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Stress in home care staff working with older adults : an exploratory study of external stressors, moderating factors, and stress outcomes.

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I have really enjoyed the opportunity to carry out this piece of work which has enabled me see first hand the specific types of stressors home carers working directly with Older adults are required to deal with every day.

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Patrick Loughran, July 1999.

Summary

Home carers working chiefly with older adults were invited to participate in the study. Fifty nine consented and completed the questionnaires. Data was collected on external stressors, mediating factors, and strain indices experienced by home carers in their workplace. Well established measures were used, the General Health Questionnaire, the Occupational Stress Inventory, the Ways of Coping Questionnaire (short-form), the Maslach Burnout Inventory, the Minnesota Job Satisfaction Scale, as well as a demographic questionnaire designed for the study.

The results indicated that the majority of home carers experienced various aspects of their jobs as stressful, namely role demands but do not necessarily report strain. A range of coping strategies used by this group were assessed. As expected wishful thinking as a coping strategy was positively correlated with the emotional exhaustion and depersonalisation dimensions of burnout, reduced job satisfaction and general emotional mental health. Social support and problem-solving were also used as strategies, the success of social support was highlighted by the negative correlations found with the emotional exhaustion and depersonalisation dimensions of burnout, and positive correlations found with job satisfaction. The differences between the home carers sample and the norm groups on the job satisfaction scale, the burnout scale, and GHQ-12 indicated significant lower levels of burnout, equal levels of job satisfaction, and a significantly lower proportion of clinical caseness.

The stressful aspects of the home carer work were discussed. Although care work was viewed as rewarding by many nevertheless some indicators of stress were present. It was conjectured that the deleterious effects of reported stress was being effectively mediated through use of the various constructive strategies, namely social support from family and colleagues. Limitations of the study are discussed both in terms of method used, the nature of the sample and the issues around the measure of stress and relevant moderators.

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Chapter One. Occupational Stress - An Overview

General Introduction

The present study attempted to explore work stress in home carers working with older adults. In order to do this, a series of questionnaires and measures were used to assess work stressors, moderating factors, and indices of strain relevant to this group. In order to provide a context for the present study the introduction will be organised as follows. The introduction will start with a brief discussion of the origins of the term stress in psychological terms. Then the symptoms of stress will be discussed, as well as, the factors that potentially cause such symptoms. The next part will include the models of stress that have tried to explain the development of stress. As the present study sought to measure moderators of stress and outcomes of stress, the next section includes a discussion of coping, burnout, job satisfaction and psychological ill health. The sources of stress pertinent to health professionals will then be discussed, followed by a specific section of job demands relevant to the home carer. Finally, a description of the study will be provided including the study hypotheses.

Stress

Most writers agree that Hans Seyle (1956) is the father of many of the theoretical bases of stress. Indeed it was Seyle who first used the term. Taking the strain analogy from engineering, he believed that what happened in the body when placed under increased pressure and demand, had a parallel in the girders of a bridge when a heavy load crosses it. But Seyle, born in the Austro-Hungarian empire, educated in Prague, and emigrated to Montreal, misunderstood the English terminology and called the phenomenon, in error, stress (Levi, 1996).

From that somewhat muddled start, the term stress has become so commonplace in popular culture that the true meaning has become rather diluted, partly because of inconsistent usage by professionals working in the area and the use of stress terms by the general public (Jex, Beehr, & Roberts, 1992). Stress is not tangible or easily observed, therefore trying to define this abstraction is not without its difficulties. The tendency has been to over use the term to describe a whole host of situations. For example, in some contexts it is used to describe a stimulus, or a response to a stimulus and as an interaction of stimulus-response (Cooper, 1998). Despite its faults, occupational stress, as a term, is unlikely to be replaced. For the purposes of the present study, stressor will be used to describe stress-causing events or conditions in the workplace; strains will be used to describe the individuals' response to stressful stimuli that are harmful both emotionally and physically; and stress will be used to describe situations where stressors and strains are both present.

Stress has become one of the most serious health issues of the twentieth century - a problem not just for individuals in terms of physical and mental health, but also for employers who have started to assess the financial consequences of work stress (Cooper, 1998). Health care professionals have long been regarded to be at high risk for developing stress-related problems, as they face particular stressors that are not part of most other occupations (Lu, Shiau, & Cooper, 1997, Payne & Firth-Cozens, 1987). Stress could be seen as an inevitable and essential part of normal living. Living involves responding and adjusting to circumstances surrounding us every day, both ordinary events and moments of crisis. It is a process which is essentially creative, but when stimulus and response do not balance there can be damaging effects on the individual, especially if this builds up over a long period. The damaging effects of this unbalanced response to stress have been well-documented, they include physical and emotional damage to the individual. The characteristic symptoms of strain for the individual can include poor concentration, irritability, tension in neck or back, sleeplessness, high blood pressure, migraine headaches,

increased absenteeism from work and increased incidence of work accidents. Employee stress can also damage the organisation namely through poor productivity, poor employee relations and increased absenteeism (Cooper, 1998; Beehr, 1998).

Sources and outcomes of stress

Stress is caused by a multitude of demands or stressors, that often involve an imbalance between what is asked of employees and what employees are capable of, and what the work environment provides and what it demands. In work a certain amount of responsibility is needed, but not every job provides what the individual can necessarily deal with. In the same way, most employees want to be kept busy and active, but posts differ in terms of duties required.

An individual's sense of control over such factors is critical to how a job is evaluated. When in control of factors such as responsibility and range of work tasks, an employee may view stress as a challenge instead of a threat. When we lack this crucial sense of control, stress can spell crisis for the individual and the organisation. When we are exposed to stressors, such as lack of control over our lives combined with excessive demands, unsatisfied needs, unfulfilled expectations, overstimulation, understimulation, or role conflicts, most people experience emotional reactions, such as anxiety, depression, uneasiness, apathy, alienation, and hypochondriasis (Levi, 1996). Stress also causes behavioural reactions. Some of us start smoking or overeating. Alcohol and drug use can be used as a comfort. Fast dangerous driving or risk taking at work can be used as tension releasers. Some resort to aggression, violence, or other types of antisocial behaviour

Cooper, Cooper and Eaker (1988) suggested five major sources of stress at work. These sources of stress have been categorised in terms of intrinsic stressors, stressors

pertaining to the role in the organisation, relationships at work, career development, and organisational culture.

Intrinsic factors include the physical surroundings of the place of work i.e., noise levels, noxious odours, poor lighting, shift work and long working hours, the need to travel as part of the job, and work overload or underload either subjectively and objectively (Cartwright & Cooper, 1997).

Ivancevich and Matteson (1980), proposed five sets of role characteristics, as potential sources of stress: role ambiguity, role overload, role underload, role conflict, and degree of responsibility. In general, work role characteristics can act as stressors when a person's role in the workplace is not clearly defined and understood and when expectations placed on the individual are also unclear and conflicting (Cartwright & Cooper, 1997).

Specifically, role ambiguity arises when the employee does not understand clearly the work objectives because of inadequate or misleading information about what is required. Role conflict exists when there is an array of conflicting demands at work. For example, an employee in the health service may often feel torn between two groups of people who demand different types of behaviour or who believe the job entails two different functions. Role overload occurs when employees either have not got the time or resources to complete a task, or believe, rightly or wrongly, that they do not have the skills or ability to do a particular job. Role underload results when an individual is overqualified for the job they hold and possesses skills that are underutilised. Finally, responsibility for the welfare of people at work has been found to be particularly stressful for employees (Cordes & Dougherty, 1993).

Relationships at work have the potential to be both sources of stress and support. For example, if people at work lose a sense of being connected with others in the

workplace, then the workplace can become a difficult place to be (Maslach, 1998). Chronic and unresolved conflict with others on the job can be particularly destructive. Such conflict produces constant negative feelings of frustration and hostility, and reduces the likelihood of social support (Maslach & Leiter, 1997).

Career development issues such as job insecurity and lack of promotion opportunities have a deleterious effect on morale and motivation within the job. Insufficient rewards can cause the employee to feel devalued, both in terms of salary and benefits and in terms of not being praised or not having good work recognised. Performance appraisals are generally a good medium for career review and progression. However if carried out inappropriately an employee can be left feeling unfairly treated and mistrustful.

The culture of an organisation can present a threat to a person's sense of freedom and autonomy. This sense of having some autonomy and control at work is an important component of problem-solving and decision-making. Lack of control can be caused by rigid policy driven organisations, as well as, chaotic poorly managed ones. This prevents problem solving, making independent choices, and having some input into the achievement of the outcomes for which they will be held accountable (Cartwright & Cooper, 1997).

Models of Stress

Psychological stress models have been categorised in three ways (Baum, 1990; Coyne & Holroyd, 1982; Hobfall, 1989), those that define stress as a stimulus, those that view stress as a response and those that treat stress as a process involving both stressors and strains. In the next section, each category will be examined separately to show how models of stress have developed over time. In addition, each model will be discussed in terms of interventions recommended.

Stress as stimulus

The first category of models focus on the environment, where stress is seen as a stimulus or a range of stimuli in the individual's work environment. Stimuli, generally referred to as stressors, can include an event or set of conditions perceived as being harmful and threatening. An example of such a model is the Holmes and Rahe (1967) environmental stress model.

Holmes and Rahe (1967) defined stressful life events as those events which either signal or initiate significant life change in the individual experiencing them. The model placed emphasis on measuring the impact of a wide range of stressors, including catastrophic events, major life events, and chronic circumstances. In order to do this, the Life Events Scale (Holmes and Rahe, 1967) was developed. It contains 43 specific life events, each matched to a number of life change units. Positive events as well as negative ones were included emphasising the fact that these life events disrupt and therefore induce stress. The accumulation of these changes was seen to cause stress. The model was valuable in recognising that stress is experienced in a variety of events, some quite routine. Probably the most enduring contribution of this model is the idea that all types of life change not just negative events can cause stress (Ross & Altmaier, 1994). However, the idea that everyone experiencing a particular life event experiences the same amount of life change and therefore the same amount of stress has been difficult to accept. In addition, it seems unlikely that different populations of people can each be accurately measured by a single events measure. Further, there are some life events that are peculiar to certain stages of life, from adolescence to adulthood to older adulthood.

With this model, stress is construed as being inherent in the work environment.. Therefore intervention is concerned with taking action to modify or eliminate sources

of stress in the work environment and thus reduce their negative impact on the individual. Examples of such interventions include job redesign, team building, participative management, and employee involvement in career development (Elkin & Rosch, 1990).

Stress as response

The second category of models view stress as a response, where the focus of study is on how people react to stressors. An example of such a model is the General Adaptation syndrome (Selye, 1956) which was based on the assumption that human beings generally strive to maintain homeostasis in their lives and in their experiences. In order to restore any imbalance caused by stress various responses are adopted. These responses can have a psychological component including behavioural and cognitive patterns and emotional reactions. The physiological component to these responses can involve raised bodily arousal - faster heart beat, dry mouth, upset stomach, and increased perspiration. Strain is seen as the combination of both responses to a stressor.

Selye (1956) suggested that the person's physical response to stress to external and internal demands would follow a universal pattern described as the General Adaptation Syndrome. This followed three stages, alarm, resistance and collapse. Selye's proposal that every response to stress followed a set pattern was challenged by research indicating that the body's response to stress can vary depending on the stressor. In addition, the model's proposal that the body responds similarly whether the demand is external or internal in nature has been challenged by research indicating that stressors, particularly those that are complex, involve both internal and external demands (Ross & Altmaier, 1994). In addition, Seyle's model ignores both the psychological impact of stressors on the individual, and the individual's ability to recognise stress and act in a range of ways to change the environment (Cooper,

Cooper, & Eaker, 1988). When applied to occupational stress, this model may account for stressors caused by certain job conditions, such as excessive noise; however, it appears inadequate to explain diverse individual reactions to complex job conditions such as role ambiguity, role conflict, or role overload (Moore & Cooper, 1998).

With this model, stress is perceived as being the reaction of the individual to stressors in the environment. Therefore it places emphasis on improving stress management skills of the individual through training and educational activities.

Stress as a process

The third category of models conceptualises stress as a dynamic relationship between the person and environment, stressors and strains. The first model described is the transactional model of stress (Cox, 1978; Lazarus & Folkman, 1984) where stress is not seen as a stimulus or a response but a dynamic process between the person and environment with the individual influencing the impact of stress through behavioural, cognitive, and emotional strategies (Folkman, 1984). Unlike the previous models, individuals are not perceived here as being victims of stress, but actively appraising stressful events (primary appraisal) and appraising their coping resources and options (secondary appraisal) (Meichenbaum, 1985). Clinical psychological treatments such as stress inoculation training (Meichenbaum & Deffenbaum, 1988) best exemplify the application of this model in practice.

The final two models presented are the Person-Environment Fit Model (Caplan and Harrison, 1993) and Karesek's demand-discretion model (Karasek, 1979; Karasek & Theorell, 1990). These two models both emphasise the role control plays in the development of occupational stress. As a consequence, both models emphasise organisational level strategies, such as redesigning the task, analysing work roles and

establishing goals, that increase the opportunity for the employee to have greater decision latitude and job control (Hurrell & Murphy, 1996). Interventions of this sort have not traditionally been within the remit of the clinical psychologist. Generally, organisational and occupational psychologists have tended to carry out such changes. However, increasingly clinical psychologists are being recruited by organisational consultancies in response to companies recognising the benefits of stress counselling and health promotion among their employees. Combining the skills of both professions is particularly useful in that employees can be treated individually but also difficulties with the how the job is organised can be addressed (Cooper, 1986).

Cognitive model of stress.

Lazarus and Folkman (1984) define stress as occurring when there is an imbalance between the individual's perceived demands and the perceived resources to meet those demands. They emphasise the dynamic nature of this 'balancing process' and suggest that individuals can influence, either in reality or perceptually, both sides of this equation, to create a balance.

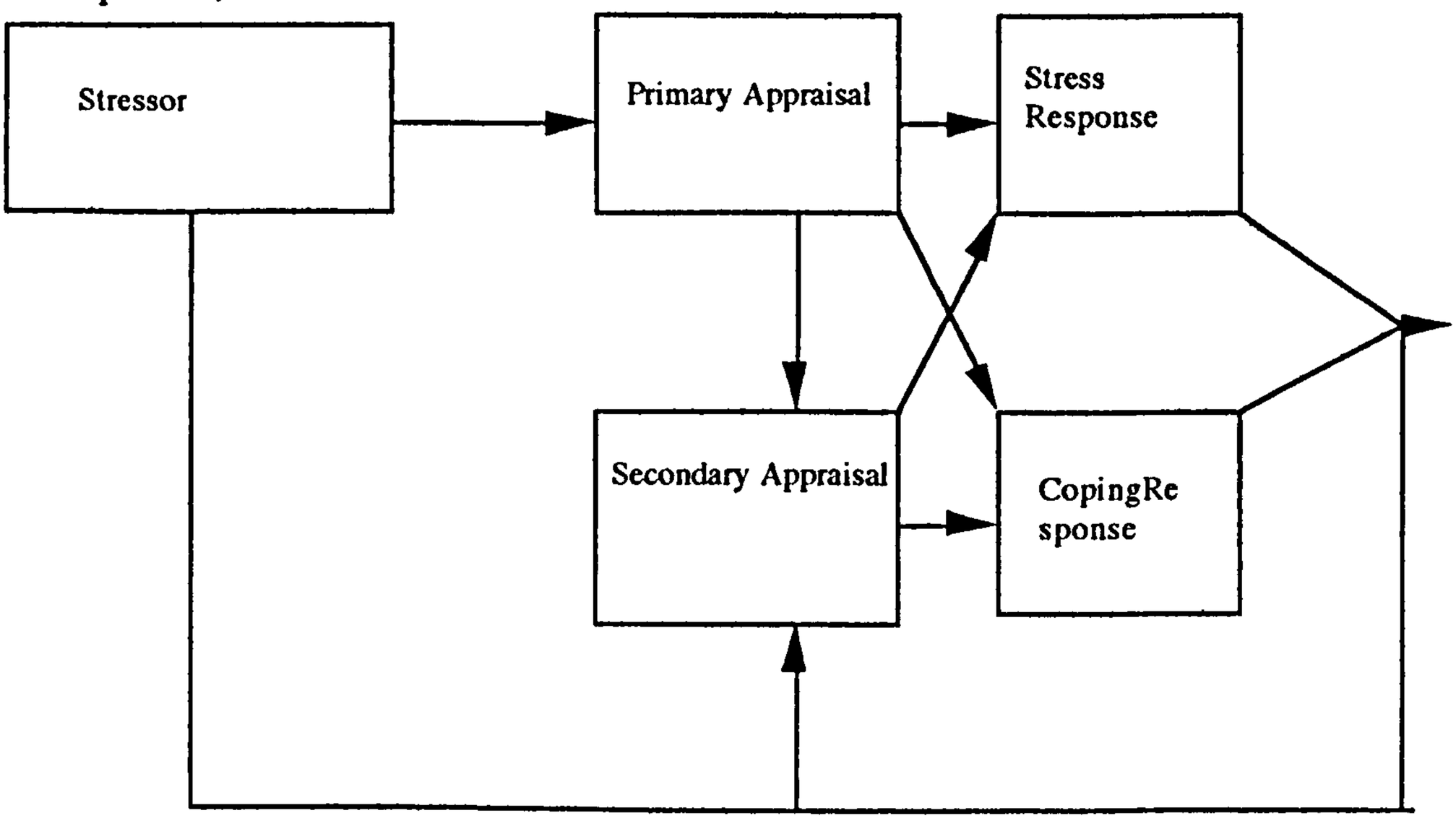

Figure 1.1 Transactional model of stress

Central to this model is the idea that psychological stress is the product of the two cognitive-behavioural processes of cognitive appraisal and coping. By cognitively appraising a situation, the person evaluates a particular situation or demand, on the likelihood of negative outcomes. Subsequently, a secondary appraisal happens where the individual attempts to define what coping strategies are needed to meet the particular harm, threat, or challenge. These options might be resource based, may take the form of a response, be of an internal or an external nature, and they may be adaptive or maladaptive in outcome (Lazarus, 1995). It is apparent that the way an individual tries to cope with a situation is crucial to understanding what effect that event will have. In this model, coping is seen as the most relevant moderator in the development of stress. In addition, coping is defined as a combination of both cognitive and behavioural processes used to master, tolerate or reduce demands that tax or exceed a person's resources (Cohen & Lazarus, 1976; Pearlin & Schooler, 1978). These efforts can focus solely on the problem, such as actively seeking information about what needs to be done to change our own behaviour or the problem in our environment. Alternatively, these efforts can also be focused on the feelings produced by the problem, for example, we might cope by trying to regulate the emotional distress caused by the problem. For Lazarus and Folkman (1984), coping was viewed as a transaction between coping efforts of the individual and the problem, which in itself causes our appraisal of the stressor to change. The success or otherwise of the coping strategy adopted was seen to dictate how we proceed.

Stress inoculation training (Meichenbaum & Deffenbacher, 1988) is a treatment approach that fits this model of stress. This approach usually includes an education component to understand the nature of anxiety, the learning of coping skills, both cognitive and behavioural, needed for anxiety reduction, and finally refining and rehearsing the use of these skills

In summary, stress is understood as the combination of personal issues and concerns, which change over time, and the resources and responses that a person can draw on in times of stress, which can also change over time. These responses, in turn, affect the initial situation or stressor, and may cause us to appraise it, or think about it, differently. The stress response is seen as transactional in this model because stress is defined in terms of a balance between demands and resources, i.e. if the demands are greater than the resources, then stress occurs. In addition, if resources are available to meet the demand, then the secondary appraisal might be one of challenge rather than harm or threat, and thus would be less stressful to the individual. In the context of work, stress is seen as the condition that results when person-environment transactions lead the individual to perceive a discrepancy between the demands of a work situation and the resources of the person's biological, psychological, or social systems (Sarafino, 1998).

Person-Environment Fit Model (Caplan and Harrison, 1993)

The core premiss of P-E fit theory is that stress arises not from the person or environment separately, but rather from a misfit between both. Two types of P-E fits are described, the first involves the fit between the demands of the environment and the abilities of the person. Demands include quantitative and qualitative job requirements, role expectations, and group and organisational norms, while abilities include the aptitudes, skills, training, time, and energy the person may utilise to meet demands. A second type of P-E fit entails the match between the needs of the person and the supplies in the environment that pertain to the person's needs. P-E fit theory characterises needs in general terms, encompassing innate biological requirements, values acquired through learning and socialisation, and motivation to achieve desired ends. Supplies refer to extrinsic and intrinsic resources and rewards that may fulfil the person's needs, such as food, shelter, money, social involvement, and the opportunity to achieve (Edwards, Caplan, & Van Harrison, 1998). Stress is seen to

arise when: (1) the environment does not provide adequate supplies to meet the person's needs; or (2) the abilities of the person fall short of demands that are prerequisite to receiving supplies. According to the theory, subjective P-E misfit leads to two sets of outcomes. The first set of outcomes comprises psychological, physical, and behavioural strains, defined as deviations from normal functioning. Psychological strains include dissatisfaction, anxiety, depression, complaints of insomnia or restlessness. Physiological strains include elevated blood pressure, elevated serum cholesterol, and compromised immune system functioning. Behavioural symptoms of strain include smoking, overeating, and elevated blood pressure, the cumulative effect of strain over a long period of time can include mental and physical illnesses such as chronic depression, hypertension, coronary heart disease, peptic ulcer, and cancer. By contrast, a sustained good P-E fit can produce positive health outcomes.

The second set of outcomes involves efforts to resolve P-E misfit, through use of coping strategies and defence strategies. Coping either involves the person adapting to the situation or the situation being changed to suit the person. Defence involves efforts by the individual to make the P-E fit less difficult by cognitively distorting the subjective person or situation, (examples are repression, projection and denial) without necessarily changing the objective counterparts. For example, a person may respond to role overload by overestimating his or her abilities or by downplaying or ignoring excess demands. A person may also respond to subjective misfit by downplaying the importance of this dimension, such as disengaging from unattainable goals. P-E fit theory provides a useful conceptual framework for understanding how person and environment constructs combine to produce strain and how coping and defence may resolve P-E misfit. However, although the theory does describe the process by which person and environment jointly influence the experience of strain, it does not specify the content of person and environment dimensions. In this regard the theory is a pure process theory, and the content of person-environment dimensions

must be derived from other theories. The theory does not specify particular relationships between P-E fit and strain, evidence seems to suggest that the relationship between P-E fit and strain may differ not only across component dimensions and indices of strain, but also across occupations. Developing hypotheses for major content dimensions, indices of strain, and occupations represents a significant, if not overwhelming, undertaking for future P-E fit research. Finally, limited attention is devoted to coping and defence, for example the theory does not specify the criteria by which the person will choose from among various methods for resolving P-E misfit. In addition the order by which coping and defence may occur is not specified, for example, defensive adaptation strategies are implemented only after attempts to change the objective person and environment have failed. The selection and sequencing of these methods of adapting to stressors are not addressed by this theory.

The demand-discretion-support model (Karasek, 1979; Karasek & Theorell, 1990; Johnson, Hall, & Theorell, 1989).

Karasek (1979) proposed a two-dimensional model, the demand-control model, about the interactions between job demands (quantitative workload and time pressures) and decision latitude (the individual's opportunity to control, participate, and engage in decision making). It was proposed that an analysis of work stress needed to distinguish between job demands placed on the individual worker and the discretion permitted the worker in meeting those demands. This model predicted that worker strain and dissatisfaction would be present at high levels of demand combined with low levels of discretion. The theory proposed that situational appraisals of perceived control refer to a judgement or belief about the possibilities of control in a specific encounter or situation. Situational appraisals of control arise from the perceived discrepancy between an individual's evaluation of the demands of a situation and his/her evaluation of personal coping resources, much like Folkman and Lazarus

(1988) interpretation of secondary appraisal. The operation of control in stressful conditions also provides the individual with informational feedback about his/her competence because the individual is able to perceive that the coping strategies have been used successfully. Therefore, as social learning theory predicts, an individual may experience an increased sense of self-efficacy as a result of exercising personal control. This aspect of perceived control may explain Karasek's prediction that satisfaction, or self-esteem, will be lowest in work environments where the employee experiences high levels of demand and low levels of discretion. The main criticism levelled at this model is that it is too simple in that it ignores personality and mediating variables such as coping style and social supports. Johnson, Hall, & Theorell, (1989) expanded the original model to a three-dimensional model, to include work-related social support. They found that high demands, low control and low support were related to experiencing stress and cardiovascular disease. In support of this model, De Jonge, Jannsen and Van Breukelen (1997) found that emotional exhaustion was higher where health care workers experienced high levels of autonomy. At the same time, feelings of emotional exhaustion were seen to increase with the level of autonomy. However, this increase was small when the levels of social support were high. Social support appeared to reduce the increase in effects of autonomy on exhaustion.

It has been found that the impact of social support on the demand-discretion model was interactive, that is acting as a moderator between both, as opposed to additive, that is impacting on both discretion and demand independently (Parkes, Mendham, & von Rabenau, 1994).

In summary, although the third set of models all propose that stress occurs as a result of an interaction between environment and the individual, the interventions recommended by each differ. For example, the Lazarus and Folkman (1984) model recommends individual or group intervention where the approach uses cognitive and

behavioural principles. By contrast, the demand-discretion model (Karasek, 1979; Karasek & Theorell, 1990) and the Person-Environment Fit Model (Caplan and Harrison, 1993) both advocate interventions at an organisational level to promote and increase worker control.

As the present study was concerned with exploring the relationship between external stressors in the person's environment, personal coping style and stress, the transactional model of stress best fitted the study sample. In addition, the OSI was selected because it too best reflected this model, sampling as it does occupational stressors, mediating factors and strain.

Coping as Moderator of stress

The way an individual attempts to cope with a stressor is crucial to understanding what effect that event will have. In the process model and P-E fit model coping plays a central part in moderating the development of stress. Coping as conceived in the transactional model is defined as cognitive and behavioural processes used to master, tolerate or reduce demands that tax or exceed a person's resources (Cohen & Lazarus, 1976; Pearlin & Schooler, 1978). Whilst, in the P-E fit model coping entails efforts to improve P-E fit, either by changing the objective person (i.e., adaptation) or the objective environment (i.e., mastery over the environment). These efforts can be focused on the problem, such as what might occur when we seek information about what needs to be done to change our own behaviour or the problem in our environment. Alternatively, these efforts can also be focused on our own feelings about the problem, as we would cope by trying to regulate the emotional distress caused by the situation. For Lazarus and Folkman (1984), coping is viewed as a transaction between coping efforts and the problem by the individual, causing in turn the appraisal of the stressor to change. The success or otherwise of the coping strategy adopted will dictate how to proceed.

Coping strategies: A large number of coping strategies and their typologies have been suggested, the most popular being problem-focused versus emotion-focused coping (Lazarus & Folkman, 1984). Problem-focused coping consists of efforts to find information about what needs to be done which informs a change in behaviour or a change in how the environment is reacted to. Coping strategies alter the person-environment relationship for the better by eliminating or reducing the psychological risk for harm or threat. The result is a changed appraisal and a changed emotional reaction. Emotion-focused coping consists of efforts to regulate the emotional distress caused by harm or threat. One basic strategy is distraction, that is avoiding thoughts about sources of threat. The other consists of a variety of strategies that change the meaning of what is happening, or what will happen, such as denial, positive thinking, and distancing. Emotion-focused coping does not change the objective terms of the person-environment relationship, but only how these terms are attended to or interpreted.

More recently, "social support" has been forwarded as a further independent category of coping (Thoits, 1986; Lu & Chen, 1996), on the basis that it is inter-personal oriented, whereas both problem-focused and emotion-focused coping are mainly intra-personal oriented. In addition, social support can be either cognitive or behavioural, and can help to either solve the problem or manage the emotion. When confronted with stressors, various coping strategies will be utilised, both cognitive and behavioural to alleviate their impact (Lazarus, 1995). Research has confirmed that both the effectiveness of coping and the breadth of coping repertoire are related to better health (Lazarus, 1993). Examining the strengths of a particular coping strategy is far from straightforward. For example, denial as a means of coping has been found to be very effective in the short-term, but maladaptive in the long-term (Suls & Fletcher, 1985). In addition, with the interactional model of stress, any attempt to manage a stressor is defined as coping regardless of whether it is

successful. In general parlance, coping is defined only in terms of successful attempts. In practice, the success or otherwise of a given coping strategy depends on the context. Several factors need to be taken into account, including the nature of the stressor, the availability of coping resources, and the outcome of the coping effort. In a psychological intervention for workplace stress these factors might be assessed using tests such as the Ways of Coping questionnaire (Folkman & Lazarus, 1988). Such questionnaires identify the individual's preferred coping strategies and can form the basis for discussion of adaptive strategies that might be adopted in the work situation. This is in contrast with the traditional method of treating coping as broad personality traits or styles of relating to the world. Although people do have such styles, their coping response is always, to some extent, governed by what is required of them in a particular situation. The key point is that no one uses one coping strategy all the time. Different coping strategies have their uses within specific contexts and need to be used and discarded where appropriate.

Coping resources: The impact of work stressors can also be moderated by coping resources consisting of personal and socio-ecological factors (Beresford, 1994). Personal coping resources refer to factors such as physical health, beliefs and ideologies, personality characteristics, locus of control and previous coping experiences. Socio-ecological factors refer to social support as well as practical and financial resources. In practise, to understand the impact of stressors on an employee an assessment of such factors could be used to structure and direct a stress management intervention.

Stress Outcomes - Burnout, Job Satisfaction, and Psychological ill-health.

Burnout: Job burnout is a prolonged response to chronic interpersonal stressors on the job characterised by an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and failure (Maslach, 1998;

Maslach, Jackson and Leiter, 1996). Burnout is often used interchangeably with occupational stress, however it is more accurately defined as a response to chronic interpersonal and emotional stressors at work (Maslach, 1997). For many years, burnout has been recognised as an occupational hazard for people-oriented professions, such as human services, education, and health care. Care work is characterised by relationships of an ongoing and intense level of personal and emotional contact. Although these relationships can be rewarding and engaging, they can also be stressful. In addition, within the caring professions, the prevailing norms are to be selfless and to put others' needs first where long hours will be worked in order to help clients. Furthermore, the work environments are very often under funded and over stretched with cut backs constantly reducing resources. In summary, the work environment can be characterised by high demands and low resources. From the evidence of the Person-Environment Fit Model (Caplan and Harrison, 1993), such an environment is likely to cause workers strain where the importance of external supports becomes more critical as a moderator.

In research the three-component model of burnout is most widely used. This model proposes that burnout is a developmental process with distinct phases of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach, Jackson & Leiter, 1996). Emotional exhaustion refers to being emotionally overextended and depleted of one's emotional resources. This has been described in various models as entailing intense weariness, an inability to sleep, a feeling of low energy, chronic fatigue and weakness. Depersonalisation refers to the development of negative, callous, or excessively detached response to recipients of care. Finally, reduced personal accomplishment refers to a decline in the ability to evaluate one's work with clients positively. The conservation of resources theory of stress (Hobfall & Freedy, 1993) has been cited as a useful framework to understand how various correlates are related to burnout. The theory suggested that burnout occurs when certain valued resources are lost, are inadequate to meet demands, or do not yield the

anticipated returns. The major demands of work include role ambiguity, role overload, and conflict at work. The major resources include social support from various sources; job promotion, participating in decision-making, and a degree of autonomy at work (Cordes & Dougherty, 1993). The theory also stated that certain behavioural and attitudinal outcomes are likely to occur as a result of resource loss and excessive demands at work, including high job turnover, reduction in organisational commitment, and job satisfaction (Kahill, S., 1988). Studies have sought to investigate which demands and resources are associated with each burnout dimension. For example, Lee and Ashforth (1996) reported how emotional exhaustion as a form of strain is directly affected by these correlates, whereas depersonalisation as a form of defensive coping and personal accomplishment as a form of self-evaluation are indirectly affected through emotional exhaustion.

Leiter & Maslach's (1988) model of burnout suggested that emotional exhaustion occurs when work demands, such as role overload are present. Depersonalisation, is the interpersonal dimension of burnout and usually develops in response to the overload of emotional exhaustion. At first depersonalisation is self-protective acting as an emotional buffer of 'detached concern'. However, a prolonged sense of detachment can be dehumanising (Maslach, 1998). The personal accomplishment component represents the self-evaluation dimension of burnout, and occurs in response to the previous two dimensions. By contrast, an alternative model hypothesised that depersonalisation is the first phase of burnout, followed by reduced personal accomplishment, and finally by emotional exhaustion (Golembiewski & Munzenrider, 1988).

Leiter and Maslach's model has received partial support. For example, Lee and Ashforth (1993a, 1993b) found several of the correlates to be associated with emotional exhaustion and depersonalisation, but the correlates were only weakly associated with personal accomplishment. As a result of these findings, Leiter (1993)

proposed a revised model in which demand and resource correlates are posited to be differentially associated with the three dimensions. Specifically, the demands are posited to be more strongly related to emotional exhaustion, whereas the resources are posited to be more strongly related to either depersonalisation or personal accomplishment. In addition, it was also posited that outcomes reflecting withdrawal tendencies are more related to either emotional exhaustion or depersonalisation, whereas outcomes reflecting positive self-efficacy are more related to personal accomplishment. Finally, the burnout dimensions were found to interrelate, where emotional exhaustion and personal accomplishment develop in parallel with each other rather than sequentially (Lee & Ashforth, 1996).

In summary, the empirical research on contributing factors has found that situational variables are more strongly predictive of burnout than are personal ones (Cordes & Dougherty, 1993; Lee & Ashforth, 1996). In terms of antecedents of burnout, both job demands and a lack of key resources are particularly important. Work overload and job demands have been found to be the critical demands, while the lack of such resources as control coping, social support, skill use, autonomy and decision involvement all contribute further. The results of burnout are seen most consistently in various forms of job withdrawal, with the implication of a deterioration in the quality of care or service provided to clients or patients. The model presented in Figure 1.2 summarises in a diagram the major research findings discussed in the reviews listed above.

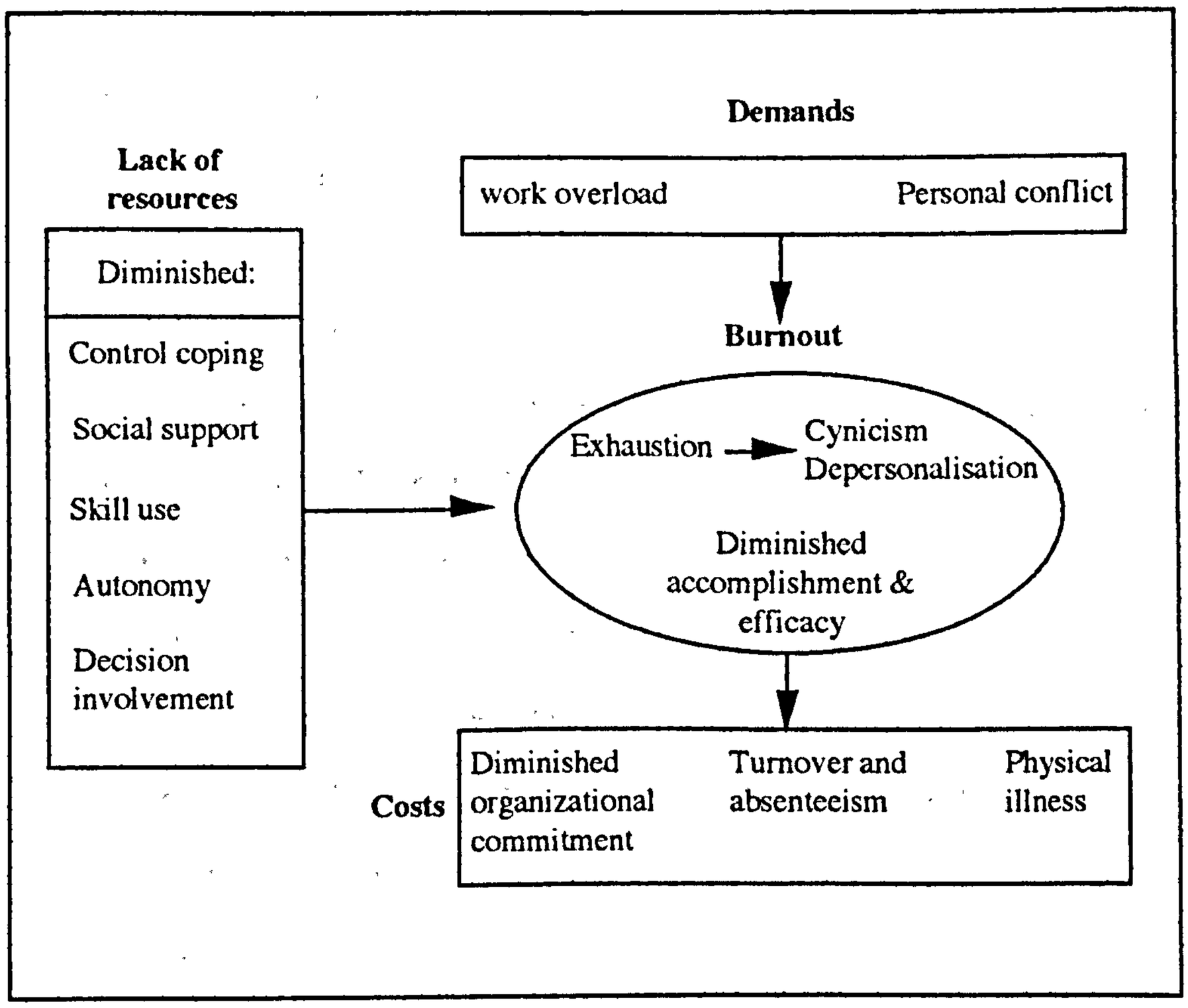

Figure 1.2 Model of Burnout

When people describe themselves or others as experiencing burnout, they are very often referring to exhaustion. Indeed of the three burnout dimensions, emotional exhaustion is the closest to the orthodox view of stress. This strong identification of exhaustion with burnout has led some to argue that the other two aspects of the syndrome are incidental or unnecessary (Shirom, 1989). However as argued by Maslach (1998), the fact that exhaustion is a necessary criterion for burnout does not mean it is a sufficient one. Exhaustion reflects the individual stress dimension of burnout, it fails to capture a critical aspect of the relationship people have with their work. Chronic exhaustion can lead people to distance themselves emotionally and cognitively from their work, so that they are less involved with, or responsive to, the needs of other people or the demands of the task. In the caring profession, this distancing takes the form of depersonalising others. Distancing is such an immediate reaction to exhaustion that a strong relationship from exhaustion to depersonalisation

or depersonalisation is found consistently in burnout research (Maslach, Jackson, & Leiter, 1996). The relationship of reduced personal accomplishment to the other two aspects of burnout is somewhat more complex. In some cases, reduced personal accomplishment appears to be a function, to some extent, of either exhaustion, depersonalisation, or a combination of the two (Byrne, 1994; Lee & Ashforth, 1996). A work situation with chronic, overwhelming demands that contribute to exhaustion or depersonalisation is likely to erode one's sense of accomplishment when feeling exhausted or when helping people toward whom one might feel disdain. However, in other settings, reduced personal accomplishment appears to develop in conjunction with the other two dimensions of burnout, rather than sequentially (Leiter, 1993). In this instance the lack of efficacy seems to arise more clearly from a lack of relevant resources, while exhaustion and cynicism emerge from the presence of work overload and social conflict.

Correlates of burnout

Lee and Ashforth (1996), carried out a meta-analysis assessing the associations between various correlates and each of the burnout dimensions. For demand correlates, such as the role ambiguity, role conflict, stressful events, workload, and work pressure, all correlations with emotion exhaustion were all greater than or equal to .5. Correlations between depersonalisation and the same demand correlates were all greater than or equal to .34, and correlations between personal accomplishment and the demand correlates were generally weak, with the highest being .22. With coping strategies, the results of this study indicated that emotional exhaustion and depersonalisation were strongly associated with the intention to leave, and commitment to the organisation but were weakly associated with problem-focused coping. Personal accomplishment was strongly related to control coping, suggesting that a problem-focused response and a positive self-appraisal may be mutually reinforcing (Lazarus & Folkman, 1984).

Job Satisfaction

Job satisfaction is an attitude based on an evaluation to a job situation. Put simply, a satisfied employee finds more to like about his or her job situation than to dislike. The main interest in investigating this construct is usually to find the factors that contribute to it, finding employees that are more satisfied with their jobs and how an individual's level of job satisfaction effects work behaviour (Jewell and Siegal, 1990). In the present study job satisfaction is of interest because it provides an indicator of employee attitudes to work and can be used to find if this evaluation differs depending on perceived levels of stress.

Schaufeli and Buunk (1996) report how low job satisfaction is highly and consistently positively related to burnout, and that burnout leads to job dissatisfaction rather than the other way around. Job satisfaction is a widely used measure of strain and is often related to many potential stressors, however Beehr (1995) states that by itself it does not necessarily indicate the presence of stress. Beehr (1995), in fact, also questions whether job dissatisfaction is in fact a true measure of strain. For example, job dissatisfaction is in most ways a milder reaction to work than other outcome measures. It is an outcome separate from strains, but provides useful additional information, in much the same way as measures of job performance, absenteeism, and turnover do.

Psychological Ill-health

By definition, occupational stressors lead to strains, at least for most people and under most conditions (Kahn & Byosiere, 1990). Strains are usually harmful and aversive to the individual experiencing them. In general, strains are the outcomes that define stress in the workplace and they are usually states associated with ill health. These

outcomes can be divided into three categories: psychological, physical or physiological, and behavioural. These correspond roughly to (poor) mental health, (poor) physical health, and behaviours likely to be deleterious to one's own health and well-being. Job stress research has focused primarily on the psychological strains possibly because of the relative ease of measurement. Nevertheless, measuring strain is not straightforward as self-report measures are subject to both over reporting and under reporting of symptoms and the common use of the word "stress" in questionnaire items can influence responses.

Sources of Stress for Health Professionals.

An ever growing body of research suggests that health care workers experience specific job-related difficulties and report elevated levels of psychological disorders compared with other professional groups (Firth & Britton, 1989; Firth, 1986; Payne & Firth-Cozens, 1987; Rees & Cooper, 1990). For example, when health care work leads to contact with and treatment of chronically ill people, the emotional burden on staff can be great (Cooper & Mitchell, 1990). Tylor and Cushway (1998), cite three factors that leave health care professionals vulnerable to experiencing stress: (1) they care for needy people; (2) they very often feel uncertain about the effectiveness of treatment and (3) they tend to hide their natural self-doubt about their own competence. Allied to this is the difficulty of being a small part of a large organisation, where decision making is not always consultative, and where change takes place on a regular basis prescribed by management. The recent changes within both the National Health Service and Social Services have also contributed to employee stress. For example, value for money and cost-cutting exercises have caused a reduction in staff morale mainly because of pay freezes, an increase in paperwork, and an emphasis of increased efficiency and productivity (Seccombe & Buchan, 1993). One outcome of this is that the caring professions are increasingly seen as an unattractive career option. Ironically, this has also led to an increase in

interest in stress research. Increasingly, hospital and community service managers acknowledge that staff stress contributes to the quality of care offered to patients, increases the number of complaints and legal actions they have to deal with annually, and raises the levels of sick leave taken and turnover of staff (Firth-Cozens, 1997).

There is growing evidence that the proportion of health workers who are showing symptoms of stress at levels indicative of being at risk for psychological problems is high. For example, Tyler and Cushway (1992) found that roughly one-third of nurses sampled, showed 'caseness' for psychological disorder. In the measures they used, Rees and Cooper (1992) found no significant differences in the sources of stress reported by the various types of health professionals, though nurses reported the highest levels of pressure in their jobs (workload, lack of variety, poor rates of pay, poor promotion prospects and role conflict), compared especially to general managers, who reported the lowest levels of pressure in their jobs in those areas.

Sources of stress for Home Carers

The context of home care work: In the Health of the Nation document (Secretary of State for Health, 1992) the need for health promotion was prioritised in the workplace. As a result, investigation of the welfare of health care staff has been given greater prominence.

Community care has become the main form of provision and welfare services for older people in most Western societies. The main aim of community care is that illness and disability should involve the least amount of disruption to the life circumstances of the individual. Practically, this means restricting the use of hospital, nursing-home and residential home beds to those whose illness and associated disability cannot be managed effectively from or within the home environment. In the case of older adult care, policies have developed where health and social

domiciliary services are increasingly used and hospital longstay beds have been reduced in their availability (Gilleard, 1996). Policy documents such as the White Paper 'Caring for People' (Department of Health, 1990) and the NHS and Community Care Act (HMSO, 1990), have emphasised the move away from institutional care to more community based care. These documents were predated by a series of studies undertaken by the DHSS (1981) that indicated the policy change away from providing residential care towards enabling older people to live independently in their own homes whenever possible, offering residential care facilities when no other option was available. In this care environment, the role of the home carer has an important one to fulfil. In general, within the NHS, provision has shifted away from long stay care and towards acute services, with a concomitant increase in residential care provided by both social services and the independent sector.

Demographic changes have also an influence on how care provision is organised and delivered. The population structure of Britain has changed significantly since the early part of this century. For example, in 1901 slightly over 6 per cent of the population were at or over current pension age (60 years for women, 65 years for men), this figure has steadily risen to reach 18 per cent in 1991 (OPCS, 1991). At the same time, the proportion of children under 16 years has fallen from 35 to 20 per cent. Therefore, the age structure of the population has changed from one in which young people predominated to a society in which people at the other end of the life span constitute a substantial proportion of the population. At the same time as the elderly population has increased in relative terms, the numbers of older people in absolute terms have also risen considerably, from just over 2 million in 1901 to about 10.5 million in 1991; (Hughes, 1995). In addition, significant numbers of older people living beyond 60 years of age are likely to experience some degree of disability. Arber and Gilbert (1989) estimated that about 6% of those aged 65-74 years, 15% of those aged 75-84 years and 41% of those aged over 85 years have

difficulties with outdoor mobility and self-care activities. Therefore the need for carers both paid and informal is set to continue growing.

The role of the home carer has developed from the "nursing mothers" of the 1940's, and the home helps of the recent past. Whilst meeting with home carers and home care managers it was clear that change is ongoing, for example, increased responsibilities and reduction in weekend hourly rates of pay. Home carers tend to be targeted at those who live alone, or those whose family caregiver needs support for reasons of age or infirmity (Arber and Ginn, 1991). Indeed elderly spouses have been reported as preferring home care services, given they do not involve separation from the person cared for (Wenger, 1990).

In general, there is a paucity of studies available that have sought to understand the sorts of difficulties and concerns home carers encounter in their work. It is acknowledged that the best place for caring for an older person is the home environment, because it is here that they are better able to maintain independent living, and where the individual's sense of self and integrity can be maintained (Kihlgren, 1990). Although, burden of care placed on family caregivers of older adults has received a lot of attention, it is recognised in this context that home carers play an important role in offering family members respite and relief of this strain. The effects on paid home carers of such care work has not as extensively been studied.

However, Ollson and Hallberg (1998) carried out a qualitative study on the challenges and stressors associated with home-based professional care for people with dementia and what managerial support was required for this staff group. It was found that home carers raised issues concerning common nursing care problems such as managing problematic behaviour during the progress of the disease, the sense of responsibility for client's welfare, and having difficulty understanding the perspective

of the older person. To support the home carers who reported such problems clinical supervision was offered providing an opportunity for the guidance of reflective practice and specifically focusing on what promotes or obstructs the carer-client relationship.

The home carer role: Given the high profile of community based care it is clear that home carers play a vital role in maintaining the client in a home environment and supporting family caregivers in their primary care roles. The job of the home carer working with older adults usually involves visiting a number of people for one to two hours each per day, and sometimes less than an hour, week days and weekends. Duties carried out vary according to identified need of each individual. Tasks can range from washing, bathing, toileting, dressing, food preparation, feeding, shopping, promoting self-care, and offering support for family carers. Home Carers usually work alone often having to make decisions by themselves, "on the hoof", since there is not necessarily another person there to discuss problems with (Trojan & Yonge, 1993). Home care services are usually provided to individuals who live alone, often to compensate for a lack of support from family or friends (Williams & Fitton, 1991). When Home Carers are employed to support primary family caregivers, a reduction in the strain of caring for elderly confused people has been reported (Levin, Sinclair and Gorbach, 1986). However, by the nature of the work, home carers carry a high degree of responsibility with limited levels of support and back-up. From the perspective of Karesek's demand-discretion model of stress (Karasek & Theorell, 1990) the way home care work is organised with a high workload, high responsibility and low autonomy the potential for strain is present. In addition, from the standpoint of the burnout literature, home care work fits in the occupational category of high frequency of interpersonal contact and high intensity of interpersonal contact, see Figure 1.3.

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Description of the study and statement of the hypotheses.

The study

This was a quantitative study of a sample of home carers working with older adults, that sought to measure external stressors, mediating factors, and stress outcomes pertinent to their work. The study was prompted by the lack of information about stress in home carers of the elderly, despite the fact that occupational stress is increasingly affecting health and caring professions disproportionately (Tyler & Cushway, 1998). It is well acknowledged that care work with older people is stressful for direct care staff (Moniz-Cook, Millington, & Silver, 1997) and family caregivers (Orbell, 1996), but as yet paid home carers have not been examined. The potential value of such research is that if the results demonstrate that this work group has high stress levels then this information may be used to develop managerial support and supervision. In addition, the ability to care is affected by stress, so the potential affect on care recipients is another reason for intervention. For example, Siddiqui (1991) reported that organisational based stress affected the quality of staff interaction with clients, in that basic care tasks are fulfilled but emotional support and care needs are less easily met. It has also been reported that care workers' experiencing significant symptoms of stress tend to experience more problems with organisational and management issues rather than with colleagues or patients (Baillon, Scothern, Neville, & Boyle, 1996).

From the research reviewed it was anticipated that given the nature of health care work and the stressors attached to this, it is likely that this group of carers will experience particular kinds of strain. Therefore the aim of the present study was to examine the nature of strain in these workers. Specifically, we hypothesise that the present sample will vary greatly in comparison with population norm groups, that

different coping styles will be associated with different levels of reported strain, and that burnout will be related to different role characteristics.

The study involved asking home carers working with older adults to complete five questionnaires and one demographic data sheet, taking on average 40 to 50 minutes to complete. The data collected included a variety of measures concerned with organisational issues and individual role issues, mediating factors, and strain. Specifically, these included measures of coping style, emotional well-being, strain, personal resources, role characteristics, job satisfaction, burnout level, and finally, home carers' personal details and views on some aspects of their work. The data was collected on a group basis at a range of work sites, over a period of two months.

The hypotheses investigated in the present study were divided between (a) those that were concerned with comparing stress outcome measures of the home carer group and relevant normative samples on these measures, (b) those that were concerned with the relationship between coping style and reported stress level, and (c) those concerned with the relationship between burnout and role characteristics as measured by the Occupational Stress Inventory (Osipow & Spokane, 1987).

Hypothesis A1. It is hypothesised that the scores of home carers on the emotional exhaustion and depersonalisation dimensions on the Maslach Burnout Inventory and the GHQ-12 will be raised compared with normative samples and that this difference will be statistically significant.

Hypothesis A2. It is hypothesised that the scores of home carers on the personal accomplishment dimension of the Maslach Burnout Inventory will be lower than that of normative samples and that this difference will be statistically significant.

Hypothesis A3. It is hypothesised that scores of home carers on the Minnesota Job Satisfaction questionnaire will be lower than those of normative samples and that this difference will be statistically significant.

Hypothesis B1. It is hypothesised that 'wishful thinking' coping as measured by the Short Form Ways of Coping Scale will show a significant moderate negative degree of correlation with the job satisfaction measure and the personal accomplishment subscale and a significant moderate positive degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

Hypothesis B2: It is hypothesised that social support based coping as measured by the OSI will show a significant moderate positive correlation with the job satisfaction measure and personal accomplishment, and a significant moderate negative degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

Hypothesis B3: It is hypothesised that 'problem-solving' coping as measured by the Shortened Ways of Coping (SWC-R) will show a significant moderate positive correlation with the job satisfaction measure and personal accomplishment, and a significant moderate negative degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

Hypothesis B4: It is hypothesised that emotional exhaustion and depersonalisation as measured on the MBI will show significant moderate positive correlation with role overload, role insufficiency, role ambiguity, role boundary, and responsibility as measured by the OSI.

Hypothesis B5: It is hypothesised that the personal accomplishment as measured on the MBI will show significant moderate negative correlation with role overload, role

insufficiency, role ambiguity, role boundary, and responsibility as measured by the OSI.

Chapter 2. Method - Procedures, Measures, Sample Description

Procedures

1. Identification of home carers

The sample used in this study were drawn from home carers working for the three social services departments in the local catchment area. Specifically, the study was interested in home carers who worked with older adults in the course of their working day. The appropriate home carer managers were contacted and informed about the nature of the present study and agreement reached to allow employees to be contacted to complete the study questionnaires. Given the large geographical patch covered by the home carers and the peripatetic nature of their work, it was decided that distribution of questionnaires would take place at staff training courses, staff meetings, and if necessary on an individual basis. The format for the group meetings included an introduction to the researcher's professional background and the reason why the study was being conducted. Respondents were asked that all questionnaires be answered anonymously to ensure confidentiality. Where questionnaires were distributed at group sessions, time was taken to discuss any questions raised about the study and issues pertaining to the difficulties attached to home care work were discussed.

Each home carer was provided with a covering letter, an information sheet, a consent form (see Appendices A, B, and C) and the study questionnaires. The consent form was not attached to the overall pack and was completed and returned immediately before the questionnaires were completed. The covering letter and associated forms were all in bilingual format as the study was carried out in an area where a large proportion of the population used Welsh as their first language. As the author was not a Welsh speaker, the research questionnaires were completed in English and in general this presented no hindrance as most home carers were proficient in English.

In addition it was acknowledged that translation into Welsh would require separate validation and reliability studies to be carried out on each measure, an exercise not practical within the time constraints of the present study.

The measures

(a) the standardised instruments.

1. Maslach Burnout Inventory (Maslach, Jackson, & Leiter 1996). The Maslach Burnout Inventory (MBI) encompasses the most commonly accepted definition of burnout. Burnout is seen to occur in phases, starting with feelings of emotional exhaustion, which produce depersonalised attitudes toward clients and then lead to a decrease in worker's sense of personal accomplishment. The purpose of using this questionnaire was to measure this particular psychological outcome of stress. The MBI comprises 22-items that are rated on a seven-point frequency of response format (see Appendix E). The scale has three separate and independent subscales. These are emotional exhaustion with 9 items, depersonalisation with 5 items, and personal accomplishment with 8 items. Subscale reliability coefficients estimated by Cronbach's coefficient alpha have been reported by Maslach and Jackson (1981) as follows: 0.90 for emotional exhaustion, 0.79 for depersonalisation , and 0.71 for personal accomplishment. The MBI has been one of the most extensively used measures in the study of stress in the helping professions and has been positively correlated with a wide range of emotional, physical and behavioural difficulties (Cordes & Dougherty, 1993).

2. Minnesota Job Satisfaction Questionnaire (Weiss, Dawis, England, & Lotquist, 1967): The brief, 20 item, version of this self-report measure was used (see Appendix F). The most often reported outcome of job based stress is an individual's lack of satisfaction with their work. The test items describe both extrinsic satisfaction

(salary, management, and supervision) and intrinsic factors to the job itself (achievement, social recognition, and responsibility) that can influence an employee's perception of their work. Each item is rated on a five point scale ranging from 'very satisfied' to 'very dissatisfied'. The internal reliability scores (Cronbach alpha coefficients) for the subscales reported in the manual were as follows, 0.84-0.91 for intrinsic satisfaction, 0.77-0.82 for extrinsic satisfaction, and 0.87-0.92 for general satisfaction.

3. The General Health Questionnaire (GHQ-12, Goldberg, 1988). The General Health Questionnaire (GHQ: Goldberg, 1972) was designed as a self administered screening test to detect mental health problems among respondents in community settings and non-psychiatric clinic settings (Goldberg & Huxley, 1980). It covers feelings of strain, depression, inability to cope, anxiety-based insomnia, lack of confidence and other psychological problems. The 12-item version of this questionnaire was used to estimate minor mental health morbidity, perceived stress and an indicator of 'caseness' (see Appendix G). The Cronbach alpha scores reported for this measure range from 0.82 to 0.90. The respondent is asked to respond to the twelve items by rating how their health has been over the previous few weeks. A four point scale is used and the 0, 0, 1, 1 scoring method is used where "better than usual" and "same as usual" are scored 0 while “less than usual” and “much less than usual” are scored 1. The number of scale items on which individuals report deterioration in their psychological state is then totalled, giving a possible scale score from 0 to 12. The scale score is then used for case classification, so the final measure is a simple dichotomy between ‘case’ or ‘non-case’. In addition the measure was used to explore the relationship between emotional distress and coping style, as well as, organisational and individual causes of stress. The GHQ was used to measure caseness in the sample since caseness predicts future psychiatric referral, and therefore absenteeism, health-related illness and dropout (Tyler & Cushway, 1992). A score of two or more was taken as the threshold for 'caseness', i.e. that scores of

two or over indicate a level of presenting symptoms that is associated with poor mental health (Goldberg & Williams, 1991).

4. Occupational Stress Inventory (Osipow & Spokane, 1987). The Occupational Stress Inventory (OSI) was selected because it measures stressors, mediators, and strain. The work role stressors measured include role overload, role insufficiency, role ambiguity, role boundary, and responsibility. The measures of emotional and physical strain include the subscales of physical environment, psychological strain, vocational strain, interpersonal strain, and physical strain. The coping strategies were measured by the recreation, self-care, social supports and rational/cognitive subscales. The inventory contains 14 subscales organised into three sections: the Occupational Roles Questionnaire (ORQ), the Personal Strain Questionnaire (PSQ), and the Personal Resources Questionnaire (PRQ) (see Appendix H). The internal reliability coefficients (cronbach alpha coefficients) were reported by Osipow & Spokane, (1987) to be .89 (ORQ), .94 (PSQ), and .99 (PRQ), while external test-retest reliability was calculated to be .90 (ORQ), .94 (PSQ), and .88 (PRQ). The test is based on the transactional model of stress (Lazarus & Folkman, 1984), where the individual's "perceptual filter" operates in a crucial way causing an event to be construed as being stressful or not (Osipow & Davis, 1988). The subscales in the occupational role questionnaire were; role overload that measures the extent to which job demands exceed resources, and the extent to which the respondent is able to accomplish expected workload; role insufficiency, measures the extent to which respondents' training, education, skills and experience are appropriate to their job; role ambiguity subscale measures the degree to which the priorities, expectations, and evaluation criteria are clear to the respondent; role boundary measures the extent to which the respondent is experiencing conflicting role demands and loyalties at work; responsibility, measures the extent to which the person has or feels a great deal of responsibility for performance and welfare of others on the job; and physical environment, measures the extent to which the respondent is exposed to high levels of

environmental toxins or extreme physical conditions. The Personal Strain Questionnaire (PSQ) contains four subscales which are organised as follows. The first subscale is vocational strain, which measures the extent to which the individual is having problems in work quality or output. Psychological strain measures the extent of psychological adjustment and/or mood problems the respondent reports. Interpersonal strain, measures the extent of disruption in interpersonal relationships with family, spouse and friends. Physical strain measures health worries and concerns, physical symptoms, and poor self-care habits. The personal resources questionnaire includes four subscales all measuring different forms of coping. Recreation measures the extent to which the respondent makes use and derives pleasure and relaxation from regular leisure activities. Self-care, measures the extent to which the respondent uses activities such as avoidance of excess alcohol and engaging in meditation or exercise to reduce stress. Social support measures the extent to which the individual feels support and help from those at work and in personal life. Finally, rational/cognitive coping measures the degree to which the individual uses a systematic approach to problem-solving work-related stressors.

5. The Shortened Ways of Coping (Revised) Questionnaire (SWC-R; Hatton & Emerson, 1995). This questionnaire is the shortened version of the Ways of Coping (Revised) Questionnaire (Folkman & Lazarus, 1988). The UK version of the WCQ-R (Knussen, Sloper, Cunningham, & Turner, 1992) consisted of 63 items representing thoughts and actions which can be used to cope with a stressful situation. Hatton & Emerson, (1995) factor analysed this test to produce a shortened version of the WCQ-R (see Appendix I). The test was designed to be quick to complete and easy to score, and sufficiently robust to show reliable associations with staff outcomes in relatively small staff groups. Earlier studies similarly produced problem-solving coping and wishful thinking coping scales (Folkman & Lazarus, 1985; Knussen, Sloper, Cunningham, & Turner, 1991; Vitaliano, Maiuro, Russo, & Becker, 1987). This measure was used in the present study to identify the pattern of thoughts and actions

used when coping with a specific stressful event. The 14 items describe strategies of coping classified as either 'problem-solving' and 'wishful thinking'. The problem solving items include both cognitive and behavioural methods to deal with the stressor. Whilst the wishful thinking items describe avoidance and denial strategies. The reported average reliability coefficients for the 'problem-solving' coping scale was 0·76, while the average reliability coefficient for the 'wishful thinking' scale was 0.65.

(b) The measures developed for the study

Demographic questionnaire.

This questionnaire was based on that used in The Claybury CPN Stress Study (Carson, Fagin, & Ritter, 1995), and provided information on age, marital status, length of professional experience and length of stay in current post, qualifications held, client caseload, sense of job security, managerial support, quality and frequency of supervision. A copy of this questionnaire is included in Appendix J.

Sample description

A total sample of 59 female paid home carers employed by three social service departments volunteered to fill in questionnaires; they represented approximately 10% of the targeted population of home care staff working with older adults. The sample fell within three broad age bands, 2 (3 per cent) were 30 years old and under, 45 (76 per cent) were between 30 and 50 years and 12 (21 per cent) were over 50 years. The sample had a mean age of 44 years. Except for three respondents all primarily worked with older adults. Those married were in the majority 47 (79 per cent) with 66 per cent (39) living with dependants at home. The number of years in post ranged from one year to twenty three years. Within the sample 64 per cent had

five years in post or more. Only three of the sample had worked in post for one year or less. The average number of clients for the sample was 12, with 75 per cent of the sample having 6 clients or more.

Table 2.1 Personal demographics for home carers (n=59)

			n	per cent
Age	Mean 44 years			Range 26-62
	30 years and below		2	(3 per cent)
	30 to 50 years		45	(76 per cent)
	50 years and above		12	(21 per cent)
Marital status	Single		4	(7 per cent)
	Married		47	(79 per cent)
	Living with partner		4	(7 per cent)
	Separated/Widowed		4	(7 per cent)
Dependants	Children at home		39	(66 per cent)
	No children at home		22	(34 per cent)
Primary client group	Older people		56	(96 per cent)
	Learning Disability		2	(2 per cent)
	Physical Disability		1	(2 per cent)
Years in job	Mean = 8	Range	1-23	
	1-5		28	(48 per cent)
	6-10		14	(238 per cent)
	11-15		10	(17 per cent)
	16-23		7	(12 per cent)
Caseload	Mean = 12	Range	1-240	
	1-5		15	(25 per cent)
	6 -10		28	(48 per cent)
	11 -15		13	(22 per cent)
	18+		3	(5 per cent)

Chapter Three: RESULTS

The results are organised in two sections:

SECTION A:

This section is organised as follows.

1. The stress outcome measure scores for home carers are compared with normative samples reported in the test manuals and from previous research.

2. The statistical analyses carried out to test the hypotheses concerned with predicting a relationship between coping strategies and measures of job strain are reported.

3. Report of the analysis carried out to assess the relationship between the Maslach measure of burnout and measures of job stressors in the OSI.

SECTION B:

This section will include the findings from the open-ended questions and biodata questions contained in the demographic questionnaire.

<u>SECTION A:</u>

Hypothesis A1. It is hypothesised that the scores of home carers on the emotional exhaustion and depersonalisation dimensions on the Maslach Burnout Inventory and the GHQ-12 will be raised compared with normative samples and that this difference will be statistically significant.

Hypothesis A2. It is hypothesised that the scores of home carers on the personal accomplishment dimension of the Maslach Burnout Inventory will be lower than that of normative samples and that this difference will be statistically significant.

Hypothesis A3. It is hypothesised that scores of home carers on the Minnesota Job Satisfaction questionnaire will be lower than those of normative samples and that this difference will be statistically significant.

These hypotheses were tested by examining the differences between the means of the home carer sample and the normative samples. The MBI norm was all-female and drawn from a wide range of occupations within the general area of the caring occupations. The normative sample used for the Minnesota Job Satisfaction scale was a general population group separate norms for male and female workers were not available. Independent t-tests for samples of unequal size (Howell, 1997) were carried out and the results are shown in Table 3.1.

Table 3.1 Sample Means compared with Norm Means for MBI, and Minnesota Job Satisfaction scale

	Home Carers		Normative Data		
	Mean	SD	Mean	SD	t
Emotional exhaustion	12.95	10.13	20.99	10.66	-5.32**
Personal accomplishment	34.52	6.95	36.5	6.56	-2.30*
Depersonalisation	3.86	7.1	7.02	6.36	-3.8**
Intrinsic Satisfaction	47.88	5.4	47.14	7.42	.77
Extrinsic Satisfaction	21.52	3.65	19.99	4.78	2.45*
Total Job satisfaction	77.52	7.83	74.85	11.92	1.71

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

The results show that on the emotional exhaustion and depersonalisation scales the home carer group means were lowered at statistically significant levels when compared to normative data . This result was not anticipated by hypothesis A1. On the personal accomplishment dimension the home carer group mean was lowered at statistical significance when compared to normative data. Therefore hypothesis A2 was supported. With the three job satisfaction scores, it was hypothesised that home carer scores would be significantly reduced compared with normative samples. The results did not support this hypothesis. It was found that the job satisfaction measures for the home carers were raised when compared to normative data, and this was statistically significant for extrinsic job satisfaction. Extrinsic job satisfaction includes salary, status and supervision, whilst intrinsic factors include sense of achievement, recognition, and responsibility. In summary, the results did not lend support for hypotheses A1 and A3 but did in the case of hypothesis A2.

To determine whether differences in observed GHQ-12 case rates between the home carer sample and a large NHS sample (Borrill et al., 1996) were statistically reliable, a simple test for the significance of the difference between proportions (i.e. chi-square) was applied. The results showed that the case rate for home carers of 7% was considerably lower (chi-squared (4, $\underline{N} = 984$) = 19.4, $p < .0001$) than that of the NHS sample. This result did not offer support for hypothesis A1. Quite clearly, the percentage of cases in the present home carer sample is substantially lower than that of NHS care staff (see Table 3.2). The NHS sample included mainly general nurses. By means of further comparison, the British Household Panel Survey (Taylor, Brice, Buck, Prentice-Lane, 1998) indicates a caseness of 30.1% for adults in the general community (see Appendix P). Therefore the home carer sample have substantially lower case rates, than both these samples.

Table 3.2. A comparison of GHQ-12 caseness levels from the BHPS, the NHS sample, and the home carer sample.

Source	Status	Sample Size	per cent caseness
BHPSa	Employed	9,275	30.1%
NHS	Employed	4,087	28.5%
Home Carers	Employed	59	7%

Note: The cut off point for caseness was a score of two or over.

a British Household Panel Survey, 7th Wave data, 1997-1998.

Hypothesis B1. It is hypothesised that 'wishful thinking' coping as measured by the Short Form Ways of Coping Scale will show a significant moderate negative degree of correlation with the job satisfaction measure and the personal accomplishment subscale and a significant moderate positive degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

In order to test this hypothesis sample scores on the wishful thinking subscale on the Shortened Ways of Coping (SWC-R) were correlated with the three burnout measures, three job satisfaction scores and the GHQ-12. Pearson correlations were calculated using the SPSS computer package and the results are presented in Table 3.2. A moderate correlation was defined as, between r=0.40 and r=0.69, whilst .20 to .39 is low, and .7 to .89 is high (Cohen and Holliday, 1982).

Table 3.3

Pearson correlation coefficients between "wishful thinking" subscale and job satisfaction subscales , burnout subscales and GHQ-12 (N=42)

	Wishful Thinking Subscale
1. Emotional exhaustion	.46**
2. Depersonalisation	.47**
3. Personal accomplishment	-.14
4. Intrinsic job satisfaction	-.18
5. Extrinsic job satisfaction	-.36**
6. Total job satisfaction	-.29*
7. GHQ-12	.29*

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

As presented in Table 3.3, positive statistically significant moderate correlations were found between 'wishful thinking' and emotional exhaustion and depersonalisation. A low negative correlation was found with the personal accomplishment dimension, although the direction of the correlation was as predicted in the hypothesis the result was not statistically significant. With the three job satisfaction scores, three low negative correlations were found, with the correlations between extrinsic satisfaction, and total satisfaction at statistical significance. However, none of these correlations were in the moderate range. The GHQ-12 and wishful thinking were found to show a low positive correlation which was statistically significant. These results were supportive of the hypothesis in terms of the direction of correlation predicted, however only the correlations with emotional exhaustion and depersonalisation were in the moderate category.

Hypothesis B2: It is hypothesised that social support based coping as measured by the OSI will show a significant moderate positive correlation with the job satisfaction measure and personal accomplishment, and a significant moderate negative degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

Hypothesis B3: It is hypothesised that 'problem-solving' coping as measured by the Shortened Ways of Coping (SWC-R) will show a significant moderate positive correlation with the job satisfaction measure and personal accomplishment, and a significant moderate negative degree of correlation with emotional exhaustion, depersonalisation and GHQ-12.

To test these hypotheses Pearson correlations were carried out using the statistical package of SPSS. Scores for social support coping as measured by the OSI, and problem-focused coping as measured by the short-form Ways of Coping was used.

Table 3.4

Pearson correlation coefficients between Social Support coping and Problem-solving and job satisfaction subscales , burnout subscales and GHQ-12 (N=59)

	Social Support	Problem-solving
1. Emotional exhaustion	-.32*	.11
2. Depersonalisation	-.26*	.03
3. Personal accomplishment	.15	.24
4. Intrinsic job satisfaction	.38**	.23
5. Extrinsic job satisfaction	.23	-.14
6. Total job satisfaction	.37**	.05
7. GHQ-12	-.11	.12

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

The correlations between social support coping and the outcome measures as shown in Table 3.4 were in the direction predicted in hypothesis B2. In addition, the correlations all reached statistical significance with the exception of personal accomplishment and GHQ-12. However, none of these correlations were in the moderate range and therefore the hypothesis was not fully supported. The correlations carried out to test hypothesis B3 indicated no statistical significant moderate correlations between problem-based coping and the outcome measures, and therefore this hypothesis could not be supported.

The next two hypotheses were concerned with the relationship between the MBI and role stressor subscales of the OSI.

Hypothesis B4: It is hypothesised that emotional exhaustion and depersonalisation as measured on the MBI will show significant moderate positive correlation with role overload, role insufficiency, role ambiguity, role boundary, and responsibility as measured by the OSI.

Hypothesis B5: It is hypothesised that the person accomplishment as measured on the MBI will show significant moderate negative correlation with role overload, role insufficiency, role ambiguity, role boundary, and responsibility as measured by the OSI.

In order to test these hypotheses further Pearson correlations were carried out using SPSS. Scores for job stressors as measured by the OSI and the three measures of burnout were correlated.

Table 3.5

Pearson correlation coefficients between job stressors as measured on the OSI and burnout subscales (N=59)

	RO	RI	RA	RB	R
1. Emotional exhaustion	.46**	.34**	.21	.13	.34**
2. Depersonalisation	.30*	.21	.26*	.32*	.40**
3. Personal accomplishment	-.02	-.16	-.36**	-.47**	.20

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

Key

RO	Role Overload	RI	Role Insufficiency	R	Responsibility
RA	Role Ambiguity	RB	Role Boundary		

As presented in Table 3.5 positive correlations at statistically significant levels were found between role overload, role insufficiency and work-based responsibility and emotional exhaustion. However, only the correlation between role overload and emotional exhaustion reached the criteria for moderate correlation. Non significant low positive correlations were found for both role ambiguity and role boundary. With the depersonalisation dimension, statistically significant positive correlations were found with role overload, role ambiguity and role boundary. Of these only the correlation with responsibility was within the moderate range. Finally, statistically significant negative correlations were found between personal accomplishment and both role ambiguity and role responsibility. The correlation with role boundary was the only moderate correlation found.

On the basis of the correlations carried out to test hypotheses B1to B5, it was evident that the burnout variables were significantly related to specific coping strategies and

stressors. To explore in more detail the relative contributions of these coping strategies and work stressors to burnout, multiple regressions were carried out. In view of the sample size it would have been inappropriate to include more than six variables in any one model, and so separate analyses were carried out for coping and work stressors (see Appendices K and L). Only variables contributing significantly to those equations were entered to the final model. The results from the two sets of multiple regressions indicated that role overload, role insufficiency, wishful thinking, and self-care were the best predictors of emotional exhaustion. For depersonalisation the best predictors were role boundary, responsibility, and wishful thinking, and for personal accomplishment the best predictors were role boundary and responsibility with none of the coping variables contributing. To further examine these results, three further multiple regressions were carried out one for each subscale on the MBI. The aim of this analysis was to find which factors remained significant when the coping and stressor factors were entered together, and therefore help develop a model of how these factors relate to each other.

Table 3.6

Summary of Multiple Regression Analysis Showing the Effect of role overload, role insufficiency, wishful thinking and self-care on Emotional Exhaustion (N=59)

Variable	**b**	**R-square change**	**p value**
Emotional Exhaustion			
Wishful Thinking	.46	.20	.0002**
Role Overload	.34	.10	.0000***
Self Care	-.25	.06	.0000***
Model F	11.73	p<.0000	
Multiple R	.62		
Unadjusted R Square	.39		
Adjusted R Square	.36		

Variable not in equation: role insufficiency.

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

The results as presented in table 3.6, indicate that the main contributors to variance in emotional exhaustion were role overload, wishful thinking and self-care (negatively). Therefore of all the job demands role overload, is the most significant predictor of emotional exhaustion, and that the self care coping style and wishful thinking were the most significant moderators either in terms of becoming emotionally exhausted or not. The remaining multiple regressions carried out indicated that for depersonalisation, wishful thinking, responsibility and role boundary were the main contributors to variance (see Appendix M). As reported earlier, none of the coping subscales contributed to the variance in personal accomplishment and role boundary and responsibility were the two work stressors that were entered in the final equation (see Appendix L).

Finally a similar analysis was carried out for job satisfaction which showed that role overload and role boundary were seen to be the main contributors to job satisfaction variance, with social support excluded from the final equation (see Appendix N).

SECTION B:

This section of the results will present tables illustrating the findings from the demographic questionnaire with preliminary discussion of the home carer sample responses to the specific questions.

Table 3.7

The most stressful aspects of the job as a home carer (Q13)

		n	% of Home Carers reporting the item
1	Time constraints	29	49%
2	Difficult clients	18	30%
3	Rushing around	10	17%
4	Working weekends/evenings	9	15%
5	Lack of support	5	8%
6	Being punctual	5	8%
7	Lack of communication/Information	4	6%
8	Worrying about clients	4	6%
9	Difficult relatives	4	6%
10	Death of client	4	6%
11	Terminally ill client	2	3%
12	No response	6	10%

The responses presented in Table 3.7 were in response to question 13 of the home carers questionnaire (see Appendix) and were ranked in order of the frequency by which they were used. Respondents were asked to provide three examples of the most stressful aspects of the job. As may be seen in the table, six respondents offered no responses, while nine offered one, 16 offered two responses, and 29 provided three responses. The most stressful aspects of their work given, describe the pressures they experience in carrying out their job. For example, having insufficient time to do the job and needing to rush around are clearly related and would suggest a job that is both demanding, in terms of workload and frustrating, in terms of having to limit time with each clients. Difficulties with clients were also described underlining the importance for providing supervision and support at work. The remaining stressors described were at relatively low frequencies but were nonetheless of interest in highlighting difficulties encountered in such work. It was anticipated that a greater number of stressors might have been generated at higher frequencies. This response pattern

could be interpreted to show that as a sample this group of home carers do not encounter what they perceive to be a large number of stressful events in their job.

Table 3.8

The most stressful event to have happened in the past month (Q14)

		n	% of Home Carers reporting the item
1	Ill client	8	13%
2	Difficult client	8	13%
3	Death of client	4	7%
4	Change of rotas	2	3%
5	Dependent clients	2	3%
6	Finding cover	1	2%
7	Nothing stressful encountered	13	22%
8	No response	18	30%

The categories presented in Table 3.8 were in response to question 14, which asked the respondent to recount the most stressful event that had happened over the past month (see Appendix J). The responses were also ranked in order of the frequency by which they were reported. The response rates to this question may be categorised as follows, 30% (18) of the sample did not respond to this question, whilst those that did 22% (13) stated that they had not encountered a stressful event in the past month. This might be for a number of suggested reasons. Firstly, perhaps respondents did not choose to repeat answers given for the previous question 13. Secondly, respondents may not have thought the question relevant because many had a relatively stress free month. Finally, perhaps the time constraints of the study did not

allow them to reflect on the question. Those that did respond indicate that welfare of clients had been a source of stress over the previous month and that organisational issues such as finding cover when on leave or through ill health was a source of difficulty.

Table 3.9 Home Carers favoured coping strategies (Q15)

		n	% of Home Carers reporting the item
1	Sport/Hobbies/interests	16	27%
2	Support from colleagues	15	25%
3	Family support	12	20%
4	Tea/coffee breaks	5	8%
6	Being of help to client	5	8%
7	Support from manager	1	2%
8	No response	10	16%

The results for this question support the results in Tables 3.4 where Social Support coping was correlated negatively with indices of strain, indicating significant negative correlations. Respondents were asked to describe what helps them cope with work pressures. From the responses given, it is clear that social support from family, friends and colleagues is an important stress moderator. Recreational activities are also frequently used ways to deal with stress for example, hobbies and interests are used by 27% (16) and taking breaks at work are used by 8%. No mention was made of using problem-solving strategies or indeed avoidance type tactics. This does not mean these strategies are not used rather these strategies are not considered to be their favourite ones.

Table 3.10 Methods of reducing stress reported in the demographic questionnaire for Home Carers

	n	Per cent of sample
Cigarettes		
None	37	(63%)
1<10	7	(12%)
11-20	15	(25%)
20+	0	(0%)
Alcohol consumption		
Never	12	(20%)
Occasionally	43	(71%)
Up to three units per day	3	(7%)
Three or more units per day	1	(2%)
Colleague support		
Yes	56	95%
No	3	5%
Managerial support		
Very supportive	19	32%
Supportive	36	61%
Unsupportive	3	5%
Very unsupportive	1	2%

The results presented in Table 3.10 indicated that the home carers in this sample were health conscious with 62.7% not smoking, 91% drinking alcohol on occasion or

never, while sick leave was taken by 51% over the past year. Of significance, was the 94.9% who felt able to discuss work difficulties with a colleague and 92% found management supportive, once again underlining the use of support for this group.

Table 3.11 Indicators of stress in the home carer sample.

	per cent of Home Carers	n
Self-rating of fitness		
Excellent	15%	(9)
Good	71%	(42)
Fair	12%	(7)
Poor	2%	(1)
Satisfaction with life		
Very Happy	27%	(16)
Happy	54%	(32)
Neither happy or unhappy	19%	(11)
Unhappy	0%	
Very Unhappy	0%	
Job security		
Yes	48%	(28)
No	52%	(31)
Absence from work during the past year		
None	51%	(30)
1-10 days	30%	(18)
11-20 days	19%	(11)
20+ days	0%	

In common with findings presented in the previous section, Table 3.11 shows responses that would indicate a sample of home carers that are positive about their fitness levels and happy with their lives. The issue of job security was almost evenly divided between those that feel secure and those that do not, possibly reflecting different contractual agreements between districts sampled and the general change in work culture throughout health services and social services.

Table 3.12 Results on the OSI for the home carer sample.

	Mean	SD	Range	Percentile rank
Role Overload	25.20	6.38	11-46	61 percentile
Role Insufficiency	23.12	7.29	10-40	38 percentile
Role Ambiguity	21.07	6.87	10-37	67 percentile
Role Boundary	21.07	6.89	10-38	48 percentile
Responsibility	21.08	6.24	10-39	37 percentile
Physical Environment	18.81	5.54	10-33	62 percentile
Vocational Strain	16.22	5.41	10-38	35 percentile
Psychological Strain	17.14	6.04	10-38	29 percentile
Interpersonal Strain	19.27	6.49	10-38	42 percentile
Physical Strain	18.54	7.71	10-42	40 percentile
Recreation	25.61	7.28	12-45	40 percentile
Self-care	23.07	5.52	8-38	31 percentile
Social support	39.31	7.69	15-50	38 percentile
Rational/Cognitive	32.85	7.34	16-47	28 percentile

The results presented in Table 3.12 include home carer sample means for each of the subscales on the OSI compared to the OSI female norm group. The results highlighted that specific stressors were endorsed by the sample such as Role Overload, Role Ambiguity, and Physical Environment. This could be interpreted to mean that for this group the role of the home carer is characterised by a high

workload, a remit that is not clearly defined, and that the work environment is often physically demanding. Whilst these are the main work demands endorsed by the sample, it is interesting to see that the strain measures are all at below average levels, and that coping strategies as described on this measure are also in the below average range, when compared to the relevant norm group. These results might indicate that although the sample have work stressors they do not lead to strain for the majority of the group.

Chapter Four: DISCUSSION

Principal findings

This section will discuss the main findings including any clear associations and differences found and those that were less clear.

The first findings were those concerned with the stress outcome measures of the home carer group compared to the relevant normative samples on these measures. It was hypothesised that in comparison to normative data the home carer group would have significantly lower job satisfaction scores and higher mean scores on the burnout dimensions except for personal accomplishment where it was predicted that the group would have lower scores.

The results showed that compared to normative samples, the home carers mean scores on emotional exhaustion and depersonalisation, were significantly lower. This result might indicate a group of workers that are not reporting the signature symptoms of burnout. The group was also lower on personal accomplishment than the norm group, indicating that lower levels of emotional exhaustion or depersonalisation does not necessarily lead to a work group that is high on personal accomplishment. These results at first sight appear to show how unstressed this group is but in another study using the same measure with a group of home carers similar low levels of burnout were found (Lintern, 1999). This raises the possibility that the general US norms underestimate burnout in this UK population (see Appendix O).

With extrinsic job satisfaction the home carers had higher scores when compared to normative data at statistically significant levels. Extrinsic job satisfaction includes salary, status and supervision. For intrinsic job satisfaction which includes factors such as sense of achievement, recognition, and responsibility, the home carer group

mean was the same as the norm group. These results are surprising that in this field extrinsic satisfaction is raised whilst intrinsic satisfaction is not.

When caseness levels on the GHQ-12 were compared with a large NHS sample (Borrill et al., 1996) and a general community sample (Taylor, Brice, Buck, Prentice-Lane, 1998), the case rate for home carers of 7% was considerably lower than both samples. These results further highlighted the lack of reported strain in the home carer sample.

In order to assess the relationships between coping and the outcome measures of burnout, job satisfaction, and psychological health, a series of correlations were carried out. The results indicated that 'wishful thinking' was significantly positively correlated with emotional exhaustion and depersonalisation, and GHQ-12, and significantly negatively correlated with extrinsic job satisfaction. Although these correlations were significant only the burnout correlations were in the moderate range. These results are supported in the literature, where avoidant coping strategies as described in the 'wishful thinking' items, are associated with worse mental illness in health professionals (Ingledew, Hardy, & Cooper, 1997; Spelten, Smith, Totterdell, Barton, & Folkard, 1993; Tyler & Cushway, 1992).

In summary, these results were supportive of the hypothesis insofar as direction of correlation predicted, however only the correlations with emotional exhaustion and depersonalisation were in the moderate category.

The correlations between social support coping and the outcome measures as shown in Table 3.4 were in the direction predicted in hypothesis B2. In addition, the correlations all reached statistical significance with the exception of personal accomplishment and GHQ-12. However, none of these correlations were in the moderate range and therefore the hypothesis could not be fully supported. These

results are supported by research where social support has been identified as a moderator between job-related stressors and strain, by helping the individual redefine the potential harm of the situation, and creating the belief that difficulties can be overcome with support from others (Cherniss, 1980; Cordes & Dougherty, 1993). Social support has also been found to be positively related to psychological and physical health, irrespective of the presence or absence of life or work stressors (Dignam, Barrera, & West, 1986).

The correlations carried out to test hypothesis B3 indicated no statistical significant moderate correlations between problem-based coping and the outcome measures. Such a result is inconsistent with the literature where problem-focused coping has been found to moderate the relationships between work stress and emotional exhaustion, depersonalisation and serious illness (Bhagat, Allie, & Ford, 1995).

The correlations were carried out to examine how work demands contributed to burnout in the sample. Positive correlations at statistically significant levels were found between emotional exhaustion and role insufficiency, work-based responsibility and role overload. Positive correlations were also found between depersonalisation and role overload, role ambiguity, role boundary and responsibility (moderate range). Finally, statistically significant negative correlations were found between personal accomplishment and both role ambiguity and role responsibility. The correlation with role boundary was the only moderate correlation found. These findings are supprted by other studies where work demands, such as role insufficiency and role ambiguity accounted for a significant amount of variance in the emotional exhaustion and depersonalisation dimensions in various occupational groups (Schwab & Iwanicki, 1982; Brookings, Bolton, Brown, & McEvoy, 1985; Jackson, Schwab, & Schuler, 1986).

The results from the multiple regressions carried out indicated that the main contributors to variance in emotional exhaustion were role overload, wishful thinking and self-care. Therefore of all the job demands, role overload is the most significant predictor of emotional exhaustion, and that the self care coping style and wishful thinking were the most significant moderators either in terms of becoming emotionally exhausted or not. The remaining multiple regressions indicated that wishful thinking, responsibility and role boundary were the main contributors to variance in depersonalisation (see Appendix K). As reported earlier, none of the coping subscales contributed to the variance in personal accomplishment and role boundary and responsibility were the two work stressors that were entered in the final equation (see Appendix M). Finally, none of the stressors contributed at significant levels to the variance in GHQ-12. However, this result might have been anticipated given that only four of the sample reached 'caseness' on the GHQ-12.

In the second multiple regression, role boundary, role overload and 'social support' coping contributed most to the variance in job satisfaction. When these three factors were entered into a further multiple regression, social support was partialled out.

Findings from Demographic Questionnaire

The responses from the demographic questionnaire are largely supportive of the statistical results. The most stressful aspects of the job were evenly divided between client related factors and organisational issues. However, when the frequencies were taken into account, organisational issues represented the more stressful parts of the home carer role, in particular having insufficient time to do what was required on the job. When asked to report on the stressful events that had occurred in the previous month, the most striking result was that 22% of the sample had not encountered any stressful event and 30% did not offer any response. Of those that responded client issues including illness, death, and difficult client behaviour all featured as stressful

events. The coping strategies listed by the sample were largely either social support or recreational. Social support coping may be the key to explaining how low levels of reported strain in this group and reported work stressors can co-exist. Social support has been found to work both directly on strain and as a buffer between stressors and strain (Cordes & Dougherty, 1993). In addition, it has been found that different types of social support play distinct roles (Leiter, 1990, 1991). For example, professional support was found to lead to raised feelings of personal accomplishment whilst being positively related to emotional exhaustion. Family support was found to be negatively related to emotional exhaustion and depersonalisation, whilst organisational support was negatively related to depersonalisation and diminished personal accomplishment. Finally, co-worker support was negatively related to depersonalisation and positively related to personal accomplishment. Clearly, the relationship between support and strain is complex, not only are the sources of support differentially effective on burnout components, but they may have a negative impact. In a future study of home carers this issue might be explored with a more detailed analysis of this construct.

The home carers were asked questions about the common methods of reducing stress. The responses indicated that alcohol and smoking are not used, whilst managerial and peer support are used by at least 95% of the sample. The perceived well-being of the sample is borne out in the low reported sick leave rate and the high satisfaction rating with life. The finding that the home carer sample are not experiencing stress is not unique, Wilber and Specht (1994) found with their sample of paid caregivers, that in contrast to expectations, carers found working with functionally impaired elders did not lead to job dissatisfaction and burnout, rather interaction with clients was overwhelmingly perceived to be the most rewarding aspect of the work.

Finally, any synopsis of results like these deals with the responses that are for the majority of the group. This overlooks the home carers in this sample who are having

difficulty at work, for example group means for the OSI subscales of role overload, role ambiguity and physical environment were above the 60th percentile and four of the home carers were at GHQ caseness levels.

The remainder of this discussion considers the limitations of the study and issues associated with the individual measures. It also considers theoretical and other outstanding issues and concludes with a discussion of possible future research directions and clinical implications of the results.

Limitations and Methodological issues.

Although the home carers shared a common job description, they could not be described as homogeneous. For example, they worked in different geographical areas including both rural and urban communities, they had different managers with a different managerial style, they worked with different client numbers, and some worked with a range of clinical populations not exclusively older adults.

Participation in the study was on a voluntary basis and inevitably there was bias in how homecarers were recruited. Some of the sample were recruited from a group of home carers attending a course to raise awareness of dementia care. The home carers attending a dementia care training course do not necessarily represent the home carer population because attendance to the course was voluntary and only those with a special interest in developing further skills in working with older people with dementia will have participated. Others in the sample were randomly selected using their employee number. They were sent an information sheet giving background information to the study and a consent form. This approach yielded a small response rate, 5 out of 200 home carers, and clearly could not be considered representative of the home carers working in that area. Additionally, there is a selection effect in trying to measure stress in employees where this is a real problem, called "healthy worker

effect", (Frese & Okonek, 1984). That is, stressed workers are often absent through illness, may not be motivated to participate, or retire sooner. Therefore they are potentially under-represented in the sample. What may in fact happen is that only motivated, satisfied, and emotionally healthy workers participate in the sudy. Another explanation might be that home carers in the catchment area of this study are not feeling stressed and have no issues to raise. Perhaps, the low emotional exhaustion and depersonalisation scores are in some respect indicative of overall low burnout scores in this occupational group and therefore completing questionnaires about stress is not seen as relevant.

Another factor relates to defensive answering described by Firth-Cozens (1997), where care workers were found to under-report work overload to mask stressors which are actually much more anxiety-provoking, such as death, suffering and intimacy. If accepted the assessment of stress in health workers highlights the difficulty in attempting to measure and identify job-related stressors. The recommendation is that the researcher needs to be aware of defensive answering on the part of the employee when analysing results (Firth-Cozens & Morrison, 1989). The possibility of defensive answering by the present sample of home carers needs to be acknowledged.

As this was a cross-sectional study taking a snapshot of a sample of home carers at a specific point in time, and as the reaction to stress can take different courses, and develop on an individual level, stress levels in any group may not fully represent the true nature of stress at work.

The time it took to complete the questionnaires varied across individuals, indeed for some completing the questionnaires represented an arduous and lengthy task. The possibility that fatigue may have played a part in how some responded to the questionnaires was acknowledged. A pilot study would have highlighted this as a

potential issue and steps might have been taken to avoid this situation. In general, qualitative methodology might have been helpful in selecting questionnaires. For example, a series of group discussions with home carers may have highlighted home carer concerns. Questionnaires could then have been selected to assess these concerns. Instead questionnaires were selecteted on the basis of previous research and what the researcher viewed as being pertinent.

The open-ended questions in the home carers questionnaire were not completely responded to by many of the group (25%). This might suggest that the time pressures on completing the questionnaires did not allow for enough time to consider these questions fully.

The language used in some of the questionnaires had an American bias and required some clarification for some of the respondents. In the case of one particular group Welsh was the first language of choice and there was some confusion over the meaning of some items. One respondent indicated how she had to translate the meaning of some of the items in her mind in order to understand them, thus finding the task quite difficult and frustrating.

Although, the home carers were informed that the item responses were to reflect their attitudes to their work, it would be difficult to prise apart whether measured stress was as a result of experienced work stress or that other life events were an alternative factor.

In addition not all of the home carers worked exclusively with older adults with or without dementia. Although a proportion of each home carer was with this client group the caseload was varied and therefore it could not be concluded which client group caused the most stress.

As a further development of this point, it was recognised that the psychological and physical ill-health associated with strain is a multiply determined variable. The work situation can only ever be one of the many areas of life which have an influence on the development of ill-health. Additionally, biological factors and early life experiences also contribute to dysfunctioning. Therefore, even if significantly low correlations are found between stressors at work and ill-health this should not lead us to undervalue such results because the workplace is only one source of stress in the life of people.

The average age might be a factor in the results found. The average age of the home carers was 44 years, with 76% of the sample aged between 30 and 50 years. For example, Tyler and Cushway (1998) reported how the older workers experienced lower demands from difficulties with clients, organisational structure, relationships with other professionals, lack of resources and self-doubt, and higher job satisfaction and greater mental well-being.

The strong association between emotional exhaustion and the role demand subscales on the OSI may be partly attributed to a measurement artifact. Three of the emotional exhaustion items on the MBI (i.e., "I feel emotionally drained from my work", "working with people directly puts too much stress on me", and "Working with people all day is really a strain for me") are direct measures of individual stress reactions. In fact, these items correspond closely to items that tap perceived stress found in the items on the role subscales.

Another limitation is that only certain demands and resources were examined here. The fact that emotional exhaustion was strongly associated with many of the correlates does not in itself signify an absence of other correlates that may be more strongly associated with the other two dimensions of burnout.

For future research I would consider using groups that were more homogeneous in terms of assigned client group, and compare stress levels between groups. This would provide a further frame of reference to make sense of the results for the home carer group working with older people.

The study was aware of the difficulty of assessing all work-based stressors and that this can lead to underrepresentation of stressors. However, measuring as many stressors as possible may increase burden on subjects and act as a disincentive to complete.

Clinical implications.

Clinical psychology has much to contribute to the treatment of stress in the workplace. This contribution may be put into context by examining the categories proposed by Beehr and Franz (1987), who proposed four categories corresponding to the professions that would usually intervene in this area. The clinical psychology approach, focuses on stressors in the work environment and on the psychological strain these cause (e.g. depression or anxiety), and offers either one-to-one or group treatment. By contrast, the medical approach provides physical treatment of strain in the individual whilst engineering psychology will recommend redesigning the physical work environment according to ergonomic principles. Finally, the occupational psychology approach identifies stressors in the psychological environment, focusing on psychological strain responses in the employee, and recommending change to the employees' organisational environment.

In clinical psychology the potential contribution to staff based stress management programmes has not been fully recognised, its development may depend among other constraints on the willingness of the profession to develop a consulting role (Øvretveit, Brunning & Huffington, 1992). This consulting role places clinical

psychologists in a prime position to provide a stress management service that could serve the dual function of helping staff manage and reduce stress in tandem with finding organisational problems across a wide range of departments, services and occupations (Michie, 1993). From the earlier review, it is clear that stress involves a complex relationship between individual and organisational factors leading to both physical and/or psychological pain. In some cases the environment may not in itself cause stress but the person may still experience strain. In these instances the source of the stress may be the individual. That could be because they may set themselves high work standards that are difficult to achieve and feel they have failed when not attained. Traditionally, the clinical psychologist has focused on such cases working at an individual level of stress whilst the occupational psychologist worked more at the organisational level (Cooper, 1987). Increasingly, the need for both perspectives to be used together is being called for and perhaps as a profession clinical psychology is better equipped to do just that.

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Appendix D

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Appendix F

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Appendix H

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Appendix I

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Appendix K

Summary of Multiple Regression Analysis Showing the Effect of Role Ambiguity, Role Insufficiency, Role Boundary, Responsibility and Role Overload on Mean GHQ, Job Satisfaction and Burnout (N=59)

Variable	**b**	**R-square change**	**p value**
GHQ-12			
Role Overload	.24	.04	.06
Model F	3.59	p>.05	
Multiple R	.24		
Unadjusted R Square	.05		
Adjusted R Square	.04		

Variables not in equation: role boundary, responsibility, role insufficiency, role ambiguity.

Variable	**b**	**R-square change**	**p value**
Job Satisfaction			
Role Boundary	-.49	.32	.0000****
Role Overload	-.23	.03	.04*
Model F	17.099	p<.0000	
Multiple R	.61		
Unadjusted R Square	.37		
Adjusted R Square	.35		

Variables not in equation: role boundary, responsibility, role insufficiency, role ambiguity.

Variable	b	R-square change	p value
Emotional Exhaustion			
Role Overload	.39	.20	.0022**
Role Insufficiency	.21	.02	.08
Model F	9.48	p<.0003	
Multiple R	.5		
Unadjusted R Square	.25		
Adjusted R Square	.22		

Variables not in equation: role boundary, responsibility, role ambiguity.

Variable	b	R-square change	p value
Personal Accomplishment			
Role Boundary	-.52	.21	.0000****
Responsibility	.29	.07	.01**
Model F	12.53	p<.0000	
Multiple R	.55		
Unadjusted R Square	.30		
Adjusted R Square	.28		

Variables not in equation: role overload, role insufficiency, role ambiguity.

Variable	b	R-square change	p value

Depersonalisation

Responsibility	.35	.15	.0042**
Role Boundary	.25	.05	.03*

Model F	8.22	p<.0007
Multiple R	.47	
Unadjusted R Square	.22	
Adjusted R Square	.2	

Variables not in equation: role overload, role insufficiency, role ambiguity.

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

Appendix L

Summary of Multiple Regression Analysis Showing the Effect of Coping as measured by the OSI and The Shortened Ways of Coping(SWC-R) on Mean GHQ, Job Satisfaction and Burnout (N=59)

Variable	**b**	**R-square change**	**p value**
Job Satisfaction			
Social Support	.37	.12	.003
Model F	9.07	p<.01**	
Multiple R	.37		
Unadjusted R Square	.13		
Adjusted R Square	.12		

Variables not in equation: wishful thinking, self-care, problem-solving, rational-cognitive, recreation.

Variable	**b**	**R-square change**	**p value**
Depersonalisation			
Wishful Thinking	.47	.21	.0001
Model F	16.72	p<.0001****	
Multiple R	.47		
Unadjusted R Square	.22		
Adjusted R Square	.21		

Variables not in equation: social support, self-care, problem-solving, rational-cognitive, recreation.

Variable	b	R-square change	p value
Emotional Exhaustion			
Wishful Thinking	.37	.20	.0001
Self-Care	-.26	.06	.02
Model F	11.24	p<.0001****	
Multiple R	.53		
Unadjusted R Square	.28		
Adjusted R Square	.26		

Variables not in equation: social support, problem-solving, rational-cognitive, recreation.

Variable	b	R-square change	p value
Personal Accomplishment			

No variables entered or removed in this equation.

Variable	b	R-square change	p value
GHQ12			
Wishful Thinking	.29	.07	.02
Model F	5.61	p<.05*	
Multiple R	.29		
Unadjusted R Square	.08		
Adjusted R Square	.07		

Variables not in equation: social support, self-care, problem-solving, rational-cognitive, recreation.

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

Appendix M

Summary of Multiple Regression Analysis showing the effect of responsibility, role boundary, wishful thinking on Depersonalisation (N=59)

Variable	**b**	**R-square change**	**p value**
Depersonalisation			
Wishful Thinking	.48	.21	.0001**
Responsibility	.38	.06	.05*
Role boundary	.19	.03	.09
Model F	9.14	p<.0001	
Multiple R	.57		
Unadjusted R Square	.33		
Adjusted R Square	.30		
Variable not in equation:			

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

Appendix N

Summary of Multiple Regression Analysis Showing the Effect of role overload, role boundary, social support on Job satisfaction (N=59)

Variable	b	R-square change	p value
Job satisfaction			
Role boundary	-.57	.32	.0000***
Role overload	-.23	.04	.04*
Model F	17.1	p<.0000	
Multiple R	.61		
Unadjusted R Square	.38		
Adjusted R Square	.36		
Variable not in equation:	Social support		

Note. *p<.05; **p<.01; ***p<.001; ****p<.0001

Appendix O

Sample Means from Lintern, T (1999) and Norm Means for MBI

	Home Carers		Normative Data		
	Mean	SD	Mean	SD	t
Emotional exhaustion	11.85	8.4	20.99	10.66	
Personal accomplishment	37.84	7.4	36.5	6.56	
Depersonalisation	2.4	3.1	7.02	6.36	

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