AN EXPLORATORY STUDY OF BURNOUT, COPING, AND SOCIAL SUPPORT IN HOME CARE STAFF WORKING WITH OLDER PEOPLE

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1998

VOLUME I OF II

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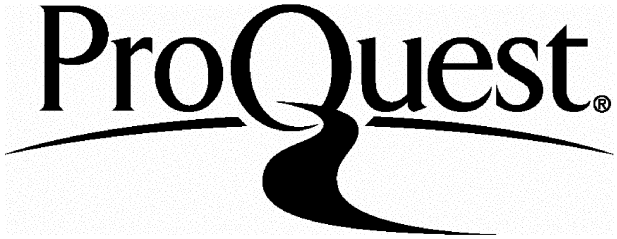

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ABSTRACT

An investigation into burnout, psychological disturbance, coping and social support among 67 Social Service Home Carers working with older people was conducted. The aim of the study was to explore the nature of stress, and level of psychological disturbance experienced by this previously scarcely studied group who are in the 'front-line' in working with older people. Quantitative data was collected using standardised questionnaires for burnout (MBI), psychological disturbance (GHQ-28), coping (WCQ-R) and social support (SSQ-R). Qualitative data was collected from a specifically designed questionnaire and from discussion groups. The Home Carers in the study reported lower levels of burnout and psychological disturbance than is found in the normal population or in similar occupational groups. Possible explanations for these findings are discussed.

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I would like to thank the home care managers and staff, in particular Dawn Cauldwell, for their help and participation in this study. I would also like to thank Val Curran for her patience and guidance in supervising this study. Last but not least I would like to acknowledge the enormous support and encouragement that I have received from my family and friends who put up with with my 'thesis neurosis' for many months.

CHAPTER 1: INTRODUCTION

GENERAL INTRODUCTION AND CHAPTER OVERVIEW

The number of vulnerable older people living alone or helping to care for an ailing spouse is increasing and is set to continue to increase into the next millennium. In the 30 year period between 1960 and 1990, the life expectancy for men and women aged 55 has increased by 22.2 and 27.3 years respectively. Additionally there has been an increase in the proportion of one-child families, in migration of adult children away from elderly parents, and in the number of individuals living alone following separation from partners. Therefore more and more older people live in the community with little or no family support (Zarit and Edwards 1996). Increasing numbers of formal carers are therefore going to be required to care for these individuals.

Supporting this view is the report in the Health and Social Services Statistics (1997) that in surveys of years 1992-96 there was a 50% increase in home help / home care activity in England to 2.5 million contact hours per week. The number of households served, however, fell by about 7% to 491,000, an increase in the number of hours provided per household. This increase may be an indication of the increased level of need of those receiving care at home.

Banergee and MacDonald (1996) surveyed older people in receipt of home care services in a London borough rating the level of mental disorder in the population. They found that the population receiving home care was older, had more female members and was more likely to be widowed and live alone than the general elderly population. They found a high prevalence of mental disorder; 26% case level depressive disorder, 15% organic disorder. The prevalence of case level depression that can be applied to people over 65 in England and Wales according to the OPCS Population Estimates Unit, 1993, is however only 9%. There was little evidence that the majority of those with depressive disorders were receiving appropriate treatment from primary or secondary health care services. In the London borough surveyed, and quite likely other areas, this means that home carers who generally have limited training in working with mental disorder are faced with a population who have a high level of psychological disorder. The other side of the coin is that vulnerable older individuals must rely for support on a group of workers who may not have the training or support necessary to work with their difficulties. In addition, because of the shortage of nurses and unpopularity of older people as a specialty, home carers may be needed in greater numbers and required to do more of the tasks previously carried out by nurses.

The MIND (1992) survey of stress in manufacturing, distribution and service industries found that 63% of respondents felt that stress was caused equally or more by work than by personal problems. The European conference on stress at work (1993) found that 48% of European workers considered that their health was affected by stress at work.

Absenteeism, increased turnover, industrial relations problems, poor decision making, low morale and accidents are all acknowledged to result from stress (Sutherland and Cooper 1990). Stress and burnout in health care staff has a negative outcome for both the carer and client.

The area of carer stress in caring for older people and those with a terminal illness has been much studied both in terms of informal or family caregivers and in terms of staff in institutional and residential settings. However there is a paucity of research into the experiences of paraprofessionals working with older people in the community.

Overview of Chapter

The first parts of the introduction present concepts and models of stress and burnout and consider the distinction between the two. There is then a brief review of literature on stress and burnout in health care occupations. In the next sections of the chapter, literature on two of the main moderators of stress; coping and social support, are presented. This is followed by a more detailed review on the effects on staff of caring for older people and the terminally ill, and specifically literature relating to home care staff. The chapter concludes with comments on methodology in the study of stress, the rationale for this study, and specific research questions.

1.1. STRESS

1.1.1 What is Stress?

Stress is a term with which everyone is familiar but for which there would probably be as many definitions as there are people defining it. There has been much confusion around the concept of stress which has been defined in a number of different ways and at many different levels. While full critical examination of the models and their empirical bases is beyond the scope of this study, a brief overview is provided to set the context for what follows.

1.1.1.i Stimulus-based and response-based models of stress

Early models of stress focused on stimulus and response which are now understood as paying insufficient attention to psychological processes (Cox 1981).

The stimulus-based or 'engineering' model posits that individuals' have a built-in level of resistance to stress. Stress is something that happens *to* the individual, not *within* the individual. External stresses are seen as giving rise to a stress reaction, or strain in the individual, the stress being located in the characteristics of the external stressor, not the person. However, individual differences and the role of perception of stress are not accounted for in this model which is primarily concerned with what causes stress.

The response-based or physiological model of stress is primarily concerned with what is happening *within* the individual. Hans Seyle (1956) defined stress as "the non-specific response of the body to any demand made upon it". These responses were held to reflect a phenomenon termed by Seyle the General Adaptation Syndrome (GAS). The three elements of this physiological concept of stress were firstly that there is a universally held physiological defence reaction that is fundamentally the same for all animals no matter what the source of the stress. Secondly that there are three phases of the GAS; an alarm reaction, increased resistance associated with adaptation to the alarm, and exhaustion which may be terminal. Thirdly, illness and disease result from prolonged and severe defence responses. This model is primarily concerned with the response to stress.

1.1.1.ii *Interactive / Process Models of Stress*

Within an interactive model three conceptual domains of the stress process are integrated; the source of stress, mediators of stress, and manifestations of stress. The works of Lazarus and Folkman (1966, 1984, 1993) dominate the field of stress process research, their work will be elaborated below in considering coping. Where interactive models of stress recognise the interactional nature of stress elements, and thus stress as a process; transactional models emphasise the role of cognitive mediation (Cox 1981). Stress therefore relates to those transactions where the demands from the environment are perceived as threatening since they challenge the individual's ability to cope. The

primary element of the transactional model of stress is that a stressor is in the eye of the beholder so to speak. A stressor is any *potential* threat in the environment, nothing will be considered a stressor unless it is so appraised, and then anything might be appraised as a stressor.

1.1.2 Occupational Stress

Occupational stress has been defined by Cox (1981) as "the psychological state that is or represents an imbalance or mismatch between people's perceptions of the demands on them (relevant to their work) and their ability to cope with those demands"

Cooper and Davidson's (1987) model of stress identifies five major sources of stress at work:

1. *Factors intrinsic to the job*: including, work overload and underload, equipment and training, job satisfaction and use of skills
2. *Role in the organisation*: including responsibility for people, role ambiguity and role conflict and organisational boundaries.
3. *Relationships at work*: including relationships with colleagues and supervisors and quality of social support in the work place.

4. *Career development*: including satisfaction with pay, lack of job security, over-promotion and under-promotion.

5. *Organisational structure and climate*: including lack of participation, lack of team working, poor communications, the role of significant other colleagues, hierarchy, complexity, rigidity, status.

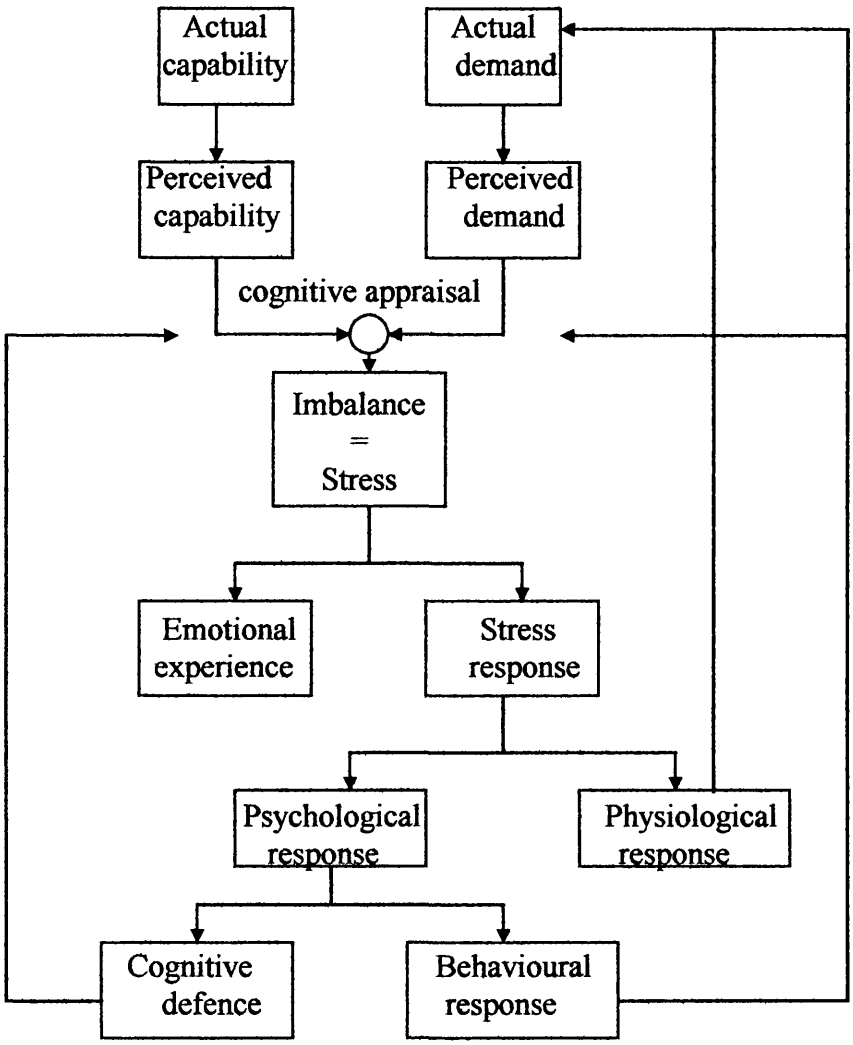
In the Cooper & Davidson model these five sources of stress combine with demands from the home, social and individual arenas to generate manifestations of stress when they are unmet by matching coping responses.

Cox, Kuk & Leiter's Transactional Model (Fig. 1) demonstrates stress as relational in nature, there is a transaction between the individual and his/her environment.

The two most widely recognised mediators of stress identified in the literature are social support (Veiel & Baumann, 1992) and coping strategies which can be regarded as external (environmental) and internal (psychological) coping resources. Coping and social support will be discussed below.

Figure. 1

Transactional Model of Occupational Stress
(Cox, Kuk and Leiter, 1993)



1.2 BURNOUT

1.2.1 What is Burnout?

Burnout, a term coined by Freudenberger in the 1970's, is now generally understood as the end result of the process of chronic accumulated stress. Freudenberger initially observed the phenomenon in a free clinic in the United States in which he was working. He noticed that over the course of about a year many of his colleagues became increasingly emotionally drained and experienced a loss of motivation and commitment. During the same period a social psychologist, Maslach, was studying 'detached concern' and 'dehumanisation in self defence' as strategies used by individuals to cope with emotional arousal in work situations. During the early development of 'burnout' the term became all encompassing with enormous variation in the meaning that writers attached to it. Since then there has been an empirical phase of research focusing on working models of burnout and particularly on the contribution of job factors. At times the concept of burnout has been used synonymously with stress, or as a negative response to stress. As with the field of stress and coping the conceptual development of burnout has now moved to the examination of the process of burnout.

Maslach and Schaufeli (1993) identify five elements that are common to most definitions of burnout:

- A predominance of dysphoric symptoms such as depression, fatigue and mental or emotional exhaustion.

- An emphasis on mental and behavioural symptoms rather than physical symptoms.

- The symptoms of burnout are related to work.

- The individuals who manifest the symptoms of burnout have no prior histories of psychopathalogical disturbance.

- Negative attitudes and behaviours result in decreased effectiveness and work performance.

1.2.2 Symptoms of Burnout

In a review of evidence of symptoms of professional burnout Kahill (1988) identifies five major categories:

- physical
- emotional
- behavioural
- interpersonal

- attitudinal

This categorisation has been carried out because of the enormous number of reported symptoms. Kahill attributes these to either the lack of conceptual clarity in the field or as a reflection of the psychological reality that as a generalised psychological distress reaction burnout will be experienced differently by different individuals. These five categories have been incorporated into a conceptual framework for burnout presented by Cordes and Dougherty (1993) (see Fig. 3).

1.2.3 Models of Burnout

There are several models of burnout cited in the literature, of which Maslach's 3 factor model is the most widely cited. Maslach (1982, p.3) describes burnout as:

> "a syndrome of *emotional exhaustion*, *depersonalisation* and *reduced personal accomplishment*...as a result of the chronic emotional strain of working extensively with other human beings particularly when they are troubled".

Maslach and Ozer (1995) describe these three central constructs of the 'multi-dimensional process' as an operational definition.

- Emotional Exhaustion: this is characterised as an expected correlate of working with difficult or unpleasant clients, dealing with death or illness, breaking bad news and conflict with co-workers or seniors. It leaves the individual with no capacity to offer *psychological support to others.*

- Depersonalisation: is characterised by a psychological distancing by the carer who avoids over-involvement, derogates the clients' view and sees them as a symptom cluster. *There is a callous and negative attitude towards colleagues and clients.*

- Reduced Sense of Personal Accomplishment: is characterised by feeling unprofessional, making negative self-evaluations, and feeling a lack of satisfaction or meaning in the work.. *Positive job performance and past achievements are played down or disregarded.*

Some commentators have queried whether or not emotional exhaustion, depersonalisation and reduced personal accomplishment actually do represent different dimensions or whether, particularly emotional exhaustion and depersonalisation, are part of the same thing. Research by Buunk and Schaufeli (1993) indicates that although the three dimensions of burnout may have common roots, the processes related to the dimensions are quite different. Burnout has also been related to a number of other concepts, most frequently to depression. Firth et al (1986) found support for their hypothesis that emotional exhaustion and 'professional depression' may describe the

same phenomenon. The concept of professional depression was correlated with depression and was measured using a version of the Beck Depression Inventory (BDI) adapted for work situations. Buunk and Schaufeli (1993) view emotional exhaustion as an indicator (common among people who are sensitive to stress in general) of general job stress. Depersonalisation is seen as a way of coping with problems associated with relationships with clients. Lack of personal accomplishment arises from a feeling of lack of control over the situation and low self esteem. Cox, Kuk and Leiter (1993) also view burnout as a phenomenon that is likely to be unique to human services workers.

Another important model of burnout is posited by Cherniss (1980) whose developmental model suggests that burnout is the final stage of a failed process of coping. Cherniss' conceptualisation of burnout is broader, more inclusive than that of Maslach. Cherniss included in the definition of burnout; a decline in motivation, involvement and motivation at work, apathy, discouragement and fatalism, rationalism of failure by blaming the clients or system, irritability or anger with clients and colleagues, in addition to exhaustion and loss of concern for the client. However, with the general acceptance and widespread use of the Maslach Burnout Inventory (MBI) and the concept of the three dimensions of burnout the model presented by Maslach has gained ascendancy.

Leiter (1991) presents a developmental process model (fig.2) of burnout based on two assertions; firstly that Maslach's three dimensions of burnout influence each other over time as they develop, and secondly that the three dimensions each have different

relationships with individual and environmental factors. Emotional exhaustion is understood as a primary reaction to occupational stresses. According to Leiter's model and research, correlations between emotional exhaustion and depersonalisation are stronger than between either of these two components and diminished personal accomplishment. In terms of stressors or predictors of burnout two main factors highlighted by this model are work overload and conflicts with people at work.

Figure 2.

PROCESS MODEL OF BURNOUT
(Leiter, 1991)

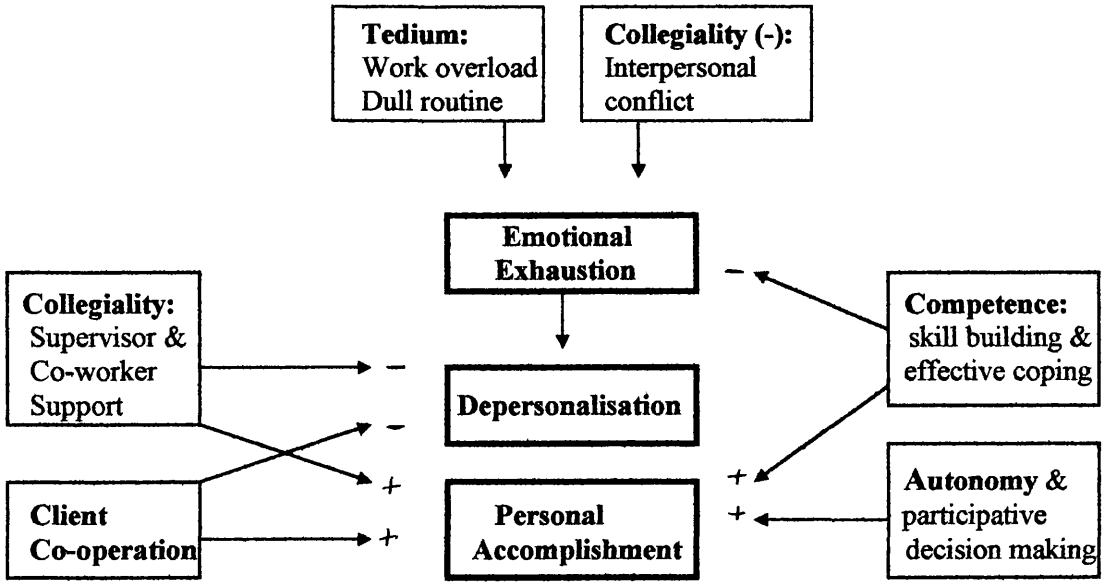
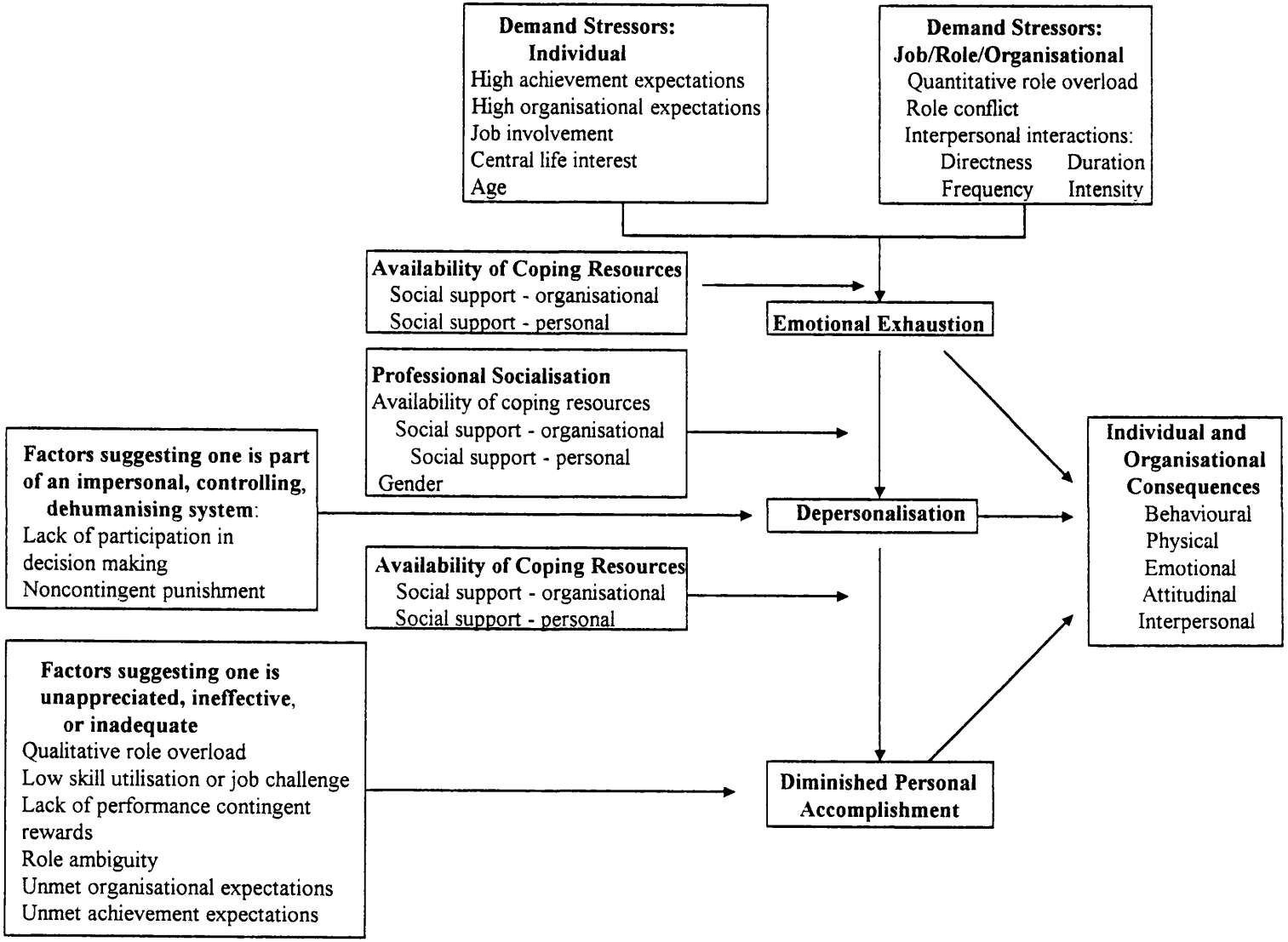


Figure. 3
(Cordes & Dougherty, 1993)

A CONCEPTUAL FRAMEWORK FOR BURNOUT



Cordes and Dougherty (1993) in their review and integration of research on burnout adopted the Maslach three component model of burnout. They suggest that the burnout process is moderated at three points by the availability of coping resources (see Fig. 3). As with Leiter's (1991) model the key component in this model is emotional exhaustion which is a reflection of the organisational and personal demands placed on the individual. Many of the demand stressors identified by Cordes and Dougherty are similar to those presented in Cooper and Davidson's (1987) model of occupational stress.

There is substantial agreement that in order to occur, the process of burnout requires time and an interaction between individual and work related elements. Consensus regarding the processes of burnout is increasing; emotional exhaustion is viewed as the central component of the phenomenon with an agreement that key organisational features involve work overload and role conflict. Additionally there is a common emphasis on the importance of coping resources (external and internal) in relation to the different components of burnout.

1.2.4 Occupational Stress and Burnout - The same or different?

In keeping with the literature on occupational stress and burnout, thus far this text has separated the two. Do these separate bodies of literature represent different but related phenomena or are they actually merely different perspectives on the same phenomenon, in which case, the issue of redundancy arises.

Maslach and Schaufeli (1993) view burnout as a concept that has a relative rather than a discrete identity with regard to other related concepts. The distinction between stress and burnout is described as one of time; burnout being a long term process of depletion of personal resources. Cordes and Dougherty (1993) also distinguish burnout from other forms of stress in terms of a response to extreme chronic work demands implying the element of time. Brill (1984) differentiates between the two concepts describing the mental and physical symptoms accompanying stress as a temporary process of adaptation as opposed to the chronic malfunctioning accompanying the breakdown of adaptation that occurs in burnout. In terms of the transactional model of stress (Fig. 1), Cox, Kuk and Leiter (1993) propose that the concept of burnout can be seen as a section cut across the stress process and that the components of burnout can be mapped onto the appropriate level of analysis of work stress.

Cordes and Dougherty (1993) identify depersonalisation, characterised as a defensive coping response to emotional exhaustion, as a stress response that is unique to burnout and does not appear in the literature on occupational stress.

1.2.5 Why study Stress and Burnout in the Health / Helping Occupations?

Sutherland and Cooper (1990) contend that it is important to understand stress for all health and helping professions for the following reasons:

- The role that these workers play in society is an important one which can be affected by stress resulting in costs to the individual, the health providing bodies and society.

- The result of burnout, illness, reduced efficiency, absenteeism and high staff turnover on the recipients of care are likely to be negative.

- There is a risk of exacerbation of vulnerability to disease or injury because these individuals are expected to remain controlled, calm and detached rather than acknowledging and expressing symptoms of distress.

1.2.6 Studies of Stress and Burnout in Health Care Occupations

The passage of time and the chronicity of the stressor is generally understood as that which differentiates occupational stress form burnout. Studies of stress and burnout in health care occupations will thus be considered together as there are a number of factors held in common. Although studies have examined stress in a wide range of occupational groups (teachers, police, social workers, factory workers, managers) the majority of studies examining burnout have been carried out with populations of nurses. Studies of burnout in health care professions have been precisely that, studies of the 'professions', i.e. qualified doctors and nurses. The available literature on less qualified or paraprofessional staff is more limited.

Burnout in mental health professionals has been associated with attempts to provide the necessary care for clients whilst denying their own emotional needs (McCarthy, 1989).

In a study by Hare and Pratt (1988) a comparison of burnout was carried out between professional and paraprofessional nursing staff, and across acute and long term care health facilities. They found that paraprofessional staff (nursing/care assistants) scored significantly higher on the dimensions of emotional exhaustion and depersonalisation than did professional nursing staff.

Hare and Pratt (1988) found that levels of burnout were higher for staff working in long term than acute care facilities which was understood as a reflection of the difference in client related factors between the facilities. Hare and Pratt (1988) also found that paraprofessionals (who experienced higher levels of burnout than professionals) reported less perceived support in their work environment than did their professional colleagues. Firth and Britton (1989) in a study of burnout, absence and turnover amongst British nursing staff reported that perceived lack of support from superiors and emotional exhaustion predicted the frequency of absences from work for more than four days. Chappell and Novak (1992) in a study of stress and social support in nursing assistants found that those who had received relevant training on cognitive impairment were less likely to experience burnout. Insufficient training of hospital nursing aides in Paris was found to heighten job stress in comparison with other workers (Estryn-Behar 1990)

Community mental health nurses have been demonstrated to experience significantly higher levels of stress than their colleagues working in hospital wards (Carson et al 1995; Fagin et al 1995).

1.2.7 Interventions to prevent or alleviate burnout

Kahn (1993) has reviewed potential interventions for addressing burnout in health service workers and has described two main groups of intervention.

- Shoring up the personal defences of carers enabling them to temporarily remove themselves emotionally: examples of this are having opportunities to take time out at work, professional skill development, and learning to utilise appropriately detached stances. (Cherniss, 1980).

- Peer support groups and supervision: these include activities both inside and outside the workplace. He describes the particular effectiveness of these interventions when they provide an opportunity for staff to experience themselves as cared for in their role at work.

1.3 COPING

Two main approaches to coping have focused on *style* which emphasises the role of personality in coping, and on *process* which emphasises the adaptation of coping

responses over time and context. A process definition of coping is that coping is a person's cognitive and behavioural efforts to manage (master, reduce, minimise or tolerate) the demands of situations which are appraised as taxing or exceeding their resources.

Dewe (1993) derives three themes from his review of coping literature which suggest that coping should be viewed as :

- a process, in contrast to traditional trait oriented approaches.
- a reflection of the relationship between the individual and the environment.
- integrative, linking all the components of the stress process.

The similarities with process models of stress and burnout discussed above are evident.

1.3.1 Lazarus and Folkman model of Stress and Coping

Coping is influenced by both the individual's appraisal of the demands of the situation and by the resources that he or she has available.

Lazarus and Folkman's model of stress and coping (Fig 4) is an interactive or transactional one in which stress results from the relationships and interactions between the event, the situation and the individual characteristics. Something is only stressful if it

is appraised as such by the individual. The theory therefore identifies two processes; cognitive appraisal and coping.

Problem and Emotion-Focused Coping

Two broad categories of coping are identified by Folkman and Lazarus (1980); problem-focused and emotion-focused. Coping strategies are not mutually exclusive, most stressors will elicit a number of coping strategies, however, generally there is a predominance of either problem or emotion focused coping.

Emotion focused coping: focuses on the regulation of stressful emotions by utilising mechanisms to avoid direct contact with the stressor. Pruchno and Kleban (1993), for example, in investigating the role of coping strategies for adult children caring for an institutionalised parent found that emotion-focused strategies mediated the relationship between stressors and mental health.

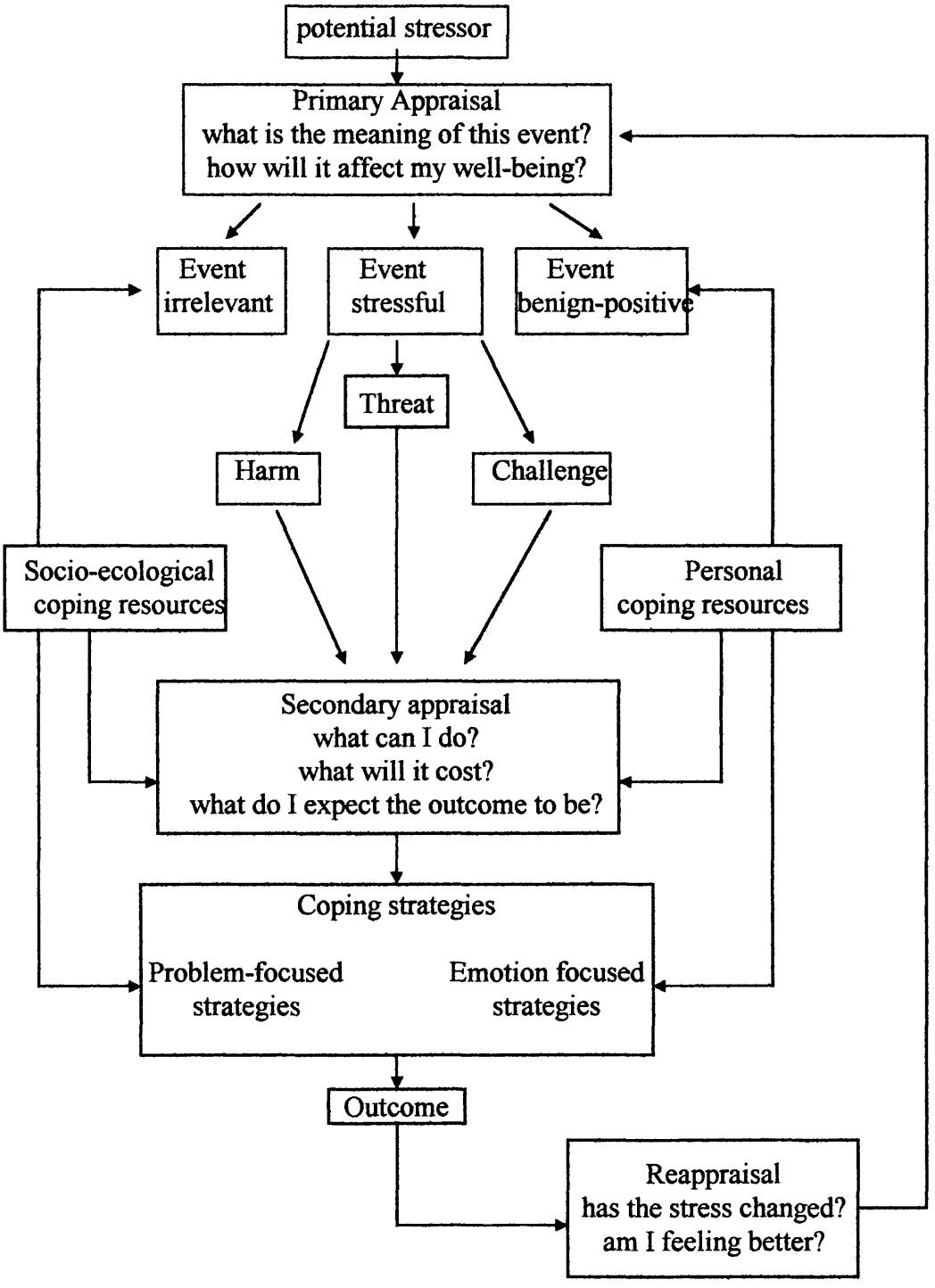
Problem focused coping: consists of efforts to alter the conditions that are the source of the stress. Problem focused coping is generally considered to be more effective in a work setting.

Occupational coping effectiveness, however, has been found to depend on the context in which the particular strategies are used (Bowman & Stern, 1995).

Figure 4.

The Process Model of Stress and Coping

(Lazarus & Folkman 1984)



In a role such as home caring, where there may be blurred boundaries between caring as a job and emotional involvement with a client, the emotion-focused / problem focused split between the personal and work arena may not be as clearly delineated as appears to be the case above.

1.4 SOCIAL SUPPORT

The term social support has become a general term for a broad array of concepts and measures which generally lacks a common and clear theoretical concept. It might generally be defined as the availability of individuals who can be relied upon to demonstrate that they care about, love and value a person across varied situations. Importantly this construct may include both availability and perceived adequacy of such relationships. Measurement of social support may be in the sphere of work or family / friends; of perceived or actual support, or of number or quality.

1.4.1 Main Effects and Buffering hypotheses of Social Support

Two models are often used in examining differential response to stressors, the 'main effects' and 'buffering' hypotheses. Although there have been contradictory findings relating to both these models in general both are confirmed by the literature.

1.4.1.i Main Effects Model

This model posits that social support is relevant to the outcome of stress regardless of the level of stress. It is relevant to needs during everyday interactions; to quality of life. The effects of objective support may be moderated by a person's perception of that support.

1.4.1.ii Buffering Hypothesis

It is argued in this model that social support acts as a buffer or moderator of stress only under circumstances of specific crises or stressful experiences, it is not relevant to outcomes under ordinary everyday circumstances. Again there are contradictory findings related to this hypothesis. Buffering has been found to be more evident in circumstances of chronic stress or strain, for example in caring for physically or mentally frail elders. Although this burden or strain is largely reported in the literature on family caregiving (Zarit & Zarit 1983, Rabins, Mace & Lucas, 1982) it is also relevant to formal carers, particularly those such as home carers.

1.4.2 Social support in the health / helping professions

Chappell and Novak (1992) investigated the role of support in alleviating stress among nursing assistants working in long care institutions in Canada. They found a fair amount of burnout in this group using the MBI. They found that those staff who had fewer

supportive people external to work and reported lower support from family and friends were more likely to experience burnout. There was no effect related to work based support. Their findings supported a main effects view rather than the buffering hypothesis.

Social support was found by Ilgen (1990) to have an impact on the health of staff and there was some support for the potential reduction of distress in crisis situations.

Leiter (1991, 1990) in his extensive work on burnout and social support in mental health employees has distinguished between support provided by family and friends, and formal and informal work-related support.

1.5 CARING FOR OLDER PEOPLE AND THE TERMINALLY ILL

High levels of stress symptoms have been demonstrated in psychogeriatric nursing staff (Norfolk & Stirton [1985], Spector [1990]) although as MacPherson et al (1994) point out, these studies lacked a clear definition of stress caseness and suffer from a preselection bias. In their study of 188 nursing staff across 16 units (including long-stay

wards and residential and nursing homes) MacPherson et al (1994) used the GHQ-30 as a measure of caseness. They were surprised to find a lower level of GHQ caseness at 26.6% than has been indicated for women in the general population 33% (Huppert et al 1988). They found that there was a strong relationship between staff psychological disturbance and aggression from clients, with disturbed staff reporting that they were

more likely to shout back at clients. This might be an indication of depersonalisation in burnout. Additionally, disturbed staff were more likely to perceive a lack of social support at work.

In their study of burnout differences between professional and paraprofessional staff in acute and long term care health facilities Hare and Pratt (1988) found that paraprofessional staff scored significantly higher than professional staff on emotional exhaustion and depersonalisation.

An important aspect when thinking about stress or burnout experienced by staff working with the elderly is the relationship with quality of care. Robertson et al (1995) in their study of nurses' job satisfaction and quality of care in psychogeriatric wards identified a strong relationship between job satisfaction and the quality of patient care. A link can sensibly be made between stress, burnout and job satisfaction.

1.6 Studies of Home Carers

Only two studies specifically including home carers were found in an extensive literature search..

Bradley and Sutherland (1995) carried out a study comparing occupational stress in social workers and home help staff with the aim of optimising planning of stress management interventions. The methodology combined a qualitative (individual interviews) with a quantitative approach. In order of importance the 10 most stressful elements of the work identified by the home helps were; client dependency, death of a client, physical demands of the job, ill health of clients, work overload, emotional involvement with the client, time pressures, keeping up a cheerful front, responsibility for client finances and dealing with difficult to manage behaviour. No significant differences in stress level were identified between the two groups, although both groups scored significantly higher than the normal population on the Occupational Stress Indicator (OSI) used as the measure of stress.

In a study of 32 home-care workers in New York Bartoldus et al (1989) found that although test scores revealed little reported stress, significant stress was revealed in interviews. Again a combination of quantitative and qualitative methodology was used. Workers said that they believed that the general public viewed them as "unskilled maids"; they viewed their jobs differently, however. Stressors that were identified were dealing with clients' emotional problems, dealing with clients' with demanding behaviour and dealing with clients' finances.

1.7 METHODOLOGY IN STUDIES OF STRESS

The use of purely quantitative methodology has been criticised in the arena of stress in health care settings as has the use of purely qualitative methodology.

The method of choice therefore appears to be a combination of both methods so that statistical analyses based on well used reliable and valid measures may be used whilst still gaining a qualitative perspective. This seems particularly important in light of an exploratory study with a little studied group.

The MBI, GHQ-28, Ways of Coping Questionnaire (revised) and Social Support Questionnaire (revised) have all been extensively used in quantitative studies of stress and burnout amongst health care professionals.

Focus Groups

Focus groups were originally used in advertising and marketing organisations, however, their usefulness is now being recognised and applied to health care (Festervand 1985, Kitzinger, 1995). The purpose of a focus group is to gather information around an area of interest by facilitating discussion by a group of people who share a common connection with the subject. The idea behind the methodology is that group processes can help people to explore and clarify their views in a way that is not possible using individual interviews.

Focus groups can be used in two main ways; at the beginning of a study to explore the meaning of issues and concepts for certain groups of people, or in the final stages of an investigation to aid interpretation. Data can be analysed in varying degrees of depth using qualitative analysis techniques to derive themes from discussions.

Krueger (1994) identifies six characteristics relating to the ingredients of focus groups:

1. *People*: the composition of groups is typically 6-10 people which should be small enough to allow all present to participate but large enough to allow a range of views to emerge.

2. *Conducted as part of a series:* this allows for the detection of patterns and trends and protects against the exceptional group which is actually unrepresentative.

3. *Homogeneity & unfamiliarity*: the group should comprise similar individuals who have in common certain characteristics determined by the purpose of the group. Members of the group should, however, be relatively unfamiliar with one another.

4. *Provision of data*: rather than aiming to achieve a consensus or goal as is the purpose of some other types of group, the aim of the focus group is to determine perceptions, feelings and manner of thinking of participants in relation to a specific topic.

5. *Qualitative in nature:* qualitative data is elicited through open-ended questions posed in a more natural environment than that of an interview. This provides insight into attitudes, perceptions and opinions of the participants.

6. *Focused discussion:* the topics addressed by the moderator, although seemingly spontaneous are predetermined and sequenced to elicit data on a specific theme using a pre-devised interview guide.

Previous studies have carried out individual interview schedules with carers; there is however, an advantage in using focus group methodology.

1.8 STUDY RATIONALE

The role of home carer requires dealing with emotionally demanding unexpected situations that can result in high levels of stress. Home carers may be particularly vulnerable to burnout and poor psychological well-being as they have high patient contact levels, work in isolation, have limited training and generally have little formal support. In addition to this, because of the blurred boundaries that develop in caring for older people in their own homes home carers may fall somewhere between professional staff such as nurses, and family caregivers, with some describing their clients as "an extended family" (Bradley and Sutherland 1995)

Sutherland and Cooper (1990) present the reasons why it is important to understand the stress affecting all health care workers. The purpose of this study is to consider a previously scarcely attended to group who may be vulnerable to high levels of burnout, affecting not only them but the older people for whom they care. As Maslach and Jackson (1986 p.2) put it "..burnout can lead to a deterioration in the quality of care or service provided". As has been demonstrated, the population being cared for by home care staff is increasing in number and vulnerability. Home carers are employed to care for older people in the community but unlike their professionally qualified colleagues in nursing and social work have no lengthy training and generally lack formal support. They have high levels of client contact, often with individuals who are mentally or physically frail, or have behaviour that is difficult to manage and they work in isolation. These are factors that have been associated with burnout.

The literature to date would indicate that the concept and operationalisation of burnout is a more appropriate approach than that of occupational stress where looking at the experiences of human service workers with a high degree of client contact. The review of the field of stress and burnout presented above demonstrates its breadth. The present study therefore includes selected factors of likely relevance to home carers that would be incorporated in the three domains of a process model of burnout: source, mediators and manifestation. Riordan and Saltzer (1992) suggest that a logical initial step in developing ways of reducing burnout in little known groups is the identification of specific stressors for the group in question. Clearly it would be beyond the scope of this study to include

the vast array of factors that have been presented in the literature. Factors therefore have been limited to elements that are considered important in an initial study of this group.

As this is a previously unstudied group the aim here is to carry out an exploratory study to gain a picture of the stressors facing the group, the levels of psychological disturbance, and the effects and predictive values of three groups of independent variables, ways of coping, social support and work related factors.

Research Questions

1. What are the main stressors identified by home care staff ?

2. What is the prevalence of burnout and general psychological distress amongst this group of workers ?

3. Is there any evidence to suggest that differences in internal and external coping resources affect psychological outcome ?

4. Is there any single factor or combination of factors which can be said to affect outcome ?

CHAPTER TWO: METHOD

OVERVIEW

This study involves a within group, non control design, with quantitative measures in the form of a specifically designed questionnaire and a number of standardised measures being used as the primary source of data collection. Qualitative data was gathered as a subsidiary part of the study through the facilitation of discussion groups based on focus group methodology.

Section 2.1 outlines the attainment of ethical approval. Section 2.2 describes the recruitment of the participants. Section 2.3 describes the quantitative measures used outlining a specifically designed questionnaire and the four standardised measures. Section 2.4 provides a description of the procedure used for quantitative data collection. Section 2.5 describes the recruitment of participants, facilitation/procedure and analysis of data from the discussion groups.

2.1 ETHICAL APPROVAL

Application was made to the West Herts Community Health NHS Trust Local Research Ethics Committee and was approved in July 1997. (see Appendix 1)

2.2 PARTICIPANTS

The participants were Social Service Home Care employees recruited from the St Albans and Dacorum district. Before drawing up the first proposal, contact was made with a home care manager to discuss the possibility of including her staff in an exploratory study of stress, coping and social support in home carers. In discussion with other team managers and some staff this was agreed. The written proposal was then agreed before applying for ethical approval.

Participants were drawn exclusively from Social Service Home Care teams, there were no carers employed by private agencies.

A total of 163 questionnaires were distributed at area home care meetings to individual carers after a description of the study had been presented. Sixty seven questionnaires (41%) were returned.

2.3 MEASURES

A questionnaire pack was made up of a specially constructed questionnaire and four standardised self-report measures.

2.3.1 **Participant Questionnaire** (Appendix 2)

A questionnaire was designed for use in this study which comprised five sections; 'About You', 'About you and your work', 'About your clients', 'Training and support' and 'Perceived work stressors'. Demographic data and information that has been found to be important in studies of similar fields (e.g. occurrence of recent life events, amount of training, number of hours worked) was gathered in this part of the questionnaire.

In the final section of this questionnaire, 'perceived stressors', participants were asked to state whether or not any of 17 stressors, 10 of which were previously identified for home carers (Bradley & Sutherland 1995) contributed to any stress experienced in their own work.. Riordan and Salzer (1992) comment on the importance of identifying stressors as a first stage in investigating stress and burnout in a group. Participants were then asked to rank the 6 most stressful of these issues.

2.3.2 **General Health Questionnaire** - *28* (GHQ-28) (Goldberg, 1981) (Appendix 3)

The various versions of the GHQ (60, 30, 28, 12) are designed to screen for 'state' (as opposed to 'trait') vulnerability to psychological and psychiatric difficulties.

The GHQ-28 is a frequently used measure of general psychological well-being comprising 28 questions which address 4 identifiable elements of distress; somatisation, anxiety and insomnia, social dysfunction and severe depression. It is an adaptation, by the author, of the original 60-item questionnaire. (Goldberg 1978)

The 28 item GHQ was chosen as it maintains good levels of validity and reliability whilst having a faster completion time for participants than the GHQ 60. It also has the advantage over other versions of the questionnaire that analysis within sub-categories can be carried out. Items are rated on a four point scale with respondents being directed to consider their experiences over the "last few weeks". There are three ways of scoring this questionnaire, the first two being the most frequently applied. The first is a likert scale scoring responses as 0, 1, 2, 3. The second method of scoring, known as the GHQ score is bi-modal 0,0,1,1. The advantage of this method of scoring is that it eliminates errors due to 'middle' or 'end' users, it is recommended by Goldberg and Williams (1988) who found little advantage to be gained by using a likert severity score. Caseness using this method is indicated by a cut off score of 4/5. Goodchild and Duncan-Jones (1985) devised another method of scoring, the CGHQ which assigns a score to those replying "same as usual" to negative items but not positive items. A negative item would therefore be scored 0,1,1,1 and a positive item 0,0,1,1 as in the GHQ method. The increased sensitivity of this method may allow detection of long-standing illness. Goldberg and Williams (1988) recommend that this scoring method should only be used

in conjunction with existing methods. For the purposes of this study the GHQ scoring method has been used.

Examples of items are: *Have you recently....*

"felt that you are ill?" (rated from 'not at all' to 'much more than usual').

"lost much sleep over worry?" (rated from 'not at all' to 'much more than usual').

"felt on the whole you were doing things well?" (rated from 'better than usual' to 'much less well').

"felt that life is entirely hopeless" (rated from 'not at all' to 'much more than usual').

2.3.3 Maslach Burnout Inventory (MBI) (Maslach and Jackson 1986) (Appendix 4)

The MBI (titled Human Services Survey by the authors for the benefit of the participants) is a measure of the burnout syndrome which is designed to assess emotional exhaustion, depersonalisation and lack of personal accomplishment. Burnout is conceptualised as a continuum and as such the three elements of burnout are not considered to be either present or absent but to exist to a low, average or high degree. Respondents are asked to consider 22 statements in terms of how often, if at all, they have felt that way about their job. Items are rated on a 6 point scale from 'never' to 'every day'. In its original form the MBI was scored for both frequency and intensity, it was found, however, that the

intensity score added little to the scale and so the measure is now based on frequency alone.

Examples of statements are:

" I can easily understand how my clients feel about things"

"I've become callous towards people since I took this job"

"I feel clients blame me for their problems".

There are two main measures of burnout available, the MBI and the Burnout Measure (BM) (Pines and Aronson 1988). The MBI was chosen as it was specifically designed for use with people working in health care settings. In their comparative review of the construct validity of the MBI and the BM, Schaufeli and Van Dierendonck (1993) found that the MBI could be "employed as a reliable and valid multi-dimensional indicator of burnout in professionals who work with people."(p. 631) The MBI is the most extensively employed instrument for measuring burnout in human services and as such enables comparison with other relevant investigations.

2.3.4 Social Support Questionnaire -Revised 6 item (SSQ-R) (Sarason et al 1987) (Appendix 5)

The 6 question SSQ (Sarason et al 1987) is a shortened version of the original 27 item scale abbreviated by the authors. The internal consistency of the SSQ-6 taken in two samples was α = .93 and .90 with correlations with the full SSQ of .95 and .96. The scale focuses on two main elements of the concept of social support, the perception of the availability of sufficient people to offer support, and the satisfaction with the support they offer. McDowell and Newell (1996) in their text on measuring health report the SSQ to be a valid and reliable measure of social support, although they do reflect on the diversity of social support measures.

The Respondents are asked to reply to six questions by indicating the number of people upon whom they could rely for support (up to 9) and their relationship to them. Then they are asked to rate their level of satisfaction from 1 (very dissatisfied) to 6 (very satisfied).

Examples of questions are:

"whom can you really count on to care about you, regardless of what is happening to you?"

"Whom can you really count on to make you feel more relaxed when you are under pressure or tense?"

This measure was chosen as a valid, reliable instrument which has been used extensively and provides a short self-report method of assessing social support in circumstances where a number of other measures are also being used and minimum completion time is essential for participant co-operation.

2.3.5 Ways of Coping Questionnaire - Revised *67 item* (Folkman and Lazarus 1985) (Appendix 6)

The Ways of Coping Questionnaire (WCQ) is probably the most widely used measure of coping responses, it has been found to have good validity and reliability. This measure can be used in two ways. Many investigators conduct their own factor analysis with respect to the groups which they are studying, one does however require a large enough sample to achieve this. Factors pertinent to more general groups have been identified and validated for a number of groups and these are used as a basis for analysis by many investigators (Folkman et al 1986). This measure does not aim to identify 'good' and 'poor' copers as such, however there is evidence that certain types of coping are more effective in certain situations and so this information can be extrapolated.

Respondents are asked to consider a specific situation that has occurred within the last month (in the case of this study a stressful work situation). They then classify each of 67 statements from 0 (not used) to 3 (used a great deal).

Examples of statements are:

"I told myself things that made me feel better"

"Went along with fate; sometimes I just have bad luck".

"Stood my ground and fought for what I wanted"

"Refused to believe that it had happened"

The Ways of Coping Questionnaire has been factor analysed for a number of different groups; using the 67 question revised WCQ Folkman et al (1986) identified eight factors or scales which are endorsed in the Manual for the Ways of Coping Questionnaire (1988) and in a review of coping theory (Lazarus, 1993):

1. *Confrontive Coping*: aggressive efforts to alter the situation.
2. *Distancing*: efforts to detach oneself.
3. *Self-control*: efforts to regulate one's own feelings.
4. *Seeking social support:* efforts to seek informational and emotional support.
5. *Accepting responsibility*: acknowledging one's own role in the problem.
6. *Escape-avoidance*: wishful thinking and behavioural efforts to escape or avoid.
7. *Planful problem-solving*: deliberate problem focused attempts to alter the situation.
8. *Positive reappraisal*: efforts to create positive meaning by focusing on personal growth.

Five of the eight scales were similar to previous analyses of different data sets comprising different populations (Aldwin et al, 1980, Folkman & Lazarus 1985). Particular to this factor analysis was self-control as a specific form of emotion focused coping, planful problem solving and confrontive coping.

2.4 PROCEDURE

Monthly area meetings of between four and sixteen carers and their managers were held at different locations around the district. I was able to attend the meetings to explain the relevant background to the study, present the questionnaires and give them to carers who were prepared to participate.

Each group was told the same information in which I described that I was a Trainee Clinical Psychologist based in London and interested in carrying out a study of the experiences of home care staff working in the community with older people. The fact that there was no connection between myself and the Social Service team by whom they were employed was emphasised. Carers were informed that there were two parts to the study; one part involved the filling in of questionnaires, the other, participation in an audio-taped discussion group that would last for approximately one and a half hours. It was also explained that it was not necessary for carers to participate in both parts of the study and that they could leave the study at any time. Carers were assured that the data gathered from them would appear as groups of statistics or possibly as an anonymous

quotation to make a point about a specific finding. The fact that there had been a number of investigations carried out into the experiences of informal caregivers and professional nursing staff in residential care, but little thinking about home carers, was explained.

Although it had originally been agreed that the carers would be given time to complete the questionnaires during their area meeting, in the event this was not possible. Carers took the questionnaire pack away with them The information sheet (appendix 7), questionnaire and consent form (appendix 8), were placed in a stamped addressed envelope to be returned to me. Carers agreed to supply their telephone numbers so that in cases where the questionnaire had not been returned by a given date I would be able to contact them. They were also asked to indicate whether or not they would be prepared to participate in the discussion groups which would be facilitated by myself. The telephone call would be to check whether or not they wished to return the forms, and if they did, whether or not they needed any assistance. After the agreed date, carers who had not returned the forms were contacted and arrangements for individual appointments were made to assist with the completion of questionnaires where appropriate.

Enclosed with the questionnaire pack was an information sheet explaining the nature and purpose of the study) and the West Herts Community Health NHS Trust consent form.
The order in which the questionnaires were presented in the package was varied to avoid order effects.

2.5 DISCUSSION GROUPS

Focus group methodology was used in the preparation and facilitation of the discussion groups with home carers. An interview schedule was drawn up based on responses regarding specific stressors gathered from the questionnaire. As advised by Morgan (1997) and Kreuger (1994) groups comprised no more than 8 individuals. Although the carers who participated were all employed by the same trust they came from different areas and were supervised by a number of different managers, they therefore fulfilled the criteria of a group with relevant characteristics in common but who were not all familiar with one another. Groups were audio-taped and the tapes were then transcribed by hand. The information drawn from the discussion groups is used for illustrative purposes to broaden the meaning of the quantitative data and support potential explanations for findings.

2.5.1 Recruitment

As described above, carers had been asked at their area meetings whether or not they would be prepared to participate in discussion groups; they were also asked to participate during follow-up telephone calls. In co-ordination with the home care manager, volunteers who had a slow period in their work schedule between the early morning and

lunch time visits were invited to attend a discussion group running from 11.00am to 12.30pm. There were two groups, one with six participants, the other with five.

2.5.2 Interview Schedule *(Appendix 9)*

The structure of the interview schedule is dependent upon the purpose of the group. The nature of the study may demand discussion of a large number of specific questions leading the group to be very focused. Alternatively, the schedule may comprise fewer, more open ended questions to facilitate a more group led discussion focused on broader areas. Kreuger (1994) identifies two formats that may be used in conducting a focus group; the 'topic guide' or the 'questioning route'. The topic guide is a list of topics or issues to be pursued in the group and consists of words or phrases to remind the group facilitator of the areas of interest. The questioning route consists of a sequence of carefully worded sentences which are followed in order.

The exploratory nature of the groups designed for this study called for a more open, broader focus and so a topic guide was used. A basis for topic areas were the primary stressors identified by participants and other findings of interest from the questionnaire designed for the study (appendix 2).

2.5.3 Group Facilitation

A room was made available in a separate part of the building in which the home care managers are based. Comfortable chairs were provided and refreshments were available in the room. A small 'walkman' sized tape recorder with a conference microphone attached was placed on a small table in the centre of the circle of chairs. Carers who had volunteered to attend the groups were given time by the home care managers late in the morning in the quiet period between early morning calls and lunchtime calls to clients.

As carers entered the room they were reminded that the group was being audio-taped but that the tape would remain confidential to the researcher and that data from the groups would be presented in such a way that they would remain anonymous. Participants were also reminded that participation in the group was voluntary and that they were free to leave at any time.

The Groups were facilitated by the researcher who explained that items from the questionnaires that had been completed were being used as a basis to guide the conversation of the group (see appendix 9, interview schedule); but that it would also be beneficial to discuss important issues that had not been mentioned in the questionnaire. Using the interview schedule as a guide, the same introduction was given to each of the groups. Open questions were asked in relation to each of the topics on the guide

(although in a few cases the topic was raised independently by the group). The topics were not pursued in the same order, but allowed to flow from the group conversation. The groups lasted for between one and one and a half hours as recommended in the focus group literature.

Field notes were made immediately after the group had finished (Krueger, 1994) with the audio tapes of the discussion being transcribed by hand shortly afterwards.

2.5.4 Analysis

There are a number of levels at which qualitative data can be analysed, the nature of the analysis depends upon the objective of data collection. In the case of the present study the two aims of the discussion groups have been highlighted as appropriate uses for focus groups (Morgan, 1997). As an exploratory study one aim was to identify general issues that might be of importance to the sample but had not been tapped through quantitative methods. The other aim was to provide data to illustrate some of the findings and interpretations of findings made by the researcher (Festervand, 1985) .

D.L Morgan states that " in my own work, I often present simple counts of codes without performing any statistical tests, p.61, and that "those who can answer their research questions without counting codes should feel well justified in doing so" p.62 (Morgan, 1997).

Bearing in mind Morgan's thoughts on analysis, the limited number of groups (2, the minimum suggested for analysis being 3) and the objective in carrying out the groups; a simple description of the discussions was performed which identified topics addressed by the groups and the time that was spent in discussion of each area. Time constraints were also a consideration in the decision follow a less rigorous analysis than is possible for such data, however, interesting and relevant findings were still derived.

The two groups were compared for subjects that arose for both, for topics that were initiated by participants and for the proportion of the groups' time that was spent engaged on a topic. Findings are included in the discussion as illustrative points and as an opportunity to offer possible insights into quantitative findings.

CHAPTER 3: RESULTS

OVERVIEW

The aim of this study is to explore the nature of the stressors experienced by home care staff, the prevalence of burnout and psychological disturbance and to explore the relationship between outcomes, factors identified within other human service populations and internal and external coping resources. The research questions guided data analysis, exploration of the experiences of this group was carried out using correlational analyses for the first two questions and multiple regression models for the second two questions. There is no control or comparison group as this is an exploratory, within group study.

A description of the sample is provided in 3.1. Research question 1, the nature of stressors experienced by home care staff is addressed in section 3.2; the prevalence of psychological disturbance and burnout, research question 2 is addressed in section 3.3. The question of the relationship between internal and external coping resources and the outcome measures is tackled in section 3.4. Findings from the discussion groups are outlined in section 3.5.

Where appropriate, qualitative material from the questionnaire pack is used illustratively.

3.1 SAMPLE DESCRIPTIVES

Table 1. summarises the sample characteristics. Not suprisingly the 67 home carers who participated in the study were all female. They varied in age from 23-62 years with a mean age of 45. Over 80% were married with 72% having been working as a home carer for more than 5 years. A serious life event had been experienced by 39% of carers in the last year. Twelve percent were currently the primary carer of an older relative with another 7% commenting that although they no longer were, they previously had been. In terms of ethnicity, 95% of the carers who participated described themselves as White UK; 3% as White other, 1% as Black Carribean and 1% as Chinese.

Table 1. Selected characteristics of Home Carers

	%		mean	sd	range	%
Age		**Years in post**	8.5	6.15	.5-30	
23-30	8	< 1				4
31-40	27	1-5				24
41-50	31	5-10				36
51-62	34	>10				36
Marital status						
single	5	**Weekly hours**	25	6.19	12-38	
married	81	< 20				12
divorce /sep /widow	14	20-25				41
Life events (1 year)		25-30				37
yes	39	> 30				10
no	61	**Unpaid hours**	1.5	.91	1.4	
		<2				25
Carer of older relative		2-4				20
yes	12					
no	88					

On average carers worked 25 hours per week (12-38) with 45% spending additional unpaid time with clients. Hours were split into morning (8am until after lunch), afternoon (4pm until after dinner) and evening (until about 10pm to help clients to get to bed).

Change in the role of home carers and the needs of their clients

Questions 20 (a) and (b) of the home carer questionnaire (appendix 1) asked whether there has been a change in the role of home carers and in the needs of their clients; 67% of respondents felt that there had been a change in their role and 79% a change in the needs of their clients. However, it is unlikely that workers who have only recently become home carers will have had an opportunity to experience changes in role and client needs. If carers who have been working for less than 2 years (11) are excluded from this calculation then the percentage of respondents perceiving a change in their role becomes 82% and those seeing a change in the needs of the client group are 95%.

Table 2. Summary of answers given by respondents indicating a change in their role and in the needs of their client group.

Home carer role	**%**	**Needs of clients**	**%**
increase in personal care / nursing	87	increase in physical frailty	48
increase in responsibility	17	increase in confusion / dementia	31
decrease in time able to spend	25		
decrease in housework / shopping	73		

Table 2 shows that of the 67% (82% with more than 2 years experience) of respondents who felt that there had been a change in their role as home carer, 87% saw this change in terms of the increased personal and nursing care required and a decrease (73%) in more 'domestic' tasks. . Some typical examples of responses are:

"we are now in a caring role, before we were glorified cleaners";

"we used to be cleaners, now we are nurses;

"a lot more personal care, talking, supporting".

Increases in responsibility were recorded by 17% of those who perceived a change in their role, as expressed by the following comments:

"more responsibility, more pressures, more demanding"

"involves personal care with greater responsibilities"

As table 2 shows, a concern of 25% of the carers who responded affirmatively to the question of role change was the reduction in time available to spend with clients.

"not enough time for care to be given fully"

"much shorter time allowed - rushed"

"less time - limited help"

"more clients, less time to do them"

The perceived change in the needs of the clients was expressed largely in terms of their mental (31%) and physical (48%) frailty:

"more confused people"

"clients are being kept in their own homes , therefore more confusion, disabilities etc."

"more are medically ill and released from hospital too early"

"have seen more strokes and dementia"

3.2 STRESSORS

3.2.1 Subjective Assessment of Degree of Work Stress

Table 3. Percentage of carers describing four levels of stress

	not at all	a little	quite a lot	extremely
%	1	55	39	5

As can be seen in Table 3. only 1% (1 carer) of the sample did not consider there to be any stress associated with their work, 55% found the work a little stressful, nearly 40 % felt there was quite a lot of stress involved in home caring and 5% found the work extremely stressful.

3.2.2. Identification of specific stressors by home carers

Table 4. shows that 85% of the carers felt time pressures were a stressor, with 70% and 69% respectively identifying paperwork and clients with behavioural problems as stressors. More than 50% of carers indicated that having to keep up a cheerful front, dependency of clients on their service, coping with the death of a client, physical demands and work overload were stressors. Being responsible for clients finances, working in isolation from colleagues, relevance of work to self and lack of training were identified by 30% or less of the participants as stressors.

Table 4. Percentage of home carers identifying stressors

Stressor	%
Time pressures	85
Clients whose behaviour is difficult to manage	70
Amount of paperwork	69
Feel that I have to keep up a front regardless of how I feel	64
Client depends a great deal on my service	63
Work overload	57
Physical demands of the job	54
Coping with the death of a client	51
Dealing with clients who are physically ill	47
Emotional involvement with client	44
Dealing with clients who are confused	38
Difficult relationships with client family members	34
Feeling of not being valued	31
Being responsible for clients finances	30
Working in isolation from other colleagues	27
Relevance of work to own current or potential life circumstances	25
Lack of training	25

3.2.3 Ranking of Stressors

When asked to rank the top six of the above stressors, home carers ranked four 'client related' stressors (physical demand, clients with difficult to manage behaviour, clients dependent on service, confused clients) and two 'work related' stressors (time pressures, work overload) see Table 5 below.

Table 5. Summary of the six highest ranked stressors

Stressor	Rank
Time pressures	1
Physical demands of the job	2
Clients whose behaviour is difficult to manage	3
Client depends a great deal on my service	4
Work overload	5
Confused clients	6

3.3 BURNOUT AND GENERAL PSYCHOLOGICAL DISTURBANCE

3.3.1 Burnout as measured by the MBI

Table 6 suggests that mean scores for the MBI subscales of emotional exhaustion (EE) and depersonalisation (DP) are lower than the normative data both for the overall range of occupations sampled and for the most similar occupational groups; social services and mental health. The mean scores for personal accomplishment were higher for the home

carer group than for social service and mental health groups and similar to the overall group.

Table 6. MBI subscale means and standard deviations for present sample and normative data

	Present study sample				*Overall		*Social service		*Mental health	
	n	**mean**	**s.d**	**range**	**mean**	**s.d**	**mean**	**s.d**	**mean**	**s.d**
MBI-EE	67	10.61	8.79	0 - 38	20.99	10.75	21.35	10.51	16.89	8.90
MBI-DP	67	2.48	3.61	0 - 19	8.73	5.89	7.46	5.11	5.72	4.62
MBI-PA	67	34.00	9.09	5 - 48	34.58	7.11	32.75	7.75	30.87	6.37

Key: EE = emotional exhaustion DP = Depersonalisation PA = Personal Accomplishment

* Normative data from MBI manual (Maslach & Jackson 1981) representing the overall sample (n=11067) comprising occupations including social services (n=1538), mental health (n=730), teaching, post-secondary education, medicine and others

Table 7 Percentage of Home Carers falling into Categories of Low, Moderate and High Burnout subscales

		Low (%)	Moderate (%)	High (%)
MBI EE	emotional exhaustion	76	18	6
MBI DP	depersonalisation	89	9	2
MBI PA	personal accomplishment	45	26	29

Table 7 shows that over 70%, and nearly 90%, of the home carers who participated in the study reported low levels of emotional exhaustion and depersonalisation, whilst only 6%

and 2% of carers respectively reported high levels of emotional exhaustion and depersonalisation.

3.3.2 Psychological disturbance as measured by the GHQ-28

The home care workers in this study demonstrated 25% caseness on the GHQ-28, lower than the normative level of 33% in the general population.

Table 8. Distribution of scores on the outcome measure GHQ-28

Measure	n	Mean	S.D	Range
GHQ- Total	67	2.93	4.51	0 - 24
GHQ- A somatisation	67	1.01	1.65	0 - 7
GHQ- B anxiety	67	0.79	1.49	0 - 7
GHQ- C social dysfunction	67	0.88	1.74	0 - 6
GHQ- D depression	67	0.28	1.24	0 - 7

Note: Possible ranges of scores: GHQ Total = 0-28; GHQ A = 0-7; GHQ B = 0-7; GHQ C = 0-7; GHQ D = 0-7 (as scored using GHQ scoring method 0,0,1,1,)

3.3.3 Relationship between the two outcome measures

Table 9 shows a significant correlation between the GHQ subscales and emotional exhaustion and depersonalisation but not personal accomplishment. Only the somatic scale of the GHQ is not correlated with depersonalisation. Although the correlation of

depersonalisation with social dysfunction is significant it is low, explaining only 8% of the variance. The strongest correlation with emotional exhaustion and depersonalisation is with the anxiety subscale of the GHQ and not with depression as might perhaps have been expected.

Table 9. Correlation between the two outcome measures, GHQ-28 and MBI (and subscales)

	GHQ Tot						
GHQ A	r = .80***	**GHQ A**					
GHQ B	r = .73***	r = .39**	**GHQ B**				
GHQ C	r = .87***	r= .71***	r= .43***	**GHQ C**			
GHQ D	r = .52***	r = .20	r=.51***	r = .33**	**GHQ D**		
MBI EE	r = .59***	r = .41**	r= .59***	r= .42***	r = .35**	**MBI EE**	
MBI DP	r = .53***	r = .16	r= .58***	r = .29*	r= .48***	r = .32**	**MBI DP**
MBI PA	r = .06	r = .09	r =-.15	r =10	r = .13	r = .05	r = -.19

*= $p < .05$; **= $p < .01$; ***= $p < .001$

Key:
GHQ tot = total score
MBI EE = emotional exhaustion
MBI DP = depersonalisation
MBI PA = personal accomplishment
GHQ A = somatisation
GHQ B = anxiety / insomnia
GHQ C = social dysfunction
GHQ D = severe depression

Pearson's bi-variate correlational analyses were carried out between the two outcome measures (MBI & GHQ-28) and situational/individual variables of age, length of service, weekly hours, number of older clients, number of frail and confused clients. The only significant correlation was between the depersonalisation on the MBI scale and the

number of clients both frail and confused (.408, p< .01) Bearing in mind the number of correlations involved there is a possibility that this is a Type One error (a false positive). However, the result is significant at the 0.01 level which would mean that only 1 in 100 would be significant by chance.

3.4 INTERNAL (COPING STYLE) AND EXTERNAL (SOCIAL SUPPORT) COPING RESOURCES IN RELATION TO OUTCOME MEASURES

Coping style was measured using the 67 question revised Ways of Coping Questionnaire the eight factors derived from this measure (Folkman et al 1986, Folkman et al 1988) are, *confrontive coping, distancing, self-control, seeking social support, accepting responsibility, escape/avoidance* and *positive reappraisal.*

3.4.1 Coping Style and Burnout

Table 10 shows a negative correlation for personal accomplishment with distancing (r = -.34, p = .01) and escape-avoidance (r = -.29, p = .02) but a positive correlation with self-control (r = .30, p = .02) Accepting responsibility is correlated with depersonalisation. Escape-avoidance is correlated with all 3 burnout subscales.

Table 10. Correlation between coping styles and the three burnout subscales of the MBI

	MBI EE emotion. exhaust.	**MBI DP** depersonalisation	**MBI PA** personal accomplish
WCQ 1 confrontive	r = -.15	r = -.04	r = -.23
WCQ 2 distancing	r = -.20	r = .05	r = -.34**
WCQ 3 self-controlling	r = -.01	r = .07	r = .30*
WCQ 4 seek social support	r = .11	r = -.18	r = .06
WCQ 5 accept responsib	r = .10	r = .25*	r = .10
WCQ 6 escape-avoidance	r = .37**	r = .43***	r = -.29*
WCQ 7 planful prob solving	r = -.10	r = -.21	r = .17
WCQ 8 positive reappraisal	r = .08	r = -.02	r - .08

**= p< .05 **= p< .01 ***= p< .001*

3.4.2 Coping Style and General Psychological disturbance

Table 11 shows that escape-avoidance is the only factor that showing a significant correlation with the GHQ total and subscales of anxiety and insomnia, social dysfunction, and depression. The only GHQ subscale with which escape-avoidnace is not significantly correlated is somatisation. As can be seen the most significantly highly correlated GHQ subscale is anxiety and insomnia. All correlations are significant at a level of at least 0.01.

Table 11. Correlation between the GHQ and coping styles as measured by the WQC-R

	GHQ Tot	**GHQ A** somatisation	**GHQ B** anxiety	**GHQ C** social dysfunc	**GHQ D** depression
WCQ 1 confrontive	r = -.09	r = -.06	r = -.11	r = -.03	r = -.10
WCQ 2 distancing	r = .02	r = .06	r = -.00	r = -.06	r = -.01
WCQ 3 self-controlling	r = .03	r = -.01	r = .10	r = -.03	r = .09
WCQ 4 seek social support	r = -.20	r = -.11	r = -.13	r = -.15	r = -.14
WCQ 5 accept responsibility	r = .19	r = -.06	r = .12	r = .18	r = .23
WCQ 6 escape-avoidance	r = .49***	r = .23	r = .43***	r = .40**	r = .39**
WCQ 7 planful prob. solving	r = -.10	r = .07	r = -.12	r = -.08	r = -.15
WCQ 8 positive reappraisal	r = .02	r = .02	r = .02	r = .10	r = -.03

*= $p < .05$; **= $p < .01$; ***= $p < .001$

3.4.3 Social Support and Burnout

Table 12. Social Support related to the three burnout subscales

	MBI EE emotional exhaustion	**MBI DP** depersonalisation	**MBI PA** personal accomplishment
SSN number	r = -.25*	r = -.28*	r = .26*
SSS satisfaction	r = -.14	r = -.09	r = .09

*= $p < .05$; **= $p < .01$; ***= $p < .001$

Table 12 shows a significant negative correlation between the number in the social support system and emotional exhaustion (r = -.25, p<.05) and depersonalisation (r = -.26, p<.05). This suggests that for this group of carers a higher number of people in the

social support system is associated with a lower level of emotional exhaustion and depersonalisation.

The significant positive correlation between personal accomplishment and the number in the social support system ($r = .26$, $p<.05$) suggests that a larger number of people in a social system is associated with a greater sense of personal accomplishment.

There is no correlation, however, between satisfaction with social support and the 3 burnout subscales.

3.4.4 Social Support and General Psychological Distress

Table 13. Social Support related to GHQ total and subscales

	GHQ Tot	**GHQ A** somatisation	**GHQ B** anxiety	**GHQ C** social dysfunct	**GHQ D** depression
SSN number	r = -.22	r = .09	r = -.22	r = .01	r = -.27*
SSS satisfaction	r = -.16	r = -.07	r = -.16	r = -.18	r = .11

*= $p< .05$ **= $p< .01$ ***= $p< .001$

The finding from Table 13 is that there is a significant negative correlation between the number of people a carer has in their social support network and the GHQ depression scale ($r = -.27$, $p<.05$). This suggests that the larger the number of people available as support the lower the level of depression as measured by the depression scale of the GHQ-28. There does not appear to be any correlation between satisfaction with social support and general psychological distress as measured by the GHQ-28.

3.4.5 Coping Style and Social Support

Table 14. Correlation of the 8 factors of the WCQ-R with the SSQ-R

	WCQ 1								
WCQ 2	r= -.01	**WCQ 2**							
WCQ 3	r= .40**	r = .03	**WCQ 3**						
WCQ 4	r = -.12	r =-.37**	r =-.31*	**WCQ 4**					
WCQ 5	r = -.07	r = -.31*	r =-.01	r = -.22	**WCQ 5**				
WCQ 6	r =.33**	r =.24	r =-.15	r =-.35**	r =.08	**WCQ 6**			
WCQ 7	r = -.26*	r = -.22	r =.09	r = -.18	r =-.34**	r =-.38**	**WCQ 7**		
WCQ 8	r = .03	r = -.25*	r = -.07	r = -03*	r = .20	r = .05	r = -.10	**WCQ 8**	
SSN	r = .05	r = -.14	r = -.15	r = .33	r = -.22	r = -.33	r = .08	r = .23	**SSN**
SSS	r = -.02	r = -.10	r = .01	r = .26	r = -.02	r = -.39	r = -.01	r = .13	r = .39

*= $p < .05$ **= $p < .01$ ***= $p < .001$

Key:
- WCQ 1 Confrontive
- WCQ 2 Distancing
- WCQ 3 Self-controlling
- WCQ 4 Seeking social support
- WCQ 5 Accepting responsibility
- WCQ 6 Escape-avoidance
- WCQ 7 Planful problem solving
- WCQ 8 Positive reappraisal
- SSN Number in support network
- SSS Satisfaction with social support

Table 14 shows no correlation between the independent variables of ways of coping and social support.

3.5 EXPLORATION OF THE RELATIONSHIP BETWEEN INTERNAL AND EXTERNAL COPING AND THE OUTCOME MEASURES

Research question 3 concerning the effect of differences in internal and external coping resources on outcome measures is addressed below.

3.5.1 Interaction of Coping Styles and Social Support with Burnout (MBI) and General Psychological Distress(GHQ-28)

A regression model with the 8 ways of coping factors and the 2 measures of social support as preditor variables for the 2 outcome measures was explored using stepwise multiple regression. This method was used as the nature of the study is exploratory. For the purpose of the regression models the GHQ total score only rather than subscales is used, this is justified by the correlation between the subscales and total score and the correlation with the MBI subscales and also reduces the number of variables entered into the equation.

Table 15 overleaf shows a multiple regression analysis of coping against MBI scores.

MBI emotional exhaustion score: a set of 3 predictor variables derived from the regression model variables accounted for 35% of the variance: F (3, 54) = 9.67, p<.001. The 3 variables were *confrontive coping* (β = .36, t= -3.06, p< .01); *distancing* (β = -.34 t= -3.06, P< .01) and *escape-avoidance* (β = .57, t= 4.80, p< .001).

This suggests that carers reporting lesser use of confrontive, and distancing coping styles in combination with higher levels of escape-avoidance may suffer a greater level of emotional exhaustion as indicated by the MBI EE.

Table 15. Multiple regression analysis of coping styles against outcome measures

Predictor Variable	**GHQ tot (n=67)**	**MBI EE (n=67)**	**MBI DP (n=67)**	**MBI PA (n=67)**
WCQ 1 confrontive	-.31*	-.36**		-.32**
WCQ 2 distancing		-.34**		-.39***
WCQ 3 self-controlling				
WCQ 4 seek social support				
WCQ 5 accepting responsib				
WCQ 6 escape-avoidance	.50***	.57***	.43***	
WCQ 7 planful prob solving				
WCQ 8 positive reappraisal				
SSN no. in support network				.26*
SSS satisf with support				
Multiple R	.50	.59	.43	.57
F test	9.16***	9.67***	13.03***	8.91***
Variance accounted for	25%	35%	19%	33%

*= p < .05; **= p <.01; ***= p <.001

MBI depersonalisation score: one predictor derived from the regression model variables accounted for 18% of the variance: F (1, 56) = 13.03, p<001. The variable was *escape-avoidance* (β = .43, t= 3.61, p< .001).

This suggests that carers who use escape-avoidance as a coping style experience a higher level of depersonalisation.

MBI personal accomplishment score: a set of three predictor variables derived from the regression model variables accounted for 33% of the variance: $F(3, 54) = 8.91$, $p < .001$. The 3 variables were; *confrontive coping* ($\beta = -.32$, $t = -2.83$, $p < .01$), *distancing* ($\beta = -.39$, $t = -3.47$, $p < .001$) and *social support (number)* ($\beta = .26$, $t = 2.32$, $p < .05$).

This indicates that those individuals less frequently using confrontive coping and distancing but having a higher number in their social support network experience a greater sense of personal accomplishment.

GHQ total score: a set of two predictor variables derived from the regression model variables accounted for 25% of variance: $F(2, 55) = 9.16$, $p < 001$.

The two variables were *confrontive coping* ($\beta = -.31$, $t = -2.49$, $p > .05$) and *escape-avoidance* ($\beta = .50$, $t = 4.07$, $p < .001$).

This suggests that those individuals reporting lower use of a confrontational coping style with greater escape-avoidance coping experience greater psychological disturbance as indicated by GHQ total scores.

3.6 INTERACTION OF STRESSORS AND SITUATIONAL VARIABLES WITH OUTCOME MEASURES

Two sets of variables were of interest in designing and analysing the questionnaire produced for this study. The first set of variables is the result of the first research question: what are the main stressors experienced by home carers? The second set of

variables are termed 'situational/individual' and these are variables such as length of experience, type of clients, perceived work satisfaction and support at work.

Both of these sets of variables have been regressed against the outcome measures using a stepwise multiple regression. This method has been chosen because of the exploratory nature of the study.

3.6.1 Interaction of Stressors with Outcome Measures

Following a correlational analysis and face value assessment a number of stressors were collapsed together; Firstly, 'time pressures' and 'work overload' become one variable; 'client dependent on service' and 'emotional involvement with client' become another variable and a third combined variable is created by 'clients whose behaviour is difficult to manage' and 'dealing with clients who are confused'. Lack of training and working in isolation from colleagues are not entered as variables as they were not shown to correlate with outcome measures, were chosen by the lowest percentage of carers as stressors and were not ranked in the top 6 stressors.

A multiple regression analysis was carried out regressing stressors against the outcome variables of the GHQ-28 total score and the three subscales of the Maslach Burnout Inventory (MBI); emotional exhaustion (EE); depersonalisation (DP) and personal accomplishment (PA).

Table 16. Multiple Regression analysis of stressors against outcome measures

Predictor Variables	GHQ tot (n=67)	MBI EE (n=67)	MBI DP (n=67)	MBI PA (n=67)
Physical demands of the job	.27*	.31**		
Time pressures/ work overload				
Confused clients / diffic behaviour			.32**	
Having to keep up a front				
Clients who are physically ill				
Client dependent /emotional involv		.49***		
Death of a client				-.28*
Diffic client family members				
Relevance of work to self				
Amount of paperwork				
Feeling of not being valued			.34**	
Multiple R	.27	.64	.52	.28
F test	4.4*	19.87***	10.61***	4.90*
Variance accounted for	7%	41%	27%	7%

*= p< .05; **= p< .01 ***= p< .001

MBI emotional exhaustion score: two predictor variables derived from the regression model variables accounted for 41% of the variance: F (2, 56) =19.87, p< .001. The variables were *physical demand*, (β = .31, t= 2.95, p<.01) and *client dependency/ emotional involvement*, (β = .49, t= 4.58, p<.001).

This suggests that home carers reporting both physical demands and client dependency/ emotional involvement as stressors are likely to experience a greater level of emotional exhaustion.

MBI depersonalisation score: two predictor variables derived from the regression model variables accounted for 27% of the variance: F (2, 56) = 10.61, p< .001. The variables

were *clients who are confused / have difficult behaviours* (β = .32, t= 2.73, p<.01) and *feeling of not being valued* (β = .34, t= 2.87, p<.01).

This is likely to indicate that individuals reporting both confused, behaviourally difficult clients and a feeling of not being valued are likely to suffer a higher level of depersonalisation.

MBI personal accomplishment score: one predictor variable derived from the regression model variables accounted for 7% of the variance: F (1, 57) = 4.90, p< .05. The variable was *death of a client* (β = -.28, t=-2.21, p<.05).

This suggests that for those home carers reporting the death of a client as a stressor there is an increased likelihood of a reduced sense of personal accomplishment.

GHQ total score: one predictor variable derived from the regression model variables accounted for 7% of the variance: F (1, 57) = 4.42, p<.05. This variable was *physical demand,* (β = .27, t= 2.10, p< .05).

This suggests that those reporting physical demand as a stressor may experience poorer psychological well-being as indicated by GHQ total score.

3.6.2 Interaction of situational variables with outcome measures

Ten of the variables included in the home carer questionnaire were chosen as predictor variables for the regression model of situational variables regressed against the outcome

measures. These variables were identified by excluding the factors that had been least important in the view of the particpants and had been insignificant in correlational analyses.

Table 17. Multiple Regression analysis of situational variables against outcome measures

Predictor Variable	**GHQ tot (n=67)**	**MBI EE (n=67)**	**MBI DP (n=67)**	**MBI PA (n=67)**
Life events			.28*	
Years experience			-.26*	
Percieved level of work stress	.50***	.48***		
Satisfaction with work			-.24*	.30*
Perceived change in role				
Perceived change in client need				
Number of frail clients			.50***	
Number of confused clients				
Number both frail &confused			.27*	
Support received at work			-.38***	
Multiple R	.50	.48	.75	.30
F test	15.92***	14.22***	9.45***	4.66*
Variance accounted for	25%	23%	57%	9%

*= p< .05; **= p< .01; ***= p< .001

MBI emotional exhaustion score: one predictor variable derived from the regression model variables accounted for 23% of variance: $F(1, 48) = 14.22$, $p < .001$. The variable was perceived level of *work related stress* ($\beta = .48$, $t = 3.77$, $p < .001$).

This indicates that as well as having higher GHQ scores carers who perceive their work as stressful are likely to experience a higher level of emotional exhaustion.

MBI depresonalisation score: a set of six predictor variables derived from the regression model variables accounted for 57% of the variance: $F(6, 43) = 9.45$, $p < .001$.

The 6 variables were; *life events* ($\beta = .28$, $t = 2.68$, $p<.05$), *years experience* ($\beta = -.26$, $t = -2.44$, $p<.05$), *satisfaction with work* ($\beta = -.24$, $t = -2.34$, $p<.05$), *number of frail clients* ($\beta = .50$, $t = 4.70$, $p<.001$), *number both frail and confused* ($\beta = .27$, $t = 2.64$, $p<.05$) and *support at work* ($\beta = -.38$, $t = -3.58$, $p<.001$).

This suggests that individuals who reported lower work satisfaction, less support at work, and less experience in combination with recent distressing life events, and high numbers of frail and clients who were both frail and confused experienced a higher degree of depersonalisation.

MBI personal accomplishment score: one predictor variable derived from the regression model variables accounted for 9% of the variance: $F(1, 48) = 4.66$, $p<.05$. This variable was *satisfaction with work* ($\beta = .30$, $t = 2.16$, $p<.05$).

This indicates that carers who reported greater satisfaction with their work felt a greater sense of personal accomplishment as indicated by scores on the MBI PA scale.

GHQ total score: one predictor variable derived from the regression model variables accounted for 25% of variance: $F(1, 48) = 15.92$, $p < .001$. The variable was percieved level of *work related stress* ($\beta = .50$, $t = 3.99$, $p < .001$).

This suggests that carers who perceive their work as stressful are more likely to report higher levels of psychological disturbance as indicated by scores on the GHQ.

3.7 FOCUS / DISCUSSION GROUPS

A simple method of description of the group data was carried out. From the field notes made after the groups and the transcription of the discussions, areas of talk were identified such as 'informal peer support' or 'organisational / role changes'. The length of time spent on each area of discussion was recorded and the two groups were compared.

Summaries of the group discussions are presented in tables 18 and 19.

3.7.1 Findings from Group Discussions

3.7.1.i Offering Emotional Support to Clients

For one of the groups the open question about time pressures led into a discussion of the 'emotional' pressure related to not having time to give to clients for emotional support, this then led into talk about the organisational and role changes experienced by staff. In the second group a similar discussion around the difficulties in dealing with emotional demands form clients developed from a group initiated discussion of organisational and role changes. Both groups spent the greatest length of time discussing this problem. The provision of emotional support to clients was felt to be an important aspect of the

work that with the introduction of a new more task oriented service was no longer recognised and therefore less supported.

Table 18: Summary of Time taken and Topics discussed by Group 1

Topics of Discussion	Time in minutes
Introduction	5 mins
Time Pressures? discussion about no.'s of clients > stress of being unable to provide emotional support perceived as needed by clients. Have to take brunt of clients' & families displeasure at assessment of tasks. Less satisfactory distribution of time, requirement to be more flexible in hours is inconvenient.	24 mins
> change in organisational demands, increase in rules and boundaries; positive in that it offers more protection, negative in that it reduces opportunity to offer other support as carer thinks necessary.	13 mins
> clients with difficult behaviour, helpful when there are several of you who have resposibility, need to adjust rest of workload accordingly as very stressful	7 mins
Residential vs home caring? different kinds of people feel more comfortable as resid & home carers, different stresses, more like member of family when caring for someone in own home, feel more responsible for client because other staff not around. Home caring more satisfying because maintaining clients in own homes.	10 mins
Support? at times not enough support from managers, better out of hours support than prior to changes , importance of informal peer support but should be provided by managers	20 mins
Training? not enough, not frequently enough, more on dementia	5 mins
What could have been done differently? questionnaire pack too long, repetitive, important to feel that views being heard, groups good, less threatening than individual interview	7 mins

Entries in italics indicate questions or statements from the facilitator

Table 19: Summary of Time taken and Topics discussed by Group 2

Topics of Discussion	Time in minutes
Introduction	5 mins
group introduced topic of organisational & role change in response to provision of information on length of time in post > talk about stress of being unable to respond to emotional needs of clients as a result of time pressures and role changes.	22 mins
Other changes? largely positive agreement on support from managers, pro's and cons of work being more bounderied	9 mins
> importance of informal peer support by telephone and at, or often after, area meetings - of particiular importance to out of hours workers	16 mins
Difficult to manage clients? not as many currently, better information available about difficult clients, easier to deal with since work tasks more bounderied.	12 mins
Residential vs home care work? satisfaction in working as a carer is about helping someone to stay in own home. More independence when working alone.	4 mins
Training? very little though more available recently, sessions too short,	8 mins
What could have been done differently? questionnaires (standardised) repetitive, did not seem relevant, lengthy.	5 mins

Entries in italics indicate questions or statements from the facilitator

3.7.1.ii Informal Peer Support

Both groups introduced informal peer support into the discussion and located it as their primary source of support at work. This informal support occurred after area meetings

and, particularly for out of hours workers, by telephone. Where there were 2 or 3 people who regularly visited the same client there was a team feeling about the care of the client.

> *" You get to know them (*the client*) well, and know what to pass on to the others, you know they'll tell you what you need to know as well, you work towards the same thing"*

It appeared that although carers gained support from family and friends they felt that only the other people having the same experience were able to offer support based on a real understanding which even managers were not always deemed to have.
One group, although positive about the effects of such support, were more negative about the appropriateness of such support which they felt ought to be more available from managers.

3.7.1.iii Changes in Role and Boundaries

In both group discussions there was agreement regarding the nature of organisational and role changes. The change in role was identified as a movement towards a greater amount of personal physical care and away from more incidental tasks such as cleaning and shopping.

Organisational changes included assessment of tasks for clients and greater flexibility in hours available required of carers. The introduction of more specifically defined tasks for each client were seen as having benefits and drawbacks. The benefit was seen as the right of carers to say no to demands from clients and be more clear about the bounderies of their work. The drawback was identified as the lack of flexibility to provide clients with a service that they had not been assessed for but which the carer felt should to be performed.

CHAPTER 4: DISCUSSION

OVERVIEW

This chapter is divided into five parts. The first part provides a summary of the research questions and main findings of the study. The second part of the chapter will discuss and interpret the findings. Part three of the chapter identifies limitations to the study. Part four proposes areas for further research and part five offers a conclusion and comments on implications arising from the study.

PART ONE: SUMMARY OF RESEARCH QUESTIONS AND MAIN FINDINGS

Research Question 1: What are the main stressors identified by Home Carers?

4.1.1 Home Carer Stressors

Seventeen stressors, ten identified in a previous study including home carers (Bradley and Sutherland, 1995) and a further seven taken from other human services literature were presented as part of the questionnaire pack. Participants were asked to respond yes or no to whether they felt each stressor was applicable to them, they were also asked to rank the six most important stressors.

The three stressors identified by the greatest percentage of home carers were time pressures (85%), clients whose behaviour is difficult to manage (70%), and the amount of paperwork (69%). Stressors identified by less than 30% of carers were; being responsible for clients finances, working in isolation from colleagues and relevance of work to own current life circumstances.

In terms of the ranking by carers of the importance of stressors; of the top six, four were client related stressors, and two were work related stressors. Client related: physical demands (2nd), difficult behaviour (3rd), client dependency (4th) and confused clients (6th). Work related: time pressures (1st) and work overload (5th).

Research Question 2: What is the prevalence of burnout and general psychological disturbance amongst this group of workers?

4.1.2 Outcome Measures (MBI, GHQ-28)

4.1.2.i Levels of Burnout

Using the Maslach Burnout Inventory (MBI) to measure burnout, three scales are produced; emotional exhaustion, depersonalisation, and personal accomplishment. The home carer group demonstrated levels of emotional exhaustion and depersonalisation that were lower than normative data for an overall population group and for the two

occupational groups, social service workers and mental health workers. There was no difference between the normative data and home care sample in personal accomplishment scores.

4.1.2.ii Levels of Psychological Disturbance

Level of psychological disturbance was measured using the GHQ-28 which produces a total score and subscales representing somatisation, anxiety/insomnia, social dysfunction and severe depression. Caseness in the general population stands at 33%, the level of caseness in the home care sample was lower at 25%.

4.1.2.iii Relationship between Psychological Disturbance and Burnout

The GHQ-28 total score and the four subscales were all positively correlated with emotional exhaustion. The GHQ-28 total score and three of the subscales were also positively correlated with depersonalisation; the GHQ somatisation scale was the only one not correlated with depersonalisation. There was no correlation between the GHQ-28 total and subscales and personal accomplishment. As a note of caution it should be recognised that the correlations between these questionnaires could be a reflection of self-report bias.

Research Question 3: Is there any evidence to suggest that differences in internal (coping strategies) and external (social support) coping resources affect psychological outcome?

4.1.3 Relationship between Coping Strategy and Outcome Measures (MBI, GHQ-28)

The first part of research question 3 was to look at any relationship between coping strategy and burnout and psychological disturbance. The eight factors of coping derived from the WCQ-R by Folkman et al (1986) were correlated with the MBI and GHQ-28.

4.1.3.i Relationship between Coping Strategy and Burnout

The coping strategy 'escape-avoidance' was correlated with all three burnout measures. It appeared that the greater the use of escape-avoidance as a coping strategy the greater the degree of emotional exhaustion and depersonalisation and the lower the level of personal accomplishment felt by participants. Acceptance of responsibility as a way of coping was associated with higher levels of depersonalisation. Distancing used as a coping strategy was associated with poorer sense of personal accomplishment, self control as a coping strategy, however, was associated with a greater sense of personal accomplishment.

Confrontive coping, seeking social support, planful problem solving and positive reappraisal as coping strategies did not appear to be associated with burnout.

Emotional exhaustion was associated with one coping strategy 'escape-avoidance'; depersonalisation with two 'escape-avoidance; 'accepting responsibility', and personal accomplishment with three; 'escape-avoidance'; 'self-control'; 'distancing'.

4.1.3.ii Relationship between Coping Strategy and Psychological Disturbance

The only coping strategy found to be associated with the GHQ-28 was that of escape-avoidance. Correlational analysis suggested that use of escape-avoidance was associated with a higher level of general psychological disturbance (GHQ total) and more specifically with anxiety, social dysfunction and depression. There was no association between escape-avoidance and somatisation. Other coping strategies were not found to be associated with levels of psychological disturbance.

4.1.4 Relationship between Social Support and Outcome

The second part of research question 3 was to look at any relationship between social support and burnout and psychological distress. Social support was measured using the revised six item Social Support Questionnaire (SSQ-R) (Sarason et al 1987) This produces two scales, the number of people the individual can turn to for support and the level of satisfaction they feel with the support they receive.

4.1.4.i Relationship between Social Support and Burnout

The number of people in an individual's social support system was found to be associated with all three burnout subscales. Lower numbers of people to offer social support were related to higher levels of emotional exhaustion and depersonalisation and a lower sense of personal accomplishment. Satisfaction with social support was not found to be associated with burnout.

4.1.4.ii Relationship between Social Support and Psychological Disturbance

The number of people in an individual's social support network was found to be associated with the depression scale of the GHQ. The lower the number of people available to offer support, the greater the level of depression. Social support was not found to be associated with either total GHQ score or any of the other subscales. Satisfaction with social support was not found to be associated with the GHQ.

4.1.4.iii Relationship between Coping Strategy and Social Support

No correlation was found between any of the eight coping factors and the two scales of social support. There was some correlation between coping strategies.

Research Question 4: Is there any single factor or combination of factors which can be said to affect psychological outcome?

4.1.5 The Relationship between Coping Strategy, Social support and Outcome Measures

From the regression model including coping strategies and social support the four key predictors of burnout and general psychological disturbance were:

- escape-avoidance
- confrontive coping
- distancing
- the number of people in the social support system.

Thirty-five percent of the variance in emotional exhaustion scores was accounted for by 'escape-avoidance', 'confrontive' and 'distancing' coping strategies. These findings suggest that individuals reporting lower use of confrontive and higher use of escape-avoidance and distancing coping strategies are more emotionally exhausted. 'Escape-avoidance' as a coping strategy accounted for 18% of the variance in depersonalisation, the greater the use of this coping strategy the higher the level of depersonalisation. Thirty-three percent of the variance in personal accomplishment could be accounted for by 'confrontive coping', 'distancing', and the 'number in the social support system'. A combination of greater use of confrontive and distancing coping strategies and a smaller

number in the social support system was associated with a diminished sense of personal accomplishment.

Twenty-five percent of the variance in GHQ total score was accounted for by 'confrontive' and 'escape-avoidance' coping strategies. Where home carers used an escape-avoidance coping strategy in combination with low levels of confrontive coping they were likely to experience higher levels of psychological disturbance. Social support was not a significant predictor.

4.1.6 The Relationship between Stressors and Outcome Measures

Ten stressors were included in a regression model with the MBI and GHQ scores. The five key predictors of outcome were:

- physical demands of the job
- clients who were confused or behaving in a way that was difficult to manage
- client dependency/emotional involvement
- the death of a client
- a feeling of not being valued.

Forty-one percent of the variance in emotional exhaustion was accounted for by 'physical demand' and 'client dependency/emotional involvement'. The combination of these two stressors was associated with a higher level of emotional exhaustion. There was a

positive association between depersonalisation and 'feeling of not being valued', and 'working with clients who are confused/have difficult to manage behaviours' which accounted for 27% of the variance in depersonalisation scores. 'Death of a client' was a predictor of a reduced sense of personal accomplishment and accounted for 7% of the variance.

4.1.7 The Relationship between Situational/Individual Variables and Outcome Measures (MBI, GHQ-28)

In the model regressing ten situational variables against the outcome measures (MBI, GHQ) there were seven key predictors of outcome:

- perceived level of work related stress
- satisfaction with work
- recent distressing life event
- years experience
- number of frail clients
- number of clients both frail and confused
- emotional support received at work

Perceived work related stress was positively associated as a predictor of higher levels of both emotional exhaustion (23% of variance) and GHQ total score (25% of variance). A combination of six variables were predictive of level of depersonalisation which was negatively associated with years of experience, satisfaction with and emotional support at

work and positively associated with life events and the number of frail and both frail and confused clients. Greater satisfaction with work was predictive of higher levels of personal accomplishment.

4.1.8 Discussion / Focus Groups

Three main themes were derived from summarising content, topics initiated by the group, and time taken over discussion of topics in the groups.

- distress caused by carers perception of clients need for emotional support, which is not always felt to be understood or acknowledged as part of job description or by managers.

- the perceived protective nature of clearer boundaries to tasks carried out by carers.

- the importance of informal peer support as a potential protector against psychological disturbance and burnout.

PART TWO: DISCUSSION AND INTERPRETATION OF THE FINDINGS

As noted in the introductory chapter there has been remarkably little research carried out on the experiences of paraprofessionals, particularly those working in the community. Evidence form the literature is therefore drawn from groups who can be seen to have some similarities to home carers such as nurses working in long-stay settings with older people and nurses working in mental health in the community. Equally as important as the similarities home carers have with these groups are the differences.

4.2.1 Burnout and General Psychological Disturbance

Levels of burnout and psychological distress were lower in this group than in the normal population or in the closest comparable groups such as social service and mental health workers. It is important to gain some understanding of, or at least develop some hypotheses around, the apparently good mental health of this group of workers in terms of implications for other employees.

The level of GHQ caseness of just 25% found in the present study is consistent with the findings of McPherson et al (1994) of a caseness of 26.6% amongst carers working with older people in hospitals and residential care homes. McPherson compares this with far higher rates of caseness found in family caregivers in the community (Gilleard, 1987)

identifying some of the factors differentiating waged carers in institutions from family caregivers. This does not, however, explain the low level of caseness compared with other health care employees.

Although emotional exhaustion and depersonalisation were considerably lower than in the most comparable occupational groups, mean personal accomplishment scores were broadly similar. There has been found to be a small but significant correlation between personal accomplishment and the other burnout dimensions in some studies. It might have been hypothesised then that with lower levels of emotional exhaustion and depersonalisation in this study, the sense of personal accomplishment in this group might be higher than in comparative groups. Van Servellen and Leake (1993) found that hospital nurses who were older and more experienced demonstrated significantly lower levels of emotional exhaustion but that more experience was also related to a lower sense of personal accomplishment. With 65% of staff in the present sample aged over 40 years and 72% having been working as a home carer for more than five years this would be consistent with the findings of Van Servellen and Leake. In the present study 81% of the participants were married, a status which has been significantly associated with lower levels of emotional exhaustion.

Hare and Pratt (1988) speculated that one of the reasons for higher levels of burnout in paraprofessionals in their study was the nature of the work tasks and low status in relation to other workers in the setting. In the case of home carers they work predominantly alone and so do not experience direct comparison with other staff. As has

previously been noted, the changes in carer role and client needs may also have led to a positive change in carers' perception of their role.

It might be hypothesised that although there is evidence of a change in the role of home carers and in the needs of their clients which might be expected to result in poorer psychological outcome, this has been offset by the emotional rewards of the job: *"we are now in a caring role, before we were glorified cleaners"*. This is consistent with views expressed by home carers in New York (Bartoldus 1989) who believed that the public viewed them as "unskilled maids" who did society's "dirty work" (p. 207) although they themselves viewed their jobs differently believing themselves to be doing an important job in a competent way.

In their study Hare and Pratt agreed with Yasko's (1983) findings that poor prognosis for survival was not a predictor of poorer staff psychological outcome. It was proposed that individuals choosing to work with this kind of population do so because it gives them a particular sense of meaning in their work, this could be speculated to be a factor for home carers.

4.2.1.i Observations from Focus / Discussion Groups

In thinking about comparing the role of a residential care worker with a home carer; participants in groups indicated that they saw their role in maintaining individuals in their

own homes as more satisfying than caring in a residential home. An independence in the work setting that was not perceived to exist in other care work was also important. Certainly the data from the questionnaires showed a generally high level of job satisfaction. This adds to the likelihood that there is a protective effect in being a highly self-selected group, as previously noted (Hare & Pratt, 1988, Yasko, 1983).

4.2.1.ii Non-Participants

As part of the procedure I was able to telephone carers who had not returned their questionnaires to check whether they needed assistance or simply did not wish to participate. This proved to be an unexpectedly valuable exercise in terms of the qualitative information gained. At the end of the conversation I explained to carers that I felt that what they had told me was very important and that I would like to include some of their points in the study in a way in which they would remain anonymous, all agreed to this. Eighty three home carers who had not declined to participate in the first instance and who had given their telephone number but had not returned the questionnaires were contacted. At this stage 32 participants had already returned the questionnaires, a further 35 were returned following the telephone call and in some cases an individual visit to assist in the completion of the questionnaire. Of the 48 individuals who on telephoning were not prepared to participate, 16 gave some indication of psychological distress or burnout as the reason for non-participation (33% of non-participants, equivalent to the level of caseness in women identified by Huppert, 1988).

For example, one carer stated;

> *"there's no point in my filling it in, I'd have to lie on it anyway, I couldn't possibly tell the truth about how I feel about them* (the clients)*, it would look as though I'm really awful, that I don't care about them, I don't see them as people anymore"*

This is a very good description of the phenomena of emotional exhaustion and depersonalisation.

The concern of non-participants that they would look bad suggests the possibility of a social desirability effect on the responses of those who did participate, leading to answers indicating better psychological outcomes than were actually the case.

A number of other home carers described current life events, for example, recent serious illness, bereavement or expected death of loved one, becoming primary carer of disabled relative which meant that they felt *"too stressed"* to participate. Nine home carers who did not wish to participate responded on the telephone in a manner that gave a strong indication of a high level of psychological disturbance or burnout. A further 7 non-participants gave lesser but still possible indication of psychological distress and or burnout. Bartoldus (1989) found that home carers were reluctant to appraise their lives as stressful on the standardised measure used in the study (the Tedium Scale) which was

not consistent with the intensity and variety of stressors identified in the interviews. The findings of the present study reflect a similar pattern.

Firth & Britton (1989) found that in nurses working in long-stay settings feelings of depersonalisation were correlated with leaving the job. Bearing in mind how long the home carers who participated had been doing the job (72% for over 5 years), it would be interesting to find out the turnover of staff with, for example, less than two years experience. It is possible that individuals who experience a higher level of burnout do so early on and simply leave the job. This would be easier perhaps for home carers than for their professionally trained nursing or social work colleagues since there is not the same personal investment in training involved.

As discussed in the introduction, a number of observers have disputed that there are three MBI scales, saying that emotional exhaustion and depersonalisation are largely showing the same thing. However in support of Buunk and Schaufeli's (1993) assertion that the processes related to emotional exhaustion and depersonalisation differ, depersonalisation is clearly different in this study in terms of predictive variables. It is the factor most predicted by situational/individual variables whereas emotional exhaustion and personal accomplishment are more predicted by coping strategy. It should be acknowledged that MBI depersonalisation items identify staff who see themselves as becoming detached or hardened towards clients, but does this actually relate to their behaviour?

4.2.2 Stressors & Client Characteristics.

Four of the six highest ranked stressors were related to characteristics of the client rather than the work situation: physical demands, confusion, behaviour that is difficult to manage, and client dependency. These factors were all found to have a significant positive relationship with one or more of the MBI subscale or GHQ-28.

Working with higher numbers of clients who were either frail or both frail and confused was found to be associated with higher levels of depersonalisation. There is evidence in the literature that the severity of the clients difficulties are associated with higher levels of burnout (MacPherson et al (1994).

Hare and Pratt (1988) compared staff working in long-term care and acute care environments. They found that nurses working in long-term care were subject to higher levels of emotional exhaustion. Many of the clients with whom home carers work, although living at home, are likely to represent a long term rather than acute care population.

4.2.2.i Focus / Discussion Group Findings

In both groups there was a conversation about the 'emotional' stress involved in the work with their clients in relation to time pressures and boundaries around the provision of services for certain assessed tasks. It seems that by nominating 'time pressures' as the single greatest stressor, home carers were meaning not only the physical impact of having

to complete a certain number of tasks in a certain time. Also, and perhaps primarily, they were referring to the way in which this affected their capacity for emotional support of the client.

4.2.3 The Changing Role of Home Caring *(focus group observations)*

An issue that was raised by both discussion groups was that of recent changes in the organisation of home caring to develop a more 'professional' outlook. Formal supervision has been relatively recently introduced along with many more boundaries and rules regarding the tasks that carers can perform. for example:

> *"I don't like all these rules really, it means that we can't decide about things like we used to, but it does mean you don't feel so put upon, you can say 'I'm not allowed to do that'"*

The sense of being more boundaried and less vulnerable to the demands of clients' was one that was repeated across both discussions. It may be that this reduction in one aspect of vulnerability to clients demands has contributed to the psychological well-being of some carers. However, for some individuals the focus on the completion of tasks, in a certain time, for which the client has been assessed and no more, was found to be stressful.

"what do you say to a lady in her nineties....as she pleads with you to spend another 15 minutes with her. You are supposed to say 'well, there are other agencies that can provide that sort of support'....but how can you say to somebody 'well you'll have to go and hire some company'.

4.2.4 Coping Strategies

It has been suggested that specific types of coping may be more or less effective depending on the "goodness of fit" with the type of stressor being faced. In essence, problem-focused coping is deemed to be more effective where the situation/stressor is one over which the individual has some control. Emotion-focused coping on the other hand is thought to be more effective when the situation/stressor is one that the individual cannot control and needs to adjust to and accept. More specifically occupational coping effectiveness has been found to depend on the context in which the particular coping strategies are used (Bowman & Stern, 1995).

Five types of coping strategy were significant in the present study, escape-avoidance, confrontive coping, distancing, self control and accepting responsibility.

4.2.4.i Escape-avoidance

Escape avoidance is an emotion-focused strategy incorporating wishful thinking which has been identified as a separate factor in some analyses. Escape-avoidance was found in this study to be associated with poorer psychological outcome. This finding is supported by findings from other studies (Aldwin & Revenson, 1987; Vitaliano et al, 1985). Escape-avoidance has been found to be used more often as a coping strategy in depressed than non-depressed women (Kuyken & Brewin, 1994).

4.2.4.ii Confrontive coping

Confrontive coping, a problem solving strategy, was not found to be significantly associated with outcome when taken alone. However, it was found to be predictive of poorer outcome in emotional exhaustion when combined with escape-avoidance and distancing; predictive of lower personal accomplishment scores when combined with distancing and lower numbers of people available for social support; and predictive of a higher GHQ total score when combined with escape-avoidance. The finding that confrontive coping is associated with poorer psychological outcome is supported by the work of Folkman and Lazarus (1988b). They found that confrontive coping was associated with a negative change in emotion towards greater distress.

4.2.4.iii Distancing

In the present study distancing, an emotion-focused strategy, was found to be independently associated with a lower level of personal accomplishment. In combination with escape-avoidance and low confrontive coping it was associated with higher levels of emotional exhaustion.

As with confrontive coping Folkman and Lazarus (1988b) found that there was a correlation between the use of this strategy for coping and increased emotional distress. In the role of home caring much of the sense of accomplishment may be related to the emotional as well as physical support of older people in their own homes. It can be understood then that the use of a distancing strategy could run contrary to the workers' perception of themselves as a 'good' carer thus reducing sense of personal accomplishment.

4.2.4.iv Accepting Responsibility

Acceptance of responsibility, an emotion focused strategy, was associated with greater feelings of depersonalisation. There is less literature available on 'acceptance of responsibility' than some of the other 8 dimensions of coping proposed by Lazarus and Folkman. It is not possible to state the direction of the association between depersonalisation and acceptance of responsibility. It is however possible to hypothesise

that in accepting responsibility there may be an attack on self-efficacy which lends itself to detachment from the focus of the loss of self-efficacy, the client.

4.2.4.v Self-control

Self-control, a problem focused strategy, was positively associated with sense of personal accomplishment. This was the only strategy that was associated with a positive psychological outcome. It can be hypothesised that this was a strategy used in situations over which the carer perceived some degree of control.

Of interest is the fact that planful problem-solving was not a significant coping strategy in this study and yet it has been consistently identified as an effective work related strategy (Folkman et al 1986,)

4.2.5 Social Support

Social support can be divided into work based support and family support. Leiter (1990) carried out a longitudinal study in which he assessed the impact of coping styles, support at work and support from family on burnout. The prediction that family resources would complement work based resources in the prevention or alleviation of burnout was supported. Leiter found that the coping and support variables were independently related

to burnout subscales. Support from family was negatively associated with emotional exhaustion, work and family based support were negatively related to depersonalisation, and work based support was negatively related to diminished personal accomplishment.

In the present study support at work was found to be associated with lower levels of depersonalisation, this does not support the findings of Chappell and Novak (1992) who found no association between MBI subscales and work support in their study of nursing assistants. However, MacPherson et. al (1994) found that of staff assessed using the GHQ-30 the most disturbed were more likely to perceive a lack of support at work. The direction of this finding cannot, however be assumed.

In Hare & Pratt's (1988) study of burnout, absence and turnover amongst British nurses perceived lack of support at work and emotional exhaustion predicted the frequency of absences.

4.2.5.i Informal Peer Support (focus group observations)

In the present study only 25% of carers identified working in isolation from colleagues as a stressor, the lowest of the stressors. It may be that although home carers work largely alone with their clients they do not feel isolated because of the amount of informal contact with, and support they get from their colleagues. A prominent theme in discussion groups was related to the high level of informal work related support through telephone contact between carers:

> " *I don't tend to talk about that (*concerns about client behaviour) *with my manager unless it is really bad, I usually sort it out with 'A' and 'B' when we talk over changes and messages"*

The qualitative report of the importance of peer support at work is supported by the findings of Leiter (1991). He reported that although support from supervisors was not associated with improved outcomes on the MBI, co-worker support was associated with a greater sense of personal accomplishment.

Any client would normally have at least two regular carers in order to meet their needs for out of hours services. In a residential or institutional setting it would be normal to have a message diary and handover meetings; the nature home caring precludes this however and much information, and with it informal peer support, is exchanged informally by telephone. Neither the specifically designed questionnaire or the SSQ-R really tapped into this element of support between the carers.

Another theme that arose during the discussion groups around support was that of the provision of support to colleagues in the form of commitment to both clients' and colleagues. As home carers work alone in clients' homes there is a sense of being

indispensable, a sense of responsibility for them, and to the other home carers who would have to step in:

> *"..yes, I don't ever think I can take time off when*
> *I'm ill, you can't be sure they'd (*the client) *get to bed,*
> *and anyway, it puts so much pressure on the other girls".*

There was an indication that for a number of participants this was a source of stress that was felt to come externally from managers as much as from their own sense of commitment.

PART THREE: LIMITATIONS OF THE STUDY

4.3.1 Generalising from the Findings

This study was carried out with a specific population, home carers working in a particular, fairly affluent, area in the home counties. There may therefore be a sample bias related to regional differences. The low level of ethnic minority groups resident in the area is reflected in the low percentage of ethnic minority home carers, again indicates the need for careful consideration in generalising particularly to less affluent areas.

At 67 participants the sample was a relatively small one, a larger sample would have increased the power of the analyses.

The sample was biased not only in that it was constituted of volunteers but also in that a number of individuals who were experiencing burnout or other psychological disturbance did not participate because they felt too distressed to do so. The level of burnout and psychological disturbance in this group may therefore have been underestimated. This, however was an important finding in terms future research design.

As discussed in the introduction, it was not possible to incorporate all the variables that have been found to be important in other studies and so the findings in this study must be understood to be based on only a selection of the possible variables.

4.3.2 Research design & measures

A full qualitative analysis of group discussions was not carried out as it was only possible to run two groups; the minimum number of groups advised when conducting a full analysis is three. Instead, basic coding in terms of the frequency of themes arising from the transcribed material was carried out and is used to illustrate, expand on, and present hypotheses about the findings .

The four standardised measures were self-report which has advantages and disadvantages. Although by using well validated standardised measures one is able to make comparisons across norms and with other studies, self-report measures are open to bias, a factor that may have been a particular problem in this study.

Support was measured in two ways; the administration of the six item SSQ-R and a question in the home carer questionnaire regarding formal emotional support at work. Important differences between formal work based support and family support have previously been identified. More specific measures of social support may have helped to elucidate findings related to this coping resource.

The eight factors for the WCQ-R identified by Folkman et al. (1986) and described in the manual for the WCQ (1988) were used in this study to explore coping strategies. A factor analysis of the coping strategies of this group of workers may have provided further insight, however the size of the sample was insufficient to carry out this procedure.

As a cross-sectional study the current investigation presents a 'snapshot' of psychological distress. Burnout however, as noted in the introduction, is generally accepted as a process which develops over time and might therefore be more amenable to a longitudinal design.

As a Correlational study the directionality of the association between significant variables and outcome measures is not clear.

4.3.3 Focus / discussion groups

There were limitations to the use of the group discussions in both the number of groups conducted and the level of analysis performed. Due to time constraints, data from groups did not go through a rigorous coding procedure as directed in literature on grounded theory (Pidgeon & Henwood, 1996).

PART FOUR: SUGGESTIONS FOR FUTURE RESEARCH

Since this was an exploratory study of a group who have been included in the literature previously only as a comparison group there is much scope for future research. A number of the suggestions for future research relate to the limitations outlined above.

With the completion of an exploratory study providing some direction for future research a comparative study with home carers from other areas with one focus being on the availability of informal peer support can be recommended. Veil & Badman (1992) describe five current strands of social support research; process-oriented research, research on the global, subjective perception of being supported, research on 'confidantes', research on the relationship between the social network and perceptions of support, and intervention-oriented research. In a more specific, less exploratory study, research on confidantes would be useful in the light of the qualitative material on informal peer support.

Comparative studies with other staff groups working with similar populations would be recommended as a next step in the attempt to gain an understanding of this group.

The question raised by Hare and Pratt's (1988) work regarding higher paraprofessional burnout as a result of lower status and the nature of the work tasks might be further explored in a comparative study with residential care workers. The gap between the needs of patients living in residential homes and those being cared for in the community appears to be reducing as older people who are vulnerable remain for longer in their own homes. Questions that arise are how this might continue to change the role of the home carer, and what changes might occur in the differences between residential and home care work.

Research design

Important qualitative material was gathered during telephone conversations with non-participants, which raises two points to consider in future investigations. Firstly, the use of individual interviews as a method of gathering qualitative data, and secondly gaining information about non-participants.

Burnout is characterised in more recent models as a progressive phenomenon which is related to chronically of stress over time. Longitudinal study of paraprofessionals caring

for older people would provide valuable insights into the development of burnout over time and potential points at which to intervene.

PART FIVE: CONCLUSION AND IMPLICATIONS OF THE STUDY

The results of this exploratory study of burnout, coping and social support in home carers indicate that this group of workers experience lower levels of burnout and general psychological disturbance than is apparent in the normal population or in similar professions. Coping strategies particularly related to poor outcome were escape-avoidance, distancing and confrontive coping reflect the findings of other studies of coping in the work setting.

A number of possible factors relating to the low level of psychological distress were identified. There is evidence that some of the more distressed carers did not participate precisely because of their level of distress. Additionally, some who did participate may have been overly positive in their responses, particularly to the MBI. Qualitative information which was not tapped by quantitative measures highlighted the potentially important roles played by informal peer support, and the introduction of clearer boundaries to work tasks, in moderating the effects of burnout

The association of situational / individual variables such as satisfaction with work , years experience and recent life events reflected findings in many previous studies.

Depersonalisation, which is characterised by a callous, negative attitude towards clients, was found to be associated largely with work and client related variables including feelings of not being valued and working with confused, difficult clients. Since support at work was also found to be a significant predictor of psychological outcome it is important that managers address these issues during individual supervision and group meetings. It might be suggested that in other settings more informal client related contact between co-workers could be promoted. Coping resources were the primary predictors of psychological outcome for the other burnout subscales and the GHQ.

Implications for other groups of carers with overall poorer psychological outcome and higher levels of burnout might be related to intervention strategies promoting increased informal peer support. (Kahn 1993), and the clarification of boundaries to their roles as carers.

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WEST HERTS COMMUNITY HEALTH NHS TRUST

LOCAL RESEARCH ETHICS COMMITTEE

16 July 1997

Miss Julia Brownlie
35 Upper Culver Road
ST ALBANS
Herts AL1 4EE

Dear Miss Brownlie

WH010/97: Stress, coping resources and psychological well-being in home care staff working with older people

Further to my letter of 8 July 1997, I write to let you know that my action to grant Chairman's approval for the above study was ratified by the full LREC at its meeting on 14 July 1997. I draw your attention to the following:

(i) It is the responsibility of the investigator to notify the LREC immediately of any information received or of which you become aware which would cast doubt upon, or alter, any information contained in the original application, or a later amendment application, submitted to the LREC and/or which would raise questions about the safety and/or continued conduct of the research.

(ii) The need to comply with the Data Protection Act 1984.

(iii) The need to comply, throughout the conduct of the study, with good clinical research practice standards.

(iv) The need to refer proposed amendments to the protocol to the LREC for further review and to obtain LREC approval thereto prior to implementation (except only in cases of emergency where the welfare of the subject is paramount).

(v) The requirement to inform the LREC should the research be discontinued or any subject withdrawn.

I would be grateful if you could inform the Committee of the progress of the research project (eg annually) and also the conclusion and outcome of the study. Enclosed for your information is a list of LREC members.

Yours sincerely

Pauline Southworth

Pauline Southworth (Mrs)
Chairman
West Herts Community Health NHS Trust
Local Research Ethics Committee

ABOUT YOUR CLIENTS

This section relates specifically to older clients with whom you work - aged 65 years+

16. Approximately how many hours of your work time is spent with older adults (age 65+) .....

17. How many older clients do you see on average during the week. .....

18. Of the older clients with whom you work:

how many seem confused or suffer from dementia .....
how many are physically frail or disabled .....
how many are both confused and frail .....

19. How many of these clients live:

[1] alone ..... [3] with other family member .....
[2] with spouse ..... [4] sheltered accommodation .....

20. Do you think, in general, that since you have been working as a home carer:

(a) your role has changed. Yes [2] No [1]

If yes, please specify in what way.....

.....

(b) the needs of the client group have changed. Yes [2] No [1]

If yes, please specify (e.g, levels of disability, confusion etc.).....

.....

TRAINING AND SUPPORT

21. Had you had any training on working with older people before working as a home carer. Yes [2] No [1]

22. Have you had training on working with older people in your current job. Yes [2] No [1]

If Yes, was it **(a)** physical aspects (e.g lifting & handling) Yes [2] No [1]

(b) understanding aging or dementia Yes [2] No [1]

(c) other (please specify) .....

.....

23. Do you think that the training you have received has been adequate in preparing you for the specific demands of working with older people and their families. Yes [2] No [1] Uncertain [0]

24. Is there formal time for providing emotional support in your team. Yes [2] No [1]

If Yes, **(a)** please describe. .....

.....

(b) how often is this support available. .....

(c) do you feel you actually make use of it. Yes No [2 1]

HOME CARER PARTICIPANT QUESTIONNAIRE

Appendix 2

Name:..... Date.....

Instructions: There are two types of questions on the next 3 pages. One type asks you to write some information (e.g your age or how long you have worked as a home carer). The other type asks you to make a choice between the answers given (e.g Yes No or Male Female), for these questions please circle your answer.

ABOUT YOU

1. Sex: M [1] F [2] (please circle)

2. Age: .....

3. Ethnic Origin: (please circle)
[1] white GB [2] white other [3] black african
[4] black carribean [5] Indian [6] bangladeshi
[7] pakistani [8] chinese [9] asian [10] other

4. Status: [1] Single [2] Married / partner [3] Divorced / separated [4] Widowed (please circle)

5. In the last year have you experienced any stressful life events (e.g. major illness, divorce, significant life change) Yes [2] No [1]

6. Are you the primary carer for an elderly or disabled relative. Yes [2] No [1]

ABOUT YOU AND YOUR WORK

7. How long have you been in your current post (years / months) .....

8. How many years / months previous experience in home caring .....

9. Have you previously worked in any other caring / health related jobs. Yes [2] No [1]

If Yes, please specify .....

.....

10. For how many hours are you currently contracted to work .....

11. On average, how many additional hours do you work weekly .....

12. Do you put in additional time for which you do not claim. Yes [2] No [1]

If Yes, approximately how much time per week. .....

13. What are the best parts of your work at present, and why (please specify)

1.....

2.....

3.....

14. What are the most difficult parts of your work at present, and why (please specify)

1.....

2.....

3.....

15. How satisfied do you feel in your work. Very [4] Fairly [3] Not Much [2] Not at All [1]

25. To what extent would you say that you find your work stressful. (please circle)

not at all	a little	quite a lot	extremely
[1]	[2]	[3]	[4]

PERCEIVED WORK STRESSORS

Below is a list of possible sources of stress that have been identified in home caring and nursing. Which of these would you say is an issue that contributes to the stressfulness of your work. (please circle either Yes or No for each statement)

	[2]	[1]
01. Physical demands of the job.	Yes	No
02. Time pressures.	Yes	No
03. Clients whose behaviour is difficult to manage.	Yes	No
04. Feel that I have to keep up a front to the clients regardless of how I feel.	Yes	No
05. Dealing with clients who are physically ill.	Yes	No
06. Client depends a great deal on my service.	Yes	No
07. Coping with the death of a client.	Yes	No
08. Being responsible for client's finances.	Yes	No
09. Emotional involvement with clients.	Yes	No
10. Work overload.	Yes	No
11. Working in isolation from other colleagues.	Yes	No
12. Difficult relationships with client family members.	Yes	No
13. Relevance of work to own current or potential life circumstances.	Yes	No
14. Dealing with clients who are confused.	Yes	No
15. Lack of training	Yes	No
16. Amount of paperwork	Yes	No
17. Feeling of not being valued	Yes	No

18. Other (please specify) .....

.....

Can you now please identify the six most important issues in those listed above, ranking the most important as 1 and so on to the sixth most important as 6 (please place the appropriate question numbers in the boxes below)

1	2	3	4	5	6

Appendix 3

THE GENERAL HEALTH QUESTIONNAIRE

GHQ 28

David Goldberg

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1 – been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 – been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 – been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 – felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 – been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 – been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 – been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

B1 – lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 – had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 – felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 – been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 – been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 – found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 – been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

Please turn over

Have you recently

C1 – been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2 – been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 – felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4 – been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5 – felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 – felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7 – been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

D1 – been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2 – felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 – felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 – thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5 – found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 – found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 – found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A ☐ **B** ☐ **C** ☐ **D** ☐ **TOTAL** ☐

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HUMAN SERVICES SURVEY

Appendix 4

Name:..... Date:.....

The purpose of this survey is to discover how people in the caring professions view their jobs and those with whom they are working closely.
Below are 22 statements of job related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have *never* had this feeling write a "0" after the statement. If you have had this feeling, indicate *how often* you have had it by writing the number (from 1 to 6) that best describes how frequently you feel that way.

HOW OFTEN:	0 Never	1 A few times a year or less	2 Once a month or less	3 A few times a month	4 Once a week	5 A few times a week	6 Every day

Statements

How Often 0-6

1. I feel emotionally drained from my work. .....
2. I feel used up at the end of the workday. .....
3. I feel fatigued when I get up in the morning and have to face another day on the job. .....
4. I can easily understand how my clients feel about things. .....
5. I feel I treat some clients as if they were impersonal objects. .....
6. Working with people all day is a real strain for me. .....
7. I deal very effectively with the problems of my clients. .....
8. I feel burned out from my work. .....
9. I feel I'm positively influencing other people's lives through my work. .....
10. I've become more callous towards people since I took this job. .....
11. I worry that this job is hardeneing me emotionally. .....
12. I feel very energetic. .....
13. I feel frustrated by my job. .....
14. I feel I'm working too hard on my job. .....
15. I don't really care what happens to some clients. .....
16. Working with people directly puts too much stress on me. .....
17. I can easily create a relaxed atmosphere with my clients. .....
18. I feel exhilarated after working closely with my clients. .....
19. I have accomplished many worthwhile things in this job. .....
20. I feel like I'm at the end of my rope. .....
21. In my work, I deal with emotional problems very calmly. .....
22. I feel clients blame me for some of their problems. .....

Administrative use only

	cat.		cat.		cat.
EE: _____	_____	DP: _____	_____	PA: _____	_____

Maslach and Jackson (1986) - Consulting Psychologists Press

Social Support Questionnaire (Brief Version) *Appendix 5*

Name:..... Date:.....

INSTRUCTIONS

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the letters beneath the question.

For the second part, circle how satisfied you are with the overall support you have.

If you have no support for a question, tick the words "No one", but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all the questions as best you can. All your responses will be kept confidential.

EXAMPLE:

Whom can you talk with frankly, without having to watch what you say?

-- No one	1) T.N (husband)	4) R.S (mother)	7)
	2) L.M (sister)	5) A.G (friend)	8)
	3) D.L (friend)	6) P.T (employer)	9)

How Satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

---

1. Whom can you really count on to be dependable when you need help?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

2. Whom can you really count on to make you feel more relaxed when you are under pressure or tense?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1- very dissatisfied

3. Who accepts you totally, including both your worst and best points?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

4. Whom can you really count on to care about you, regardless of what is happening to you?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

5. Whom can you really count on to make you feel better when you are feeling generally down in the dumps?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

6. Whom can you count on to console you when you are upset?

-- No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied

WAYS OF COPING QUESTIONNAIRE (REVISED) *Appendix 6*

Name: ..... Date:.....

Please read each item below and indicate, by circling the appropriate category, to what extent you used it in the past **month** to cope with a specific work related situation that you found stressful.

	Not used	Used some-what	Used quite a bit	Used a great deal
1. Just concentrated on what I had to do next - the next step.	0	1	2	3
2. I tried to analyse the problem in order to understand it better.	0	1	2	3
3. Turned to work or substitute activity to take my mind off things.	0	1	2	3
4. I felt that time would make a difference.	0	1	2	3
5. Bargained or compromised to get something better from the situation.	0	1	2	3
6. I did something which I didn't think would work, but at least I was doing something.	0	1	2	3
7. Tried to get the person responsible to change his / her mind.	0	1	2	3
8 Talked to someone to find out more about the situation.	0	1	2	3
9. Criticised or lectured myself.	0	1	2	3
10. Tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11. Hoped a miracle would happen.	0	1	2	3
12. Went along with fate; sometimes I just have bad luck.	0	1	2	3
13. Went on as if nothing had happened.	0	1	2	3
14. I tried to keep my feelings to myself.	0	1	2	3
15. Looked for the silver lining, so to speak: tried to look on the bright side of things.	0	1	2	3
16. Slept more than usual.	0	1	2	3
17. I expressed my anger to the person(s) who caused the problem.	0	1	2	3
18. Accepted sympathy and understanding from someone.	0	1	2	3
19. I told myself things that made me feel better.	0	1	2	3
20. I was inspired to something creative.	0	1	2	3
21. Tried to forget the whole thing.	0	1	2	3

	Not used	Used some-what	Used quite a bit	Used a great deal
22. I got professional help.	0	1	2	3
23. Changed or grew as a person in a good way.	0	1	2	3
24. I waited to see what would happen before doing anything.	0	1	2	3
25. I apologised or did something to make up.	0	1	2	3
26. ! made a plan of action and followed it.	0	1	2	3
27. I accepted the next best thing to what I wanted.	0	1	2	3
28. I let my feelings out somehow.	0	1	2	3
29. Realised I brought the problem on myself.	0	1	2	3
30. I came out of the experience better than when I went in.	0	1	2	3
31. Talked to someone who could do something concrete about the problem.	0	1	2	3
32. Got away from it for a while; tried to rest or take a vacation.	0	1	2	3
33.Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.	0	1	2	3
34. Took a big chance or did something very risky.	0	1	2	3
35. I tried not to act too hastily or follow my first hunch.	0	1	2	3
36. Found new faith.	0	1	2	3
37. Maintained my pride and kept a stiff upper lip.	0	1	2	3
38. Rediscovered what is important in life.	0	1	2	3
39. Changed something so things would turn out all right.	0	1	2	3
40. Avoided being with people in general.	0	1	2	3
41. Didn't let it get to me.	0	1	2	3
42. I asked a relative or friend I could respect for advice.	0	1	2	3
43. Kept others from knowing how bad things were.	0	1	2	3
44. Made light of the situation; refused to get too serious about it.	0	1	2	3
45. Talked to someone about how I was feeling.	0	1	2	3
46. Stood my ground and fought for what I wanted.	0	1	2	3
47. Took it out on other people.	0	1	2	3

	Not used	Used some-what	Used quite a bit	Used a great deal
48. Drew on my past experiences, I was in a similar situation before.	0	1	2	3
49. I knew what had to be done, so I doubled my efforts to make things work.	0	1	2	3
50. Refused to believe that it had happened.	0	1	2	3
51. I made a promise to myself that things would be different next time.	0	1	2	3
52. Came up with a couple of different solutions to the problem.	0	1	2	3
53. Accepted it since nothing could be done.	0	1	2	3
54. I tried to keep my feelings from interfering too much.	0	1	2	3
55. Wished that I could change what had happened or how I felt.	0	1	2	3
56. I changed something about myself.	0	1	2	3
57. I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58. Wished that the situation would go away or somehow be over with.	0	1	2	3
59. I had fantasies or wishes about how things might turn out.	0	1	2	3
60. I prayed.	0	1	2	3
61. I prepared myself for the worst.	0	1	2	3
62. I went over in my mind what to say or do.	0	1	2	3
63. I thought about how a person I admire would handle this situation and used this as a model.	0	1	2	3
64. I tried to see things from the other persons point of view.	0	1	2	3
65. I reminded myself how much worse things could be.	0	1	2	3
66. I jogged or exercised.	0	1	2	3
67. I tried something entirely different from any of the above (please describe below).	0	1	2	3

Appendix 7

PARTICIPANT INFORMATION SHEET

You are being asked to participate in a research project. It is an investigation into the experience of non-medically qualified staff caring for older people who are physically frail and or suffer from dementia. Previous research has focused on families caring for relatives, or on staff caring in hospitals. There has been little attention given, however, to the experiences of residential and home carers.
We know that caring for potentially vulnerable older people in residential homes and in the community can be stressful. It is hoped that if we understand more about this experience and how you manage, it will contribute to our knowledge about caring and how to support carers, allowing them to provide continuing good care for clients.

There are two parts to this study;
1. Filling in some questionnaires which should take less than an hour.
2. Participating in a closed group discussion about your work.

If you wish to participate *it is not necessary to be involved in both parts of the study,* completing the questionnaires does not mean that you will also be expected to join in group discussions.

The questionnaires are **confidential.** Information will not be available to any member of your team and will not be presented anywhere so that individuals can be identified. The researcher, a Clinical Psychologist in Training, will guide the discussion group which will be attended only by other carers.

If you have any questions about taking part in this study I can be contacted via your manager.

Thank you for your help

Julia Brownlie
(Clinical Psychologist in Training)

Appendix 8

WEST HERTS COMMUNITY HEALTH NHS TRUST

AGREEMENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF PROJECT

.....

STRESS, COPING & SOCIAL SUPPORT IN SOCIAL SERVICE HOME CARERS WORKING WITH OLDER PEOPLE.

I (name) .....

of (address) .....

.....

voluntarily consent to take part (or give consent that my child/ward may take part) in this research project.

I confirm that I have read and understood the information describing this project and all my questions have been answered to my satisfaction. I also understand that I may withdraw from the project at any time if I find that I am unable to continue for any reason and that if I do so, it will not adversely affect my future medical care.

I understand that I am entitled to receive a signed copy of this form.

Signed: ..... Date: .....

Witness: ..... Date: .....
(if participant aged under 16)

Investigator's Statement

I have explained the nature, demands and foreseeable risks of the above research to the subject.

Signature: ..... Date: .....

Appendix 9

DISCUSSION GROUP

Interview Schedule

Intro: no hidden agenda, opportunity to share thoughts and feelings freely.
Only ground rules are that there are no right or wrong answers.
Speak one at a time, tape recorder is just an extension of my memory.
Confidential and anonymous.

(opening question)
Begin by introductions - name, area/manager, how long in job

Opportunity to hear about your experiences and get a picture of home caring in a way that questionnaires can't.
Purpose of group is to think a bit more about some of the specific things that came out of the questionnaires that were interesting and to hear about things that weren't included that perhaps should have been.

I'd like to begin by thinking about some of the things that people indicated were most stressful, perhaps talk a bit about whether or not things have changed for home carers.

(open questions, allow discussion to move between topics but ensure that by the end of the time all areas have been covered)

Time Pressures

Difficult to manage behaviour

Support

Training, enough?, how useful?, what else would be helpful

Effects of changes in the role of the home carer / organisational changes

Does the work differ from work in residential settings - is that good or bad?

Anything that could have been done differently in terms of this study

Appendix 10

TRANSCRIBED EXTRACT FROM GROUP DISCUSSION

From group discussion (2) involving five home carers and the researcher

(summing up a previous few comments)...

R: So there are two kinds of pressure? One I suppose might be called physical, the paperwork, time pressures of seeing a lot of clients, lifting and handling, that sort of thing. The other perhaps, um, a more emotional pressure when as you said, you go to someone and they need the company. *(pause)* Are these pressures different to cope with?

1: Yes, yes that's the hardest..*(pauses)*

3: People see no-one but you, they're lonely, they want to have a chat.... what do you say to a lady in her nineties with a frame as she pleads with you to spend another 15 minutes with her (*other members of the group nodding in agreement).* You are supposed to say 'well, there are other agencies that can provide that sort of support', that's what we really should be doing but how can you say to somebody 'well you'll have to go and hire some company'..

2: ..but that's what you're doing isn't it.. *(speaking across one another)*

3: ..talk about stresses and pressure, that's one of the ultimate stresses.

4: you really want to stay with them but you know that you have got to say to everyone afterwards 'sorry I'm late' and make up some excuse or whatever...

5: ..I normally just blame my manager, I mean they never see her

(group laughs)

4: emotional pressure is definitely the worst...

1: ...well, you think how you would feel if you were in that position, if you were the frail old lady and you were pleading with somebody just to spend a few minutes with you

5: I seem to have time though. I've had nothing hardly at all to do lately...

2&3: ...*(laughing)* we should come and join your team then

2: with just having the tasks to do, just time allocated for that, you can't spend the time with them; but how are you supposed to get to know them...

later during same group....

R: I wonder about having more specific tasks to do, you said, it allows you to say 'no' to people.

4: yes but in a way that's more pressure because you end up doing the emotional supporting bit informally or you just have to tell them you haven't got time. If they've got problems it's easier just to sit and listen, it's worse for them and us *(being more task based.)*

2: it can become like a production line, if the clients wanted that they'd go into a home.

1: it should be a caring thing

4: they're getting to be just numbers....but that's not what we came into the job for. *(long pause)*

R: I noticed you mentioned people in homes, do you think there's a difference in caring for people in a home?

5: Well, you don't get the satisfaction of knowing you're helping them to stay in their own homes, like '2' said, it's a bit like a production line....

2: ...you don't know them as well in a home, there are more of you looking after more of them. I like the independence, you are much more your own boss, you can decide on how you do things even with the stricter timetables we have now.

3: I've worked in a home before doing this, I think a lot of us doing the job have *non-verbal agreement from group)* and we are people who just prefer doing this. *(smiling)* I mean, you'd have to love it or be mad to do a job like this for the money we get.
(group laughter and agreement).

Key: R = researcher No.'s 1-5 = the five home carers participating in the group