence of instrument reliability and validity. Reliability was tested by calculating Cronbach's alpha. Construct validity evaluated through hypothesis testing. All four hypothesis were supported, although the first hypothesis only was supported by nurse group. Nurses with more experience demonstrated more MD. This relationship did not hold for physicians. The other three construct validity test were

Researcher	Title	Goal & Design of study	Methods	Findings
			correlation, independent t-test, and analysis of variance - ANOVA statistics to analyze relationships.	significant in the hypothesized directions.
Houston, S., Casanova, M., Leveille, M., Schmidt, K., Barnes, S., Trungle, K., and Fine,R. 2013	The intensity and frequency of moral distress among different healthcare professionals	Objective: to assess and compare differences in intensity, frequency, and overall severity of MD among a diverse group of healthcare professionals; Nurses (RN), social workers (SW), Chaplains, Pharmacists (RX), Physicians (MD), Therapists.	Participants from Baylor Health Care System with a response rate of (18.1%). completed an online MD survey containing nine core clinical scenarios and additional scenarios specific to each participant's discipline. Statistically significant differences in mean MD scores by age, sex, years of service in the system and in their profession were tested by Kruskal-Wallis nonparametric test. Significance was defined as p<.05 with two tailed test. The analysis of variance (ANOVA) was run to test for differences in mean MD scores by job role and demographic characteristics within each role. Cronbach's alpha was estimated to measure reliability/internal consistency of MD intensity and frequency scales.	Intensity of MD was high among all disciplines, although the causes varied among disciplines. Mean MD intensity was highest among nurses. Cronbach's alpha for both MD frequency and intensity scales revealed high internal consistency (.88 and .91) respectively. The ANOVA revealed statistically significant differences of MD among job roles, and Tukey's post hoc test identified nurses and therapists as the two most significantly different scores. Nurses had the highest score, followed by SW's, residents, MD's, chaplains, RX's and therapists.
Leggett, J.M., Wasson, K., Sinacore, J., Gamelli, R.L. 2013	A pilot study examining moral distress in one United States Burn Center	Descriptive, case study to evaluate an intervention aimed at decreasing MD in nurses on an ICU. burn unit.	Thirteen nurses were recruited and randomized into two groups. A separate sample pretest-posttest design was used. Group A completed the Moral Distress Scale-Revised (MDS-R) and Self-efficacy (SE) scale before completing a 4-week educational intervention involving weekly 60-minute sessions. Group B completed both scales	The MDS-R median score for group B (92.0) was significantly different statistically than group A (40.5). with P=.032 directly after the intervention. No significant difference was found in the median SE scores between group A -(34.5) and group B-(34.0); P=.616%. The median for group B was

Researcher	Title	Goal & Design of study	Methods	Findings
			afterward. Participants also completed written evaluations following each session. Both MDS-R and SE were re-administered to both groups 6 weeks after the intervention was completed. Given the size and distribution of the sample, non-parametric data analysis was used.	69 and group A was 60.5 (P=.775). At the 6 week follow-up the difference between the groups was no longer observed. Conclusion: The pilot study concluded that the nurses reported experiencing MD related to their work. The inconclusive findings raise questions regarding possible contributing factors (i.e. Years of experience). The subject of this study would benefit from a larger more broad-based study involving multiple burn centers, and larger population of nurses. Additionally, the larger study should be refined to develop strategies for interventions that become part of the culture that ultimately reduce MD. Overall the study has evidence to support that an understanding of MD can reduce to frequency and intensity of MD.
Ko, H.K., Chin, C. C., Hsu, M. T., 2016	Moral distress model reconstructed using grounded theory	Descriptive, grounded theory study. Aim: to reconstruct the model of moral distress using grounded theory. Participants: twenty-five nurses working with adult pediatric, acute, critical disease, and end of life care in Kaohsuing,Taiwan.	Theoretical sampling was used to recruit participants from three teaching hospitals. Data were collected using intensive 2 to 3 hr. interviews with each participant. Audio recordings were transcribed and analyzed using grounded theory. Derived 6 categories based on axial coding. The axial category was moral distress. Internal/external rigor was determined with the use of Lincoln & Guba's Trustworthiness	The perspective that nurses take toward moral events reflects their moral values, which trigger moral cognition, provocation, and appraisal. The moral barriers that form when moral events contradict personal values may later develop into MD. In handling moral barriers, nurses make moral judgements and determine what is morally correct. Influenced by moral efficacy, the consequence may either

Researcher	Title	Goal & Design of study	Methods	Findings
			measures; (Credibility, Transferability, Dependability, Confirmability)	be a moral action or an expression of personal emotion. The National Health Insurance resources and Chinese culture are key sources of MD for nurses in Taiwan. The role of self-confidence in promoting moral efficacy and the role of heterodox skills in promoting moral actions represent findings unique to this study.

Table 7:

Empirical Research in Social Work

Researchers	Title	Design	Aim of study	Methodology & Results
Maija Manttara-van der Kuip, (2016)	Moral Distress among social workers: the role of insufficient resources	Explanatory, descriptive studies of MD in SW.	Research question: what is the role of the ever-shrinking resources in predicting experiences of moral distress?	A study measuring reactive MD among social welfare workers based on insufficient resources. Three variables: 1 – impaired mental well-being, 2- experience of not being able to do one's work in a way they would like, 3- being forced to work in a way that conflicts with personal values. Sampling strategy: A link to an electronic questionnaire was sent to all social workers working in public social welfare services in every municipality across the mainland of Finland. Overall response rate (46.5 %)-(n=817). Methods: Both parametric and non-parametric methods were used for descriptive analysis. Hierarchic logistic regression was used to estimate the role of different groups of variables – i.) individual background ii.) organisation-related background, iii.) experiences of insufficient resources. Results: the individual background variables did not seem to be linked to MD. Hierarchical regression revealed no statistical significance between them. The organization related background variables did not notably explain MD either. Only 7.7 % of the variance were explained by these variances. However, experiences of insufficient resource variables were all statistically significant predictors of reactive MD. In total these variables explained 30.2% of the variance, with nearly 11 percent of participants reported experiencing MD and perceived resource insufficiencies strongly explained their experience. 77 percent reported they were often unable to do their work as well as they would like., and 36 percent felt that they were often forced to work in a manner that conflicted with their personal values.
Sagit Lev and Liat Ayalon, Israel, 2016	Moral Distress among long-term care social workers: Questionnaire Validation	Exploratory analysis	To describe the quantitative validation of a unique questionnaire to measure MD among social workers in long-	Methods: The total number of participants was 216 social workers working in long term care facilities. They completed electronic questionnaires that were based on a secondary analysis of a qualitative study that addresses moral dilemmas of social workers in long term care homes in Israel (Lev & Ayalon, 2015, 2016). Three themes were identified and

Researchers	Title	Design	Aim of study	Methodology & Results
			term care facilities in Israel.	determined to make up the framework of the questionnaire. The *first* theme encompassed respondents' perceptions of ethical behavior as it 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. The *third* theme addressed perceived actions in accordance with obligations to the residents in these situations. In addition to the questionnaire participants provided sociodemographic information consisting of gender, age, marital status, religion, strength of religious belief, country of origin, education, and seniority among social workers. Additionally, they described the type of institution and population with which they worked, and completed specific questionnaires on ethical environment, support, burnout, and intention to leave the job. In order to establish convergent validity questionnaires from a previous pilot study (Lev and Ayalon, 2015, 2016) were tested for correlations with ethical environment, support, burnout, and intention to leave the job. Two scales were used. One assessed the occurrence and frequency of MD and the other measured the occurrence of distress and its intensity. Evaluation of scales; the first measure (frequency), the second (intensity), multiplication of the two scales as a measure of overall MD. Results: The internal reliability was assessed by determining Chronbach's coefficient for each of the three moral distress scales, results were (.92) for all three scales. An exploratory factor analysis suggested a single-factor solution. Pearson correlations were computed to assess the construct validity of the questionnaire. In its final version the questionnaire consisted of 15 items. The conceptual definition of MD was not specifically defined. Conclusion: the questionnaire can contribute by broadening and deepening ethics discourse and research regarding moral conflicts and moral distress in Social work

Researchers	Title	Design	Aim of study	Methodology & Results
Gough, J., and Spencer, E. 2014, Alberta	Ethics in action: An exploratory survey of social workers ethical decision making and value conflicts	An Exploratory Survey	To develop and distribute a survey to SW students, educators, practitioners, and administrators. To identify ethical decision-making processes and value conflicts from a variety of circumstances and contexts.	**Methods**: Online questionnaire sent to all registered social workers in Alberta. Total number of completed responses (n=300). The survey was comprised of 20 questions. The first two questions were constructed to assess conflicting values based on a Likert scale. The other 18 questions were open ended questions allowing the participants the opportunity to elaborate on their story. **Analysis:** Both Likert scale responses were tallied and reported quantitatively on a percentage basis. The other 18 responses were sorted into identifying themes, conflicts and contexts that contributed to difficulties for social workers in making good ethical decisions. **Results**: High percentage of respondents reported value conflicts, with the highest being conflict between personal values and the organization they were employed (82%), client value conflicts (75%), conflicts with school/SW educational program (66%), and with the profession (53%). Issues regarding the code of ethics and standards of practice were identified. Inconsistencies and contextual features regarding organizational structure and relationships of power imbalances that result in failing to protect the clients' interests and confidentiality.
Browning, E.D., & Cruz 2018 Philadelphia, PA, USA	Reflective Debriefing: A social work intervention assessing moral distress among ICU nurses	A pre/post-test experimental design with a control group was utilized	The aim of this study was to develop and test a protocol for alleviating moral distress through regular, social work-facilitated debriefings with ICU nursing staff, including both reflective and educational components, with a secondary goal of evidencing organizational recognition and support for nurses coping with moral distress	**Methods:** The MDS-R was administered to ICU nurses to obtain a baseline moral distress score, after which the Reflective Debriefing intervention was offered once per month for 6 months. At the end of the 6-month period of intervention, the MDS-R was administered to ICU nurses again, along with a postintervention survey created by the researchers. A control group who did not participate in the intervention also completed the MDS-R at both times. **Analysis:** Data were analyzed utilizing the Statistical Package for the Social Sciences (SPSS). Descriptive statistics were calculated. Two-tailed partial correlations were used to determine if there were significant correlations between nurses' characteristics and their moral distress scores. The level of significance for all analyses was set at < 0.05. Independent *t*-test, Mann–Whitney *U* test, and regression analyses were used to analyze relationships and differences. **Results:** Nurses who participated in debriefing demonstrated a reduction in their MD scores, although the change was too small to be

Researchers	Title	Design	Aim of study	Methodology & Results
				considered significant. However, both an independent samples *t*-test and a more rigorous Mann–Whitney *U* test indicate lower moral distress scores for the experimental group (*n* = 23) as compared to the control group (*n* = 19), demonstrating that participating in Reflective Debriefing may positively impact nurses' ability to cope with the effects of moral distress. Including a Monte Carlo simulation also indicates a high confidence that the debriefing intervention, rather than another variable, accounts for this outcome. Moreover, the model summary of adjusted *R*2 indicates that nurses' subjective experience of moral distress was positively impacted by the intervention. ICU nurses who completed the MDS-R either at Time 1 (*M* = 81.81, SD = 37.43) or Time 2 (*M* = 100.55, SD = 43.47) displayed low to moderate levels of MD. The highest scores fell in the range of 117–219, substantially lower than the highest potential scores of 225–336.
Baker Collins & Cranmer-Byng (2018)	Things I Cannot Change	Exploratory qualitative research	This research study is specific to moral distress among social workers who worked as case managers in southern Ontario. The focus was particularly on the role of structural constraints, such as policy restrictions as contributors of moral distress.	Methods Interviews with SW case-mangers (N=15) in southern Ontario. Participants were recruited formally and informally via local service agency personnel with a snowball sampling method (Patton 2015). The case managers were representative of experience and case management roles. They varied from income eligibility and employment counselling to community outreach, training, and working with particular populations including the homeless, youth, and those with addictions and mental health issues. Interviews were audio recorded, transcribed and analyzed using the MAXQDA qualitative data analysis program. Aspects which related to the nature of the job were coded and analyzed, including the rewarding and challenging aspects of the job, workload, and supervision. Interviews were analyzed inductively for moral distress and codes of moral distress and 'not social working' emerged. The findings revealed two broad themes; the first included systemic and contextual factors that contributed to case managers' moral distress, and the second was resistance demonstrated in strategies used by case managers to cope with and respond to moral distress The barriers under systemic and contextual factors reflected rule-bound constraints on the managers ability to establish relationships with

Researchers	Title	Design	Aim of study	Methodology & Results
				clients and offer holistic services, resulting in practices that have the potential to do harm. Barriers to moral agency included lack of time for clients, heavy caseloads- "crazy overworked". Limited time to get the job done let alone time to have a relationship with clients that makes room for understanding the challenges in their life. Large caseloads meant increased record keeping. Technology reorganizes institutional practices and replaces conversations with clients and limits their ability to respond to clients' needs. Other factors included oppressive policy resulted in the inability to meet very visible and pressing needs of the client due to restrictive legislation and inadequate welfare incomes. These are the "things we cannot change" trying to work within these restrictive policies requires creativity, but the difficulty is not being able to find or implement a loophole to benefit clients. The worst cases are when they are unable to bend the rules to meet pressing needs. However, case managers made it clear that the inability to act in the clients' best interest is not always the case of moral distress. In some instance rules and eligibility criterion demand the worker to sanction clients and cut them off assistance. Likewise, managers take "fraudulent letters" from landlords as a means to sanction clients.
Olcon and Gulbas (2020)	Their needs are higher than what I can do": Moral disress in providers working with Latino immigrant families	Olcon and Gulbas (2020) implemented an instrumental case study design selected only those interviews of participants providing mental and behavioral health services to learn how do the constraints social service providers experience	The goals of the larger study were to identify: (1) community mental health concerns and service barriers and (2) avenues to promote health among Latino immigrant families.	The data for this study was drawn from a larger study that explored the experiences, perspectives, and needs of community leaders, stakeholders, and social service providers who worked predominantly with Latino immigrant families. The participants (N=24) were recruited from non-profit agencies, school-based services, primary care and behavioral health clinics, churches, and after school programs. Findings from this larger study were that behavioral health providers, including social workers, mental health counsellors, and healthcare outreach coordinators, described feeling helpless in their capacity to assist their clients. to uncover deeper insights into this preliminary observation Analysis proceeded in three stages. First authors generated preliminary themes through a comprehensive reading half of the instrumental readings. Then they defined and arranged preliminary themes into a codebook which was revised by reading the remaining cases. Saturation was reached after the

Researchers	Title	Design	Aim of study	Methodology & Results
		shape burnout.		analysis of 15 cases. During the second phase the authors developed the properties of emerging themes by comparing and contrasting dimensions of the themes with existing literature on burnout. Efforts to capture empirical realities of burnout led them to the concept of moral distress. Weinberg's (2009) framework on moral distress was operationalized in two dimensions; (1) structural barriers limiting works from delivering services in ways them deem ethical and (2) the emotional ramifications of experiencing those barriers. In the third phase each author coded the interviews independently to compare, revise, and contextualize the theme and dimensions of moral distress within the interviews. Four main themes identified in the findings were: (1) the system had failed them (poverty, inadequate housing, isolation, inaccessible healthcare services, deportations) , (2) compromised service quality (limited services, lack of resources, long waitlists, large caseloads, shortage of bilingual providers), (3) who really can help (helplessness, stress, frustration, self-doubt, disempowerment), (4) individual solutions to structural problems (counselling, psychosocial education, support groups).

Table 8

Summary of theoretical methodological literature in social work

Author(s)	Title	Design	Aim of Study	Main Points
Merlinda Weinberg, Halifax, Nova Scotia, 2009	Moral Distress; A missing but relevant concept in social work	Analysis of the concept and development of theory for social work	Conceptualize moral distress in SW. address how social workers can overcome the disjunctions between how they would like to act and the constraints they experience.	- Welfare state being dismantled due to political restructuring towards a global capitalist society. - Results in reduction in resources, increase in expectations and development of market driven system that measures the bottom line before client needs. The neo-liberal environment creates huge stressors due to erosion of the safety net, reductions in resources, and increasing restrictions on the autonomy of professionals, making it very difficult for social workers to fulfill that desire for goodness. - Social workers have a responsibility to act as agents for social transformation. Recognizing systemic forces that impede anti-oppressive practice is a first step. MD helps frame the structural barriers. MD recognizes the political nature of SW in a manner that "ethical dilemma" does not.
Merlinda Weinberg, Halifax Nova Scotia, 2010	The social construction of social work ethics: Politicizing and broadening the lens.	Descriptive theoretical analysis	To provide an explanation of how the construction of ethics evolved, and what interests are served by the current emphasis on policies and procedures, organizational structures, legislation and funding requirements.	Professionalization of SW has embraced a psychoanalytic approach to caseloads, believed that the scientific advance would lead to legitimizing SW as a profession. Dominant discourse regarding ethics in SW is attached to the juridical-theoretical model, which encourages social workers to conduct one to one relationships with clients through the lens of codes of universal principles, such as confidentiality, and to regulate themselves by self-evaluating themselves to censure their behavior so they do not violate the codes; thereby regulating their own behavior and aligning their personal choice with the ends of government/organizational policies.
Carolyn Oliver, British Columbia, 2011	Critical Realist Grounded Theory: A new approach for social work research	Descriptive theoretical analysis	To explore the potential for grounded theory to be adapted for use within a critical realist paradigm	Critical realism and grounded theory are highly compatible, sharing a focus on abduction and commitment to fallibilism, attending to evidence and meaning, individual agency and social structure, theory building and the pursuit of emancipatory goals. This results in a highly compatible suited approach to research in SW
Carolyn Oliver, British Columbia, 2013	Including Moral Distress in the new language of social work ethics	Descriptive theoretical analysis	To inform the SW literature on MD and introduce it into the discussion of relational ethics;	Social work students are increasingly being exposed to relational ethics, but will often work in settings that continue to use traditional ethical frameworks, formalized in agency rules and decision-making algorithms. It is the conditions of increased moral sensitivity that come at a cost to social workers and results in

Author(s)	Title	Design	Aim of Study	Main Points
			because the two go hand in hand	MD. There are lessons to be learned from MD literature on how to support practitioners in managing the negative effects of MD.
Sophia Fantus, Rebecca Greenberg, Barbara Muskat, and Dana Katz Toronto, Ont. 2017	Exploring moral distress for hospital social workers	Analysis of the concept and development of theory for social work	To describe the concept of MD and theorize how this ethical phenomenon transpires in the field of hospital social work	The study is a critical examination of how MD emerges among hospital social workers. The authors theorize that MD must be preceded by a moral dilemma that includes value conflicts that threaten the moral integrity of the worker. Their theory is supported by referencing various clinical situations, and structural/systemic conditions endured by hospital social workers in two case vignettes. The first illustrates an example of a social worker being pressured by her manager to discharge a patient into what is believed to be an unsafe environment. The power dynamics are such that the social worker feels powerless to advocate for the patient's needs. The second Vignette highlights a pediatric example in which it has been recommended that a 3-year old child with a complex metabolic disorder have a tracheotomy. The social worker is uncertain about the impact of the intervention on the quality of life of the child and does not believe it is in the child's best interest to have the procedure done. Additionally, he believes that the demands associated with caring for this child will completely overwhelm his mother who is already depressed and exhausted. The team is pressuring the social worker to help the mother accept the intervention. He is torn between the request of the medical team and his feelings about the impact on both the child and mother.
Chris Clark 2005, Edinburgh, U.K.	Moral character in social work	Analysis of the concept and development of theory for social work	This article makes the case for the inclusion of virtue ethics over the standard deontological and consequentialist forms that are based in individualistic liberalism	The social work role requires more than competent delivery of standardized service: it involves modelling ways of life and counselling over morally problematic issues. Practitioners must uphold familiar ethics of respect, justice, autonomy, beneficence, and so forth. However, that alone will not suffice to separate suitable from unsuitable practitioners. The new standards and processes of registration have, in effect, sharpened the focus on character (as opposed to principle and duty) in ways that have perhaps not been fully recognized.

Author(s)	Title	Design	Aim of Study	Main Points
Linda Openshaw 2011, Pittsburgh, PA	Moral distress and the need for moral courage in social work practice	Analysis of the concept and development of theory for social work	The goal of this paper is to provide a description of moral distress in social work and examples of moral courage to do the right thing	Social workers constantly face moral dilemmas in their practice. Moral dilemmas can lead to moral distress. Social work ethics is the embodiment of values turned into guidelines for behaviour. Social workers learn ethics by having experienced the modeling of ethical teaching. However, ethical behaviour is not clearly defined. Knowing the expected code of conduct does not help when it conflicts with agency policy. Social workers need moral courage to advocate for their values and beliefs in the face of resisting authority, following along with the popular decision, or fear of retribution.
Deborah Lynch , Australia & Catherine Forde, Ireland 2016	Moral distress and the beginning practitioner: preparing social work students for ethical and moral challenges in contemporary contexts	Descriptive theoretical analysis	Addresses the question of how SW education prepares students to manage MD, and respond to social injustices they may encounter in their work.	The study discusses three recurring themes as important for students: 1- recognising risks, 2- acknowledging moral dissonance in a critically reflexive manner, 3- understanding that all SW takes place in a policy context and engaging with policy is a fundamental element of practice. …"we cannot encourage students to be political without helping them to develop skills and practices to sustain themselves in the field. We argue for more nuanced and creative forms of activism to address social justice concerns."
Shannon Jaskela, Juliet Guichon, Stacey, A. Page, Ian Mitchel Canada 2018	Social Workers' experience of moral distress	Qualitative descriptive study	With the primary focus on causes of MD among SW in health care this study aims to describe the causes, effects, and supports for MD among SW in health care.	The three main themes, (causes, effects, and supports) captured the following; Causes = *other health care professionals, caseloads, external resources, organizational rules*. Effects = *exhaustion, sleep disturbances, emotional dysregulation, anger, frustration, disappointment and sadness, self-doubt and low self esteem, withdrawal from patient care.* Supports = *team members and peer support, self-care, exercise, attitude and perspective, age , wisdom and increased experience helped to alleviate negative symptoms.* Recommendations – educate other health care professionals on the role of SW and it code of ethics, Organizations inform Mgr.'s of MD causes and effects, reduce caseload ratio of PT's to SW, Mgr.'s encourage SW's to participate in regularly scheduled peer support mtgs.

Author(s)	Title	Design	Aim of Study	Main Points
Maija Manttara-van der Kuip, (2020);	Conceptualising *work-related moral suffering: Exploring and refining the concept of moral distress in the context of social work.*	Descriptive, conceptual study	The goal of this study is to enhance conceptual clarity to moral distress as it has been applied in nursing and social work literature. The author theorizes that there are two interconnected components of moral distress, 1. the existence of some sort of event that is characterized by the person as having restricted moral agency and 2. the psychological and physiological suffering, i.e. distress this induces. Jameton's (1984) definition provides the foundation for describing causal factors arising from institutional constraints.	Manttara-van der Kuip describes a two-stage model of moral distress similar to Jameton (2013) and the empirical and Fourie (2015). Stage one directly follows one's inability to act, the second stage is a reactive distress to that inability to act which then becomes a lingering state that impairs well-being over a longer period of time Jameton (1983). This reactive stage has also been termed moral residue Hamric (2009), Webster & Baylis (2000). The following description, supported in literature, is provided the author, constraints to ethical practice originate from external barriers (institutional), Jameton (1984), and internal predisposition (self-doubt, socialization), Wilkinson (1987/1988). These also factors included in the Moral Distress Scale measurement (MDS) (Corely et al. (2001) that were later revised MDS-R Corley, Hamric, 2012). The MDS and MDSR included questionnaires designed to measure the frequency and intensity of moral distress and are based on the previously mentioned factors. The measurement included two scales, 1) the frequency of the predefined moral phenomena that is acting on the professional beliefs and 2) the existence and intensity of distress as a response to the first factors. The author argues that if the root causes (predefined moral phenomena) in the first measurement are specified as predetermined causes of moral distress, then the phenomenon is being conceptualized form the relatively narrow perspective of readily defined constraints, leaving little space for subjective judgements and evaluations. Manttari-van der Kuip (2020) proposes that influencing factors of moral distress vary considerably among social workers and a more subjective, relational and contextual approach to constraints would be more fruitful. Therefore, in might be beneficial to different the phenomenon itself from its antecedents or predictors (root causes). Moreover, there are additional influential factors to consider in social work that cannot be directly defined as institutional constraints. For example, a social worker might experience moral distress when she becomes aware that she does not

Author(s)	Title	Design	Aim of Study	Main Points
				have the requisite skills or necessary knowledge to perform a given task in an ethically appropriate way, yet she feels an obligation or duty to act. The social worker might also notice the existence of oppressive practices in her employing organization but fails to challenge them for fear of losing her job. The author adds that internal constraints also influence moral distress. For example, working with a lack of resources can make social workers less sensitive, and that moral insensitivity can serve as a coping mechanism for moral distress. Additional factors are that some constraints are not real but perceived. There are perceptual barriers that seemingly can be eliminated through good works. To conclude the author is suggesting the existing understanding of MD is not sufficient to measure. MDS and MDS-R are too restrictively focused on institutional/organizational constraints and must be expanded to include internal sources and subjectivity. Existing studies have suffered from an oversimplified idea of the role of constraints to moral action and MD is a more complex and dynamic phenomena. A new conceptual understanding must also include the interaction between external and internal constraints, and to respond to questions such as, what does it mean to pursue the right course of action, or how does one know if they are pursuing the morally correct action?

Appendix D

Informed Consent Form

Title: **Illuminating moral distress in social work: A grounded theory study informed by critical realism**

Researcher: Richard Lavoie, umlavoier3@myumanitoba.ca

Research Advisor: Dr. Sid Frankel, 204-474-9706 Sid.Frankel@umanitoba.ca

The information collected from participants will be used as data for my Master's thesis in social work. Your involvement is completely voluntary and your refusal to participate will have no consequences whatsoever. This consent form, a copy of which will be left with you for your records and reference, is only a part of the process of informed consent. It should provide you with a basic idea of what the research is about, and what your participation will involve. Your consent is understood to be on an ongoing basis and you are welcome to drop out at any time. You can withhold a response to any specific question simply by advising me (the researcher) of your intentions. In the event that you disclose information revealing maltreatment or harm to yourself or vulnerable persons, I am legally obligated to report it to the appropriate authorities. Feel free to contact me with any questions or concerns about this form or the research study. Please take the time to read and understand this information carefully.

There are no identifying questions asked in the interviews or reported in the research findings. All identifying information that comes up during the interview process will be removed from transcripts of interviews immediately and not used in the study. Confidentiality will be maintained with the use of pseudonyms for all participants and any other identifying names, places, or other identifying features that come out of the study. My research supervisor, thesis advisor, transcriptionist and I will be the only ones to see the data. Participants' names, transcripts and all other identifying data will be kept separate and locked in a file cabinet. Please be aware that any disclosures regarding child maltreatment will be reported as required by law.

You will have an opportunity to discuss the nature of the study and ask questions related to it following the interview. You may be invited to participate in a follow-up interview. A list of resources will be provided should participants experience emotional distress resulting from their involvement in this study.

Interviews will be in a quiet private space, such as an office or meeting room at a time and date mutually agreed upon. The interviews will be audio recorded with a handheld device. An assistant will later transcribe what was said verbatim. (This assistant will have signed a pledge of confidentiality). I will also take written notes to help me recall the discussion and serve as a backup in case the recording is inaudible.

Interview questions concerning moral conflict may result in unwanted feelings such as anxiety, guilt or remorse. In the event that the interview is upsetting, a list of available resources will be provided prior to the interview. Discussion of previous moral conflict can also be enlightening and helpful to participants. The results of this study can be used to inform social work educators of potential ethical conflict between SW curricula and professional practice, existing organizational structures, policies and procedures impeding ethical SW practice and work towards a more comprehensive understanding of moral distress in SW.

In appreciation for your participation in this study, you will receive a 10.00 gift card for a local coffee shop. If you require money for bus fare to the interview location, please let me know and I will reimburse the amount in cash.

After the interview is transcribed, a copy will be sent for your review. All identifying information will be removed from the transcripts prior to sending them. You are invited to delete comments, or add commentary. You will have two weeks to review the transcript after which time a reminder email will be sent. If there is no reply, I will assume you have approved it as is.

These data will be used as data for my Master's thesis. The results may also be shared at professional development events and through professional and academic publications. I will send a copy of the findings upon your request. Please indicate whether you would like a summary at the bottom of the debriefing statement following the interview. All confidential information will be kept on a password-protected USB in a locked office accessible only to the primary researcher. It will be stored for six years following the defense of my Master's thesis. At the end of six years (December/2025), all data will be destroyed. That includes deleting electronic files, and audio recordings, and shredding all interview transcripts and other written data.

These data will be used only for academic research. All identifying information will be removed and not included in the data. Upon consent you agree to allowing the interview to be audio taped and transcribed into a written document. All the documentation and results can be obtained upon request. The data from this study will be used only for academic research. All confidential information will be kept on file for six years following the defense of my Master's thesis.

Your signed consent indicates that you have understood to your satisfaction the information regarding participation in the research project, and agree to participate in the study. In no way does your agreement waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. If you choose to withdraw, all the information related to your participation will be destroyed. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout

your participation. The University of Manitoba may look at your research data to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology and Sociology Research Ethics Board (PSREB). If you have any concerns or complaints about the project you may contact me or my Advisor Sid Frankel204-474-7243 or by email at Sid.Frankel@umanitoba.ca

You can also contact the Human Ethics Coordinator (HEC) at 204-474-7122 or by email at humanethics@umanitoba.ca.

Participant's name (printed)_____

Participant's Signature_____
Date:_____

Researcher's Signature_____

___ Yes, I wish to participate ____ No, I do not wish to participate

Appendix E

Instructions

Thank you for volunteering to participate in this study. The concept of moral distress has been studied and well defined within the nursing profession. The aim of this study is to conceptualize moral distress from within a social work context. Your role as a participant and experienced Social Worker is extremely important in establishing that context.

As a participant you will receive a phone call to arrange an agreed upon time and place for an interview.

To prepare, I am providing a copy of the guide containing questions I will ask. You will have plenty of opportunity to expand on the discussion and present your own ideas to supplement the questions in the guide. I am hoping that before the interview you will reflect on the questions and your experience as a social work practitioner.

You are also invited to review the Manitoba College of Social Workers (MCSW) code of ethics and standards of practice as they pertain to each question. If you are not able to locate your booklets you can access them electronically simply by clicking on the following links.

https://mcsw.ca/wp-content/uploads/2018/04/Code-of-Ethics-MAR-2018-WEB.pdf

https://mcsw.ca/wp-content/uploads/2018/04/Standards-of-Practice-MAR-2018-WEB.pdf

Appendix F

Related theoretical concepts

Ethics stress	Ethics related stress is an occupational stress that concerns the emotional, physical and psychosocial consequences of not being able to fulfill moral obligations (Raines 2000; Ulrich et al. 2007).
Moral Injury	Moral injury occurs when individual experience deeply troubling cognitive dissonance between their internal moral code and the actions they engage in or witness (Litz et al, 2009). Moral injury is synonymous with lasting emotional, psychological, and existential harm that occurs when an individual "perpetuates, fails to prevent, bears witness to or learns about acts that transgress deeply held moral beliefs and expectations" (Litz, B.T., Stein, N., Delany, E., Lebowitz, L., Nash, W.P., Silva, C., Maguen S. (2009). Research on moral injury has be conducted within a military context. The military operates from a strong moral code and has a focus on self-sacrifice and helping others gain freedom, liberty, and safety (Sugrue, 2019). This definition may seem similar to some variations of MD. However, moral injury does not align with the notion of constraints preventing moral agency. Moral injury occurs after an individual mistakenly or freely transgressed their moral expectations. The action and one's interpretation of one's actions as being morally transgressive leads to moral injury, regardless of whether the action occurred of any constraints placed on the individual actor (Sugrue, 2019 p.14).
Ethical trespass	First coined by Hannah Arendt and later conceptualized by Orlie (1997). The term refers to harmful effects that inevitably arise not from our intentions and malevolence but from participation in social processes and identities that become associated with unethical conduct. This concept implies that moral harm occurs without a willful plan, due in part, to the setting of terms for what constitutes 'normal' or 'healthy' or 'good'. Orlie (1997) proposes that those with privilege are the most likely to trespass, yet it is those groups who determine ethical norms (Weinberg, 2015).
Moral stress	Lutzen and Kvist (2012) argue for changing the term moral distress to moral stress, so that the focus is more on the healthy tensions experienced by healthcare providers on a daily basis. They suggest that moral stress ensuing from ethically challenging experiences fosters the positive pursuit of moral action. In this regard, moral stress is perceived as a healthy, positive awareness of ethical factors and does not always lead to troublesome symptoms or outcomes. This perspective is critical to instituting a positive influence toward ethical action. Lutzen and Kvist's alteration of moral distress signifies a shift away from trying to eliminate moral distress, as if it is a disease itself, to a more mindful management approach (Lutzen & Kvist, 2012). Most of our understanding of moral distress comes from North American literature. However, the Scandinavian countries have a body of work on

	similar concepts (Glasberg et al. 2006; Lutzen et al., 2003, 2006, 2012). Lutzen et al 2006 describe that "moral stress" occurs when nurses are aware of what ethical principles are at stake in a situation and external factors prevent them from making a decision that would reduce the conflict between the contradicting principles" (p.314). They further note that moral stress is similar to moral distress in that the moral component is present in both concepts; However, moral stress captures the physiological dimensions not usually associated with moral distress.
Moral sensitivity	Moral sensitivity is one's ability to discern the morally salient dimensions of ethical situations (Rushton, Kaszniak, & Halifax, 2013, Lut- zen et al., 2006), including one's role and ethical responsibility within that situation (Rushton, 2016). Research studies have discovered that increasing moral sensitivity is an effective way of building resilience against moral distress (Corley, 2002; Rushton, 2016; Hamric; 2012; Eisenberg, 2000). The hypothesis is that increased moral sensitivity reduces moral uncertainty and subsequently reduces risk of MD. Moral sensitivity includes self-refection through clarity and commitment to learning one's deepest intentions, commitments and values, and discerning what one truly stands for in life (Rushton, 2016). Among other forms of knowledge, ethics education enhances moral sensitivity and provides alternative theoretical approaches to conceptualize moral problems as well as methods for resolving them (Rushton et al 2016, Hamric, 2012). Other scholars have argued that moral sensitivity comes at a cost (Oliver, 2013). Oliver claims the more sensitive one becomes to ethical and moral challenges the higher the risk of moral distress.
Ethical climate	how organizations articulate goals, treat clients, staff, students, and community, organizational practices related to ethical decision-making and the management of power, trust, and human interactions (Ulrich et al., 2007).
Stress of conscience	This refers to stressful situations and the degree to which they trouble the conscience (Glasberg et al., 2006).
Moral Uncertainty	Moral decision making can be challenging when one does not know the ethically correct choice. Moral uncertainty refers to situations in which a person feels something is morally wrong but cannot accurately identify it. Some descriptions of moral distress focus only on situations in which constraints are specifically identified, while others refer to occurrences that stem from moral uncertainty; situations in which the practitioners simply do not know the ethically correct response (Hamric, 2012; Rushton, et al., 2009;2013).

	Professionals cannot always know the right thing to do; they might not have sufficient information to guide their moral decision-making, and they cannot predict where their decisions will lead them (Campbell et al, 2016).
Perspective taking	Ethical dilemmas are sometimes rooted in misinformation and individual assumptions. Being able to obtain an accurate cognitive understanding of the situation, reduces the risk of misunderstanding and overgeneralizing, however, it requires finely tuned communication skills. Communication skills are an essential part of providing ethical healthcare, and it is the responsibility of practitioners to establish safe environments for clients to feel comfortable in sharing their stories. Allowing clients to provide their own descriptive details and developing an accurate understanding of their story will help caregivers adopt an objective perspective (Batson et al, 2007).
Moral residue	Building from the seminal work of George Webster and Francois Baylis (2000) we accept moral residue as an implicit component of moral distress. Philosophers Webster and Baylis (2000) define moral residue within the context of clinical ethics; "moral residue is that which each of us carries with us from those times in our lives when in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised. These times are usually very painful because they threaten or sometimes betray deeply held and cherished beliefs and values" (Webster & Baylis, 2000 p. 218). Moral residue is comprised of lingering impressions that remain in our thoughts; hence the term moral residue.
Moral development	As previously stated, one's ability to manage moral challenges is in part determined by their level of moral sensitivity which in turn is dependent moral development. One of the most influential theoretical approaches to moral development is based on the cognitive-development model initially proposed by Piaget (1964) and later expanded on by Kohlberg (1976). Piaget determined that children learn values and morals as a result of interactions with their environment. As cognitive ability develops, people have greater capacity to consider rules more critically and make up their own mind about what is right and wrong. The central feature of moral development theory proposes that the sophistication of a person's moral reasoning predicts his or her moral behavior and expectations (Kohlberg and Candee, 1984). Therefore, becoming aware of ethical problems involves both conscious and unconscious processes (Eisenberg, 2000). From that understanding we can hypothesize that moral development generates limits which directly impact moral sensitivity and therefore directly alters the frequency and intensity of MD. Even when people are aware of moral inconsistencies, they are reluctant to change their values to accommodate the dissonance.
Burnout & Compassion fatigue -	Burnout and compassion fatigue are two commonly used terms in social work literature. Some researchers argue that they are overused terms and in certain situation mistakenly used to refer to instances of MD (Oliver, 2013;

	Weinberg, 2009). Although they share similar features, they are not interchangeable concepts. The overall defining feature that separates MD is its moral component. Burnout and compassion fatigue largely overlook value laden experiences and the social causes of moral conflict. Compassion fatigue (CF), also known as secondary or vicarious trauma, is viewed as a typical response associated with the exposure to other people's narratives involving personal trauma (Figley, 1995). When experiencing CF the SW's ability to care for clients is compromised because of symptoms similar to posttraumatic stress disorder. SW practitioners might avoid situations involving patient suffering as a way of protecting themselves from intrusive thoughts or dreams of distressing symptoms, anger, or guilt. CF is influenced by the practitioner's empathic response to others and is unique to working with trauma victims. Practitioners may experience: lowered concentration, apathy, minimization and preoccupation with trauma, irritability, moodiness, withdrawal, sweating, rapid heart rate, and dizziness, (Figley, 1995; Portnoy, 2011). Burnout, on the other hand, can be considered as a depletion of internal resources similar to a battery-operated device running low on power. Burnout has been defined as 'a state of prolonged physical, emotional and psychological exhaustion (Borritz et al., 2005). Burnout can be primarily considered as a prolonged reaction to chronic stressors and interactions in the environment, whereas compassion fatigue results more from the relationship between clinician and patient. These conditions however, are not mutually exclusive and some clinicians are at risk of both. Burnout develops gradually and progressively worsens as a result of daily stress, emotional exhaustion, and a reduced sense of accomplishment. Symptoms of burnout include illness, fatigue, cynicism, anger, disillusionment, difficulty sleeping, and a sense of helplessness and hopelessness, emotional exhaustion, dissatisfaction with work, all of which can result in cynicism and detachment from work, social withdrawal, interpersonal conflicts, poor judgment, and addictive behavior. (Hooper, Craig, Janvrin, et al., 2010). Based on the above noted characteristics one can surmise that symptoms of burnout and compassion fatigue can accompany moral distress however, they are not the cause of it, and are certainly not synonymous with MD.
Grit	Concepts such grit and resilience, generally used to describe the ability to persevere through hardships to meet goals, are rapidly emerging topics in both popular press and peer-reviewed literature (Stoffel et al., 2018). Grit is defined as perseverance and passion toward long-term goals and encourages sustained commitment toward completing a specific endeavor despite episodes of failure, setbacks and adversity (Stoffel et al., 2018). To measure ones willingness to attain goals through adversity and moral adversity is a concept that should be considered in moral distress research.

Shame & Guilt	Zuzelo (2007) further developed Jameton's conceptual definition of MD to include two categories: initial and reactive moral distress. "These categories differentiated between the distress initially felt by professionals when confronted with institutional barriers versus the reactive distress experienced by the same people when they fail to act on their initial distress" (Zuzelo, 2007, p. 345). Overall, MD has been described in emotional terms ranging from anger, frustration and resentment to feelings of anxiety, sadness, embarrassment, shame and guilt (Rushton and Adams, 2009). At first blush reactive responses of MD may be compared with common guilt. Elements of both guilt and shame accompany MD. There are distinct definitions are required to distinguish MD from common guilt and shame. Firstly, there need be no moral component to common guilt. It can be associated with any particular act in which one regrets what one has done. It may be helpful to begin with closer look into the characteristics of these concepts. Guilt stems from one's behavior, "I did a bad thing", whereas, shame is linked to one's self "I am a bad person". Guilt arises when one makes internal, undesirable judgments about one's actions, which lead to negative feelings about that specific behavior (Tracy & Robins 2004). Guilt motivates action to correct a perceived wrong, whereas shame arises when one makes internal, unstable, judgments about one's self, which lead to negative self-evaluation (Tracy & Robins, 2004). Shame initiates a desire to escape and hide due to the violation of social norms and perceived exposure to social condemnation. Shame leads to beliefs of feeling defective and unworthy. Moral distress and moral residue derive from compromised moral integrity whereas shame and guilt can occur with no moral issues present.
Values	Values represent ideals to which an individual, family, group, organization or community aspires (Barsky, 2010). Personal values are shaped and influenced by a combination of cultural, spiritual, religious, educational, political and other social experiences, and classify what people believe is right, good and valuable. They are important factors in determining what we determine to be right and wrong (Barsky, 2010). People tend to see their own values as morally correct, otherwise they would change them to align with their thoughts. My personal experience has been that values evolve through experience, knowledge, reflection and self-evaluation which replicates the gradual and continuous process of moral development.
Role Conflict Theory	Also prominent in early research (Corley et al., 2001) on MD is role conflict theory. In their research to evaluate the MDS, Corley et al. (2001) characterized role conflict as a type of stress that results when nurses are expected to satisfy two organizational authorities (facility manager's and physicians) who expect conflicting responsibilities. When the dual sources of supervision impose conflicting professional expectations, it leads to role conflict.

Role identity theory	Social workers, as do other professionals, often adopt the identity of their profession, thereby integrating professional values and practice guidelines as personal moral standards by which to measure themselves. Most often these values are congruent. However, given certain circumstances, individual and professional values become incompatible. Siebert and Seibert (2005) describe role identity and its influence in social work with a framework for understanding how social workers are vulnerable to incompatible moral challenges. Role identity theory suggests that social workers experience overlapping professional and personal identities as helpers of others, which is reinforced by the expectations of clients, friends, and family, as well as their own expectations of themselves (Siebert & Siebert, 2005). As a result, social workers become overwhelmed by attempts to meet unattainable demands that they themselves have created through a commitment to self-perceived conceptualizations of what is expected of them. Due to the nature of social work and practitioners' perceived self-identity, social workers have difficulty recognizing and admitting that they have personal problems that prevent them from seeking help. "Social workers have overlapping professional and personal identities as helpers of others, reinforced by the expectations of their clients, friends, family, and their own expectations of themselves." (Siebert and Seibert, 2005)

Appendix G

Invitation to participate

INVITATION TO PARTICIPATE

Illuminating moral distress in social work: *A grounded theory study informed by critical realism.*

If you are a social worker with a minimum of 5 years experience in:

- Child protection
- Mental health
- Geriatrics

Please consider participating in this thought provoking study

The purpose of this study is to identify contextual factors contributing to moral distress in social work. Results from the study can be used to improve workplace environments and inform social work educators of the ethical challenges in front-line social work.

Participation includes:

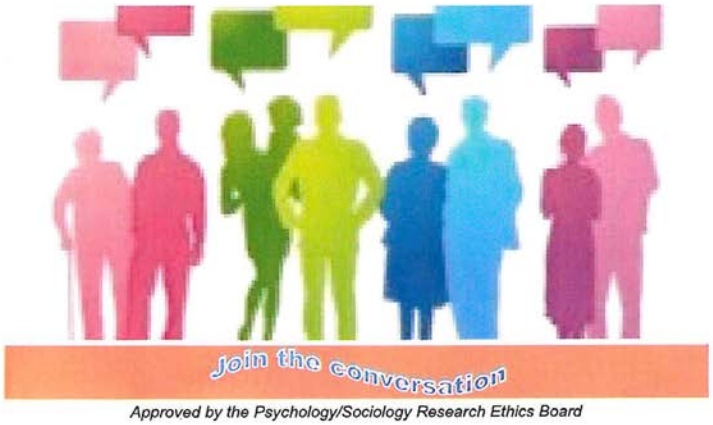
Approximately 1 hour interview
Question Guideline will be provided in advance.

What will it be about?
A: Information about your experience with ethical challenges facing social workers in your area of practice.

This research is part of a master's degree research thesis at the University of Manitoba and a commitment to improving safe work environments and building resilient social workers. Your experience is vital to conceptualizing moral distress in a social work context.

For further information contact,
Richard Lavoie, MSW candidate at
lavoier3@myumanitoba.ca

This is an excellent opportunity to bring forward moral challenges placed on your values as a social worker



Approved by the Psychology/Sociology Research Ethics Board

University of Manitoba

References

Abbott, A. A. (1981) Durkheim's theory of education: A case for mainstreaming, *Peabody Journal of Education*, 58, (4) pp. 235–241.

Angen, M.J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*. 10(3). 378-395. doi:10.1177/104973230001000308

Archer, M. S. (1995). *Realist Social Theory: The Morphogenetic Approach*, Cambridge: Cambridge University Press.

Archer, M. S. (2000). *Being Human: The Problem of Agency*, Cambridge: Cambridge University Press.

Archer, M. S. (2007). *Making Our Way Through the World*, Cambridge: Cambridge University Press.

Arrington, P. (2008). *Stress at work: How do social workers cope*? National Association of Social Workers. Membership Workforce Study. Washington, DC: National Association of Social Workers. http://workforce.socialworkers.org/whatsnew/stress.pdf.

Attrash-Najjar, A., & Strier, R. (2020). Moral Distress and Privatisation: Lost in Neoliberal Transition. Ethics and Social Welfare, 14(1), 21-38 doi: 10.1080/17496535.2020.1720107

Austin, W. (2012). Moral distress and the contemporary plight of health professionals. *HEC forum* 24(1), 27-38. doi:10.1007s10730/-012-9179-8

Baker Collins, S., Cranmer-Byng, S., (2018). Things I cannot change: Moral distress in the implementation of Ontario Works. Canadian Social Work Review, 35, (2), 5-24. https://doi.org/10.7202/1058477ar.

Barsky, A., (2010). Ethics and values in social work: An integrated approach for a comprehensive curriculum. New York, NY: Oxford University Press Inc.

Batson, C. D., Eklund, J. H., Chermok, V. L., Hoyt, J. L., & Ortiz, B. G. (2007). An additional antecedent of empathic concern: Valuing the welfare of the person in need. *Journal of Personality and Social Psychology*, *93*(1), doi: 10.1037/0022-3514.93.1.65

Bennett, D., Sadrehashemi, L., Smith, C., Hehewerth, M., Sienema, L., & Makolewski, J. (2009). Hands tied: Child protection workers talk about working in, and leaving, BC's child welfare system. *Pivot Legal Society.* http://www.pivotlegal.org/Publications/reportsht.htm

Bernhardt, B. A., Rushton, C. H., Carrese, J., Pyeritz, R. E., Kolodner, K., & Geller, G. (2009). Distress and burnout among genetic service providers. *Genetics in Medicine*, *11*(7), 527-535. doi:10.1097/GIM.0b013e3181a6a1c2

Bernhardt, B. A., Silver, R., Rushton, C. H., Micco, E., & Geller, G. (2010). What keeps you up at night? Genetics professionals' distressing experiences in patient care. *Genetics in Medicine, 12*(5), 289-297. doi:10.1097/GIM.0b013e3181db82d9

Bhaskar, R. (1978) A realist theory of science, Brighton: Harvester Press.

Bhaskar, R. (1986) Scientific realism and human emancipation, Thetford, Norfork, The Thetford Press.

Bhaskar, R. (1989) The possibility of naturalism. Hemel Hempstead: Harvester Wheatsheaf.

Bhaskar, R. (1993). *Dialectic: The Pulse of Freedom*, London: Verso.

Bhaskar, R. (1998). *The Possibility of Naturalism*, London: Routledge.

Birks, M., & Mills, J. (2015). Grounded theory: A practical guide. Thousand Oaks, CA: Sage.

Bogo, M., Raphael, D., Roberts, R. (1993). Interests, activities, and self-identification among social work students: Toward a definition of social work identity. Journal of Social Work Education Vol. 29 (3) p279-292

Bonnycastle, C.R. (2011). Social justice along a continuum: A relational illustrative model. *Social Service Review.* Vol 85 (2) pp. 267-298, The University of Chicago Press. http://www.jstor.org/stable/10.1086/660703

Borritz, M., Bültmann, U., Rugulies, R., Christensen, K. B., Villadsen, E., & Kristensen, T. S. (2005). Psychosocial work characteristics as predictors for burnout: Findings from 3-year follow up of the PUMA Study. *Journal of occupational and environmental medicine*, *47*(10), 1015-1025. doi: 10.1097/01.jom.0000175155.50789.98

Boyle, P. J., DuBose, E. R., Ellingson, S. J., Guinn, D. E., & McCurdy, D. B. (2004). *Organizational ethics in health care: Principles, cases, and practical solutions* (Vol. 22). San Francisco: Wiley.

Brian-Lawson, K. (2012) Response: Critical realism: Response to Longhofer and Floresch, *Research on Social Work Practice*, 22(5), 523–528, doi:10.1177/1049731512454015.

Browning, E.D., & Cruz, J.S. (2018). Reflective Debriefing: A social work intervention addressing moral distress among ICU Nurses. *Journal of social work in end-of-life & palliative care*, 14(1), 44-72.

Burr, V. (2005). *Social constructionism.* London: Routledge

Burston, A., and Tuckett, A. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. Nursing Ethics 20 (3): 312–324.

Campbell, S. M., Ulrich, C. M., and Grady, C. (2016) A broader understanding of moral distress, *The American Journal of Bioethics,* 16(12), pp.2-9.

Canadian Association of Social Workers (2015) *Your stories, Profession of choice*, retrieved from http://www.casw-acts.ca/en/Profession-of-Choice.

Canadian Association of Social Workers (2005). Code of ethics. Ottawa: on Canadian Association of Social Workers (CASW).

Carey, M., (2008). Everything must go: The Privatization of State Social Work. *The British Journal of Social Work,* vol. 38 (5) pp. 918-35. Oxford University Press. doi:10.1093/bjsw/bcl373.

Carse, A. (2013). Moral distress and moral disempowerment. *Narrative Inquiry in Bioethics* 3(2), pp. 147-151.

Chambon, A. Irving, A. Epstein, L. (1999). *Reading Foucault for social work.* NY, Columbia University Press.

Changing lives: Report of the 21st century social work review, S executive - 2006 - Edinburgh: Scottish Executive.

Chapman, M., Zahn-Waxler, C., Cooperman, G., & Iannotti, R. (1987). Empathy and responsibility in the motivation of children's helping. *Developmental Psychology*, *23*(1), 140-145. Retrieved from http://psycnet.apa.org.uml.idm.oclc.org.

Charmaz, K. (2008). Constructionism and the grounded theory method. In editors *Handbook of constructionist research.* (pp. 397-412), New York, NY: Guilford.

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage.

Christen, M., Katsarov, J., (2016) Moral sensitivity as a precondition of moral distress, The *American Journal of Bioethics*, 16:12, 19-21, DOI: 10.1080/15265161.2016.1239787

Clark, C. (2006). Moral character in social work. British journal of social work, 36(1), 75-89. Doi: https://doi.org/10.1093/bjsw/bch364.

Clay D. Siebert, & Siebert, C. F. (2007). Help seeking among helping professionals: A role identity perspective. *American Journal of Orthopsychiatry*, *77*(1), 49-55. http://dx.doi.org.uml.idm.oclc.org/10.1037/0002-9432.77.1.49

Cohen, M., G., (1997). From welfare state to Vampire capitalism. In P.M. Evans & G.R. Wekerle (eds.), Women and the Canadian welfare state: Challenges and change (pp.28-67). Toronto University Press.

Collins, K. M. T., Onwuegbuzie, A. J., & Jiao, Q. G. (2010) *Toward a Broaderunderstanding of Stress and Coping: Mixed Methods Approaches*, Charlotte, NC: Information Age Publishing.

Collier, A. (1994). Critical realism: An introduction to Roy Bhaskar's philosophy. London, Biddles Ltd.

Conneely, E., Garrett, P.M. (2015). Social workers and social justice during a period of intensive neoliberalization: A preliminary investigation from the republic of Ireland. *Journal of Progressive Human Services.* 26(2), pp.126-47.

Corbin, J., & Strauss, A. (2008). Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks, CA: Sage.

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing ethics*, *9*(6), 636-650. Retrieved from https://doi-org.uml.idm.oclc.org/10.1191%2F0969733002ne557oa

Corley, M. C. (1995). Moral distress of critical care nurses. *American journal of critical care*, *4*(4), 280-285.

Corley, M., Elswick, R., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal Of Advanced Nursing, 33*(2), 250-256. doi: j.1365-2648.2001.01658.x10.1046/j.1365-2648.2001.01658.x

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing ethics*, *9*(6), 636-650. Retrieved from https://doi-org.uml.idm.oclc.org/10.1191%2F0969733002ne557oa

Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, *12*(4), 381-390. doi:10.1191/0969733005ne809oa

Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing philosophy*, *12*(2), 119-127. doi: 10.1111/j.1466-769X.2011.00484.x

Danermark, B., Ekstrom, M., & Jakobsen, L. (2002). Explaining society: An introduction to critical realism in the social sciences. London, Routledge.

D'aprix, A. S., Dunlap, K. M., Abel, E., & Edwards, R. L. (2004). Goodness of fit: Career goals of MSW students and the aims of the social work profession in the United States. *Social Work Education*, *23*(3), 265-280. Doi. //doi-org.uml.idm.oclc.org/10.1080/0261547042000224029

Denzin, NK. (1978). Sociological methods. New York, NY: McGraw-Hill.

Devilly, G., Wright, R., & Varker, T. (2009). *Vicarious trauma, secondary traumatic stress is simply burnout? Effect of trauma therapy on mental health professionals.* Australia and New Zealand journal of psychiatry, 43, 373-385. doi:10.1080/00048670902721079

Dreyfus, H. L., & Rabinow, P. (2014). *Michel Foucault: Beyond structuralism and hermeneutics*. Chicago, Ill.: The University of Chicago Press.

Eisenberg, N. (2000). Emotion, regulation, and moral development. *Annual review of psychology, 51*(1), 665-697. Retrieved from https://doi-org.uml.idm.oclc.org/10.1146/annurev.psych.51.1.665

Eisenberg, N., Fabes, R. A., Schaller, M., & Miller, P. A. (1989). Sympathy and personal distress: Development, gender differences and interrelations of indexes. *New Directions for Child and Adolescent Development*, 1 (44), 107-126, doi:10.1002

Eizenberg, M. M., Desivilya, H.S., & Hirschfield, M.J. (2009). Moral distress questionnaire for clinical nurses: Instrument development. *Journal of advanced nursing, 65*(4), 885-892 doi: 10.1111/j.1365-2648.2008.04945.x

Elpern, E., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American journal of critical care, 14*(6), 523-530

Emmel, N. (2013). Sampling and choosing cases in qualitative research: A realist approach. Thousand Oaks, Ca.: Sage.

Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The journal of clinical ethics*, *20*(4), 330-342. Doi. https://www-ncbi-nlm-nih-gov.uml.idm.oclc.org/pmc/articles/PMC3612701/

Epstein, L., (1994). The therapeutic idea in contemporary society. In Adriene S. Chambon and Allan Irving, (eds), Essays on postmodernism and social work, (pp.3-18), Toronto, On.: Canadian Scolars' Press.

Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. *Annals of family medicine*, 9(22) 100-102, doi:10:1370/afm.1239

Fantus S., Greenberg R.A., Muskat B., Katz D. (2017). Exploring moral distress for hospital social workers. *British journal of social work* 0. 1-18 doi: 10:1093/bjsw/bcw113.

Ferguson, I., & Lavalette, M. (2007). " Dreaming a great dream": Prospects for a New, Radical Social Work. *Canadian social work review/revue Canadienne de service social*, 55-68. Doi: http://www.jstor.org/stable/41669860

Figley C.R. (ed) (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York, NY and London: Brunner-Routledge.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International journal of social research methodology*, *20*(2), 181-194. Doi. https://doi-org.uml.idm.oclc.org/10.1080/13645579.2016.1144401

Fouault, M. (1978). The history of sexuality. An introduction. New York, NY: Random.

Foucault, M. (1982). The subject and power. *Critical inquiry*, *8*(4), 777-795. Retrieved from http://www.jstor.org/stable/1343197

Foucault, M. (1984). The Foucault reader. New York, NY. Pantheon.

Foucault, M. (1988). Technologies of the self: *A seminar with Michel Foucault,* (eds). L. H. Martin, H. Gutman & P.H. Hutton, Amherst, University of Massachusetts Press.

Foucault, M. (1991) Governmentality, In G Burchell, C. Gordon & P. Miller (eds), The Foucault effect. Studies of governmentality with two lectures by and an interview with Michel Foucault. Chicago Ill.: The University of Chicago Press.

Fourie, C., (2015) Moral distress and moral conflict in clinical ethics, *Bioethics,* 29(2), pp. 91-97.

Furedi F., (2004) Therapy culture: Cultivating vulnerability in an uncertain age. New York, NY: Routledge.

Gastmans C., McCarthy J., (2015) Moral distress: A review of the argument-based nursing ethics literature*;* Nursing ethics, 22(1) 131–152 doi:10.1177/0969733014557139

Gausel, N., & Leach, C. W. (2011). Concern for self-image and social image in the management of moral failure: Rethinking shame. *European journal of social psychology*, *41*(4), 468-478 doi:10.1002/ejsp.803.

Germain, C. B. (1991) Human behavior in the social environment: An ecological view, New York, NY. Columbia University Press.

Gilbert, P. (2004). Evolution, attractiveness, and the emergence of shame and guilt in a self-aware mind: A reflection on Tracy and Robins. Psychological Inquiry, 15(2), 132-135. Doi http://www.jstor.org/stable/20447216

Glasberg, A. L., Eriksson, S., Dahlqvist, V., Lindahl, E., Strandberg, G., Söderberg, A., and Norberg, A. (2006). Development and initial validation of the stress of conscience questionnaire. *Nursing Ethics*, *13*(6), 633-648. Doi: http://doi-org.uml.idm.oclc.org/10.1177%2F0969733006069698

Glaser, B. (1992). Basics of grounded theory analysis. Mill Valley, CA. Sociology Press

Glaser, B., Strauss, A., (1999). The discovery of grounded theory: Strategies for qualitative research. London, Aldine Transaction.

Glesne, C. (2016). Qualitative researchers: An introduction. New York, NY., Pearson Education Inc.

Goleman, Daniel (1995). Emotional intelligence. New York, NY., Bantam Books.

Gough, J., & Spencer, E. (2014). Ethics in action: An exploratory survey of social worker's ethical decision making and value conflicts. *Journal of Social Work Values and Ethics*, *11*(2), 23-40.

Greenwood, E. (1957) Attributes of a profession, *Social Work*, vol. 2, no. 3, pp. 45–55. Doi: http://www.jstor.org/stable/23707630.

Grootegoed, E. and Smith, M., (2018). The emotional labour of austerity: How social workers reflect and work on their feelings toward reducing support to needy children and families. *The British Journal of Social Work.* doi 10.1093/bjsw/bcx151.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational communication and technology, *29*(2), 75. Doi: https://doi-org.uml.idm.oclc.org/10.1007/BF02766777

Gustafsson G, Eriksson S, Stranberg G and Norberg A. (2010) Burnout and perceptions of conscience among health care personnel: A pilot study. Nursing ethics; 17(1): 23–38. doi: 10.1177/0969733009351950

Halpern, E.S. (1983). Auditing naturalistic inquiries: The development and application of a model (doctoral dissertation), Indiana University, Bloomington, IN

Hammersley, M. (1992). What's wrong with ethnography: Methodological explorations. London: Routledge.

Hamric, A. B. (2012). Empirical research on moral distress: Issues, challenges, and opportunities. *Health ethics forum*, 24(1), 39-49, doi:10.1007/s10730-012-9177-x.

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*(2), 422-429. doi: 10.1097/01.CCM.0000254722.50608.2D

Hamric, A. B., Borchers, C. T., Epstein, E. G., (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. AJOB Primary Research, 3(2); 1-9. doi:10.1080/21507716.2011.652337

Hanna, D. R. (2004). Moral distress: The state of the science. *Research and theory for nursing practice*, *18*(1), 73-93. Retrieved from http://uml.idm.oclc.org/login?url=https://search-proquest-com.uml.idm.oclc.org/docview/236937078?accountid=14569

Hasenfeld, Y, (2000). Organizational forms as moral practices: The case of welfare departments. *Social Service Review* (74) (3) University of Chicago Press. Doi http://www.journals.uchicago.edu/t-and-c.

Hansung, K., & Stoner, M. (2008). Burnout and turnover intention among social workers: Effects of role stress, job autonomy and social support, *Administration in Social Work*, 32(3), pp 5-25, http://dx.doi.org/10.1080/03643100801922357.

Hayes, D. D. & Varley, B. K. (1965) Impact of social work education on students' values, *Social Work*, 10 (3), 40–46. Doi: http://www.jstor.org/stable/23708257

Hooper, C., Craig, J., Janvrin, D.R., Wetsel, M.A., Reimels, E., & Clemson, S.C. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of emergency Nursing*, *30*, 420-427. doi:10.1016/j.jen.2009.11.027

Houston, S. (2012). Response: Reviewing the coming crisis in social work: A response to Longhofer and Floersch, *Research on Social Work Practice*, 22(5), 520–522, https//:10.1177/1049731512441264.

Houston, S., Casanova, M., Leveille, M., Schmidt, K., Barnes, S., Trungale, K., and Fine, R. (2013). The intensity and frequency of moral distress among different healthcare disciplines, *Journal of clinical ethics*, 24(2), 98-112. Doi: http://europepmc.org/search;jsessionid=D8FFC89D1F3599D147479D62DFA5449C?query=JOURNAL:%22J+Clin+Ethics%22&page=1

Huffman, D. M., & Rittenmeyer, L. (2012). How professional nurses working in hospital environments experience moral distress: A systematic review. *Critical care nursing clinics of North America*, *24*(1), 91-100. Doi: https://doi-org.uml.idm.oclc.org/10.1177%2F1359105315595120

Hughes T., (2013). Achieving the best for all children. Royal Commission of Inquiry into Circumstances Surrounding Death of Phoenix Sinclair: Vol. 1, p.23. https://www.phoenixsinclairinquiry.ca

International Federation of Social Workers (2018). Global Social Work Statement of Ethical Principles: Retrieved from https://www.ifsw.org/global-social-work-statement-of-ethical-principles

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

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. The association of women's health, obstetric and neonatal nurses, *Clinical issues in perinatal and women's health nursing*, 4(4), 542-551

Jameton, A. (2013). A reflection on moral distress in nursing together with a current application of the concept. *Journal of bioethical inquiry*, *10*(3), 297-308. Doi: https://doi-org.uml.idm.oclc.org/10.1007/s11673-013-9466-3

Jaskela, S., Guichon, J., Page, S., & Mitchell, I. (2018). Social workers' experience of moral distress. Canadian Social Work Review/Revue Canadienne de service social, 35(1), 91-107

Johnstone, M. J., & Hutchinson, A. (2015). 'Moral distress'–Time to abandon a flawed nursing construct?. *Nursing ethics*, *22*(1), 5-14. Doi: https://doi-org.uml.idm.oclc.org/10.1177%2F0969733013505312

Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P., & Arnetz, B. (2004). Living with conflicts-Ethical dilemmas and moral distress in the health care system. *Social science & medicine*, *58*(6), 1075-1084. doi: https://doi-org.uml.idm.oclc.org/10.1016/S0277-9536(03)00279-X

Kanter, J. (2007). Compassion fatigue and secondary traumatization: A second look. *Clinical social work journal*, *35*(4), 289-293. doi:10.1007/s10615-007-0125-1.

Kagan, C., Burton, M., Duckett, P., Lawthom, R., & Siddiquee, A. (2011). Critical community psychology. Chichester: Wiley.

Kapoulitsas, M., and Corcoran, T., (2015). Compassion fatigue and resilience: A qualitative analysis of social work practice. Qualitative social work, 14(1), 86-101. doi: https://doi-org.uml.idm.oclc.org/10.1177%2F1473325014528526

Kelly B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. Journal of advanced nursing, 28(5): 1134–45. doi:10.1046/j.1365-2648.1998.00810.x

Kjørstad, M., & Solem, M. B. (2017) Basic concepts of critical realism in`Kjørstad, M., & Solem, M. B. (Eds.). (pp. 13-21) London: *Critical realism for welfare professions*. Routledge.

Kochanska, G., Murray, K., Jacques, T. Y., Koenig, A. L., & Vandegeest, K. A. (1996). Inhibitory control in young children and its role in emerging internalization. *Child development*, 67: 490-507. doi: 10.1111/j.1467-8624.1996.tb01747.x

Ko, H.K., Chin, C.C., & Hsu, M.T. (2016). Moral distress model reconstructed using grounded theory. The journal of nursing research, 26(1): 1-70. doi:10.1097/jnr.0000000000000189.

Kohlberg, L., & Candee, D. (1984). The relationship of moral judgment to moral action. In Kurtines, W.M., Gerwitz, J.L., (Eds.) (52-73) *Morality, moral behavior, and moral development*, New York, NY., Wiley.

Kohlberg, L. (1976). Moral stages and moralization: The cognitive-developmental approach. *Moral development and behavior: Theory, research, and social issues,* 31-53.

Kopala B and Burkhart L. (2005) Ethical dilemma and moral distress: Proposed new NANDA diagnoses. International journal of nursing; 16(1): 3–13, doi: 10.1111/j.1744-618x.2005.00001.x

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress, 19*(3), 192-207. doi https://doi-org.uml.idm.oclc.org/10.1080/02678370500297720

Leggett, J. M., Wasson, K., Sinacore, J. M., & Gamelli, R. L. (2013). A pilot study examining moral distress in nurses working in one United States burn center. *Journal of Burn Care & Research*, *34*(5), 521-528. doi: 10.1097/BCR.0b013e31828c7397

Lev, S., & Ayalon, L. (2016). Moral distress among long-term care social workers: Questionnaire validation. Research on social work practice, 1(10), 1-10. doi:10.1177/1049731516672027.

Lev, S., & Ayalon, L. (2018). Development and content validation of a questionnaire to assess moral distress among social workers in long-term care facilities. Social work in health care, 57(3), 190-205

Levenson, R.W. & Ruef, A.M. (1992). Empathy: A physiological substrate. *Journal of personality and social psychology.* 63(2). 234-246. doi: http://psycnet.apa.org.uml.idm.oclc.org/doi/10.1037/0022-3514.63.2.234

Lewis, H. B. (1971). Shame and guilt in neurosis. New York, NY: International Universities Press.

Lincoln, Y., & Guba, Egon G. (1985). Naturalistic inquiry. Beverly Hills, CA.: Sage.

Lincoln, Y. & Guba, E. (1989). Forth generation evaluation. Newbury Park, CA.: Sage

Liljegren, A.L., Dellgran, P., and Höjer, S., (2008) The heroine and the capitalist: the profession's debate about privatisation of Swedish social work, European Journal of Social Work, 11:3, 195-208, DOI: 10.1080/13691450802220933

Litz, B.T., Stein, N., Delany, E., Lebowitz, L., Nash, W.P., Silva, C., Maguen S., (2009). Moral injury and moral repairing war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review* 29 (8), 695-706.

Lizano, L., Borak, M., (2015). Job burnout and affective wellbeing: A longitudinal study of burnout and job satisfaction among public child welfare workers, Children and Youth Services Review 55, 18-28, https://doi.org/10.1016/j.childyouth.2015.05.005

Lützén K, Johansson A., Nordstrom G., (2000). Moral sensitivity: Some differences between nurses and physicians. *Nursing ethics,* 7, 521-30. doi https://doi-org.uml.idm.oclc.org/10.1177%2F096973300000700607

Lützén K, Conqvist A and Magnusson A (2003). Moral stress: Synthesis of a concept. Nursing Ethics, 10(3): 312–322 doi: 10.1191/0969733003ne60809

Lützén, K., Dahlqvist, V., Eriksson, S., & Norberg, A. (2006). Developing the concept of moral sensitivity in health care practice. *Nursing ethics*, *13*(2), 187-196. doi: https://doi-org.uml.idm.oclc.org/10.1191%2F0969733006ne837oa

Lützén, K., & Kvist, B. E. (2012). Moral distress: a comparative analysis of theoretical understandings and inter-related concepts. In *Health ethics forum* (24, (1), 13-25). Springer Netherlands. doi: https://doi-org.uml.idm.oclc.org/10.1007/s10730-012-9178-9

Lynch, D., & Forde, C. (2016). ‘Moral distress’ and the beginning practitioner: Preparing social work students for ethical and moral challenges in contemporary contexts. Ethics and social welfare, 10(2), 94-107. Doi: //doi-org.uml.idm.oclc.org/10.1080/17496535.2016.1155634

Madigan, S. P. (1992). The application of Michel Foucault's philosophy in the problem externalizing discourse of Michael White. *Journal of family therapy*, *14*(3), 265-279. doi: 10.1046/j..1992.00458.x

Maiden, J. (2008). *A quantitative and qualitative inquiry into moral distress, Compassion fatigue, Medication error, and Critical care nursing*. San Diego, CA: University of San Diego.

Maiden, J., Georges, J. M., & Connelly, C. D. (2011). Moral distress, compassion fatigue, and perceptions about medication errors in certified critical care nurses. *Dimensions of critical care nursing*, *30*(6), 339-345. doi: 10.1097/DCC.0b013e31822fab2a

Malterud, K. (2001). "Qualitative research: Standards, challenges and guidelines." The lancet. 358: 483-488.Retrieved from https://doi-org.uml.idm.oclc.org/10.1016/S0140-6736(01)05627-6

Mänttäri-van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International journal of social welfare*, *25*(1), 86-97. doi: 10.1111/ijsw.12163

Mänttäri-van der Kuip, M. (2020). Conceptualising Work-Related Moral Suffering—Exploring and Refining the Concept of Moral Distress in the Context of Social Work. *The British Journal of Social Work*, *50*(3), 741-757.

Marcus, R. B. (1980). Moral dilemmas and consistency. *The journal of philosophy*, *77*(3), 121-136. doi:10.2307/2025665

Marston, G., & McDonald, C. (2012). Getting beyond 'heroic agency'in conceptualising social workers as policy actors in the twenty-first century. *British journal of social work*, *42*(6), 1022-1038. https://doi-org.uml.idm.oclc.org/10.1093/bjsw/bcs062

Marek, T., Maslach, C. (2017). Professional Burnout: Recent Developments in Theory and Research. United Kingdom: Taylor & Francis.

McAuliffe, D., Williams, C., and Briskman, L., (2016). Moral outrage! Social work and social welfare. Ethics & social welfare, 10(2), 87-93. doi: http://www.tandfonline.com.uml.idm.oclc.org/doi/full/10.1080/17496535.2016.1159776

McCarthy, J., Deady, R. (2008). Moral distress reconsidered. Nursing ethics 2008; 15(2): 254–262. doi:10.1177/0969733007086023

McCarthy, J., Gastmans, C. (2015). Moral distress: A review of the argument-based nursing ethics literature. *Nursing ethics*, *22*(1), 131-152. doi: https://doi-org.uml.idm.oclc.org/10.1177%2F0969733014557139

McHoule, A., & Grace, W. (1993). *A Foucault primer. Discourse, power and the subject.* Dunedin, NZ: University of Otago Press.

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. International journal of nursing practice, 12(1), 8-13. doi: 10.1111/j.1440-172X.2006.00543.x

Morrison, T., (1990) The Emotional Effects of Child Protection Work on the Worker, Practice, 4:4, 253-271, doi: 10.1080/09503159008416902

Morse, J. (1994). "Designing funded qualitative research." In NK. Denzin and YS Lincoln (Eds.) Handbook of Qualitative Research (pp. 220-235). Thousand Oaks, CA: Sage.

Morse, J. M. (2010). Sampling in grounded theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory*(pp.229-244). London: Sage.

Mullaly, B. (2007). The new structural social work (4th ed.) Ontario. Oxford University Press.

Nathaniel, A. (2006). *Moral reckoning in nursing*. Western journal of nursing research, 28(4), 419-438. doi: http://journals.sagepub.com.uml.idm.oclc.org/doi/abs/10.1177/0193945905284727

Nathaniel A. Theory of moral reckoning (2008). In: Smith MJ and Liehr PR (Eds). Middle range theory for nursing, (second edition) 277–292. New York, NY: Springer.

Olcon, K. & Gulbas, L., (2020). "Their needs are higher than what I can do": Moral distress in providers working with Latino immigrant families. *Qualitative Social Work* 0 (0), 1-17. Doi: 10.1177/1473325020919804.

Oliver, C. (2011). Critical realist grounded theory: A new approach for social work research. *British journal of social work*, 42(2), 371-387, doi: 10.1093/bjsw/bcr064

Oliver, C. (2013). Including moral distress in the new language of social work ethics. Canadian social work review/Revue Canadienne de service social, 30 (2), 203-216. doi: http://www.jstor.org.uml.idm.oclc.org/stable/pdf/43486770.pdf

Openshaw L., (2011). Moral distress and the need for moral courage in social work practice. Paper presented at National Association of Christian Social Work Convention. Pittsburg, PA.

Orlie, M.A., (1997). Living ethically acting politically. Ithaca: Cornell University Press.

Patton, MQ. (1999). Enhancing the quality and credibility of qualitative analysis. Health Services Research. 34 (5) 1189-1208. Retrieved from https://www-ncbi-nlm-nih-gov.uml.idm.oclc.org/pmc/articles/PMC1089059/#

Patton, M.Q. (2015). Qualitative evaluation and research methods. Thousand Oaks, CA: Sage.

Pauly B., M., Varcoe, C. and Storch, J. (2012). Framing the issues: Moral distress in health care. *Health ethics committee forum* 24(1), 1–11. doi. https://doi-org.uml.idm.oclc.org/10.1007/s10730-012-9176-y

Pauly, B., Varcoe, C., Storch, J. & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. *Nursing ethics 16* (5), 561-573. doi. https://doi-org.uml.idm.oclc.org/10.1177%2F0969733009106649

Payne, M. (2014). Modern social work theory (4ed). Chicago Ill, Lyceum Books Inc.

Peter, E., & Liaschenko, J. (2004). Perils of proximity: A spatiotemporal analysis of moral distress and moral ambiguity. *Nursing inquiry*, *11*(4), 218-225. doi. 10.1111/j.1440-1800.2004.00236.x

Pellegrino E. (1985). *The virtuous physician and the ethics of medicine*. In: Shelp, EE. Virtue and medicine: Explorations in the character of medicine (237–55). Boston, MA: D. Reidel.

Piaget, J. (1964). Part I: Cognitive development in children: Piaget development and learning. *Journal of research in science teaching*, *2*(3), 176-186. doi:10.1002/tea.3660020306

Portnoy D (2011) *Burnout and compassion fatigue: Watch out for the signs.* Health progress 92(4), 46-50. doi: http://europepmc.org/abstract/med/21838112

Pumphrey, M. W. (1959). *The teaching of values and ethics in social work education.* New York: Council on Social Work Education.

Rabinow, P., & Rose, N., (Eds.). (1994). *The essential Foucault. Studies of governmentality with two lectures by and an interview with Michel Foucault.* New York, NY: New Press.

Raines, M. L. (2000). Ethical decision making in nurses: Relationships among moral reasoning, coping style, and ethics stress. *JONA'S healthcare law, ethics and regulation, 2*(1), 29-41.

Reamer, F.G. (1999). Social work values and ethics (2nd ed.). New York, NY: Columbia University Press.

Repenshek M. (2009). Moral distress: Inability to act or discomfort with moral subjectivity? Nursing ethics; 16(6): 734–742. Doi: https://doi-org.uml.idm.oclc.org/10.1177%2F0969733009342138

Rizzo, J. R., House, R. J., & Lirtzman, S. I. (1970). Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly,* 15, 150-163. doi: 10.2307/2391486

Rokeach, M., (1979). Understanding human values; Individual and societal. New York, NY: The Free Press.

Rose, N. (1998). Inventing ourselves. Psychology, power and regulation. NewYork, NY., Cambridge University Press.

Rothman, J., (1989). Client self-determination: Untangling the knot. Social Service Review, 63(4), 589-612

Rushton, C., (2016). Moral resilience: A capacity for navigating moral distress in critical care. Advanced critical care nursing 27 (1), 111-119. doi: 10.4037/aacnacc2016275

Rushton, C., Adams, M. (2009). Asking ourselves and others the right questions: A vehicle for understanding, resolving, and preventing conflicts between clinicians and patients and families. Advanced critical care nursing 20 (2) pp. 295-300. doi: https://www.upaya.org/dox/cynda-rushton-principled-moral-outrage.pdf

Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2013). Addressing moral distress: Application of a framework to palliative care practice. *Journal of Palliative Medicine, 16*(9), 1080-1088. doi: 10.1089/jpm.2013.0105.

Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2013). A framework for understanding moral distress among palliative care clinicians. *Journal of palliative medicine, 16*(9), 1074-1079. doi: https://doi-org.uml.idm.oclc.org/10.1089/jpm.2012.0490

Sandelowski, M. (1993). "Rigor or rigor mortis: The problem of rigor in qualitative research revisited." Advances in nursing science. 16(2), 1-8. doi: http://journals.lww.com.uml.idm.oclc.org/advancesinnursingscience/abstract/1993/12000/rigor_or_rigor_mortis__the_problem_of_rigor_in.2.aspx

Siebert, D. C., & Siebert, C. F. (2005). The caregiver role identity scale: A validation study. *Research on social work practice, 15*(3), 204-212. doi: https://doi-org.uml.idm.oclc.org/10.1177%2F1049731504272779

Siebert, D.C., (2006). Personal and occupational factors in burnout among practicing social workers: Implications for researchers, practitioners, and managers, *Journal of social service research,* 32(2), 25-44. Retrieved from https://doi-org.uml.idm.oclc.org/10.1300/J079v32n02_02

Sinnott-Armstron, (1988). Moral dilemmas. Oxford: Basil Blackwell.

Skorupski, John, (1998). Morality and ethics. The Routledge Encyclopedia of Philosophy.Abingdon: Taylor & Francis.

Spicker, B., (1990). Social work and self-determination. British Journal of Social Work, 20(3), 221-236.

Sporrong, S. K., Armetz, B., Hansson, M.G., Westerholm, P., & Hoglund, A.T., (2007). Developing ethical competence in health care organizations. Nursing ethics, 14(6), 416-427. doi: https://doi-org.uml.idm.oclc.org/10.1177%2F0969733007082142

Sporrong, S. K., Hoglund, A.T., Armetz, B. (2006). Measuring moral distress in pharmacy and clinical practice. Nursing ethics, 13(4), 416-427. doi: https://doi-org.uml.idm.oclc.org/10.1191%2F0969733006ne880oa

Strauss, A.L. and Corbin, J.M. (1990) Basics of qualitative research; Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Stifter, C. A., Spinrad, T., & Braungart-Rieker, J. (1999). Toward a developmental model of child compliance: The role of emotion regulation in infancy. *Child Development*, *70*(1), 21-32. doi:10.1111/1467-8624.00003

Stoffel, J.M., Pharm, D., Cain, J., Ed, D., (2018). Review of grit and resilience literature within health professions education. American Journal of Pharmaceutical Edcuation, 82 (2) doi: http://www.ajpe.org.

Sugrue, E., (2019). Understanding the effect of moral transgressions in the helping professions: In search of conceptual clarity. *Social Service Review.* The University of Chicago. Doi 132.174.250.038, http://www.journals.uchicago.edu/t-and-c.

Tangney, J. P. (2003). Self-relevant emotions. In J. P. Tangney & M. R. Leary (eds), Handbook of self and identity (pp. 384–400). New York, NY: Guilford Pres.

Taylor, M.F., & Bentley, K. J. (2005). Professional dissonance: Colliding values and job task in mental health practice. *Community Mental Health Journal.* 4 (4) pp. 469-480 https:// doi: 10.1007/s10957-005-5084-9.

Tracy, J. L., & Robins, R. W. (2004). " Putting the self into self-conscious emotions: A theoretical model". *Psychological inquiry*, *15*(2), 103-125. Doi: https://doi-org.uml.idm.oclc.org/10.1207/s15327965pli1502_01

Tracy, J.L. and Robins, R.W. (2006). Appraisal antecedents of shame and guilt: Support for a theoretical model, *Personality & social psychology bulletin*, 32(10), 1339-1351 doi: https://doi-org.uml.idm.oclc.org/10.1177%2F0146167206290212

Tuffin, K. (2005). Understanding critical social psychology, London: Sage

Ulrich, C., P. O'Donnell, C. Taylor, A. Farrarr, M. Danis, and C. Grady. (2007). Ethical climate, ethical stress, and the job satisfaction of nurses and social workers in the United States." Social science and medicine 65 (1): 1708–1719. Doi: https://doi-org.uml.idm.oclc.org/10.1016/j.socscimed.2007.05.050

Ulrich, C., Hamric, A., & Grady, C. (2010). Moral distress: A growing problem in the health professions. *The Hastings Center Report*, 40(1), pp. 20-22. Retrieved March 22, 2021, from http://www.jstor.org/stable/40407684

Unison Industrial Action Committee (2004), Social work: Qualifications and professionalism. Jones, C., Lavalette, M. Submission to the University of Liverpool.

Varcoe, C., Pauly, B., Webster, G. & Storch, J. (2012). Moral distress: Tension as springboards for action. *Healthcare ethics committee forum*, 24(1), 51-62. doi:10.1007/s10730-012-9180-2.

Walsh, A. (2010). Pulling the heartstrings, Arguing the case: A narrative response to the issue of moral agency in moral distress. *Journal of medical ethics*, *36*(12), 746-749. doi: http://dx.doi.org.uml.idm.oclc.org/10.1136/jme.2010.036079

Webster, G. & Baylis, F. (2000). Moral residue. In S.B. Rubin & L. Zoloth (eds) Margin of Error: The ethics of mistakes in the practice of medicine (pp. 217-230). Hagerstown, MD: University Publishing Group.

Welten, S., Zeelenberg M. & Berugelmans. S.M., (2012). Vicarious shame, cognition & emotion, *Journal of cognition & emotion* 26 (5), 836-846. doi: 10.1080/02699931.2011.625400.

White, W. A. (1933). The moral judgment of the child. *Psychoanalytic review*, *20*(2), 215-220.

Weinberg, M (2007). Ethical "use of self": The complexity of multiple selves in clinical practice. In D. Mandell (Ed.) Revisiting the use of self: Questioning professional identities (pp 213-233). Toronto: Canadian Scholars Press.

Weinberg, M., (2009). Moral distress: A missing but relevant concept for ethics in social work, Canadian social work review, 26 (2): 139-151 Doi: http://www.jstor.org/stable/4166990

Weinberg, M., (2010). The social construction of social work ethics: Politicizing and broadening the lens. *Journal of progressive human services*, 21(1), 32-44. doi:10.1080/10428231003781774.

Weinberg, M., and Taylor, S., (2014). 'Rogue' Social Workers: The Problem with Rules for Ethical Behaviour. *Critical Social Work*, 15(1), 74–86.

Weinberg, M., (2015). Professional Privilege, ethics and pedagogy. *Ethics ands Social Welfare*, 9:3, 225-239, doi: 10.1080/17496535.2015.1024125.

Williams, B. A., & Atkinson, W. F. (1965). Symposium: Ethical consistency. *Proceedings of the Aristotelian Society, Supplementary volumes*, 103-138. doi: http://www.jstor.org/stable/4106568

Wilkinson, J. (1987). Moral distress in nursing practice: Experience and effect. Nursing forum; 23(1); 16–29. doi: 10.1111/j.1744-6198.1987.tb00794.x

Wocial, L. D. (2016) A misunderstanding of moral distress, *The American Journal of Bioethics*, 16(12), pp21-23.

Yeung, H. (1997). Critical realism and realist research in human geography: A method or a philosophy in search of a method? *Progress in human geography*, 21(1), pp.51-47. doi:191/030913297668207944

Zuzelo, P. (2007). Exploring the moral distress of registered nurses. *Nursing ethics, 14*(3), 344-359. doi:10.1177/0969733007075870.