THE EMOTION WORK OF CARE ASSISTANTS WORKING WITH OLDER PEOPLE LIVING IN A CARE HOME

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ABSTRACT

This thesis examines the emotion work of care staff working with older people living in care homes, by integrating both sociological and psychological perspectives relating to emotions. By exploring both the empathy and emotional labour undertaken by care assistants from their own perspective, this thesis provides insights into the emotional demands of care work that are of both theoretical and practical relevance. The thesis examines how care staff respond to many emotional challenges in their daily work, which require both emotional skills and labour in order to provide emotional support for the residents.

Using a mixed-methods approach care assistants participated in semi-structured interviews (n=36) and filled self-completion questionnaires (n=68), this thesis confirms the importance of both empathy and emotional labour in providing emotional support for the residents, while also highlighting the diverse forms and applications of these two constructs within care homes. Those emotional challenges facing care staff are presented and analysed using an interpretative approach, revealing both daily situations and also some resident characteristics that require staff to work hard at managing their emotions. Staff characteristics and organisational factors were also investigated. Personal experiences of caring as well as effective teamwork were both particularly relevant to the emotion work of care staff.

This thesis concludes that emotional labour is associated with both the emotional support of residents and also the wellbeing of staff, with staff being vulnerable to exhaustion if they did not receive effective support. This relationship is complex, with the context in which emotion work is undertaken and the perceived outcome both being important. Understanding the perspective of care assistants, the challenges they face, and the common emotional reactions they have when responding to these challenges, enables care homes to support and train staff, thus enhancing the emotional care they can provide for residents.
ACKNOWLEDGEMENTS

I would like to express my thanks to some of the people who have supported and contributed to this thesis.

- Professor Sara Arber, Department of Sociology and Dr Vicky Senior, Department of Psychology, University of Surrey, whose advice, guidance and enthusiasm during the past four years as my PhD supervisors has supported and motivated me through the many challenges of completing this thesis.

- The care home staff and managers who generously gave their time in participating in this research. Their support and was greatly appreciated and their contribution has already made a difference. With particular thanks to Friends of the Elderly and their interest and participation in this research.

- Rosemary Hurtley, Suzie Friend and Wendy Adams who were invaluable in gaining access to the care homes involved in this research.

- To some of my colleagues at the University of Surrey, Nick Allum, Ingrid Eyers and Pam Smith for your advice, mentorship and inspiration over the past 4 years.

- With thanks to the NCHR&D and the Emotions Interest Group, both of which have provided vital motivation and a much needed network of colleagues.

- To my family for their constant encouragement and patience throughout my continued education. In particular to Anne for all your practical and emotional support, and Hannah for her advice and endless enthusiasm for older people and care homes.

- Especially to my partner Tom Adams, for the many small sacrifices you have made particularly during the 4th year of this PhD, for celebrating each milestone and for being such a good friend through the many months of writing up.

- In recognition of the ESRC who funded this research.
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CHAPTER 1

INTRODUCTION

The focus of this research is care assistants working in care homes for older people and specifically, the emotion work these care staff undertake. This chapter will outline the importance of care homes research within an ageing society, and in particular research to understand the lives of care staff, before focusing on the central role of emotion work in this caring context. The researcher's experience of working as a care assistant and how this motivated the current study is discussed before setting out the general aims of this research and thesis structure.

Population Statistics and the Role of Care Homes

In practical terms, the need for residential care for older people is expected to increase over the next 25 years. This is mainly due to the expected growth in the older UK population, in part corresponding to the ‘baby boom’ generation. In particular, it is expected that there will be a large increase in those aged over 85 as people remain healthier and live for longer (Office of National Statistics, 2005). In addition, an increase in age related health problems is expected. Currently, physical and mental health problems are the most common reasons for older people to enter a care home (Bebbington et al. 2001).

Current research suggests that 1 in 14 people over the age of 65 has dementia and 1 in 6 over the age of 80 (Personal Social Services Research Unit, PSSRU, 2007). The prevalence of dementia grows to almost 1 in 3 for those aged over 90. Based on population projections, this report commissioned by the Alzheimer's Society (PSSRU, 2007) has estimated that currently there are just under 684,000 people in the UK with dementia, but this will grow to 940,110 by 2021 (a rise of 38%). It is expected that the increase in numbers of people with dementia will proportionally increase the need for care homes and other services specifically designed for those with dementia.
In recent years the UK government has provided more support to frail older people wishing to remain living in their own homes. Consequently, more older people requiring low or moderate levels of support are living at home and those moving into care homes are more likely to require higher levels of support. Therefore, older people entering care homes now have higher levels of physical and psychological needs (Bebbington et al. 2001). Given the increase in numbers of older people and higher needs of care home residents, understanding the core concepts of high quality care is of increasing relevance.

This research will focus on residential homes as opposed to nursing homes. These homes do not employ nurses and, when appropriate, health care specialists are brought in from outside agencies. Residential homes are only permitted to care for residents with a certain level of (usually physical) healthcare needs. The vast majority of the care in all care homes, but particularly residential care homes, is provided by care assistants. Given that the number of care home places needed in the future is set to rise, higher numbers of care staff will also be required. Today, many care homes are struggling to recruit and retain staff (Centre for Policy on Ageing, 2001a; Netten et al. 2003a), a situation which is likely to become worse unless there are marked changes within the care homes industry. Care homes research has highlighted that care assistants are an undervalued and underpaid group of workers who receive little training for what can be an extremely demanding job (Eyers, 2000b). Understanding the working lives of care staff and the care they provide is, therefore, an essential component of care homes research in order to inform policy and practice.

The current research will specifically address the work undertaken by care staff from their own perspective. In this respect the study differs from the majority of current research. In recent years there has been an increase in academic research within the field of gerontology as a whole and focusing on care homes in particular. A comprehensive review of current care homes literature titled 'My Home Life': Quality of Life in Care Homes (prepared for Help the Aged by The National Care Homes Research and Development Forum, 2007) provides an excellent overview of different
aspects of care and how these relate to residents' quality of life. This extensive review of UK literature covers themes such as 'Working to help residents maintain their identity', 'Creating a sense of community' and 'End of life care'. It does address care staff within the theme of 'Keeping the workforce fit for purpose' (Meyer, 2007), but with a strong emphasis on the training and educational needs of staff. The 'My Home Life' review reveals how little research actually addressed the working lives of care assistants (as opposed to nurses) and their own understanding of the work they do. Notable exceptions are the work of Hurtley (2003) who studied the motivation and job satisfaction of care assistants, and Nolan et al.'s. (2002) 'six senses framework', a theoretical model which aims to integrate the needs of care home staff, residents and families.

Given both the increasing need for care staff, and the relative lack of current research focusing on care assistants, there is a strong argument for gaining a greater understanding of the work undertaken by care staff. By exploring the work that care staff are required to do, and how they manage to achieve this, valuable insight can be gained into the care provided for older residents and the wellbeing of the care staff themselves.

Emotional Support and Emotion Work

In the past, research and policy primarily focused on the more medical and practical aspects of care. More recently, there has been a proliferation of research into person- or relationship-centred models of care, as will be discussed in chapters 2 and 3. These models place strong emphasis not only on the physical and health needs of residents, but take a more holistic approach based on the overall needs of the individual. Thus, the more modern models of care place a strong emphasis on the emotional support of older people. The 'My Home Life' literature review (NCHR&D, 2007) reveals the extent to which the emotional needs of residents have been explored with an aim of understanding how services could be improved. While medical and practical care of residents is also highlighted as important, their emotional wellbeing is vital if they are
to live the final years of their life in the most positive way possible. The current research is interested in what facilitates care staff in providing this emotional support for residents.

In order to provide emotional support for residents, the care staff are required to undertake emotion work. This is an area in which almost no training is explicitly provided, yet in the researcher’s experience can be the most difficult aspect of care for staff. How care assistants undertake this work, the skills they have to do this and the emotional aspects of care they find difficult to deal with, are all important areas to be explored in order to gain understanding as to how this emotion work impacts on the staff themselves as well as the emotional support they provide. This research will not focus on one aspect of care or emotional support, but aims to gain insight into the emotion work undertaken in terms of the daily working reality of care staff, including managing group living, personal care, domestic tasks and how staff work with and relate to each other.

The research builds on both sociological and psychological theories to address the complex concepts of emotion work and emotional support. In particular, the sociological theory of emotional labour (Hochschild, 1983) and the more psychologically based construct, empathy. The literature relating to emotional labour and empathy is discussed in Chapter 2.

**Personal Experiences Relating to Care Homes**

I have worked as a care assistant on and off for 9 years, some of which was full-time, but the majority part-time alongside my studies. During this period of time I have worked in six care homes, and as permanent, bank and agency staff. I have also known family members and friends who have entered residential care. My own experiences have not only motivated this research but also shaped its direction and the focus on the emotional aspects of care.
My interest in researching care assistants arose from my recognition, while working in care homes, that the residents were largely dependent on the care staff for their physical and also emotional wellbeing. This low status and poorly paid job involves a high level of responsibility and a great many challenges. Prior to reading any literature on emotional labour, I was well aware of the emotion work involved in caring for older people and in coping with the organisational demands of a care home. My preferences regarding which care homes were better to work in were based on the emotion work undertaken in the home to a far greater extent than the physical work. In homes that were very busy or especially where it was difficult to find other staff to help with a resident, it was the emotions of feeling the care I provided had not been good enough and the frustration of not receiving any support that made me leave the home, not the physical tiredness. Therefore care assistants and emotions became my main research interest when contemplating a PhD.

While working in care homes, I observed some brilliant carers who were very popular amongst both residents and staff and strove to provide individual support for the residents. In contrast I also saw poor care, by staff who lacked motivation and training and who were unfamiliar with the home and residents. Most staff fell somewhere in between, they delivered reasonable care which could have been better. It was the range in the quality of care provided by staff that has led me to focus on differences between staff, in their emotional skills as a carer, their background, and the care home environment they were working within.

**General Research Aims and Thesis Structure**

My doctoral research aims to present a broad view of the working lives of care assistants and the reality of caring for large numbers of elderly residents with varying needs. In particular, the emotion work that care staff undertake, how this relates to the emotional support of residents and the impact it may have on the staff themselves will be explored. My research will argue that the individual characteristics of care assistants as well as the care home organisation and environment, impact on the
emotion work undertaken by care staff, and so ultimately on the quality of care received by the resident.

Therefore, the main aim of this research is to explore those social factors, including staff characteristics, that influence the provision by care assistants of emotional support for older residents living in a care home. Specifically, this research will focus on the emotional labour and empathy of care assistants, as well as other staff characteristics and the care home environment, in order to understand the emotional support of care home residents. This thesis addresses these aims by building on, and integrating, theories and literature relating to care and emotions from the disciplines of psychology and sociology.

Chapter 2 reviews the literature relating to emotional support, emotional labour and empathy and outlines a theoretical model of these three constructs and how they each relate to care work. This multidisciplinary chapter draws on sociological, psychological and nursing, therapeutic and caring literature that involves both qualitative and quantitative studies to explore the complex topic of emotion work in paid care. In Chapter 3 the current research on staff characteristics, resident characteristics and organisational factors and how these relate to emotional labour, empathy and emotional support is discussed.

Chapter 4 states the aims of this research and outlines the qualitative and quantitative methodologies used to achieve these aims. Self-completion questionnaires were distributed to care assistants, a sample of whom also participated in qualitative interviews. These methodologies reflect the previous research into emotions, but also aim to explore the emotion work of care staff from their own perspective. The integration of the findings from these methods is also discussed.

The analysis is predominantly qualitative, reflecting the richness of the interview data. The analysis of the data relating to empathy are discussed in Chapter 5, while, Chapters 6, 7 and 8 all focus on the different aspects of the emotional labour of care
work. Chapter 6 examines the emotional challenges relating to everyday situations that arise when caring for residents, Chapter 7 discusses those resident characteristics staff perceive as requiring higher levels of emotion work, and Chapter 8 explores how some of the staff characteristics, interactions between staff and organisational factors influence the emotional work of staff.

The main quantitative analysis is presented in Chapter 9 which outlines the statistical findings for the Empathy, Emotional Labour and Emotional Support scales used in the questionnaire. Chapter 10 integrates the qualitative and quantitative findings, both highlighting some important similarities between the two types of data and also differences and weaknesses of each.

The concluding chapter discusses the main findings from the analysis in the context of the previous literature, highlighting the contribution of this research to both the theoretical understanding of emotion work and also the relevance of the findings to care homes policy and practice.
CHAPTER 2

EMOTIONAL SUPPORT, EMOTIONAL LABOUR AND EMPATHY

This first literature review chapter outlines the three theoretical constructs which form the basis of this research: Emotional Support, Emotional Labour and Empathy. The chapter outlines each construct before situating each within a caring context and stating the research aims associated with each. The chapter outlines a theoretically based argument for combining these three constructs and drawing on both sociological and psychological perspectives. The chapter concludes by presenting a conceptual model of empathy, emotional labour and emotional support, a foundation from which to explore each concept and the associations between them. In order to present a cohesive theoretical argument for understanding the three constructs together, a review of literature from two large academic fields, empathy and emotional labour, has been covered in one chapter.

Part A: Emotional Support

The focus of this research is the emotional work undertaken by care staff and how this relates to the emotional support of elderly care home residents. Emotional support is a broad term and is closely related to concepts of care, but places emphasis on the emotional or psychological needs of residents rather than their physical and practical needs. James (1992) defines a carer as "Someone who gives sustained, close, direct mental and physical attention to the person being cared for" (pp. 489). This is a definition with which many care home staff would agree, and it serves to emphasise the intimate and emotional aspects intrinsic to the definition of care. The concept of emotional support will be argued to be both of practical importance in a care home setting and also, of theoretical value when conceptualised in relation to emotional labour and empathy.
For the purpose of the current research a general definition of emotional support has been formed, partly based on literature and also influenced by the researcher's personal experiences working within a care home. Three areas of emotional support particular to care homes have been identified; day-to-day support, support during times of stress and providing dementia care.

*Day-to-Day Support*

This type of support is required by residents daily, and includes understanding their needs, knowing and appreciating their likes and dislikes, listening to worries and concerns, and minimizing embarrassment during personal care. Personal care includes helping an older person to get up and get dressed in the morning, helping them to bed at night, assisting them to go to the toilet and assisting with baths and showers. Smith (1992) in her research with student nurses found that day-to-day emotional support was often referred to as 'the little things', those small gestures over and above basic physical or practical care that showed the patient that the nurse cared, or that their wishes were important to the nurses. Day-to-day support is one important contributory factor to resident's quality of life. Lopez (2006) provided examples of how care staff in US nursing homes provided emotional support for residents within the home routine, a routine which tends to be based around physical and medical needs. Even though aspects of the routine could not be moved (such as meal times and medication) care given within the routine was tailored to resident's own wants and needs, including small details such as always asking residents in wheelchairs where they would like to be taken.

Help the Aged commissioned an extensive literature review into UK care homes, titled ‘My Home Life’ (NCHR&D, 2007). Citing quality of life research by Gerritsen et al. (2004) and Gabriel and Bowling (2004), the review identified ‘relationships’ as one of three key themes that residents identified as being essential to their quality of life. Within this theme, relationships with care staff were paramount and these were based on effective communication by and with staff. Communication, both verbal and non-verbal, between care home staff and residents is important to resident welfare, but
is an area in which staff could benefit from training (e.g. Carpiac-Claver & Levy-Storrs, 2007).

**Support During Times of Stress**

The second area relates to emotional support during times of stress. Older people often enter care after a stressful incident, either a fall, serious health problem or following bereavement. The transition into a care home is well documented to be a time of worry and stress for residents and their families (e.g. Davies & Nolan, 2004; Ryan & Scullion, 2000). Although care assistants themselves will not usually have been involved in the events or decisions leading up to moving into the home, they are one of the main sources of support once the new resident arrives. Transition into a care home is one of the identified ‘My Home Life’ themes, which includes guidelines originally developed by Oleson and Shadick (1993) that include the suggestion that care staff should ‘Help to maintain a reasonable emotional balance by managing upsetting feelings aroused by the situation’. This indicates that high levels of emotional support are usually required at this time.

Settled residents may also go through times of distress such as following a fall, deterioration in health, and bereavements. This type of emotional support is easier to define and also to observe as care staff make a concerted effort to comfort a distressed resident or to help them focus on other activities or rehabilitation.

Within the theme ‘times of stress’, care during illness and also end of life care could be included. Currently approximately 21% of UK deaths occur in care homes and this percentage is expected to rise in the future (Froggatt et al. 2006). While there are both frameworks (eg National Service Framework, NICE; Gold Standard Framework) and ‘pathways’ (eg. Liverpool Care Pathway, Ellershaw & Wilkinson, 2003; Preferred Priorities for Care) designed to support staff in providing good end of life care in a range of settings, it has also been noted that dying is a ‘complex process’ involving multiple loss (Holman et al. 2004) so is difficult to encapture in models of practice. The notion of ‘complex loss’ emphasises the challenge of providing emotional support.
for older people during this time. The My Home Life literature review (2007) highlights the lack of internationally agreed definitions of end of life care; Palliative care, Terminal care or End-of-Life-Care, depending on where you live. However, the different definitions emphasise emotional support, for example:

"...provision of psychological, social and spiritual support is paramount"  
(NICE, 2004, pp20)

Schell and Kayser-Jones (2007) investigated the use of empathy in end-of-life care, by nursing assistants in a US care home. Their research is particularly relevant as it reflects the reality of providing support for a dying resident in a care home while continuing to care for other residents.

Dementia Care

A third area relates to the emotional support required when caring for residents with dementia, and encompasses within it day-to-day needs and support during times of stress. However, as residents with dementia are likely to have different emotional needs to those without, dementia care will briefly be discussed. As all residential care homes care for residents with dementia and these numbers are set to increase (PSSRU, 2007), the emotional support of these residents is an important aspect of care home work. The effects of dementia are commonly; memory loss, forgetfulness, loss of awareness of place, reduced attention span, restlessness, anxiety, fixed ideas, suspicions, seeing and hearing things that are not there and confused memories (Brearly, 1990). The emotional support needed by a person with dementia particularly focuses on communication, reassurance and security. Communication includes both verbal and non-verbal communication. It becomes harder for a person with dementia to understand what is being said to them or to respond so that others can understand them. Therefore the language used, how words are spoken (tone and volume) and also non-verbal communication become increasingly important (Jones & Mieses, 2004). Carers may become the only source of communication for some residents with dementia, if they are to make their wants and needs understood.
Providing reassurance and security is also vital to the wellbeing of a person with dementia. Taking time to explain any confusion, reassure the person that they are at their new home and safe, and ensuring they have those items that make them feel secure (such as a handbag or photos) is particularly important.

Residents with dementia can also be more likely to become verbally and physically aggressive towards carers than other residents. Generally termed 'challenging behaviour', this behaviour arises from resident's distress, anxiety, and perceived (or real) threats (e.g. Fetherstone et al. 2004, Jones & Mieses, 2004, Marshall, 1990). Therefore residents require emotional support to comfort them. Dementia care training is one way in which emotional support by staff could be improved and the literature contains a wide range of intervention studies (e.g Freeman-Asthill, 2004; Cassidy & Sheikh, 2002, Featherstone et al, 2004). Recently, Dementia Care Mapping (DCM) has become an important tool in assessing and improving quality of care for residents with dementia (Brooker, 1995). One of the primary DCM tools has been developed by the Bradford Dementia group and is based on Kitwood’s theory of dementia (1997). The technique involves observations of residents with dementia over a period of time and recording information on specific areas or a range of areas relating to how the residents experience their care. The data are analysed and fed back to staff in order to highlight areas that could be targeted and improved.

While a detailed literature review of dementia care research will not be given here it is important to highlight that ethical issues are numerous when caring for a person with dementia in a care home setting. On a daily basis, carers must balance the rights of a person with dementia and their autonomy, with the rights of other residents and issues of health or security. Hertogh (2004) highlights this problem by using case studies to describe two common problems. Firstly, residents who ask to go home and become agitated, banging on the doors. Secondly, residents who refuse all care as they do not believe or are denying that they need support. In this situation the care staff must decide the extent to which a resident can refuse care as part of their own choice, and the point at which continuing to not provide care becomes abuse (Jones, 2001).
In recent years policy makers have back-tracked on how to best care for someone who says they want to go home or is worrying about a deceased loved one. Previously carers were meant to orientate people back to reality (Marshall, 1990). More recently carers are encouraged to enter the resident’s reality to calm or reassure them, but avoid lying unless it is absolutely necessary (e.g. Jones & Mieses, 2004). Diversion to other subjects is also encouraged. Many of the guidelines laid down by care homes, leave carers in an ethical dilemma when patients have dementia.

*Level of Emotional Support*

Emotional support can be provided by care staff to a greater or lesser extent. At the extreme ends of the continuum are elder abuse, such as verbal abuse, intimidation and neglect, and on the other end, high quality care that provides each individual with the emotional support they require. Most care provision falls somewhere in between and it is the aim of this research to understand those social factors that impact on the nature and extent of emotional support provided by staff, with a view to providing practical advice to care homes. This research takes the perspective of care staff as opposed to the residents, in order to gain greater understanding of the emotional support care staff provide, the strategies they use to do this and the impact of providing emotional support on the care staff themselves. In order to address the emotional work care staff undertake to provide emotional support for residents, two theoretical constructs will be examined: Emotional Labour and Empathy. This thesis combines both psychological and sociological theories to address the complex issues of emotion work within a caring context.

**Part B: Emotional Labour**

This review will argue that in order for care assistants to provide emotional support for care home residents they are required to undertake Emotional Labour. Arlie Hochschild (1983) first introduced the term Emotional Labour in her book, *The Managed Heart: The Commercialization of Human Feeling*. As the title suggests, Hochschild was concerned with the sociology of emotions in the workplace. Already
well defined and researched in the work literature were the concepts of physical labour and mental labour, and these types of work can be further described as professional, skilled or unskilled. Hochschild introduced a new concept of emotional labour and also a vocabulary with which to explore it. Of course emotion work had always been there, but Hochschild argued it was mostly implicit and traditionally a female role deemed woman's 'natural' work, lacking social status or financial reward.

In her initial study, Hochschild described how two contrasting occupation groups, flight attendants and debt collectors, managed their emotions in the workplace to influence the feelings of others. Hochschild described emotional labour as:

"The induction or suppression of feeling in order to sustain the outward appearance that produces the proper state of mind in others – that of being cared for in a safe and convivial place" (1983. p7)

This statement refers to the emotional labour of flight attendants, but could equally be used to refer to care workers.

Hochshild was drawn to Erving Goffman's (1959) theory of symbolic interaction in which, using a dramaturgical perspective he argued that we all have to behave differently in different social settings or 'social stages'. Goffman argued that in different social settings people just alter their outward appearance or demeanour, effectively acting the part for a particular social stage. Hochschild integrated this concept of 'acting' into her theory but further argued that different social situations could have a deeper effect, that is change actual emotion and not just the presentation of it. Within her theory, Hochschild outlined three main components of emotional labour; deep acting, surface acting and feeling rules.

**Deep and Surface Acting**

Deep and surface acting both refer to the emotion work done when the felt emotion conflicts with what is an appropriate emotional display in that social setting. Feeling
rules guide what is deemed appropriate for a given social situation and these are discussed in a later section. In psychological terms, the unpleasant internal state experienced when felt emotions conflict with appropriate display, could be regarded as emotional dissonance, based on Festinger's (1957) cognitive dissonance. As with cognitive dissonance, the worker feels uncomfortable with the inconsistency between their actual feelings and the appropriate emotional display and will seek to address this. Hochschild argued that workers either employed a method of surface acting: maintaining the conflicting emotion and altering the emotional display, or deep acting: altering their emotions to bring them into line with the correct emotional display. In a care home setting an example of surface acting may be when a carer is changing a resident who has been sick. The carer may feel disgusted by this but give the outward appearance of being relaxed and not bothered by the task in order to reduce the upset or embarrassment of the resident. An example of deep acting may be if a care assistant is finding a resident difficult or annoying. Feeling annoyed by a resident conflicts with the expected emotion of a care worker and so they may work hard to try to understand why the resident may be behaving in that way in order to feel more positively towards them. In this way the carer will then be able to both feel and display the correct positive emotions when working with that resident.

Hochschild argues that surface and deep acting are both directed by the desires of the employers. That is, the employer demands a certain outward emotional response from the employee and they must work hard in order to achieve this. In this sense, emotional labour could be seen as a negative aspect of work and exploitation on the part of the employer. Furthermore, Hochschild proposed a ‘transmutation’ theory whereby, particularly through deep acting, workers’ emotions were transformed from being part of the private individual, to that of the collective organisation. However, while the presence of emotional labour has been determined in a number of employment settings, little evidence has been found to support the transmutation theory. It appears that employers do not have the level of control on their employees emotions as was proposed. Lopez (2006) argues this point in his study of US nursing homes. He argues that care staff can form genuine relationships with residents and
feel real, but also socially appropriate, emotions without 'organisational manipulation'. He supports this argument with similar findings from literature across a range of occupational settings. Waitresses (Paules, 1991), checkout workers (Tolich, 1993) and flight attendants (Bolton and Boyd, 2003) not only found job satisfaction from their use of emotional skills, but considered their exchanges of 'emotional gifts' to be autonomous. Staff understand the expectations of management regarding their demeanour, but also felt they were in charge of their own emotions and the extent to which they used them. The relationship between staff and customer was also important with staff gaining pleasure from positive interactions and also aiming to reduce their own workloads by resisting excessive demands.

In terms of care workers, to assume, as Hochschild has, that all emotional displays are determined by management and that care staff do not feel any genuine emotion for the vulnerable people in their care is an overly pessimistic view. To remove autonomy from emotions not only undermines the choices care staff make when deciding to undertake this type of work, but their compassion and empathy for those they care for. This research will instead start with the more positive assertion that care staff can and do form meaningful relationships with residents on an individual basis. As individuals, care staff engage emotionally to varying degrees, as will be discussed later, but as organisations, care homes can encourage or suppress effective emotional labour by their staff.

*Non-Dissonant Emotions*

More recently it has been emphasized that emotional labour does not always involve or lead to emotional dissonance (Brotheridge & Lee, 2003; Zerbe, 2000; Morris & Feldman, 1997). Workers may genuinely feel the emotions they display rather than constantly fighting against socially inappropriate emotions. Their emotions may still need to be managed, for example when feeling genuinely upset for or concerned about a resident, only some displays of emotion are appropriate in order to comfort the resident. Brotheridge and Lee (2003) successfully argue that this still involves emotion work. Furthermore, the intensity and variety of emotions was cited as
increasing emotional labour. Feeling and managing intense emotions in the workplace and also frequent changes, sometimes referred to as the 'emotional rollercoaster', also involves high levels of emotional labour and can lead to fatigue. Coming from a more psychological perspective, they also argued that duration and frequency of emotional feeling or display are important contributing factors to emotional labour in various occupations. Brotheridge and Lee (2003) in their development of an Emotional Labour Scale explicitly outline a six factor model of emotional labour. This model consists of frequency, intensity, variety and duration of emotional display, as well as surface acting and deep acting. This scale, and other occupation and language/culture specific scales have been used in a number of studies of different occupational groups, particularly in relation to emotional intelligence and burnout, both of which will be addressed in later sections.

Unconscious Emotions

More recently Theodosius (2006) argued that the current sociology of emotions, largely based on Hochschild's work, focuses only on the cognitive and conscious aspects of emotion. Working to manage emotions is a cognitive process that assumes a certain awareness on the part of the worker as to their current emotional state, and the socially desirable emotional display. Theodosius argues that this underestimates the role of unconscious and relational emotions, those automatically felt and maybe not recognised by the worker.

A greater understanding of unconscious emotions can be found in the psychological literature and more specifically that which stems from the psychoanalytic field. Psychologists, notably Sigmund Freud and Melanie Klein, argued that unconscious thoughts and feelings had a central role in our mental lives. Menzies Lyth (1988) undertook an in-depth study of nurses working in a large hospital in the late 1950s, and, using a psychodynamic approach, described both the high levels of stress and anxiety experienced by nurses, relating them to both the more obvious stressors, and also the unconscious emotions that relate to a person's childhood. Individuals varied in how they dealt with these stressors, either using 'primitive' or more mature defence
mechanisms. Menzies Lyth argued that the social environment within hospitals was in part designed to contain nurses anxieties, for example by being task orientated to avoid nurse-patient relationships, 'check list' focused to avoid decision making and blame, and encouraging the depersonalisation of both the patients and the nurses. Menzies Lyth argued that these social mechanisms were largely unconscious, but primitive, often resulted in other forms of stresses, were inefficient for patients, unrewarding for staff and did not actually work well as a defence against anxiety. However, staff were unwilling to change 'the system' as unconsciously, they 'clung on' to the social defences that they were used to. More recently Holman et al’s psycho-dynamic (2006) study into complex grief on a continuing care unit for older people, highlighted both the expected and articulated emotion work of the care staff, but also the less conscious emotions. For example, feelings of hopelessness relating to expending large amounts of time and effort caring for unresponsive residents was reflected by staff generally not referring to them, or not seeing the point of talking about them, while more 'feisty' (although sometimes abusive) residents were spoken about in a more active and creative manner. In this way, staff defended themselves against the less conscious, negative emotions they felt towards the unresponsive residents.

The current research is using and interpretative approach, that is, taking the opinions and experiences described by care staff, generally at face value. A psychoanalytic or psycho-dynamic study requires a different analytic approach to explore the emotions underlying a person’s explanations to try to understand the less conscious or unconscious emotions involved. However, the work of Mezies Lyth (1988) and in particular of Holman et al (2006), both serve to add to the argument that care work has a strong emotional component which impacts on the care staff and their emotional wellbeing.

The present study will encompass a wider notion of emotional labour than that introduced by Hochschild (1983) and will use the scale designed by Brotheridge and Lee (2003). The qualitative aspect of this research seeks to understand the emotional
labour care staff engage in from their own perspective. The care staffs' own understanding of their emotions may or may not compliment the constructs defined above (eg surface acting, variety of emotions) and could also reflect automatic emotions, those not readily in the workers control.

**Feeling Rules**

Feeling rules, also referred to as emotion rules, are the socially appropriate ways of acting and expressing oneself in a given social situation. In forming this concept, Hochschild (1983) was heavily influenced by Goffman's notion of different social stages in which we, the social actors, must perform. In the case of Hochschild's flight attendants, they were explicitly expected, and also trained, to behave in a particular manner, always smiling and always calm. In contrast debt collectors were supposed to behave in an authoritative manner, verging on the threatening. The notion of feeling rules has been widely supported, but scholars have varied in their interpretation of the depth and scope of these rules.

For example, Lopez (2006) makes a distinction between emotional labour and 'organized emotional care' based on his understanding of the application of feeling rules. In the former the employer dictates a specific set of emotion rules and imposes them on the workers, which in itself creates emotional labour for the worker. In the latter, the employer creates an organisational system in which the emotion work of care can flourish and staff can negotiate their own feeling rules with residents. Lopez makes the theoretical distinction between universally imposed feeling rules by an organisation, and those rules negotiated by carer/resident dyads. However, Pam Smith (1992) conducted an ethnographic study of student nurses, and understood feeling rules, not only as a prescribed set of appropriate emotional displays, but also as a more general 'emotional tone'. This emotional tone either encouraged and supported emotional engagement and relationships between patients and staff or suppressed it. In this way, Smith does not separate feeling rules into those of the organisation and those with patients, but rather maintains that feeling rules are organisational, but that they can be either oppressive or nurturing for staff.
Oppressive feeling rules implicitly (or sometimes explicitly) state that it is not appropriate to form a meaningful relationship with a patient, treat them as individuals or place emotional need above routine, while nurturing rules state the opposite. Therefore a nurturing or supportive emotional environment as described by Lopez' organized emotional care, does not suggest a lack of organisational feeling rules, but rather rules that normalise genuine emotions. To apply feeling rules to carer/resident dyads seems overly complex, as these dyads could more simply be described as relationships which are either encouraged or not by the feeling rules of the organisation.

While Hochschild described differences in feeling rules between occupational groups, Smith (1992) highlighted those found within an occupational group, specifically within hospital based nursing. She described how the emotion rules could vary greatly between wards and between shifts. Smith found that emotion work was recognised to a greater or lesser extent depending on the type of ward. For example on psychiatric wards emotion work was made explicit and was included as part of the training. Not only was the emotional labour done by the nurses seen as an important part of their job, but the emotional welfare of the student nurses themselves was also a priority. The nurses were very supportive of each other and took time to talk over and recover from any incidents that occurred. In contrast, on surgical wards little attention was given to patient or family emotions, but the focus was on medical techniques and patient turn-over. The general wards were also frequently found to barely recognise the role of emotions. Smith noted that the emotion rules on all wards, but the general wards in particular, were influenced by the leadership style of the ward manager (or matron) and a range of organizational factors. These specific influences on the feeling rules of wards and also factors specific to care homes will be discussed in Chapter 3 (Part C).

Job Satisfaction/Burnout

One of the aims of the research is to explore the outcome of emotional labour for both the residents and the care staff themselves. To date, the majority of research literature
on outcomes for staff has focused on emotional exhaustion or burnout, and to a lesser extent job satisfaction. Hochschild (1983) argued that the effort involved in emotional labour could produce psychological stress and possible loss of emotional control. The link between emotional labour and burnout has been of particular interest in the domains of organisational and health psychology where the predominant research method has relied on psychometric scales.

A number of studies have determined a link between emotional labour and emotional exhaustion across different occupations, including; police officers (van Gelderen, et al. 2007), call centre workers (Goldberg & Grandey, 2007), customer service staff (Johnson & Spector, 2007a), GPs (Martinez-Inigo et al. 2007) and teachers (Naring et al. 2006). These studies also provide evidence that different types of emotional labour impact differently on worker’s psychological wellbeing. Brotheridge and Lee (2003) found that surface acting was associated with higher levels of emotional exhaustion, depersonalization and negative affectivity, a finding that has been supported by other research (Goldberg & Grandey, 2007; Johnson & Spector, 2007; Martinez-Inigo et al, 2007; Naring et al, 2006). In contrast, Brotheridge and Lee (2003) found that deep acting was associated with a sense of personal accomplishment and identification with one’s role. The association between positive well being and deep acting has only been partly supported, with some papers replicating these findings, but others suggesting it has no impact (Goldberg & Grandey, 2007; Martinez-Inigo et al, 2007). Naring et al (2006) in their study of teachers found that only ‘emotional consonance’, not engaging in either deep or surface acting, was related to feelings of personal accomplishment.

Taken together, the psychological research suggests that deep acting is a more effective method of coping with emotional dissonance than surface acting. Intuitively, in relation to care assistants it would make sense that a carer who was able to feel more positively towards a resident rather than just altering their emotional display would feel more positive about their work and may also consider themselves to be a better carer. However, the predominant methodology of the literature has been self-
report psychometric scales. This method lacks the depth to fully understand the effects of deep and surface acting.

In terms of gerontological research, burnout has been particularly found among staff and family members caring for those with dementia (e.g., Chappell & Novak, 1992, 1994; Cole et al., 2000, Baines, 2006). Cole et al. (2000) argued that the literature was not conclusive and it was not clear that different resident needs directly impacted on staff welfare, rather staff support was more important. Their own research findings supported this view. However, the methodology only used ‘challenging behaviour’ as a measure and not all aspects of dementia care, and the research used only self-report questionnaires, lacking detail and depth.

The current research is not specifically focused on burnout and job satisfaction, but rather these are just two of the possible outcomes of emotional labour that care staff may refer to during interviews.

*Emotional Labour and Care Homes*

This thesis is specifically concerned with the emotional labour involved in caring for older people living in care homes. There is a current lack of research addressing the emotional labour undertaken by care assistants. This section will therefore address the current philosophy of care within the care home sector and how, although not made explicit, it is evident that emotional labour and skills are central to achieving these goals.

As with the health care sector, care homes have undergone changes in their ideologies of care over the past decades. The current philosophy in care homes is that of person-centred care, which in a care home emphasises independence and choice based on the resident’s own personal history and background rather than the needs of the care home, with an aim to maintain the resident’s identity. This is one of the current standards set out in the National Service Framework for Older People (DOH, 2001). Person-centred care (PCC) has been interpreted in a number of ways. Brooker (2004)
focuses on PCC for residents with dementia. However, while the concept of PCC has immense value, the emotional work required by staff in order to achieve this is less well researched and understood.

There is a relative wealth of care home literature focusing on staff interventions (e.g. Moxon et al, 2001), and specific aspects of care such as dementia care (eg Jones & Mieses, 2004; Richardson et al, 2004), nutrition (DoH, 2007) and palliative care (Gross, 2000). Much of this literature has a strong, although often implicit, emotional aspect. However, there is a tendency to focus on what needs to be done, and changes that could be implemented to care staff’s practice, but without understanding the emotional labour already being undertaken by care staff.

In essence care work is regarded as unskilled work, which is paid on a par with working in a supermarket. The low social status of care assistants is also reflected in academic research. Psychological journals into ageing, care and dementia barely mention care assistants working in care homes. The sociological literature on care homes is more prevalent, but relatively little focuses on care assistants. One notable exception is the work of Ingrid Eyers (2000a). Eyers highlights the often difficult work that care assistants do and their low social and professional status. In her cross-country study of care homes in England and Germany, the emotional labour of care assistants was briefly explored and was highlighted as an important part of their job.

Lee Treewick (1998) argued that emotional labour was not merely a commodity used by management to encourage conformity amongst care workers as argued by Hochschild (1983). Instead she argued that care assistants use emotional skills to manage and control the behaviour of the residents with the goal of maintaining some social order within the home. This had the positive effect of creating a caring atmosphere for many residents and staff, but the negative side was that residents not fitting the social or emotional mould could be excluded from the social group and have emotional support withdrawn. Lee Treewick therefore proposes that resident
characteristics impact on the emotion work undertaken by care staff. This issue is discussed further in Chapter 3 (Part B).

This research aims to add to the sparse literature on care assistants and emotional labour, to highlight the important and often difficult work done by care assistants and also the positive influence they can have on the lives of the residents. It also aims to provide a greater understanding of the emotion work done and the feeling rules within care homes.

*Emotional Labour and Emotional Support*

The emotional support literature, including the highly relevant research of Smith (1992), implicitly assumes that emotional labour and emotional support are synonymous. That is, it is assumed that if a worker is doing emotional labour, then the target of that labour (the patient or resident) will be emotionally supported. On the surface that makes sense, the whole purpose of the emotional labour is to influence the feelings of the patient/resident. However, it can be argued that the emotional work done by the worker and the emotional support that is actually received by the patient or resident, while positively associated, are not directly proportional. For example a care assistant may be upset due to personal issues arising outside the home and therefore may need to exert a particularly high level of emotional labour to maintain a relatively relaxed and happy appearance while working with residents. Their high level emotional labour is not then being exerted in order to provide a particularly high level of emotional support, but in order to maintain reasonable support. Therefore it can be argued that a high level of emotional labour does not necessarily indicate a high level of emotional support, especially if the emotional labour is not directly linked to the resident but arises from other sources such as personal problems, other staff and organisational pressures. While the concept of emotional labour is an extremely useful tool for understanding the work done and skills needed by care assistants, it should be separated from the emotional support/care actually received by the resident. In this research a clear theoretical distinction has therefore been made between emotional labour and emotional support.
Differences in Emotional Skills Amongst Care Workers

The concept of emotional labour as outlined by Hochschild (1983) focused on the worker doing the emotional labour and the social context in which they undertook this work. Her focus was on the undervalued, possibly psychologically exhausting and the gendered nature of this work. The emphasis of the current research is somewhat different as it also focuses on the end product of emotional labour, the emotional support received by the resident. In order to examine factors influencing the provision of emotional support it is impossible to overlook differences in the skills of care assistants. This research is not only concerned with how much emotional labour is done, but how good the care assistant is at doing it. Hochschild argues that the work done in emotional labour is undervalued and should be treated as a skill and not just women's natural work. From a psychological perspective, the assertion that emotion work is a skill suggests that there are individual differences in how effective workers are at doing it.

"For the most part the emotional labour of care consists of day-to-day responses to common situations...Though like much physical labour the outcomes of emotional labour are likely to depend on how skillfully each situation is managed" (James, 1992, pp 500)

The idea that care staff and nurses vary in how adept they are at understanding and responding to different situations and using their emotions in order to do this, is not a new one. Research to date has tended to look at the impact of emotional labour on stress, burnout or number of errors made. It is not understood how using emotional labour in a given situation impacts on positive and negative outcomes. The individual differences in how successful student nurses were in relation to their emotional labour was not explored by Smith (1992). She did however make a distinction between ward sisters' who set a positive or negative emotional tone on the ward, therefore describing a range of emotional capabilities and how these impacted on the other staff and patients. She also argued that the skills of emotional labour were greatly
overlooked, including by the nurses themselves who frequently used the word ‘just’ when talking about emotional aspects of care. For example “It’s just common sense”.

It is expected that care staff will vary in their emotional ability and motivation in undertaking care work and particularly emotion work. How then could these differences in emotional ability be determined? In the past decade, research into the concept of Emotional Intelligence has rapidly expanded within the psychological and management literature.

**Emotional Labour and Emotional Intelligence**

In researching emotional skills, the relatively new area of emotional intelligence would appear to address the issues of individual differences. It could potentially provide a framework for establishing how emotionally skilled a person is and, in the case of care assistants, which carers are able to provide a high level of emotional support to residents by using the most effective emotional labour. McQueen (2004) argued the emotional work done by nurses would be better acknowledged and appreciated if it were seen in the context of an intelligence. However, as will briefly be explained, Emotional Intelligence (EI) is not a suitable framework for understanding the emotional labour required in a care setting, but empathy, which has recently been associated with high level emotional intelligence and also the skills specifically needed for care, is far more relevant to care home research.

Mayer and Salovey’s (1997) definition of Emotional Intelligence includes four separate groups of skills:

a) accurately perceiving and expressing emotion  
b) using emotion to facilitate cognitive activities  
c) understanding emotions  
d) managing emotions for both emotional and personal growth

At face value, the fourth skill, ‘managing emotions’ would appear to bear similarities to Hochschild’s (1983) definition of emotional labour. The most complex skill within ‘managing emotions’ is:
"Ability to manage emotion in oneself and others by moderating negative emotions and enhancing pleasant ones, without repressing or exaggerating information they may convey." (1997, p.37)

This appears to represent Hochschild's 'deep acting' in which she argues that workers alter their emotional state in order to fit the environment. However, this possible link has not been supported by recent research which found no association between Deep Acting and EI (Austin et al, 2008). Alternatively, surface acting requires displaying the correct behaviour while still experiencing and accepting a contrasting emotion. Surface acting does not correspond to Mayer and Salovey's (1997) model of EI as they state that emotions should not be repressed. Austin et al. (2008) found a negative association between surface acting and a measure of EI. This starts to highlight the problem with studying emotional intelligence in the context of the emotional labour of care work. EI assumes that to behave 'intelligently' means behaving in a way that is in your own best interest. However, this is rather a simplistic view given that a care workers 'best interest' is likely to be closely connected to a positive outcome for the resident. It is not clear from the literature if the most 'emotionally intelligent' response is in the resident's best interest and would therefore constitute good care. The literature does however indicate the importance of emotional self-preservation for individuals and could help to explain possible differences in what residents or organisations require and what care staff are actually capable of giving.

Emotional Intelligence then, lacks the social context which is so central to emotional labour. In contrast empathy has been described by Mayer and Salovey (1997; Salovey, Brackett & Mayer, 2004) as being associated with a range of high level emotional skills. When applied to a care setting, empathy can be argued to have an important role in the emotional competencies required by care staff to provide emotional support for elderly residents.
Part C: Empathy

The empathy literature is immense and inconsistent. The current research is concerned with both the psychological, individual differences based aspects of empathy, but also those which are socially based and specific to the work of care staff. By looking at empathy as a skill, the impact of differing levels of empathic engagement on the emotional support care staff provide for residents can be examined. Therefore, this review will firstly focus on the literature which explores the individual differences associated with empathy, drawing on links between emotional intelligence, other characteristics and empathy.

The second part of this review will position empathy within the social situation under study, within the working lives of care assistants working in care homes. This research is specifically interested in how empathy is used by care staff, what purpose it serves and the organisational or social factors that encourage or reduce empathic engagement with residents. Therefore the applied literature which is most closely associated with the work of care assistants, including therapeutic and nursing literature, as well as care homes based literature will also be reviewed.

Defining Empathy

The concept of empathy is closely associated with that of sympathy and has been studied within several areas of psychology. There is a lack of clarity about what is meant by empathy and how it is best conceptualised: a personality dimension, an experienced emotion, or an observable skill (MacKay et al 1990). For example, Morse (1991) and Peplau (1987) describe empathy as an ability, Carper (1978) as a capacity, Davis (1983a) as a visceral emotional reaction and Williams (1990) a biological tendency. A general textbook defines empathy as:

"... the arousal of an emotion in an observer that is a vicarious response to the other person's situation... Empathy depends not only on one's ability to identify someone else's emotions but also on one's capacity to put oneself in
the other person's place and to experience an appropriate emotional response." (Morris, 1995, p.442)

This definition of empathy includes an affective component, a cognitive component and also a behavioural component. Empathy involves experiencing emotions, but also requires a degree of cognitive effort.

A further area of conflict within the empathy literature is as to whether behaviour is included within the definition of empathy. Most theorists refer only to the affective component (eg Davis, 1983a, 1983b; Williams, 1990), but some literature, including much of the nursing and therapeutic literature includes a behavioural component in response to the emotions felt, or emotional empathy. This stance is argued by Traux (1961)

"Accurate empathy involves more than just the ability of the therapist to sense the clients 'private' world as if it were his own. It also involves more than just the ability of the therapist to know what the client means. Accurate empathy involves the sensitivity to current feelings and the verbal facility to communicate this understanding in language attuned to the client's feelings." (pp.2)

In support of this view, Mehrabian and Epstein (1972) found that people who scored high on emotional empathy were more likely to be emotionally responsive to another person's needs. However, it is unlikely that the relationship between emotional empathy and behaviour is a direct one and this point will be further argued later.

Empathy and Individual Differences

Davis (1994) refers to characteristics of the observer which influence empathic response. He described them as 'biological capacities', 'individual differences' and 'learning history'. He argues that 'biological capacities' are cognitive and so closely associated with the concept of low level emotional intelligence, such as determining
emotions from facial expressions. Theorists of emotional intelligence (EI) have linked empathy and Davis’ model with high level emotional intelligence (Mayer and Salovey, 1997; Mayer, Caruso and Salovey, 2000). Davis contends that ‘individual differences’ in empathy distinguish whether a person engages empathically, as well as how accurate they are in understanding the perspective of another. He argues that this is a dispositional tendency, probably related to personality, inherited tendencies and family and parenting during the formative years. This relates to ‘learning history’ which includes the socialization of empathy-related values and behaviours. Davis argues, drawing on past research (Davis, 1980; Hogan, 1969; Mehrabian & Epstein, 1972) that this dispositional empathy is a generally stable trait throughout adulthood. More recently Mangione et al. (2002) assessed empathy of medical residents in four different years of their training finding that empathy remained relatively stable over this time and was not altered by the effects of medical training.

Davis argues that the tendency to relate empathically is a combination of inherited and environmental factors. The inherited predispositions are mainly related to personality (e.g. Goldsmith, 1983; Loehin etc al, 1988) with a substantial genetic component in individual differences of affective, or emotional, empathy (Matthews et al, 1981; Rushton et al, 1986; Zahn-Wexler et al 1992). The literature on the influences of socialisation on empathy has been inconsistent, but in general there is support for the impact of parental relationships with their children on empathy (Roe, 1980; Miller et al, 1989).

The argument as to the precise contributions of genetics and socialisation for emotional empathy is not of relevance here. It is widely accepted however that both play a significant role in contributing to individual differences in empathy. The literature provides strong evidence that empathy is an emotional skill and that individual differences exist in a person’s likelihood to engage in empathy as well as their competency in doing so. For the purposes of the current research, empathy will be used and explored in two ways. Firstly it will be measured quantitatively to provide an indication of individual differences in an everyday emotional skill.
Likelihood of engaging empathically is relatively stable and should be unrelated to the care home environment, that is, it is assumed that carers already have a certain level of empathic tendency that is internal to them and so this can be used to compare between care assistants. Secondly, it will be analysed qualitatively to understand the role of empathy in the care home environment.

Davis (1983b) outlined a model of empathy which showed the antecedents that determined empathic engagement in a given situation. This included not only a persons' stable trait empathy, but also the 'strength' of the situation (the neediness of the target) and the similarity between the observer and the target. Therefore, while trait empathy is important, it is not the only predictor of empathic engagement. As will be argued in this chapter, empathy is directly related to positive outcomes in various aspects of patient or resident care. Therefore, practitioners are interested in methods to increase patient/resident directed empathy in their staff. The possible impact of intervention or training on a person’s empathy, specifically within a care environment is discussed in Chapter 3 (Part A).

**Empathy and Emotional Support**

As already discussed, some definitions of empathy, particularly those from therapeutic literature, include emotional empathy and empathic behaviour. Reynolds et al. (2000) when writing about nursing, emphasise these two components in therapeutic relationships: the cognitive component (the intellectual ability to identify and understand another’s feelings and perspectives from an objective stance) and the behavioural component of empathy (an ability to convey this understanding to the patient). However, Reynolds et al, suggest that there is not a direct link between the two, and argue that empathy training could be of great benefit for nurses who engage empathically but then find responding to a patient more difficult. This stance is supported by Watt-Watson et al. (2000, cited in Campbell-Yeo et al. 2007) who conducted a study on nurse empathy and patient pain. They found that even the most empathic nurses, still failed to administer appropriate pain relief 25% of the time even when these nurses reported the patient felt severe pain. This is a clear, practical
example that understanding of a patient's situation does not necessarily translate into an empathic behavioural response.

In the present research, the affective component of empathy will be measured using Davis' IRI scale (1983b). While this indicates the likelihood of a care assistant to engage empathically on an emotional level, it does not measure their behaviour in response to these emotions. The behavioural component of empathy, that is actually responding to the resident, equates to the current research's definition of emotional support. Empathy will therefore be conceptualised as specific to the affective component, that which is felt, and the behaviour will be described as one aspect of emotional support. This is not just a matter of semantics, but also makes a theoretical differentiation. As this research is concerned with the care assistant's own perspective, how they empathise and how that makes them feel as well as how they then respond to those feelings are all relevant.

**Empathy in a Caring Context**

The importance of empathy in various forms of caring work has been highlighted in many studies, particularly within the therapeutic and nursing literatures. Reynolds and Scott's (1999) review of decades of literature concluded that "empathy is crucial to all forms of helping relationships" (p. 363). The papers reviewed included those from psychotherapy, counselling, therapeutic and nursing literature, but Reynolds and Scott argued that all of the writers referred to a similar purpose of empathic engagement. These included:

1) *Initiating supportive interpersonal communication in order to understand the perceptions and needs of the other person*
2) *Empowering the other person to learn, or cope more effectively with their environment.*
3) *The reduction or resolution of the problems of another person*

(p.363)

Reynolds and Scott (1999) argued that these three outcomes were all essential to a 'helping relationship' and each depended on the empathy of the care giver to achieve
this goal. They also claimed that while the literature (Gladstein 1977, Coffman 1981, MacKay et al. 1990 and Fleuren et al. 1998) largely supported the view that empathy is central to helping relationships, there were also arguments against, that time demands and high patient turn-over may make building patient relationships and engaging empathically unrealistic (Morse et al. 1992). One area in which the relevance of empathy to training and practice has been particularly highlighted is the nursing literature. The role of a nurse is assumed to be a caring role, where nurses spend more time with each patient than most doctors and are therefore may be better placed to build an empathic relationship with patients. The link between time and empathy relates to several factors: the practitioner/nurse having time to listen, gathering information about the patient and their situation, and knowing a patient well enough to know how they are normally and when they are ‘not themselves’. Similarly to nurses, care assistants working in care homes potentially see residents for many hours a week over months or years, thus giving them greater opportunity to engage empathically.

The nursing literature highlights the role of empathy in a range of areas, including making moral judgements (Renolds et al. 2000), responding to pain (Campbell-Yeo et al. 2007) and caring in general (Smith, 1992). Furthermore there is recent evidence from research within care homes that empathy relates to reduced depression amongst residents (Hollinger-Sampson & Pearson, 2000) and sensitive palliative care (Schell & Kayser-Jones, 2007). In the Hollinger-Sampson and Pearson (2000) study changes in depression, as rated by the residents were associated with staff empathy as also rated by the residents, but not to self-reported empathy by staff. It is apparent from this study that it is not just a person’s empathic behaviour that is important, but how that behaviour is then interpreted by the patient/resident. In general terms then, it is clear that empathy is relevant to care work and there is an association between staff empathy and the quality of outcome of resident/patient care. However, this relationship is not clear and simple as empathy is interpersonal in nature. The positive outcome for the patient depends not only on the practitioners ability to understand the
patient's perspective and respond appropriately, but on the patient's interpretation of that response.

The current research includes care staff's experience of caring for residents with dementia. While it is understood that some forms of dementia impact on a person's ability to read another's emotions and to empathise, it is not well understood how care staff engage empathically with a person with dementia. Empathy is interpersonal in nature, and it has been proposed that accurate empathy may depend on the resident's ability to express their emotions as well as the care staff's ability to read that emotion (Zaki et al, 2008). It is possible that care staff find empathising with some residents with dementia more challenging. This position will be explored in the qualitative analysis of care assistant interviews.

The current research is interested in the impact of self-reported empathic engagement on the emotional support of resident, as self-reported by care staff. This study is investigating the working lives of care staff as a whole and not one aspect (such as mealtimes) or one type of resident (such as only those with depression or dementia). In this complex setting, the purpose of, and daily use of empathy will be explored qualitatively. Furthermore, the social factors impacting on empathy will also be analysed, that is what features of organisations or individual care staff's backgrounds influence their use of empathy.

**Empathy and Emotional Labour**

When considering the social factors impacting on empathy, there are some similarities between the empathy and emotional labour literature, especially when empathy is placed in a caring context. Reynolds et al. (2000) described how organisational factors act as barriers to what they term 'clinical' empathy, particularly the affective component of empathy. These barriers include other staff attitudes, staffing levels, workload, rapid discharge, and fear of taking a risk when patient emotions are overwhelming. These environmental factors resemble those observed by Smith (1992) when describing the emotion rules of a ward. In the same way that emotional
labour is to a great extent influenced by the emotion rules, so is empathic engagement and behaviour. Furthermore, Reynolds et al. (2000) use the term ‘clinical’ empathy, defining empathy in terms of nurses’ professional work. This inadvertently highlights the link between empathic behaviour and emotional labour. Nurses are not just asked to respond empathically but in a therapeutically empathic way. The empathy they are asked to display is part of their job, not of everyday life.

Davis et al. (1999) undertook three experiments in which participants chose whether or not to enter into situations in which ‘needy targets’ might be found. In the context of the present research, the situations involving ‘needy targets’ are situations involving higher emotional labour. Davis et al’s results supported the hypothesis that those who reported higher levels of empathic concern, anticipated that they would feel positive emotions and therefore satisfaction from helping needy targets. Therefore the level of empathy impacted on a person’s choice in entering an emotional situation. Drawing on this link between empathy and behaviour, it could be that a care assistant with higher empathy, will be more likely to enter into situations where residents require emotional support, effectively seeking situations that require emotional labour.

The link between empathy and emotional labour was explicitly stated by Larson and Yeo (2005) in their paper exploring empathy amongst physicians. They propose that empathy can be viewed as a form of emotional labour. In this paper they describe empathy in terms of deep and surface acting. In ‘deep acting’ the physician purposely engages in empathy with a patient so the physician will feel the emotions necessary in order to give a correct response. In ‘surface acting’, the physician relies on a set of learned responses to respond in a way that appears empathic to the patient, without actually feeling the empathic emotions. Larson and Yeo also highlight the possible negative effects of physicians with heavy workloads engaging in the emotional labour of empathy, in particular resulting in stress and burnout. The paper is theoretical rather than based on data analysis. However, in terms of the current research the suggestion that some forms of empathic engagement could also be viewed as one
aspect of emotional labour, within the context of paid care work, could be of value in understanding these constructs.

**A Model of Empathy, Emotional Labour and Emotional Support**

The literature reviewed in this chapter has provided a general understanding of some of the theories related to the complex area of empathy before specifically focusing on areas relating to care work. For the purposes of the current research, an affective model of empathy has been adopted with empathy referring to the cognitive and emotional aspects of understanding another’s perspective. The behavioural component has been encompassed within the current concept of emotional support. The literature has provided insight into the importance of empathy in caring relationships. However, strong evidence also highlighted that empathising does not directly translate into successful communication or action in relation to the felt empathy. It is argued then, that social factors may influence both a person’s likelihood to engage empathically and also their behaviour in response to this empathy. This research aims to examine these social factors and how they impact on empathy and its’ behavioural component, emotional support. Finally, the association between empathy and emotional labour has been highlighted and will be further explored in the present research. The current research will examine whether there is any quantitative association between self-reported empathy and emotional labour, as well as qualitatively exploring these two constructs and their relationship. It is expected that empathy will be associated with emotional labour, in particular with ‘deep acting’. This theoretical position is demonstrated in Figure 2.1.
This model of emotional support is currently conceptual and highlights the relationship between empathy, emotional labour and emotional support that has been discussed in this review. In the model, empathy represents the likelihood of care staff to engage empathically with residents, which is partly determined by trait empathy, but also other antecedents to empathy (Davis, 1983b) as described in Part C of this review. It is argued that the effects of empathy on emotional support are either direct, suggesting a behavioural response to emotional empathy only, or mediated through emotional labour which encompasses emotional rules and the social context of care work. A direct association between emotional labour and emotional support has been found, highlighting that emotional labour does impact on emotional support but that these two constructs are not one and the same. This model also includes three groups of variables, labelled staff characteristics, resident characteristics and organisational factors. The resident characteristics and organisational structures are grouped together, as from the perspective of the care staff, these factors form their working environment. Research literature on the influence of staff characteristics, resident characteristics and organisational factors will be explored in Chapter 3. As can be
seen in Figure 2.1, it is expected that staff characteristics will indirectly impact on emotional support through self-reported empathy and emotional labour, for example experience and training could impact on the type and amount of emotional labour undertaken by staff. Resident characteristics and organisational factors directly impact on emotional labour as they directly influence the emotional rules of the care home or unit.

This chapter has drawn together the concepts of emotional support, emotional labour and empathy. In order to study the quality of emotional support received by elderly residents there needs to be a better understanding of the emotional work done by care assistants. The concept of emotional labour not only describes the type of work being done by carers, but also the social context that the work is done within. Understanding the emotion rules of care homes is essential if care assistants are to be encouraged to work to their potential in order to provide emotional support for residents. However, it has been argued that the emotional labour literature fails to address individual differences in how good workers are at doing this emotion work. The role of empathy in care work has been discussed for some time in therapeutic literature and also has a strong element of individual differences within the psychological literature. However, in nursing literature on empathy it has been assumed that empathy consisted of both affective empathy and empathic behaviour. It has been argued that empathic behaviour would be better characterised as emotional support as this behaviour could also be mediated by emotional labour. Empathy and emotional labour have not been analysed together in this way in previous research and it is hoped that each will add to understanding of the within the context of care assistants working in a care home.

In conclusion, this research aims to examine the extent to which empathy and emotional labour influence emotional support and to understand the relationship between these three variables.
CHAPTER 3

SOCIAL FACTORS AFFECTING THE USE OF EMOTIONS IN CARE WORK

This chapter will review the current literature on the social factors that impact on empathy, emotional labour and the emotional support that care staff provide for residents. These social factors have been divided into: staff characteristics (Part A), which focus on those variables which differ between staff such as age and training, resident characteristics (Part B) and organisational factors (Part C) such as management style. These three types of social factors and their association with empathy, emotional labour and emotional support are shown on the theoretical model of emotional support (Figure 2.1).

Part A: Staff Characteristics

Workforce Statistics

This section examines staff characteristics in relation to the range of staff that make up the care home workforce. Currently there is a lack of reliable and accurate statistics as to the size and make-up of the care home workforce. Eborall (2005) suggests some reasons for this lack of information, including: The fragmentation of social care, the mix of public and private employers, lack of official classification of staff and poor data collection techniques.

The current research specifically focuses on residential care homes as opposed to home care or nursing homes, but most of the available statistics do not differentiate between care home types. However, some estimates are available. According to Eborall (2005) and also Commission for Social Care Inspection (CSCI, 2006), staff working in care homes are predominantly female (at least 95%), the average age is 32 (CSCI, 2006) with many in their 40s and 50s, and around half work part-time (Eborall, 2005).
The current research examines those staff factors already reported in the literature that could impact on emotion work in general or empathy, emotional labour and emotional support specifically. This review will address these staff characteristics in terms of how they may impact on the emotional work of care staff and the emotional support they provide for residents.

Age and Experience

The ages of care staff range from 18 up to retirement age (usually 60-65). There is no literature on the direct impact of age on a person’s emotional labour. Rather, Smith (1992) suggests that nurses’ experience and training or role-modelling, impacts on the emotional labour strategies they use. It is expected that age is likely to relate to other factors, including number of years working as a care assistant and also life experiences (older staff are more likely to have children etc).

While CSCI (Platt, 2006) make the link between the large numbers of care staff in their 40s and 50s and the wealth of experience, gained throughout their lives, it is not clear what types of experience are important and how they impact on care work. For example, does the experience of raising children prepare care staff for their work with older people, or are the two types of caring too different for one to influence the other? Platt (2006) appears to suggest that both personally gained and work related experiences are of value, but does not specify further.

While Davis (1980, 1994) amongst other researchers argues that the likelihood to engage empathically is a stable trait in adulthood, trait empathy is not the only characteristic that could impact on empathy in a specific situation. Davis’ organizational model of empathy also includes ‘the situation’ as an antecedent to empathic engagement. He argues that the strength of a situation, that is the power of a situation to evoke an emotional response from an observer, also predicts empathy. ‘Powerful’ situations are not only those in which the ‘target’ is weak or helpless, but those which the observer can relate to due to their own experiences. For example a mother may not in general be more empathic due to her experiences of raising
children, but she might have more empathy for the situation of a new mother whose experience she can identify with. Therefore, life experiences make some situations more emotionally relevant than others. It follows then that personal experiences of caring could be more likely to provoke empathy in associated aspects of paid care work.

**Gender**

As the statistics above show, care work is deeply gendered, with 95% of the care workforce being female. As argued in this section, emotional labour is also a very gendered type of work which is generally greatly undervalued because of this. Hochschild (1983), Smith (1992), Guy and Newman (2004) and many other academic researchers have argued that emotional labour is seen as part of women’s natural work and an extension of their private, presumably caring lives. It is possible then, that the gendered nature of women’s personal lives, impacts on the emotion work undertaken during paid labour.

Literature on gender differences and empathy is conflicting, however Hoffman (1977) found evidence that adult females scored significantly higher when decoding the visual and auditory cues of others. Females have been found to score higher than males on self-report empathy scales, but Davis (1994) argues that reported differences are based on sex-role stereotypes to a far greater extent than as the result of any physiological or psychological differences.

There is also some evidence for gender differences in emotional labour. Firstly, on a social level, with emotional labour theorists including Hochschild arguing that roles requiring emotional labour tend to be female dominated (e.g. cabin crew, nurses, care staff). She argued that as emotional labour was an ‘invisible’ form of labour, it went unnoticed and unpaid. Literature also suggests that within occupations, women tend to, or are expected to, engage in the tasks requiring higher emotional labour. For example female PCs are more likely to be found in family liaison roles, or be asked to conduct sensitive interviews with victims of crime (Brown & Heidensohn, 2000). It is
argued that female dominated professions such as caring are poorly paid, precisely because they are female dominated and with the societal expectation that caring work is women's 'natural' work, so hardly a skill at all (Guy & Newman, 2004).

There is also some evidence to suggest that males and females respond differently to different forms of emotional labour. For example Johnson and Spector (2007b) found that females were more likely to experience negative consequences, such as emotional exhaustion, as a result of surface acting.

While it is possible that gender differences are relevant in relation to empathy and emotional labour, it is unlikely that there will be enough males in the present study to examine gender differences. However, the gendered nature of care work and emotional labour are of direct relevance, even if no comparisons between the genders can be drawn.

Training

According to the National Minimum Care Standards for Care Homes for Older People, a minimum of 50% of care assistants (including agency staff) working in a given care home should have NVQ 2 by 2005 (Department of Health, 2002a) which includes the period of data collection for this research. However, according to CSCI (2005) many care homes were struggling to meet the qualification criteria, in part due to a shortage of NVQ trainers and examiners. The NVQ 2 is specifically in health and social care. It is usually advised that staff have at least 6 months experience before undertaking the NVQ 2. New, inexperienced care staff are encouraged to undertake TOPPs 5 training, which can later contribute towards NVQ 2. This training is mostly practical, for example safe physical handling of residents using wheelchairs and hoists. The NVQ 2 (City & Guilds) consists of 6 units in total. There are 4 core units, of which at least 2 must be completed:

- Communicate with, and complete records for individuals
- Support the health & safety of yourself and individuals
- Develop your knowledge and practice
- Ensure your own actions support the care, protection and well being of individuals

There are a further 26 units, of which between 2 and 4 must be taken. These do include units with an emotional element, e.g.

- Support individuals during therapy sessions
- Support individuals who are distressed
- Contribute to effective group care
- Protect yourself from the risk of violence at work

There are no statistics as to which NVQ 2 units are most commonly completed. Some units are inappropriate for care home staff as they refer to community care. It is also interesting to note that not one unit specifies dementia care or night-time care. From the researchers' own experience, the NVQ 2 units predominantly require staff to complete a workbook which is then marked. They are also observed providing care, either focusing on one particular element or continually for several hours.

NVQ 3 is recommended for senior staff or team-leaders and includes a managerial element. It is expected that very few care staff will have this qualification, but it is possible some experienced staff will have moved directly to NVQ 3.

Aside from the NVQ 2, care homes also provide in-house training or send care staff on training days outside of their home, usually at another care home. This training is either guided by the home manager or the care chain, which the majority of care homes are now a part of. This training varies between homes and is not standardised. This range of training interventions is also reflected in the care homes literature.

There is a lack of research into the effectiveness of NVQ training, in part due to the recent deadlines for the new minimum standards. There is more research and insight into the current and future role and training of nursing staff working in care homes which include nursing care. In particular, Nolan and colleagues (2002) have studied the training of student nurses, especially the training outcomes for care home
placements, finding that the placements had a greater impact on student desire to work with older people than classroom based training.

Nolan et al. (2002) conducted a three and a half year longitudinal study into the education of student nurses in preparation for working with older people. Detailed case studies with student nurses revealed that the nature of student’s experiences in long term care wards or nursing homes influenced their future career choices and opinions about working with older people. Nolan et al. described two learning environments ‘enriched’ and ‘impoverished’. In ‘impoverished’ environments, poor staff attitudes and lack of resources meant most students were put off working with older people and did not gain much in terms of learning. In contrast, ‘enriched’ environments valued the older people, students and staff and the needs of these groups were recognised. This study and the outcomes did not focus on the training of care assistants, however the complexity of training outcomes is revealed to be not just dependent on courses and training materials, but the attitude and organisational factors within the home. Organisational factors, including those described by Nolan et al. (2002) will be discussed in Part B of this chapter.

**Empathy and Training**

This section has so far addressed the current training for care staff and it has been argued that this training does not specifically address the emotion work of care staff. However, training and intervention studies which specifically relate to empathy of staff have been undertaken, particularly within medical and health care professions. In Chapter 2 (Part C) it was argued that empathy is a stable trait. However, that is not to say that the use of empathy can not be influenced by training in the same way that a person can be trained to pass exams on specific subjects but their IQ remains the same. There are two areas in which training could impact on a person’s empathy use. Firstly, training could encourage and motivate staff to engage in empathy more often. Secondly, training could focus on the behavioural response to empathy, that is how a practitioner translates their empathic feelings into a response to the patient. Mete (2007) undertook research with nurses in Turkey during their four years of training
which included empathy related training. Throughout the course, significant improvements occurred in how good nurses were at accurate empathy and giving an appropriate behavioural response, but not how likely they were to engage empathically. These findings were very similar to those of Oz (2001) who found that nurses receiving empathy training significantly increased in empathic communication skills but not in empathic tendency.

The impact of empathy on training is mixed and further complicated by the use of different measures of empathy. This has resulted in a call to identify the basic empathy skills involved in nursing and the impact of different interventions on these skills (Kunyk & Olson, 2001; Alligood, 2001). Taken as a whole however, the research does suggest that intervention can influence the behavioural aspects of empathy, but will not increase empathic tendency. It is not clear however, if this intervention does lead to improved outcomes for the patient, and if the patient feels empathy has increased. There is a link between training and empathy, and between empathy and patient outcome, but with the range of measurements, definitions and perspectives used, it is difficult to form an overall picture of the relationship between empathy training and patient outcome.

Overseas Staff

Many UK care homes employ staff from overseas, some care chains directly recruit from overseas to fill vacancies. Overseas staff include any staff who were born and lived in another country before moving to the UK. However, this includes both care staff who have lived in the UK for many years and those who recently moved to the UK. In particular, this research is interested in possible communication barriers, particularly effecting those staff who speak English as an acquired language, and cultural differences, as these could impact on both the emotion work of care staff and the support they provide to the (predominantly British) residents.

Statistics detailing the prevalence of overseas care workers are not readily available. However, the annual population survey (Office of National Statistics, 2006) combines
both care assistants working in care homes and home care workers to provide a useful estimate of the national employment rates of overseas (or migrant) care staff. In 2006 about 16% of registered care staff were born overseas, representing over 100,000 people. This figure varies greatly between geographical areas, with overseas care workers in London forming an estimated 68% of the workforce. These overseas care staff originated from a variety of countries, most commonly Zimbabwe, Nigeria, the Philippines, Ghana and Poland, although with recent changes to the structure of the EU, numbers of ‘Eastern European’ care staff are now likely to have risen (ONS, 2006).

There is a paucity of academic research into overseas care staff working in care homes. However, there has been an increasing awareness and also research into migrant nurses working in the UK, and with regards to the emotional aspects of caring, this research is useful in informing the current research. Winkelmann-Gleed (2006) argued that successful integration of migrant nurses depended in their personal and also work-related identities. These identities included their motivation to work, commitment to the organisation and how diversity in the workforce was managed. Winkelmann-Gleed undertook a large quantitative and qualitative study and lists some reasons nurses are motivated to migrate to the UK, including:

- Historic links with the UK
- Family-related (family members working in UK)
- Economic reasons (high unemployment or lower pay in country of origin)
- International recruitment (directly recruited by UK to fill vacancies)
- Desire for adventure
- Desire to learn English or gain work experience in UK
- Threats and persecution in country of origin

It is very likely that many of the same reasons apply to the motivation of overseas care staff to undertake care work in the UK. However, there are also some differences with most migrant nurses already being trained as nurses and therefore having made that career decision prior to moving. Overseas care staff however are far less likely to have already worked as care staff in their country of origins, in part because of the differences in social care systems (for example lack of care homes in some countries).
Therefore, it is more likely that motivations for migration were related to living in the UK (or not living in their country of origin) and motivation to work as a care assistant could be very different to that of UK staff. As argued by Winkelmann-Gleed (2006), motivation impacts on how well migrant staff integrate in their workplace and the relationships they form with other staff (and presumably patients/residents).

Communication between staff and also between staff and residents is an essential aspect of good teamwork and also care. Winkelmann-Gleed (2006) provides some specific examples of nurses from different countries struggling to fully understand one another. In particular she highlights difficulties in comprehension of slang and humour as not only linguistic but cultural challenges. While some work environments were supportive of overseas nursing staff while they are assimilating new linguistic skills, others, often due to time and staffing pressures, were less so. It was highlighted that staff who lacked fluent language skills were assumed by colleagues to lack the necessary qualifications and education for the job. It could be that this related to perceptions of some other countries being ‘less advanced’ or ‘well developed’ than the UK. In a care home communication with both residents and other staff could be more difficult for those care staff who speak English as an acquired language, or who have strong accents. Cultural differences could mean that everyday concepts and assumptions made by UK staff (for example about food and drink, about illness and death or historical events such as wars) need to be learnt by overseas staff in order to meet the cultural needs of the residents.

Some reports on nurses, particularly within the NHS, have uncovered examples of organisational racism (Alexis et al. 2004; Allan, 2007; Smith & Mackintosh, 2007; Larsen, 2007), including overseas nurses working in positions below their skills and training, lack of promotion opportunities and lack of attempts to understand the experiences of overseas staff. This research addresses organisational or work cultures of racism as opposed to focusing on individual staff who may be racist. In care homes there are some overseas nurses working as care assistants while waiting for relevant paperwork or opportunities for training in order for them to practice as a nurse in the
UK. Care homes in general lack opportunities for promotion and have a poorly structured career path unlike careers in nursing. Therefore it is unclear as to the extent organisational racism in terms of career progression exists in care homes. This research will consider the extent that care homes understand the needs of their overseas staff and support them effectively.

Research and reports into racism in care homes tend to be limited to racism by residents and their friends/relatives. For example Anchor Trust (Burton-Jones & Mosley, 2007) undertook research to understand and address racism within a group of their care homes. The homes were in Southwark and a 2000 survey revealed that only 17% of care staff were white (any origin) compared to 95% of the residents. The Anchor report discussed resident problems in understanding some staff with strong accents, underlying racist attitudes in a significant proportion of the older residents, and the sometimes negative reactions of residents with dementia towards black staff. The report found that staff dealt with racism in a number of ways, including:

- Making allowances – not doing anything due to vulnerability of residents.
- Feeling guilty – in general for not belonging and ‘intruding’
- Playing down the impact – not knowing if staff would be supportive, worried about taking up managers time
- Not reporting due to previous negative experience- from no reaction by senior staff to being blamed for incident
- Speaking to the relative to address issue

The majority of staff did not report racism, and when it had been reported, Anchor conceded that positive action had not consistently been taken. This reduced the likelihood of staff reporting racism or admitting distress in the future. Anchor does not dwell on the form of the racism, but it would appear to include verbal and also physical abuse of care staff. Anchor sets out future plans and trials to support staff who have suffered racial abuse, to deal positively with incidents, to encourage staff to report incidents, and to provide information and inductions for residents and their families addressing racism in a sensitive way. It is possible that racism will arise in the present research as one of the contributors of emotional labour in the interview data. In terms of empathy, it would be understandable if care staff struggled to
empathise with residents who were racist toward them, however the reaction ‘making allowances’ would appear to suggest that care staff do still try to understand the perspective of residents even in these circumstances.

Cultural difference between overseas and UK staff or residents is a broad topic which can not be fully addressed here. Anchor Trust (2007) emphasises the need for overseas staff to be given extra support and maybe training in order to more fully introduce them to the prominent culture of the residents in their care. Equally Winkelmann-Gleed (2006) emphasises clashes between different cultural norms, such as an Indian nurse not pushing patients head-first on trolleys as this to her was a symbol that the patient would die. A nursing lecturer also described cultural problems surrounding concepts such as privacy.

“In a war torn area you don’t think ‘Oh, I should cover the patient with a blanket when I do a bed bath. I need to ensure privacy’ or whatever. For them to come to this country and practise differently takes time. He has no concept how to handle a bed bath with dignity and respect and therefore conflicts with UK nursing” (pp. 104)

For overseas staff to understand important aspects of UK culture, both in general and with respect to care, and to change their practice requires a great deal of effort. Therefore new overseas staff may well exert more mental and emotional work in order to take on this extra learning workload. Culture clashes and how they are dealt with by other staff and residents, either positively or negatively, presumably also impacts on the emotion work of overseas care staff.

This section of the review has focused on some of the likely sources of emotion work undertaken by overseas care staff. It is likely that overseas staff experience some different situations and so engage in some different emotion work to UK staff. However, it is not clear if overseas staff engage in higher or lower levels of emotional labour or if the differences are qualitative, that is, different types of emotional labour.
Furthermore it is not understood how these differences could impact on the care staff themselves and the emotional support they provide for residents.

Aims and Conclusions: Staff Characteristics

The literature in this section has revealed evidence in relation to empathy and emotional labour, or 'emotion work' in general, that individual characteristics could influence these constructs and so ultimately impact on the provision of emotional support. Overall though there is a paucity of research into characteristics that could impact on emotional labour and emotional support with most focusing on empathy, a traditionally 'individual differences' based construct. These staff characteristics have not been examined together or with the aims of understanding these variables in a care home context.

This research aims to quantitatively examine the possible associations between these staff characteristics and the three constructs; empathy, emotional labour and emotional support. This research also aims to qualitatively explore staff characteristics in order to understand how they impact on emotion work.

Part B: Resident Characteristics

This section will focus on the residents being cared for by the staff, and relate different 'resident characteristics' to staff empathy and emotional labour. From the perspective of the care staff, residents make a substantial contribution to their working environment and also the emotion work they undertake. The characteristics of the residents and organisational factors together make up their working environment.

The needs of the residents impact on the emotion work of care staff in several ways. Firstly, the emotional needs of residents differs in one-to-one care, some requiring more emotion work than others. Secondly, the overall mix of residents and their physical and mental health needs is at the core of the care home workload. The needs
of the residents as a group are directly related to the amount of work, and time pressures within a care home.

Most of the available statistics outlining the physical and mental health needs of residents are related to admissions data. The Office of Fair Trading (2005) lists 12 most common reasons for care homes admission amongst older people, see Table 3.1.

**Table 3.1: Reasons for admissions into a care home**

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health problems</td>
<td>69%</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>43%</td>
</tr>
<tr>
<td>Functional disablement</td>
<td>42%</td>
</tr>
<tr>
<td>Carer stress</td>
<td>38%</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>22%</td>
</tr>
<tr>
<td>Present home physically unsuitable</td>
<td>15%</td>
</tr>
<tr>
<td>Family breakdown (including loss of carer)</td>
<td>8%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>6%</td>
</tr>
<tr>
<td>Fear of being a victim of crime</td>
<td>4%</td>
</tr>
<tr>
<td>Abuse</td>
<td>2%</td>
</tr>
<tr>
<td>Loneliness or isolation</td>
<td>2%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>1%</td>
</tr>
</tbody>
</table>

NB: more than one reason may be given

(OFT, 2005. pp 23)

The OFT (2005) data are cited from Bebbington et al. (2001), which was based on 1995/1996 longitudinal survey data, so it is very likely there have been changes over the past decade. However, this overview of reasons for admissions serves to highlight the range of needs of care home residents. All of these reasons relate to loss of independence and some level of distress for the resident.

Bebbington et al. (2001) further identify illnesses associated with care home admissions, including cardiovascular disease, stroke, respiratory disease, deafness, depression, fractures and blindness. They identified that 38% of admissions to care homes relate to dementia, and estimate that cognitive impairment is widespread with only 1/3 of residents being classed as intact or borderline, and 1/3 as severe. While levels of cognitive impairment are higher in nursing homes, there are still large
numbers of severely impaired people in residential homes. Residential homes can also be classed as Elderly Mentally Infirm (EMI) homes, or have an EMI unit within them. Bebbington et al's (2001) research reveals the complexity and range of physical and mental health issues that are common amongst care home residents.

**Dementia and Challenging Behaviour**

An overview of the emotional support required by older residents with dementia has already been provided (Chapter 2, Part A). Effective communication, providing security and responding to a range of behaviours (some classed as challenging), are all important aspects of dementia care. The brief review also highlighted the complex ethical considerations involved in caring for a person with dementia. In particular, responding to a resident who wishes to go home, or a resident who is searching for a deceased loved one were common, but ethically challenging situations that staff regularly dealt with. In the emotional labour literature review (Chapter 2, Part B) the relationship between dementia care and staff burnout was explored, but the research to date is inconclusive, relying on self report scales and tending to focus on 'challenging behaviours'. The section concluded that while there is research conducted in care homes, much of it relates to interventions with staff which focus on dementia care. While the emotional needs of the residents may be paramount in these interventions, the emotional labour and empathy undertaken by care staff prior to intervention, and that which is presumably needed to enforce change has not been addressed.

Challenging or disruptive behaviour regularly appears in dementia based research and relates to situations in which emotions can be intense for both residents and staff. Challenging or disruptive behaviours are those perceived by other residents and/or the staff to be endangering, stressful, frightening, frustrating, socially unacceptable, or isolating in nature (Beck et al. 1998). Bair et al. (1999) described disruptive behaviours as those that either interrupted the care of the resident themselves or that of the other residents. Bair et al. also identified these behaviours as a source of stress and frustration for nursing staff in a US nursing home. Staff resented these behaviours if they felt they were unable to provide enough care to other residents as a
result. Challenging behaviours also include aggression, either physical or verbal. Rodney (2000) found a direct link between nurse’s threat appraisal and their stress levels. While most studies have focused on actual physical aggression, the perceived threat of aggression either from verbal threats or past behaviours is also highly stressful for staff. Long-Foley et al. (2003) studied staff perceptions of challenging behaviour and found that staff perceived a greater threat from patients whose behaviour was unpredictable, and by patients who were physically large, usually men. These studies suggest that care staff must work hard to manage the stress they feel when responding to these situations. Assuming care staff strive to maintain a calm demeanour in these situations, emotional labour can be assumed to be essential, and directly effected by the perceived threat they feel.

Cassidy and Sheikh (2002) conducted research in dementia care institution in the US and found that frontline staff were adept at using the least invasive interventions of verbal communication, ignoring behaviour and redirecting behaviour. They argue that verbal one-to-one communication, which was most frequently attempted, involved high levels of emotional labour for care staff. From their observations, Cassidy and Sheikh argued that staff needed a break, or time to talk with colleagues after incidents involving aggression, but that this almost never occurred, only if the staff member was actually injured. This finding, and that of Cole et al. (2000) who argued that staff support was more important to staff welfare than different resident needs, highlight the role of organisational structures on staff emotions which will be explored in more depth later in this chapter.

Resident ‘Attractiveness’

More recently, Campbell (2005) has attempted to understand the attitudes of care staff towards residents by determining those resident characteristics which are perceived as ‘attractive’ or ‘unattractive’. This unusual terminology in relation to resident characteristics does not just relate to physical appearance but includes a range of aspects. Campbell used a combination of analysis of staff perceptions and also previous literature to determine themes of attractiveness of the residents to care staff.
Table 3.2: Components and descriptors of resident attractiveness

<table>
<thead>
<tr>
<th>Component</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical appearance</td>
<td>Physical appeal, neatness, cleanliness</td>
</tr>
<tr>
<td>Cognition</td>
<td>Understanding, orientation, alertness</td>
</tr>
<tr>
<td>Communication</td>
<td>Includes ability and willingness to communicate verbally and nonverbally with others; also family/friend communications</td>
</tr>
<tr>
<td>Behavior</td>
<td>Demonstrated through actions and responses to others and care</td>
</tr>
<tr>
<td>Humanness</td>
<td>Relates to experiences of pain, suffering, and trajectory toward end of life</td>
</tr>
</tbody>
</table>

(Campbell, 2005. pp 109)

Campbell argues that the perceived 'attractiveness' of residents by care staff impacts on how staff approach care and so the outcome for the resident. This model has yet to be tested, but there is evidence that staff attitudes do indeed impact on the care they provide and so resident outcomes (e.g., Storlic, 1982; Skovdahl et al. 2004). Several of the components that contribute to 'attractiveness' correspond with the reasons for admission as previously described. Cognition relates to dementia and other mental health needs, communication is related to both dementia and physical health problems including stroke. Behaviours regarded as challenging are most commonly associated with dementia (see previous section). Lack of motivation as well as any number of the other reasons for admission could impact on physical appearance and how neat and clean a resident appears to be.

Campbell's approach could be considered controversial in that she does not shy away from directly stating those physical and behavioural characteristics of some residents that care staff could find least appealing. She notes however that denying staff's true feelings is an unhelpful approach, as she argues that staff attitudes towards residents can be changed through interventions, but this intervention needs to be based in reality, not an assumption that care staff are not subject to preferences and dislikes.

Physical appearance, including neatness and cleanliness is the first basis on which people, in general, make judgements about others. As discussed in the previous chapter, the likelihood of a person to engage empathically with another in a given situation in part depends on how alike they see themselves to the other person.
Physical appearance could be a barrier to some staff empathising. However, another factor is the 'neediness' of the other person, and physical appearance could well also strongly relate to how much in need they are perceived to be. In terms of emotional labour, if it is assumed that staff do indeed have a negative attitude towards some residents based on their appearance, they are more likely to need to engage in deep or surface acting with these residents in order to cover these negative emotions. Campbell (2005) highlights the concern staff have for expressing the negative emotions they have regarding residents appearances as they feel they ought not think in that way, supporting the idea that staff are likely to cover their true emotions.

Campbell argues that after initial judgments based on appearance are made, communication is the most important tool humans have to attract others. For many care home residents, both verbal and non-verbal communication are limited. They therefore struggle, not only to make their needs and wants known, but to build positive, reciprocal relationships with staff. Therefore, Campbell argues that residents who can not, or choose not to, readily communicate with staff are at a disadvantage in terms of staff perceptions. Based on Davis' (1994) model of empathy, it is difficult for staff to establish how alike they are to a person with whom they struggle to communicate and without communication they may fail to understand the perspective of the resident beyond knowing that the resident can not easily communicate.

*End of Life Care*

Campbell (2005) argued that care staff gained satisfaction from helping residents and seeing them improve. In contrast, those residents who were on a 'downwards trajectory', in pain, or near the end of their life, were less 'attractive' to staff. The explanation for this was that some staff did not like to be faced with extreme frailty and death as it reminded them of their own mortality and fears about their own death. It would appear that this part of Campbell's argument differs from the other themes of 'attractiveness' as it is related to what the resident represents, rather than the resident themselves. This fear was not apparent in all care staff. Although not directly drawing on emotion work or emotional labour, Campbell's argument suggests that
care staff find working with these residents evokes negative emotions which they must work to control. Therefore, what Campbell describes as ‘lack of attractiveness’ can also be argued to relate to the exertion of emotional labour. Holman et al. (2006) also argued that care staff can feel strongly negative emotions relating to non-responsive patients, particularly those who were in the end stages of their life so would not improve, but could be in this state for months or even years. They argued that care staff felt hopelessness when caring for these patients, but that they were less conscious of these feelings than of other emotions and as a result tended not to refer to these residents and focus more on more ‘feisty’ patients. This supports Campbell’s assertion that caring for dying residents can evoke strong negative emotions but also suggests these emotions are both complex and may not be fully recognised.

Schell and Kayser-Jones (2007) found that 25% of care staff struggled to talk to residents about death and were uncomfortable with the topic. In contrast to Campbell’s findings however, they found staff tried to actively engage in role taking (a form of empathic engagement), to try and understand the needs of residents at the end of their lives. This involves actively engaging emotionally with the resident and their experience. It seems likely that many staff do find working with residents that are near the end of their lives difficult, especially if the resident’s decline is slow and distressing. However, that does not necessarily mean they avoid these residents or do not try to provide them with sensitive care.

Conclusion and Aims: Resident Characteristics

This section has highlighted some of the resident characteristics that are relevant to the emotion work undertaken by care staff. Older people entering residential care have a range of physical and mental health needs which care staff need to respond to. Dementia is prevalent amongst care home residents and can relate to challenging forms of behaviour, which are recognised within the literature as being difficult to respond to. Researchers have recognised that staff find some residents more appealing to work with than others based on a range of attributes (Campbell, 2005) but this research does not explore the effects of these attributes on the emotion work
of staff. The current research aims to explore those resident characteristics that influence the emotion work of the care staff. For example, the emotional labour involved in caring for residents who exhibit ‘challenging behaviour’, how empathy is used in this care, the emotional support provided for these residents, and how the staff themselves are effected will be investigated.

Part C: Structural and Organisational Factors

This section of the chapter addresses the research and statistics relating to structural and organisational factors within care homes. These, will also be jointly referred to as ‘environmental factors’ as from the perspective of the care assistant, these make up their working environment, along with the residents. Research relating to environmental factors and emotions specifically will be explored, including linking Hochschild’s (1983) notion of ‘feeling rules’ with known structures within care homes. This section will also draw on current research and statistics relating to care homes that, although not specifically addressed in emotions literature, are likely to impact on the emotion work of care staff.

Staffing

Staffing levels in care homes concern both policy makers, who set staffing ratios, and also care homes, who must recruit and retain staff. Staffing levels in care homes are designed to reflect the needs of the residents. The Residential Forum (2002) placed resident’s needs on a continuum from low to high dependency, with care assistant hours per resident ranging from 16 to 20 hours per week. Yet these standards are not rigidly applied and levels of dependency are not easy to calculate.

Recruitment and retention of staff is a major issue for most care homes, especially in London and the South East, where the cost of living is high (King’s Fund; Buchan et al. 2004). Netten et al. (2003a) argued that this was in part due to care staff being paid the same as for other much less demanding and stressful jobs such as supermarket checkout staff, therefore unless there are increases in staff wages, these
problems would continue. Staff wages are largely determined by the overall funding structure in care homes, and are therefore part of a wider social and economic context, which will not be discussed here. Staffing levels in care homes directly influence time pressures placed on individual staff and their stress levels, and these in turn impact on both empathy and emotional labour.

Staff shortages and inappropriate staff ratios both increase time pressures on staff. Increased time pressure directly decreases a person's willingness to engage empathically (Reynolds et al. 2000). Morse et al. (1992) in their study of doctors, argued that time demands and high patient turn-over may make engaging empathically unrealistic. Schell & Kayser-Jones (2007) also suggested that more time needed to be set aside for care staff to support residents at the end of their lives, specifically role taking required time. It is clear then that increased pressures of time, reduces staff willingness and/or ability to engage in the affective component of empathy. However, if staff do engage in affective empathy, time constraints are likely to impact on how they respond behaviourally. Schell & Kayser-Jones (2007) argue that without adequate understanding by an organisation that palliative care requires staff to spend more time with one resident, staff will struggle as they understand what a resident may want, but are unable to deliver it.

Emotional labour is also directly impacted on by staffing levels, in that inadequate staffing decreases the time staff spend with each resident and increases their overall stress levels. According to Hochschild (1983) staff would then engage in surface or deep acting to maintain a calm outward appearance as stress levels increase. This view is supported by the literature (Smith, 1992; Eyers, 2003) which provides evidence of increased emotional labour for staff as time pressures increase. It has been previously argued that emotional labour can be linked to job satisfaction (Chapter 2, Part B). However, the combination of added stress, emotional labour and staff being aware that, due to time constraints, they were unable to care for residents/patients as they would ideally wish, lead to dissatisfaction and burnout over time.
Care Home Culture

This section will address the complex and difficult to define concept of care home cultures. There are many examples of care homes research, particularly intervention based research, which cite the importance of care home culture, also described as the atmosphere, philosophy or care priorities in a home. For example Youll & McCourt-Perring (1993) evaluated the introduction of the 'Caring in Homes' initiative in 100 homes. They reported that a significant proportion of homes failed to complete the process, arguing that any changes needed to be legitimated and supported by the philosophy, policies and practices of the organisation. Titman (2003) defined key areas of information that people felt they would like to have when making choices about care homes, which included: Atmosphere, staff, resident interaction and philosophy. The 'My Home Life' literature review (NCHR&D, 2007) includes a chapter titled 'Promoting positive culture in care homes'. Care home culture, according to both industry and academic literature, and also in the researchers own experience working in care homes, is central to both the experience of care staff and the quality of care received by the residents. What is less clear is what different cultures consist of, how readily specific care home cultures can be identified, and how these relate to the emotional work of care staff. The following sections discuss some of the organisational factors that contribute to care home culture and relate these to the 'feeling rules' of a home. As discussed in Chapter 2 (Part B), the feeling rules or 'emotional tone' impact on the emotion work of care staff.

Senior Staff and Management

The role of managers and senior staff in care homes can vary, with some being almost entirely office based and others being much more a part of the 'on floor' care team. Smith (1992) in her ethnographic study of student nurses, found that the ward matron set the emotional tone of a given ward. One aspect of this was whether they were visibly hands-on with patients, providing student nurses with a role-model, or whether they were distant and more administration focused. Role-modelling was important for students, not only so they could learn clinical skills, but so they could observe experienced nurses responding to patients and reacting in emergencies or highly
stressful situations. Smith found that student nurses’ descriptions of good role-models, were highly emotionally focused. Students aspired to appear as calm and caring as some of the matrons, whom they viewed as efficiently completing their work, while still paying attention to the smaller, more individual aspects of caring. In stressful situations, it was the matrons that largely determined how students responded, either by calmly encouraging them or becoming tense and critical. After an emergency or death, it was the matrons who also determined the emotional outcome for students, by either acknowledging their emotions, taking time to talk to them and ensuring they had a break, or by ignoring the student’s often negative emotions. There are obviously differences between the roles and environment on a hospital ward and within a care home, but as Smith’s work particularly focused on the emotional labour of the student nurses, the findings are of relevance to the present research.

The approach of management and senior staff in care homes has been linked to both staff and resident outcomes. Hurtley (2003) studied staff motivation and job satisfaction in care homes, and argued that staff and resident wellbeing were not separate but interdependent, with emotional health being prominent to this wellbeing. Hurtley’s findings support those of Smith (1992), as she highlights the importance of ‘actively modelling’ key values and skills, which reflects Smith’s role-modelling for nurses. Nolan et al. (2002) in their longitudinal study of nursing placements within care homes, state that ‘exposure to good role models and environments of care’ are essential for positive learning experiences. Furthermore, Schell and Kayser-Jones (2007) also specifically state that role-modelling by supervisors promotes an atmosphere which supports empathy. Together, these studies suggest that role-modelling is important for care staff to understand and also implement effective use of both empathy and emotional labour. This in turn, could increase the job satisfaction and wellbeing of staff.

Hurtley (2003) also addresses the need for management not only to be open, but to actively find out about their staff’s wellbeing by asking specific and pertinent
questions. Similarly, Anderson et al. (2003) identified ‘open communication patterns’ as one aspect of management style that would positively impact on their care staff. Schell and Kayser-Jones (2007) extended the need of open communication with senior staff to include the importance of staff knowing that this communication would be acted on. Staff who felt that their reports to senior staff did not result in action were not motivated to continue communicating with management. The authors argued that if staff felt powerless to make changes, they were less likely to empathise with dying residents, as they found understanding a resident’s needs but being unable to meet those needs distressing. Similarly, in the Anchor Trust report (2007) into racism, already described above, senior staff not acting on reports of racism was seen as a barrier to future reports and positive action being taken. The evidence from both nursing and care home literature strongly suggests that management communication and response are important in terms of staff support and impact on care assistant’s willingness to engage emotionally with residents.

Another important aspect of leadership identified by Anderson et al. (2003) is the ‘formalisation of rules’. They argued that care homes varied in the extent to which staff were persuaded to follow rules and procedures as a way of ensuring predictability and performance. Highly formalised settings were found in homes where residents had a greater prevalence of health complications and immobility. Lopez (2006) also referred to the way in which rules were laid down and implemented in a comparison of 3 USA care homes. The homes ranged from promoting specific feeling rules, namely ‘remaining professional at all times’, to promoting relationships between staff and residents. Lopez argued that the specific feeling rules were a barrier to staff forming relationships with residents, and that staff needed support in establishing their own feeling rules with the residents. Explicitly stating that staff remain professional at all times, appears at face value, to be a reasonable expectation. However, Lopez argues that this increases staff’s emotional labour and decreases person centred care. In particular he found staff stoically accepted verbal and physical abuse by residents, engaging in emotional labour to remain calm. In doing so, they failed to address either their own working conditions or the possible reason the
resident was responding in this way. In contrast, in homes with 'organized emotional care' which allowed resident/staff dyads to form their own feeling rules, staff members were observed calmly explained to an aggressive resident that they would leave the room until he had calmed down, and then they returned and tried to discover the reasons underlying his anger. In doing this, the staff member and resident engaged in a reciprocal relationship, whereby the resident knew the staff member was unhappy with aggressive behaviour, but the staff member also sought to understand the reasons for the aggression. The staff’s emotional labour was overall reduced, as they did not have to pretend that aggression did not affect them, and they felt they had some ability to change and improve the situation for themselves and the resident.

Schell and Kayser-Jones (2007), in their study of the role of empathy in palliative care given in care homes, identified two further important aspects of leadership which promoted empathy amongst care staff. Firstly, senior staff that recognised the role of empathy in resident care and so gave positive feedback to staff on the emotion work they were doing. Secondly, the relationship or bond between the resident and staff member was not undermined and staff were told about a resident’s decline or death sensitively. These methods of leadership both involve the senior staff being very aware of what aspects of care work involve emotionally as well as having a good knowledge of the care staff and residents and their relationships.

Learning Environment and the Six Senses Framework
The standard training for care assistants, has previously been discussed under 'staff characteristics', specifically the NVQ level 2. However, it is not clear how successful the introduction of the NVQ 2 has been, and to what extent it is the learning environment within a home, as opposed to the learning materials, that impact on the outcome in terms of staff learning and improvements to care. Nolan et al. (2002) described 'enriched' environments for learning for nurses on placements within care homes. Although there are differences between nurse and care assistant experiences and training, the care home cultures identified by Nolan et al. are also relevant to care staff. These environments were described using 6 themes, based on the 'six senses
framework (Davies et al. 1999; Nolan et al, 2001, 2006). This framework is discussed below as it not only relates to staff training, but to important aspects of the care home culture.

The six senses framework (Davies et al. 1999; Nolan et al, 2001, 2006) is based on a ‘relationship-centred’ philosophy of care and aims to provide a balance between the needs of all care home participants, namely the older people, the staff and the family members. In doing so, the authors emphasise that the needs and wellbeing of the care staff are intrinsically linked to the quality of care they provide for the residents. The framework recognises that all participants have similar needs and many of these needs are related to emotions. Nolan et al. (2002) summarized the ‘six senses’ for residents, staff and family members. Those aspects relevant to staff are given below.

• A sense of security
To feel free from physical threat, rebuke or censure. To have emotional demands of work recognized and to work within a supportive but challenging culture.

• A sense of continuity
Positive experience of work with older people from an early stage of their career, exposure to good role models and environments of care. Expectations and standards of care communicated clearly and consistently.

• A sense of belonging
To feel part of a team with a recognized and valued contribution, to belong to a peer group, a community of gerontological practitioners.

• A sense of purpose
To have a sense of therapeutic direction, a clear set of goals to which to aspire.

• A sense of achievement
To be able to provide good care, to feel satisfied with one’s efforts, to contribute towards therapeutic goals as appropriate, to use skills and ability to the full.

• A sense of significance
To feel that gerontological practice is valued and important, that your work and efforts matter.

(Nolan et al. 2002 pp61).

In particular ‘a sense of security’ strongly refers to staff emotions and also to concepts already discussed, for example abuse from residents and also senior staff recognising
emotional workloads (for example during palliative care). The authors also link the need for staff support with the more positive notion of challenges as work. In an emotional labour context, this relates to issues of burnout and job satisfaction discussed in Chapter 2 (Part B). A sense of purpose, achievement and significance also relate to job satisfaction, and presumably, without these senses, emotional exhaustion could be more prevalent. These descriptions can be readily related to the literature examined so far. For example, being able to provide good care and use skills to the full, can relate to time pressures and staffing levels. Feeling your work is valued relates to management understanding and praise, but also to seeing positive outcomes for residents. These aspects of the framework can not easily be related to staff empathy, but in terms of emotional labour, they are aimed at focusing emotion work towards residents, but in a fulfilling and supportive environment. Therefore, while emotional labour is a necessity of care, less is being expended outside of direct care of the residents, for example, care staff are less likely to have to cover up negative emotions relating to the care home environment. The framework highlights the need for staff support and also recognition of their emotion work, suggesting that while emotional labour is expected, the outcome for staff can be much more positive give encouragement and support.

The sense of continuity correlates strongly with the roles of staff and management as discussed earlier in this section, for example the importance of role models. A sense of belonging strongly suggests the need for staff to feel part of a team within the home, but also part of a wider community of care workers. Davies (2003) also argues that effective teamwork amongst staff is vital for a positive community within a care home.

The six senses framework is a particularly useful tool for addressing the complex issue of care homes culture and in aiding understanding of how person and relationship-centred care could be achieved in practical terms. However, while the six senses framework does relate to aspects of the literature, it is by no means exhaustive.
It is also not clear which senses are most important for care staff in terms of the impact they have on the emotion work staff undertake.

**Care Routines**

Care homes tend to be highly routinised, with set mealtimes, set procedures for medication, staff shift changes, and a daily cycle of getting residents up, personal care and helping residents to bed. Some aspects of care, such as nutrition, medication, incontinence and hygiene, strongly influence these routines, but there is still a great deal of variation in the flexibility of care provision between homes. The current goal of person-centred care, suggests a lack of routine, and care that is entirely driven by the needs of the individual. In reality, in a group living setting, individual needs are addressed within and around the routine of the home, to a better or worse extent. Care home routines have been argued to erode resident's identities (NCHR&D, 2007).

Smith (1992) in her study of student nurses, found that highly routinised wards, which were run by task orientated matrons could impose extra stress on nurses, as they tried to meet targets that were often arbitrary. In wards where routine was paramount, nurses only saw the practical aspects of care as being actual work, and emotion work was an added extra that was not regarded as part of the job. Nurses engaged in emotional labour in order to make sure patients fitted into the routine. The routinisation of wards was linked to the feeling rules, or emotional tone of the ward. If maintaining order and routine was the most important aspect of care, the emotion work of staff was undermined, and their own emotions tended to be of little relevance. Staff on these wards were less likely to see good role-models of emotion work or to receive emotional support themselves.

Menzies Lyth (1988) in her study of nurses in the late 1950s, described the rigid hospital routines, checklists and task focused nursing, to be an unconscious effort to contain the anxiety of nurses. By reducing the opportunity for nurses to form relationships with patients and reducing decision making, the nursing system unsuccessfully attempted to reduce nurses' anxieties, but ultimately created an
unsatisfactory care system and a poor work environment for nurses, 1/3 of whom chose to leave training. Although there have been many changes within hospitals and care systems, Menzies Lyth’s work highlights that some environments or actions that may be viewed as simply ‘poor care’ could also relate to attempts to support or protect care staff from excessive emotional or cognitive demands.

While care homes, should be comparatively much less routinised than hospital wards, there is, in reality a great deal of variation. Research to date (Forte, Cotter and Wells, 2006; Chaudhury, 2003) has emphasised the impact of routines on resident care. Staff who strictly adhere to routines are unlikely to cater for the individual emotional needs of residents. There is little evidence as to what impact routines have on the care staff themselves. Lopez (2006) found staff with more autonomy at work engaged in less emotional labour as they were able to change the routine to suit the resident’s needs and so were less likely to engage in power struggles with residents. In this way, emotional labour of care staff was bound to the positive and negative responses of residents due to their own emotional needs being met by the system.

**Conclusion and Aims: Structural and Organisational Factors**

This review has highlighted some of the important structural and organisation factors that could impact on empathy, emotional labour and emotional support, while recognising that care home structures and cultures are varied and complex. While there has been research that focuses on the needs of care staff in relation to care home organisation, there is a lack of research specifically addressing the emotion work of care staff.

This research aims to address this gap by exploring the impact of these organisational factors on the emotional labour of care staff. By understanding the perspective of care staff, those factors that staff find most relevant and how these relate to the emotional labour undertaken can be better understood. The research will also focus on empathy, which can be viewed as an emotional skill as well as an important component of caring relationships (see Chapter 2, Part C), and how empathic engagement is
influenced by organisational factors. While environmental factors within a care home are not expected to impact on care staff's trait empathy, it could impact on their likelihood to engage empathically in the workplace. The effect of environmental factors on empathy within care homes has not received much academic attention and is not well understood. While models of care such as the six senses framework (Davies et al. 1999; Nolan et al, 2001, 2006) conceptualise the welfare and support of staff as inextricably linked with the quality of care of residents, this research aims to understand this link specifically in relation to the emotional support of residents.

Conclusion

As explained in this chapter and also displayed in the conceptual model of emotional support (see Figure 2.1), staff characteristics and environmental factors are both expected to impact on emotional labour and empathy, and indirectly influence emotional support. Environmental factors, which include both resident characteristics and organisational factors, are also expected to impact directly on emotional support. This reflects the findings from the literature (for example relating to resident attractiveness and also the six senses framework) which make a clear link between these factors and quality of care for the resident. This research aims to explore each of the emotional constructs in the model in Figure 2.1 from the perspective of the care assistants, as well as the association between these theoretical constructs (as described in Chapter 2). The research further aims to explore the influence of staff characteristics and environmental factors on these constructs. The methodology and the use of both qualitative and quantitative methods to achieve these aims are described in Chapter 4.
CHAPTER 4

METHODOLOGY

Part A: Overview

Research Aims

The overall aim of the research is to explore and understand those social factors, including staff characteristics, that influence the provision by care assistants of emotional support for older people living in a care home.

The theoretical model of emotional support first presented in Figure 2.1 and included here for clarity will be used to illustrate the specific aims of the research.
ii) To gain insight into how empathy and emotional labour influence both the emotional support provided for residents and how undertaking this emotion work impacts on the staff themselves.

iii) To explore qualitatively those staff characteristics and environmental factors that influence empathy, emotional labour and emotional support from the perspective of the care staff.

iv) To develop an emotional support scale for use within a care home setting.

v) To explore self reported empathy, emotional labour and emotional support quantitatively, in terms of the constructs themselves and any associations between them.

vi) To explore quantitatively, any associations between a range of staff characteristics and empathy, emotional labour and empathy.

vii) To integrate the qualitative and quantitative findings to produce and explain a research based model of emotional support from the perspective of the care staff.

Design

A mixed design was used to achieve these aims. Quantitative data were collected using self-report questionnaires that were completed by care assistants in 8 care homes. The questionnaires contained demographic and other information about staff. Three short scales were included in the questionnaire to provide a quantitative measure of Empathy, Emotional Labour and Emotional Support. A structured interview was conducted with a senior staff member in each of 5 homes to gather quantitative data associated with organisational factors in these care homes.

Qualitative data were collected by conducting semi-structured digitally recorded interviews with a sample of care staff, who had already completed questionnaires from each of 5 homes. This qualitative data aimed to provide detailed staff perspectives on the social factors being investigated and further insight into emotional support provided and the use of empathy and emotional labour within a care home setting.
**Rationale for Design**

A mixed method design has been applied for several theoretical and practical reasons. On a theoretical level the combination of quantitative and qualitative data is partly a reflection of the combination of psychological and sociological approaches and the past methodologies that have been applied when researching emotional labour and empathy.

A large body of mainly qualitative data exist in the area of emotional labour. This literature is mostly concerned with the process of emotional labour and the effects on the individuals doing the emotional labour. As argued in Chapter 2 (Part B), this mainly sociological literature implicitly assumes that if emotional labour is done then emotional support is achieved and does not address the question as to whether all emotional labour is producing the same quality of support for recipients. The field of empathy is associated with both emotional intelligence and personality, both of which are psychological and have been represented previously using strongly quantitative approaches. Studies into empathy as a phenomenon in its own right have also tended toward quantitative data. However, little is understood about the process and uses of empathy in a caring context, specifically in everyday work in a care home which can be best achieved through qualitative methods.

This study is concerned with the emotion work undertaken by care staff from their own perspective. As will be discussed in Part D of this chapter an interpretative analytical approach has been taken, with the care staff's recollections and opinions being generally taken at face-value. Ultimately this research is interested in how this emotion work relates to the quality of emotional support being provided for older care home residents. In order to understand the quality of emotional support being provided, both a method of measuring or quantifying emotional support is required, but also a deeper understanding of what provision of emotional support involves. This includes an understanding of the emotional work that individual care workers contribute and how the care home supports or constrains these emotional aspects of
care. Because of a lack of previous quantitative work on emotional support an Emotional Support scale was developed as part of this research.

The mixed methods were used in two different ways. Firstly, in order to provide an early indication of the validity of the emotional support scale for specific use in a care home setting, triangulation of the two types of data was implemented. The reliability of the emotional support scale was tested statistically, while the validity was assessed by comparing responses on the scale to responses on particular in-depth interview questions which were rated. This analysis was important but not part of the main statistical analysis and is found in Appendix 8.

In order to explain the extent to which emotional labour, empathy, staff characteristics and environmental factors impact on emotional support and to understand the relationships between these variables, the quantitative and qualitative data were used in a complementary style. Initially the two methods were analysed independently and reported separately (Chapters 5-8 report qualitative findings and Chapter 9 quantitative findings). The two sets of findings are then combined (Chapter 10) to understand how they compliment or contradict each other, and the strengths and weaknesses of each method in a care home setting. The intention was that the two techniques would provide different types of information about the provision of emotional support in care homes that together provide theoretical advances in the field of emotion and also practical insight that could be of benefit to care providers and care assistants.

Part B: Sample of Care Homes and Care Assistants

Care Home Sample and Selection Criteria

Eight care homes in South-East England participated in the research. Five took part in both questionnaires and interviews (homes 1-5), this was inclusive of the pilot study that was been conducted care home 1. Care staff in 3 homes completed questionnaires only (homes 6-8) as following data collection in the first 5 homes, the interview
sample was considered large enough, but a larger sample of questionnaires were needed. The period of data collection was December 2005 to June 2007.

Due to the range in the types and sizes of care homes, selection criteria were applied to enable comparisons between homes. The geographical limit to the South East of England was chosen as varying challenges are experienced by care homes in different parts of the UK, in part due to the cost of living and relatively low wages that care assistants receive.

The size of the care homes was limited to medium and larger sized care homes, those with a capacity of 35 or more residents. Smaller homes were excluded as the environmental and organizational factors tend to be very different, and there would be too few staff to provide a reasonable sample.

Homes were all registered as Residential Care Homes (or care homes without nursing) as opposed to Nursing Homes (or care homes with nursing). Two of the 5 care homes that took part in interviews were registered as Elderly Mentally Infirm (EMI) homes, and so provided for higher numbers of residents with dementia and other mental health problems. Homes without nursing are not required to employ a nurse and therefore the vast majority of care is carried out by care assistants, with support from senior staff (not usually nurses) and community health care professionals, such as district nurses. Much of the care home literature has tended to focus on nursing rather than residential homes. However as the needs of older people entering residential care have increased, the boundary between nursing care and social care has blurred, with residential homes caring for residents with a range of physical and mental health needs (Bebbington et al. 2001).

The care homes were from the independent and voluntary sectors. These homes are run by independent companies, many of which are not-for-profit, but can receive both private funding from residents and also social services funding on behalf of residents. The cost to the resident or to social services varies between homes. Private and
voluntary care providers account for 84.6% of the care homes sector (Laing & Buisson, 2004a), so it was felt these best reflected care homes today. NHS homes are nursing homes, and relatively few local authority residential homes remain.

**Negotiation of Access to Sample of Homes**

Gaining access to care homes was a difficult and time consuming process. Firstly, initial contact with either a senior member of the care chain or the care home manager was made. In order for a manager to consider participating in the research, trust was essential. This trust was established in one of two ways; either by the researcher knowing or meeting a senior employee of a care home or care chain, or by introduction by an already trusted third party. The researcher made the decision not to 'cold call' care homes, as it was apparent that trust was an understandably important issue for care home managers.

**Contact and Negotiation with Managers**

Three care homes were accessed through direct contact with a senior employee of the care home or the care chain the home belonged to. Access to home 5 was gained through meeting a care chain manager at a conference. Access to home 4 was gained through meeting the home's deputy manager in an informal setting. Access to home 3 was gained through friendship with an employee of the care chain. A phone call was then made to the manager of each home to arrange a visit to the home to meet the manager. At the meeting any questions were answered and the least disruptive way the research could be conducted was negotiated.

Even through this more direct method of access, the time taken between contacting, or making initial agreements with the known employee, to the first meeting with the manager took between 2 weeks and 4 months. Internal procedures were necessary in some care chains which took weeks or months. Following the meeting with the manager, research usually started the following week, except in home 5 which was visited before Christmas and research started in the New Year.
The remaining 5 care homes were accessed through an intermediary, already known to the home, who either introduced the researcher to the home or agreed to act as a referee on behalf of the researcher. Contact with homes 1, 2, and 8 was initiated through meeting other care homes researchers with established relationships with those care homes. A meeting was set up with the manager of each of the homes in order for the researcher to explain the project and what participating would involve for the home. In homes 1 and 2, the meeting was used to negotiate the least disruptive way the research could be conducted. In home 8, only questionnaires were completed and these were distributed by the manager and returned by the researcher who had made the initial recommendation.

Access to home 7 was gained through a family member working as a health care professional in that home. In home 7, only questionnaires were completed, and these were distributed at the initial meeting and collected by the family member during her usual employment at the home. Home 6 was contacted following a recommendation by a care homes association member. The manager agreed to participate over the phone. The questionnaires were distributed by the manager and then collected by the researcher.

Approximately 20 homes were contacted overall, 8 of which went on to participate in the research. The managers in some of these homes were either not interested in the research or felt unable to participate at that time, usually citing staffing problems and not wishing to add to their staff's workload. In two homes, following a number of attempts the researcher was unable to contact the manager or the manager did not respond to repeated telephone calls. Only in one home, after an initial positive response with the manager did the home not go on to participate due to the manager leaving the home.

Meeting Senior Staff and Care Assistants

Following an agreement by the care home managers to participate, A4 posters (see Appendix 1a) were placed in the staff room to provide some information for care staff
on the project. The researcher then informally met and spoke to senior staff, who were most commonly the facilitators of the research, and the care assistants. Building trust with the staff was essential for them to participate. The researchers own experience and continued work as a care assistant was of great importance at this stage, as was meeting the researcher in person in a relaxed manner. There was no set method for speaking to and recruiting care assistants as each home varied. The researcher was flexible within the routine and needs of the care home. Some care staff were spoken to during handover, other in the staff room during breaks. In one home, the manager planned the researchers visit to coincide with a staff party so the research was explained to all the staff at the same time. In some homes the researcher was able to go around any part of the care home chatting to both residents and staff.

Part C: Quantitative Methodology

The quantitative data consisted of a self-completion questionnaire for all care assistants in homes 1-8 and also a structured interview with a senior member of staff in homes 1-5.

Structured Interview with a Senior Staff Member

One senior member of staff from each home that participated in both the questionnaires and the care assistant interviews (home 1-5) was interviewed. This recorded interview was structured and asked for detailed information about the home including the physical environment and organizational factors. The senior member was required to have been working at the home for at least 6 months and be familiar with the care staff and the residents. The interview could occur at any stage of the data collection process.

The structured interview asked for details regarding the organizational structures, staff, residents and routines in each home (See Appendix 2). The interview schedule was based on organizational features identified by the researcher based on her own
experience working in a range of care homes, and also findings from 3 pilot interviews with directly recruited care assistants from 3 different homes (see section on ‘initial pilot study’).

Self-Completion Questionnaire

Care Assistant Sample

The sample consisted of day-time care staff, which could include staff who worked both day and night shifts as long as they regularly worked in the day. Night shift work and contact with residents is different to day shift work (for example, very few or no baths given, no meals etc) and day and night staff characteristics could potentially differ. It was decided that comparisons across staff should be limited to those with experience as day staff.

The questionnaires were designed for care assistants rather than managers or senior staff. However, the organisational structures of homes differed, with some senior staff or team leaders, working on the floor as care staff, but with more responsibilities, such as dispensing the medication. Those staff that spent the majority of their time working on the floor with other staff and residents were therefore included, but more office based staff were not.

Questionnaires were distributed to all day time care staff that were available over the period of the data collection in each home (approx 3 weeks). Therefore almost all staff (except those that were ill or on leave) had the opportunity to participate. The sample of care staff who completed questionnaires was therefore self-selecting, i.e. questionnaires were only completed by those staff who wished to do so. This was ethically necessary and it was not possible to gather a random or representative sample. The mean completion rate was 57% for homes 1-5. The completion rates in home 6-8 was lower (see table 4.1 below) probably due to the researcher not regularly being in the home over a 3 week period as in homes 1-5.
<table>
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<th></th>
<th>Home 1</th>
<th>Home 2</th>
<th>Home 3</th>
<th>Home 4</th>
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Table 4.1: Questionnaire completion rates by care home

Research information sheet and consent forms

The Research Information Sheet was developed specifically for the care assistants in participating homes (See Appendix 1b). It contains contact details for the researcher should the participant have any queries or wish to withdraw their data from the study. This form was attached to the front of the questionnaire, to be removed and kept by participants if they wished to.

The Information Sheet was written in the 1st person and gave some information about the researcher, highlighting her current and previous experience working as a care assistant. This was particularly important as it helped to gain the trust of the carers. The tone of the information sheet was designed to provide relevant information about the research and also strike a balance between highlighting emotion work in care so the scales in the questionnaire would seem relevant, but also not making emotional support so explicit that staff gave uncharacteristic responses.

In the ‘How you can take part’ section, a brief outline of the questionnaire is given and it is explicitly stated that ethnic background will be asked for. This gave participants the opportunity to withdraw or ask questions should they find this a sensitive question. The final paragraph introduces the interviews and states that they will be recorded. This was to give care assistants time to think about whether they would be comfortable being interviewed before asking them personally. (Information relating to the interview was removed for homes 6-8 as it was not relevant, see Appendix 1c)
The Questionnaire Consent Form fulfills the ethical criteria of the BPS, BSA and University of Surrey ethics committee (see Appendix 3a). It states that participation is voluntary and staff did not have to take part or complete the questionnaire if they did not wish to. The issues of confidentiality and anonymity were highlighted (see section on ethics for more information). In home 6-8 it was decided that while the information sheet was essential, the signed consent was not necessary as staff were not going to be asked to participate further (see Appendix 1c). Instead, by completing the questionnaire consent was given. These staff were still able to remove their data at any time and had the researchers contact details.

Participants were asked to read the consent form and then date, print their name and sign the form. An ID number on the consent form corresponded to that on the first page of the questionnaire. This enabled the Information and Consent forms to be removed from the front of the booklet so the data and the identity of the participant were kept separate. It also linked the questionnaires to interview IDs, so real names were not used alongside the stored data.

**Questionnaire**

The questionnaire consists of an 8 page booklet (See Appendix 3b for full Care Assistant Questionnaire). Following the information and consent forms, the questionnaire started with an empathy, emotional labour and emotional support scale, which will be briefly described here. (Full rationale for empathy and emotional labour scale selection and changes is given in Appendix 8).

*The Empathy Scale.* The empathy scale is the first scale on the questionnaire. The scale consists of two subscales of the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983b); Perspective Taking and Empathic Concern. The scale contained 14 items. This scale was chosen as it has already been validated and been found to be reliable (Davis, 1980, 1883b, 1994, see Appendix 8 for details of reliability). The scale relates to the likelihood of participants to engage in the affective component of
empathy, as opposed to the behavioural component, and has been widely used in the psychological literature on empathy.

*The Emotional Labour Scale.* The Emotional Labour Scale (ELS) is the second scale in the questionnaire and is based on a scale designed and validated by Brotheridge & Lee (2003). Some changes to the original scale were made (see Chapter 9). The scale measured five facets of emotional display in the workplace. These facets are: the frequency of emotional display; intensity of emotional display; variety of emotional display; surface acting; and deep acting. This scale was chosen as it was the only previously tested scale that included both deep and surface acting and non-dissonant aspects of emotional labour.

*The Emotional Support Scale.* The Emotional Support scale is the third scale in the questionnaire and was designed by the researcher specifically for use within a care home. The aim was to create a relatively short scale that related to care assistants’ experiences at work and that could provide an indication of the emotional support care staff provide for residents. The basis of the items in the Emotional Support scale was the researcher’s own experiences working as a care assistant and also data from pilot interviews conducted with a convenience sample of 3 care assistants from separate homes unrelated to the sample of homes used for the main body of this research.

Some general themes relating to emotional support were used to generate the items for the scale, namely: Knowing the resident and understanding their needs, communication, empathising with residents, prioritizing emotion work and specific emotional labour (*See Appendix 8 for scale items grouped into themes*). The ES scale consists of 19 self-report items. Participants indicate how well each statement describes them using a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree.

The aim of this Emotional Support scale was to measure emotional support as perceived by the care staff as opposed to as it is perceived by the residents.
Methodologically, it would be very difficult to ask residents about the care they receive from individual care assistants.

This research has drawn upon the researcher’s own experience, residential care and dementia care literature (Brearley, 1990; Jones & Mieses, 2004) and nursing literature (Smith, 1992) to develop a scale of emotional support. This scale is therefore a practical indicator for health care professionals and care assistants. The purpose of the scale is to indicate the level of emotional support given by care assistants, as reported by the care staff themselves.

Following the pilot interviews with 3 care assistants, it was also felt that the empathy and emotional labour scales missed some important aspects that specifically related to care work. In particular, the empathy scales were felt to be more abstract, and the concept of imagining a resident to be a parent or loved one was not included. Therefore the scale includes some empathy and emotional labour items that relate directly to care work.

Staff Information. A range of staff variables were included in the care assistant questionnaire:

Demographic Information
Age
Gender

Work-related Experience
Full/Part-time
Time worked as care assistant
Time worked in that home
Staff type (permanent, bank, agency)
Other homes currently worked in
Other current jobs

Education & training
Currently in education
Highest level of education
Completed care training courses (including NVQ2)
Working towards training qualifications
Personal Experience
Do you have any children?
Have you cared for a dependent, elderly or disabled relative?
Have you known a close friend or relative enter residential care?

The personal experience questions relate to care staff's experiences of caring roles or of residential care outside or prior to working as a care assistant. As briefly discussed in Chapter 3 (Part A), the CSCI (Platt, 2006) make the link between the large numbers of care staff in their 40s and 50s and their wealth of experience, gained throughout their lives. These items are designed to examine the possible association between some of these life experiences and empathy, emotional labour and emotional support.

The final two questions ask for ethnic background and whether English is their 1st language. This has a dual purpose. Firstly to determine any differences between 'UK' and overseas care assistants in terms of emotional support and any other variables. Secondly, whether care staff speak English as a first or an acquired language may impact on the research in terms of the reliability and validity of the scales. As will be outlined in the 'statistical analysis' section, the reliability of scales for those who speak English as an acquired language was first established before analysing the data.

Initial Pilot Study
A convenience sample was recruited by sending emails to staff and postgraduate within the departments of psychology and sociology at the University of Surrey. Five care assistants who worked in different homes (not the home the researcher worked in) took part in a preliminary pilot study. Three took part in recorded interviews in order to gauge their response to the items and to make any necessary changes to the interview questions. These 3 care staff also completed the empathy, emotional labour and emotional support scales. Two care assistants completed a full questionnaire to assess how long it took, and any obvious problems. This resulted in some changes being made to the number of items in the emotional labour scale (see Chapter 9) and items being added to the emotional support scale (see above). These pilot participants
were not included in the final data set, and were aware that their participation was aiding the design of a larger project.

*Full Pilot Study (Home 1)*

The first care home in which a full study was undertaken was both a pilot home and also included in the final data set. Care staff were told this was the pilot/1st home and asked to write any comments on the questionnaire or leave a question mark by questions they did not understand. One member of staff emailed comments to the researcher. At the start of the interviews for participating care staff, the researcher asked if they had any problems with the questionnaire and what they thought of it. Some relatively minor word changes were made to the empathy and emotional labour scales to make items easier to understand. The emotional support scale was the most positively received and no changes were made. The box on the questionnaire for staff to list their training was made larger as this was identified as a problem.

*Questionnaire Data Collection*

The following procedure is based on that of the pilot study but also includes an indication as to what extent this procedure varied between homes.

Prior to starting data collection in the pilot home a meeting was arranged with the manager to provide detailed information about the research and to negotiate how the data collection would proceed. It was the decision of the manager that all research should be conducted in the home’s time (i.e. when staff were on duty) and not in the staff’s own time. This was the case for all the participating homes. A tour of the home was given by the manager and the researcher was introduced to the members of staff working at that time. The researcher then spent some time with senior staff members (referred to as team leaders, they are the senior carer on duty on any given shift) explaining the research and gaining information as to the best times and days to start questionnaire distribution.
It was the senior staff (team leaders) that provided most support for the data collection and the researcher as they were most aware of what was happening on the floor at any given time. The researcher gained information about daily staffing levels, so the most appropriate days and times were chosen to cause least disruption for the home.

An interview with a senior member of staff was negotiated and took place a few days into data collection (see Appendix 2 for interview schedule). The recorded interview took place in the team leader's office and involved 2 team leaders as both were keen to contribute. In other homes only 1 senior member of staff took part, usually in the office they worked in.

Informing Staff About the Research
Information sheets about the research were displayed in the staff room and the team leader's office with permission (See Appendix 1a). As there was no staff meeting scheduled at that time, the researcher introduced herself to staff during staff handover (shift changes). These occurred at 8am and 2pm. It was explained that the questionnaire should only take 10 to 15 minutes to complete but could take longer if English was not their first language. Staff were asked to make comments about the questionnaire if they had any comments to make or if they found any items ambiguous.

Questionnaire Distribution
As the morning shift in the pilot home, and in all homes, was usually busier than the afternoon shift it was decided that the questionnaires would mostly be distributed in the afternoon as there was a greater chance of them being completed and returned during that shift. It was found that questionnaires taken home were more likely to be mislaid. Over the 1st week the researcher attended 6 afternoon handovers and 2 morning handovers to ensure that staff that only worked mornings were included. The researcher remained in the home after 2pm and visited each of the units in the home to ensure all staff had the opportunity to take a questionnaire and also to be available for questions. Two members of staff were given one-to-one assistance with the
questionnaire by the researcher as English was not their first language and they did not understand all of the questions. This provided useful information as to some of the vocabulary that was more difficult for overseas staff.

Staff were asked to return the questionnaires by posting them into a sealed post box in the staff room. These instructions were given again in writing at the end of the questionnaire. A large box of chocolates was placed by the post box to thank staff for their participation.

In the pilot home, after the 1st week only 12 questionnaires from a staff of 27 had been completed. It was decided that interviews would start and that questionnaire distribution would continue throughout this time. This was replicated in all homes, as waiting for all questionnaires to be returned before starting interviews was impractical. Low return rates were a problem as staff readily took the questionnaires, but a high proportion did not return them. It is also likely that there was a self-selective bias in those that did not complete questionnaires. Some staff may have struggled with the questionnaire as they did not speak English as a first language. However roughly half the questionnaires were completed by overseas care assistants which represented the balance of overseas and UK staff in the pilot home. Two staff members refused to complete the questionnaire as they did not like the questions. Some staff had a high distrust for any 'outsider' although the majority were welcoming and appeared to appreciate the attention being given to their work.

When the researcher spoke with the senior staff in the pilot home they very accurately predicted who would and would not complete questionnaires without actually knowing who had. This was based on how involved staff were with activities in the home, how much paperwork they generally did and whether they were considered 'difficult' or 'lazy'. While none of this can be confirmed it would suggest a bias in my data collection towards care assistants that were generally thought to be more motivated in their work and who had greater participation within the home.
Variation in data collection between care homes

In homes 3, 4 and 5 a similar method of questionnaire distribution occurred. Questionnaires were given out during staff handovers, in staff breaks and in homes 3 and 4 in quiet time of the day when staff were working, but not so busy. In home 5, all questionnaires were given out during handover, with the manager giving out questionnaires to some part-time staff who were missed by the researcher. Questionnaire distribution and collection continued throughout the time of the research in each home (approx 3 weeks), overlapping with interviews. In home 2, only one staff handover was attended and questionnaires were distributed before serious illness within the home disrupted data collection. No visits were possible for several weeks in home 2 and on returning to the home, staff numbers were low and management were particularly stressed accounting for the low response rate at this home (see Table 4.1)

After completion of homes 1-5, it was apparent that the sample size of the questionnaires (54) was smaller than was ideal in order for the power of the statistical analysis to be strong enough to detect differences between groups. Cohen (1992, cited in Field, 2005) suggests that for a standard α-level of 0.05, and recommended power of 0.8, a sample of 85 participants are needed to detect a medium effect size and 28 to detect a large effect size. The aim was to increase the sample size to as near to 85 as possible. There was however, a large enough sample of interviews. It was decided that further questionnaire collection would occur to provide a larger sample of questionnaires to allow comparison between care staff.

In homes 6 and 8, questionnaires were distributed by the manager. The manager was asked to give a copy to each day time care assistant. In home 7, questionnaires were distributed to the staff present on one day by the researcher, and the manager distributed the remaining questionnaires. These three homes only participated in questionnaires. A total of 68 complete or near complete questionnaires were obtained.
Statistical Analysis

Analysis of the questionnaire data involved two distinct stages. Firstly, the data were tested for reliability and validity (see Appendix 8) before comparative statistical analysis was undertaken (see Chapter 9).

Reliability and Validity

Prior to undertaking multivariate analysis, missing data analysis, test of reliability and factor analysis were conducted on the Empathy, Emotional Labour and Emotional Support scales using Field (2005) and Tabachnick and Fidell (2001) (see Appendix 8 for detailed methodology and analysis). Missing data were imputed where appropriate and reliability analysis determined any differences between staff who spoke English as a 1st language and those who spoke English as an acquired language. Unreliable items were removed.

The newly designed Emotional Support Scale was validated using a method of triangulation involving the qualitative data (See Appendix 8). The questionnaire responses were compared to interview responses for those care staff that had completed both.

Multivariate Analysis

Regression analysis was conducted on the empathy, emotional labour and emotional support scales and subscales to determine any associations between the three constructs. The association between staff characteristics and empathy, emotional labour and emotional support was analysed using t-tests and ANOVAs. Any differences between the care homes was also assessed using ANOVAs. As no differences were found between the care homes, further analysis of the specific information gathered for each home was not conducted as it was unlikely any significant findings would be obtained.
Part D: Qualitative Methodology

The qualitative methodology consisted of recorded semi-structured interviews with care staff (See Appendix 4b for interview questions). These were then analysed using an interpretative method in order to gain insight into the perspectives of the care assistants. This method was chosen in order to provide an opportunity for care staff from different homes to describe their own work, including personal care which can not easily be observed by researchers.

Sample of Care Assistants for Interview

Only care staff who had already completed questionnaires took part in the interviews. The initial plan was to recruit a representative sample of care assistants for interviews to reflect as closely as possible the overall mix of staff. It was estimated that 8-10 care assistants from each home would be interviewed. However, this method had assumed a higher return rate for questionnaires. In practice it was found that a high proportion of the staff that completed questionnaires also took part in interviews, and that these were again a self-selecting group (see Table 4.1, Part B for number of completed questionnaires and interviews in each home). Some staff who had completed questionnaires did not wish to be interviewed or were not available (ie on holiday or sick).

Research Materials

The interview was semi-structured and recorded. The questions built on those used by Smith (1992) in her research with student nurses and also the researcher’s own experience of care homes and working as a care assistant. The questions did not specifically refer to emotion, but rather to situations that should involve higher levels of emotional support or emotional labour. Neutral prompting was important to further explore some responses while maintaining a relaxed conversational style for the interview.
The interview schedule was piloted with 3 care assistants from separate homes unrelated to the care homes in the main body of the research. The interview schedule was adjusted based on the findings from these interviews and some wording was changed. The interview guide was designed for interviews of approximately 45 minutes and in practice most interviews took between 25 and 60 minutes.

The Interview Guide (See Appendix 4b):
The start of the interview asks for general information about the home and is intended as a warm-up for the care assistants. It also provides an indication as to what aspects of the home are important for them.

The following 4 questions ask for information about the care assistant. In the pilot interviews it was found that emotion work was often included in what carers found positive and also difficult about their work. The question referring to preferences in working with other care staff often elicited a description of 'good and 'bad' staff in the pilot interviews. It was found to be a sensitive item however and some care assistants were cautious when responding.

The interview guide then focuses on staff giving personal care to a resident during their most recent shifts. Participants were asked to give a specific example and give the researcher a step-by-step account of what they did. It is not possible to observe personal care but this is one of the 'hidden' aspects of caring that involves higher emotional support as it is intimate physically, and also involves one-to-one interactions with staff which may be more rare the rest of the day.

Care assistants were then asked to describe some experiences that they have had in the home over the past month or so. These questions are based on those by Smith (1992). The majority of staff were very open about situations they had found difficult. If the care assistant did not refer to the senior staff when talking about a stressful shift, they were prompted to.
The final questions referring to staff's motivation and future plans also served as warm down questions as these topics were not particularly sensitive.

**Information and Consent Forms**

The information sheet provided for interview participants was the same as that for the questionnaire (see Appendix 1b). Participants were given a copy to take away so they could contact the researcher if they wished.

The Consent Form was also similar to that on the questionnaire as it highlights confidentiality and also anonymity (see Appendix 4a). It was explained that any names of staff, residents, units or the home will be anonymised and only the researcher will have access to the interview recordings which will be kept separately from identifying information.

**Digital Recorder and Data Storage**

Interviews were recorded using a digital recorder (iriver H40). The interviews were paused if there were any interruptions. All of the interviews were recorded successfully. The interview recordings were transferred and saved in computer files. The interviews were coded with no reference to staff names. The interviews were transcribed into word using 'transcription buddy' software and stored with the recordings.

**General Procedure for Conducting Interviews**

All interviews were conducted at a time convenient to the home and the individual staff members. This was generally in the least busy times of day, between 10am and 12.30pm and more commonly, between 2pm and 4pm. The researcher first spoke with senior staff to ensure it would be convenient. No interviews were conducted on days where there were too few staff or the staff were particularly busy. On several occasion the researcher arrived at a care home to find an unexpected staff shortage or an incident had occurred and so left the home without conducting any interviews. The
needs of the staff and residents were paramount and the staff greatly appreciated this flexible approach.

The first few interviews in any home were a convenience sample based on which care assistants, that had completed the questionnaire, were working on any given day and wished to participate. Staff were approached in person about the interviews and a day and time for an interview was 'pencilled in' on the understanding that it could change should the shift be too busy.

A quiet and private room was found within each home to conduct the interviews. This was either a staff training room, an unused living or dining room, the staff room (when not in use) or, on a few occasions, the garden. Other staff on duty were aware where the interview was conducted so they could interrupt should the participating staff be needed. Only one interview had to be stopped early as the staff member was needed.

All staff participating in the interviews were given the information sheet and consent form to read and sign. Issues of confidentiality and anonymity were verbally explained and it was made clear that they could stop the interview at any time or not answer a question.

On completion of all interviews in the home, the researcher made a donation to each care home's 'resident's fund' or equivalent to thank staff for their time and support. One home had a staff fund which was contributed to instead. Individual payments were not made as the interviews took place in the home's time (when staff were on duty) and not in the staff's own time. This was discussed with the manager and staff.

Methodological Issues from Pilot Home

During the pilot study a 'representative' sample of the care home staff for were interviewed was by using the responses in the completed questionnaires, to select a range of staff that roughly represented the homes' staff mix. In other homes where
the number of questionnaires completed was lower, the interview sample was not representative, but consisted of all the staff who had completed a questionnaire and agreed to participate in interviews.

Some methodological issues did arise, especially surrounding interviews with staff who spoke English as an acquired language. Of the 8 care assistants interviewed in home 1, 4 spoke English as an acquired language. The level of English of two of these carers was particularly good although it was still difficult to fully understand what was being said at times, mainly due to their dialect or accent. The interviews also tended to be shorter, possibly reflecting the lack of detail in the responses due to their reduced vocabulary. Overseas carers also tended to respond to all the questions in generalities rather than give specific examples. The importance of transcribing the interviews as soon after they had been completed was found to be very important, as understanding accents on a recording was difficult, but helped by fresh memories of the interview. Field notes, taken (where possible) straight after each interview were also essential, as some overseas staff were very good communicators, even if their language skills were not as good as many UK staff, but this was not easily reflected in voice recordings.

Although there were initial worries as to the depth and quality of the interviews with staff who spoke English as an acquired language, on re-listening to the interviews, they were still found to be rich sources of data and also covered some areas that were not present in ‘UK’ staff interviews. The interviews were rich in details relating to emotions even if some lacked fluent language skills. It was decided that while the linguistic skills of care staff should be taken into account when analyzing the data, these interviews were a rich source of data and provided an important subgroup of the overall sample.

Qualitative Data Analysis
One of the aims of this research is to gain insight into the use of empathy and emotional labour in care homes and how these related to emotional support, but from
the perspective of the care staff. In order to explore how care staff experience the emotional aspects of their work and how they make sense of their role as a care assistant, a qualitative methodology was used. This method also provided insight into those staff characteristics and organizational factors that were linked to empathy, emotional labour and emotional support.

There are many different approaches within the qualitative methodologies. This research utilises an inductive approach aimed at exploring care staff's perspectives and generating theory relating to emotion work. Within inductive qualitative methodologies, Willig (2001) argues that each method takes a different position regarding epistemology, reflexivity and also critical language awareness. This research is interested in care staff's view of their working lives and believes that this can be explored by analysis of interviews. While the research attempts to capture the care staff's emotional experiences at work, it is also accepted that a perfect understanding of care staff's own perspectives can not be achieved as it is interpreted through the researcher's own view of the world. In simple terms then, this research uses language as a tool to understand the emotion work of care staff, as opposed to language being the object of research in itself, but in doing so, the role of the researcher is understood to be significant. The methodology used in the majority of the qualitative analysis (IPA) is further discussed in the following section.

Analytical Approach: Interpretative Phenomenological Analysis (IPA)

An interpretative approach was used in the analysis of the qualitative interview data. This approach was chosen as it fulfilled the aim of the research which was to understand the emotional aspects of care assistant's working lives from their own perspective. The method was informed by the theoretical position of Interpretative Phenomenological Analysis (IPA), although there were some differences in the implementation of the method due to the sample size and breadth of the 'phenomenon' under investigation.
IPA has been particularly utilized within health psychology, where it originated (Smith, 1995, 1997; Smith et al. 1999) but also within the social sciences in general. IPA is based on two theoretical premises; critical realism and the social cognition paradigm. Critical realism (Bhaskar, 1978) accepts that aspects of reality are stable and constant and these exist independently of human conceptualization. Differences in human meaning and understanding of these different aspects occur because they experience different parts of reality. The social cognition paradigm (Fiske & Taylor, 1991) is rooted in the belief that human speech and behaviour can reflect these differences in meaning. Therefore analysis of semi-structured interviews is a useful method to understand these differences. The current research is interested in care assistant’s understanding of the emotional aspects of care work, and it is expected that staff emotions and their understanding of their work will differ. As with IPA, it is the lived experience of care staff that is of interest.

IPA shares some attributes with Discourse Analysis (DA; Edwards and Potter, 1992), but there are also important distinctions between them. DA regards verbal descriptions given by participants as behaviours in their own right and is sceptical of mapping these descriptions onto the thoughts and feelings of the participants directly. In contrast, while IPA also focuses on the descriptions given by participants, it is directly concerned with the feelings and thoughts of the participant in relation to a phenomenon. There are also some similarities with Grounded Theory (Glaser & Strauss, 1967), particularly the focus on bottom up analysis that avoids the early generation of hypotheses. However, grounded theory does not necessarily seek to understand the perspective of the participant, but is ‘grounded in observation’, that is the researcher tries to understand what is at work ‘behind’ what a participant says from the stand-point of the researcher. IPA therefore, is interpretative as is DA, and also inductive, as is grounded theory, but it is interested in the thoughts and feelings on the participant in relation to a phenomenon and not specifically the language.

The role of the researcher in IPA is made explicit. While the aim of IPA is to gain insider understanding of a phenomenon, the researcher’s beliefs are regarded as
necessary to make sense of other’s experiences, rather than biases which need to be eliminated. Therefore reflexivity is seen as a useful tool for researchers to understand their interpretive position, as opposed to a method for removing bias (Smith et al. 1999). This view is of particular relevance in the current research given the researcher’s prior experience as a care assistant. This experience is an essential part of understanding the perspective of others, but it is also important to acknowledge the researcher’s position.

In terms of the research, the phenomenon under analysis was the emotional aspects of care work, either generalized or relating to specific incidents. The qualitative analysis was purposely undertaken before the quantitative analysis to avoid any statistical findings influencing the qualitative analysis process. The approach taken by both IPA and also Grounded Theory (Glaser & Strauss, 1967) is that the analysis should be data driven, so is therefore a bottom up (or inductive) rather than top down process. In the current research some top-down coding was used, firstly to broadly code for any references to emotions and then to code within this the broad themes of empathy, emotional labour and emotional support. Therefore the method was not entirely inductive, these main themes were already determined prior to analysis. However, within these themes an inductive approach was used. For example, emotional labour was not coded or analysed in terms of deep and surface acting or intensity and variety of emotions, as described in the literature. Instead fresh analysis was undertaken which was less concerned with the type of emotional labour, than with understanding emotional labour, its sources and impact, from the perspective of the staff undertaking it.

*Coding Using NVivo*

The analysis was undertaken using Computer Aided Qualitative Data Analysis software, specifically NVivo7. The data set consisting of 36 interviews was larger than is most commonly used for IPA and the initial coding involved non-theoretical coding in order to ‘chunk’ the data and make comparisons in later analysis. The process was as follows:
Initially data were coded in terms of the subject being talked about by the care assistant (CA):

1) Actors: Who the CA was referring to broadly speaking about, including other care staff, themselves, residents, family members and senior staff
2) Organisation: What place the CA was referring to, the care home, another care home or another country
3) What activity (if any) the CA was referring to, such as personal care, residents general interaction, breaks and training.

Following transcription of the interviews, notes were made as to some common themes for coding. These included any references to:

1) Dementia
2) Organisational aspects, including staffing, training, physical environment
3) Emotions (staff or resident). Any reference directly involving emotions of the staff, residents or others.

Care Assistant perspectives were then coded as either generally positive or negative, some data were coded as both.

After all the data relating to emotions were coded, the broad themes of empathy, emotional labour and emotional support were used as subthemes within the very large ‘emotions’ data set.

The data were then split into different ‘chunks’ using combinations of the codes used above. For example, within emotional labour, positive experiences involving residents could be compared to negative experiences. This could further be subdivided by activity. In this way, the data were broken into manageable sections so comparisons could be made between the responses of care staff. Coding for each section was built into sub-themes (or clusters). The sub-themes emerged across different ‘chunks’ of data and these were used to form overall themes (See Appendices 5a, b and c for interview excerpt and coding example).

One area of coding did not in general follow the perspective of the care assistant and that was the coding of examples of specific care as ‘good, neutral or poor’ quality care particularly relating to emotional support. This aspect of the coding was not
interpretative, but rather a general indication of the outcome for the resident (which analysis also showed was closely related to outcome for the care staff). This was also used as the basis for the ratings given to interviews to compare to scores on the Emotional Support scale in order to validate the scale (See Appendix 9 for examples of ratings).

Role of the Researcher

The role of the researcher is central to the interview process in this study. It is now generally acknowledged that it is not only an understanding of the experiences of the participants, but also of the researcher that constitutes a fundamental part of the research process (King, 1996). King, drawing on Schwandt (1994), argues that in order for researchers to be reflexive they are required to “analyse and display publicly, their own their history, values and assumptions, as well as the inter-relationship with their participants” (pp. 176).

The qualitative analysis method of IPA also highlights the usefulness of reflexivity as a technique for understanding a researcher’s own interpretative position (see earlier section on analytical approach and IPA). My own values and assumptions in relation to the research topic are largely formed by my experiences working as a care assistant (See Chapter 1) and the impact of some of these experiences are expressed below.

I am aware that I have a generally positive bias towards care staff. My belief that care work is challenging and difficult, and grossly under-rewarded motivated this research. I have felt for a long time that the media’s insistence that there is a staff shortage because people ‘don’t want’ to undertake care work failed to understand that many people ‘couldn’t’ undertake care work, they simply did not have the capacity to be a good care worker. I myself have never had any intention of remaining in care work, but have great respect for those who chose it as a life course and remain for many years as care staff. One underlying aim of this research is to highlight the complex and difficult work care staff do, and to understand the skills they have and need in order to do this. I would never claim that I am a perfect carer or in any way better
than other care staff, especially not as a result of any academic achievements. I am well aware that I have made many mistakes, been influenced by pressures of time and struggled to go against the tide of negative care home culture and practices. I am equally aware that some of these situations have arisen due to my own lack of experience or skill as a care worker, but that others have been related to the organisation and attitude within the care home. I see care staff as a potentially vulnerable group, open to abuse from the system which employs them, and the residents in their care.

This 'insider' position can be argued to be a bias, but I would argue that there is not a non-bias position on care homes as it is generally an emotive subject and everyone has their own ideas and opinions on the topic (something that has become evident during the course of my PhD). The 'outsider' position of researchers with little knowledge of care homes could also be more prone to influence by the overwhelmingly negative media view of care homes.

Two different roles
Throughout the research I continued to work part-time as bank staff for a local care home. This care home was not part of the research, although on application I made my position as a researcher in other homes clear. My relationship with my colleagues was not that of a researcher, it was usually that of a more junior member of staff, given I was both part-time (only working 1 shift per week for the first 3 years, increasing in 4th year) and bank staff. When conducting research in the participating homes, my role was distinctly different. While my work as a care assistant was apparent to the participants, my role as a researcher was more dominant to me and probably for the participants. My status as a PhD student also changed between the roles. As a care assistant, my academic qualifications were of little value, I still undertook training before starting (TOPPS5) and was required to take courses throughout my employment (e.g backcare and dementia care courses). Having a BSc and MSc was of little practical use when caring for the residents, and others had much more experience and up to date knowledge of residents. In contrast, my research
skills and qualifications were of direct interest to participating care home managers and care assistants, who either wanted to understand what qualified me to undertake such research, or were just interested in what an academic path actually involves and what it takes to gain a PhD.

I did not feel that managing the two roles of member of care staff and researcher was complex, and did not find changing between the two difficult. I felt that the two roles positively informed one another. In general, while working as a care assistant I focused on the work at hand, sometimes having the time to reflect on mine and others practice and feelings in light of my research and reading. I also maintained a personal diary of my shifts throughout my 1st year. Initially, my care home work was necessary as a grounding for my research, to prevent me from drifting into a purely theoretical and literature based frame of mind and forgetting the reality of working in a care home. By the later stages of my PhD, working became a financial necessity and my motivation to work therefore changed. At this stage, my work in the care home became less reflexive, but I also became a fuller member of staff in the care home, and gained more understanding of the effects of working longer hours.

Gaining the trust of care assistants can be very difficult especially as the majority of media reports about care homes and care assistants are so negative. Presenting myself as not only a researcher but a care assistant was vital to gaining access and also to gaining trust. I also have an understanding of the working pattern of care assistants and care homes. In most of the homes I was accepted as a part of the home for the period of the research and made to feel very welcome. Senior staff spoke openly in front of me and I got to know some of the staff. I do not aim to present myself as a model care assistant as I am sure I am not, instead I am in a position to understand the requirements of the job and to empathise with other care assistants. I think this came across to the care staff I interviewed who did not in any way treat me as they would a home inspector or visitor to the home (something which I have first hand experience of).
During the interviews themselves I aimed to build a rapport with the care assistants. I could understand aspects of what they told me and probed in directions which a researcher with less experience of care work may not have done. I was genuinely interested in their stories and could relate to different incidents and also 'types' of residents. During the interviews I avoided leading questions but at times reflected back on what they had said by telling them about a similar experience I had. I also used my knowledge of care homes to explain questions and provide examples to some overseas staff both in the interviews and when completing questionnaires.

**Part E: Mixing Methods**

Two different forms of methods were used in this research, which were combined in two ways. Firstly, triangulation of the interview data and the emotional support scale was used to validate the Emotional Support scale prior to using the scale in multivariate analysis (see Appendix 8). Secondly, the findings from the qualitative and quantitative analysis were combined in a complementary style after separate analysis had taken place.

*Validation of the Emotional Support Scale*

The method of triangulation, when used to validate a scale in this way, relies on the assumption that if different methods produce similar findings in relation to a particular measure or phenomenon, then this reflects positively on the validity of that measure (Campbell & Fiske, 1956, cited in Moran-Ellis et al. 2006). In this case, the Emotional Support scale was compared to my ratings of emotional support from the indepth interview data on specific instances from the interview with the same participant. Moran Ellis et al. (2006) highlight however that there is an argument that different methods could in fact have similar flaws and therefore amplify rather than eliminate biases (Fielding & Fielding, 1986). This research accepts that the likely validity of the Emotional Support scale can only be supported using this method.
**Integrating Methods**

Integrated methods refers to the "Specific relationship between two or more methods where the different methods retain the paradigmatic nature but are inter-meshed with each other in the pursuit of 'knowing more'" (Moran Ellis et al. 2006. pp 51).

Moran Ellis et al. (2006) argue that researchers must make clear at what stage in the research process integration of methods occurs and how it is operationalised. In the current research, integration occurred late in the analytic process, after the qualitative and quantitative analysis had been completed separately. The aim of this integration was to determine any complementary findings between the two types of data and how together they inform theory. This integration was also expected to highlight different findings between the two methods, and findings unique to each method. This not only informed theory, but was valuable in determining the unique contribution of each method and their specific use in care homes research.

The integrated analysis used the model of associations generated by quantitative analysis as its base. In this way, all the main quantitative findings were integrated with their 'qualitative counterparts', but some qualitative findings were not included in the mixed methods integrated analysis. First, the quantitative and qualitative findings regarding each of the main constructs, empathy, emotional labour and emotional support were used to provide greater understanding of each. The associations between each construct were addressed, with the significant quantitative findings being compared with the qualitative findings and being used to inform the overall model. The social factors that had emerged as statistically significant and their association with each of the constructs were discussed, drawing on both qualitative and quantitative findings. (see Chapter 10 for integrated analysis). In this way, a theoretical model of emotional support was formed, which contained both statistical associations and the depth of qualitative insight.
PART F: Transferability of Findings

The aim of this research is to gain insight into the emotion work of care staff, with the ultimate goal of understanding how care staff provide emotional support to residents and how this support could be encouraged or improved. Therefore the issue of the transferability of the research findings arises. Care homes in the UK vary widely, as do the mixes of staff and residents. It cannot therefore be argued that this research reflects all of the emotion work of UK care staff, but rather provides a general theoretical framework as to the types of emotional challenges care workers can face, and how they may react to them, thus providing insight into how staff could be supported.

In terms of the statistical analysis, the sample is not random, nor is the sample size large. Therefore, these data alone cannot be used to form a statistical generalisation to the general population of care staff. However, these data do add to the current theoretical literature relating to empathy, emotional labour and emotional support, and the complementary analysis of the statistical and qualitative data supports some of the main statistical findings, suggesting that, some findings are particularly relevant.

The qualitative analysis is concerned with the subjective experience of care staff and adding to theory relating to the phenomenon of emotion work. In terms of theoretical generalisation relating to emotion work, it can be argued that, if replicated with another sample of care assistants, these same theoretical parameters could be replicated (Yin, 2003b; Smith & Henry, 1999). As argued by Johansen and Christensen (2004) "A well developed theory explains how something operates in general... and it enables one to move beyond the findings of and single research study" (p.19). That is not to argue that the same specific events are experienced by other care staff, or that two people would have the same reaction to the same events, but rather that the events and reactions of care staff in general can be better understood and explained by application of the theory developed in this research.
A number of presentations have been given at a range of care home, NHS and dementia related conferences, and the current research has been found to be of immense interest to managers and practitioners in a range of healthcare settings and has been positively received by care staff. The reactions of care staff and 'on the floor' manager suggests the theories put forward have face validity. By using examples and explanations given in the analysis, practitioners are able to reflect on their own specific client group and think about the emotion work of their own staff. Some themes that have emerged from the data will not be relevant to all care situations, for example, some are more commonly related to dementia. Furthermore, many care homes include nursing care, and this aspect has not been explored. However, many themes are still very relevant. For example, by explaining that care staff can become emotionally exhausted when they undertake emotion work but receive no positive feedback from residents, managers may be motivated to specifically encourage and support staff working with these types of residents.

The mixed findings provide a strong argument for some aspects of the qualitative and quantitative findings, in particular the importance of care staffs' life experiences in their emotion work. These findings serve to highlight the emotion work and skills of care staff and could be used to reflect on training relating to these emotional aspects of care work.

The research does not intend to form a set of fixed rules for care homes to follow, but rather to make suggestions in light of the findings that could well be of value to a great number of care homes and to encourage care providers to think about the perspective of their care staff as an essential aspect of improving care. While the research does not contain an exhaustive account of the emotion work of care staff in the UK, it does provide an indication as to common challenges they face, raising the profile of care staff working with older people.
Part G: Ethics

Full ethics approval was obtained through the University of Surrey Ethics Committee (See letter of approval Appendix 6). The research adheres to both the BSA and BPS ethical guidelines.

This research did not include the participation of care home residents, however the researcher came into regular contact with residents on visits to the homes. The researcher had a current Criminal Record Bureau (CRB) check, gained from her employment at a care home. The researcher completed any forms required by care home managers. For example in one home a job application form was completed, and in another fire procedure forms were read and signed.

Anonymity and Confidentiality

Participant’s names were on the consent forms only and were not given on the questionnaires or on the interview transcripts (See Appendix 3a and 4a for the questionnaire and interview consent forms). An ID number was used to link the participant’s name with the questionnaire and interview data. The questionnaires and consent forms were stored separately. Only the researcher had a record of names linked to the interviews. This identifying information was kept securely and separate to the general research. Transcriptions were anonymised, with all staff, resident and home names removed or replaced with pseudonyms. Only those parties which had a specific part in the research process knew which homes the data were collected from: The researcher, supervisors, and the care homes themselves.

Interviews and Sensitive Information

As discussed in earlier sections, participants were provided with a consent form explaining issues of confidentiality and anonymity and also emphasising that they were free to end the interview at any time and may also refuse to answer a question without giving an explanation (See Appendix 4a).
There was a small chance that a care assistant may disclose some sensitive information during the interview for example, concerning elder abuse or staff bullying. The researcher had experience of care home structures and complaints procedures should these have been necessary. In the unlikely event of a serious incident having been reported the researcher would have sought advice from her research supervisors (PhD supervisors), while keeping the participant identity anonymous, and if necessary would have contacted the School of Human Sciences ethics committee which adheres to BPS and BSA ethical guidelines. In the event, no such issues arose. While there were reports of staff bullying and very poor care or elder abuse, it was always in relation to other staff or other care homes, or in reference to events that happened many months earlier.

Some sensitive and upsetting issues for participants, such as a resident that had died, memories of a family member who had been in a care home did arise. These were dealt with sensitively and the interviewee was assured they could stop at any time or choose not to answer any of the questions. Overall however, the care staff found it to be a positive experience as many rarely talked about themselves or their work. The 'cooling down' items at the end of the interview were found to be effective and lightened the mood prior to ending the interview. The interviewer always asked if staff had any questions or if they wished to add anything that the interview had not covered at the end.

*Feedback for Participants and Participating Homes*

Feedback was provided to all the care homes in which interviews were conducted except for one. In home 2, due to an outbreak of sickness, the sample was too small and anonymity and confidentiality was assessed to be at risk if there had been an individual report on that home. A written report was given to the other care home managers based on early analysis of findings from their care home. The reports contained a mixture of positive and negative findings within each home, and examples of the emotion work care staff undertook. A larger report was also provided at the end of the research for those homes that were interested.
Acknowledging Homes

One care chain, Friends of the Elderly, wished to be identified in research dissemination, for example at the end of conference presentations and in acknowledgements. The chain owns a number of homes and the participating home has not been identified.

Conclusion and Overview of Analysis Chapters

In conclusion, this chapter has outlined the overall research methodology in which full details of the qualitative methodology was provided. A more detailed discussion of quantitative methodologies are provided in the quantitative analysis chapters (Chapter 9 and Appendix 8). Throughout the data collection process it became clear to the researcher that the qualitative interviews had provided both a rich source of data and also a substantial volume of data. In comparison, the numbers of completed questionnaires were not, in statistical terms, very large and issues of missing data and reliability were complex (detailed in Appendix 8). The qualitative analysis is therefore the more prominent of the two, and as will be argued during analysis and discussion, has provided the greatest insights into the emotion work of care assistants working in care homes.

The following analysis chapters contain 4 qualitative, 1 quantitative and 1 integrated chapter. The method of analysis used for each of the qualitative chapters is the same, and has been described in this methodology chapter. Chapter 5 is an analysis of empathy, and Chapters 6, 7 and 8 contain analysis of emotional labour. The emotional support of residents is integrated into these empathy and emotional labour chapters as, from the perspective of the care staff, these concepts of emotion work and emotional support are intrinsically linked. The emotional labour analysis is divided into three parts. The first two relate to the emotional labour undertaken when working with residents. Firstly, those situations staff found to be emotionally challenging, and secondly, those resident characteristics which required greater emotion work by staff.
The third emotional labour chapter looks at the staff characteristics and organisational factors which influenced the emotional work of care staff.

As already described, the reliability and validity analysis of the Empathy, Emotional Labour and Emotional Support scales was complex (see Appendix 8 for methodology and analysis), but essential in order to undertake multivariate analysis. Chapter 9 contains all the multivariate statistical analyses, which presents associations between empathy, emotional labour and emotional support, and the social factors under investigation. Following this separate analysis of the qualitative and quantitative data, Chapter 10 discusses the integration of the two sets of findings in order to more fully explore the emotion work of care staff. The thesis conclusions are presented in Chapter 11, including both theoretical findings relating to empathy, emotional labour and emotional support and also practical suggestions for policy and practice within care homes.
CHAPTER 5

EMPATHY

This qualitative analysis chapter focuses on the use of empathy by care staff in relation to their work with residents. This analysis chapter aims to explore the use of empathy by care staff from their own perspective and to gain insight into those social factors that support or hinder empathic engagement. Examples of empathy arose during the semi-structured interviews with care staff, and were analysed using an interpretative approach (See Chapter 4). As will be discussed in this chapter, care staff used a variety of different types of empathy, both when working directly with residents and when thinking about the care they provide in more general terms. The analysis is structured around these different types of empathy with examples given of each from interview excerpts. A table of care staff pseudonyms which are given alongside their quotes, and some relevant information relating to each interview participant is given in Appendix 7. The role of empathy in the emotional support of residents is integrated into this chapter and is discussed throughout. This analysis also explores some of the social factors that influence empathy as well as the emotional and social barriers to care staff engaging empathically.

Variation in the Extent to Which Empathy was Referred to

The interview schedule did not specifically refer to the care assistants using empathy, rather it prompted them to talk in general terms about their work, what they liked and disliked and to give some examples of providing personal care to specific residents. It was found that there was great variation in the extent to which care assistants either responded empathically during the interview when discussing residents or explicitly recalled incidents or situations in which empathy was used.

It is likely that this variation occurred for a number of reasons. Firstly, it does to some extent reflect the differences in how often care staff engage empathically with
residents. People with a history of caring for a loved one, for example, were more likely to make particular types of empathic responses. This will be explored in greater detail in this chapter. Secondly, it reflects the extent to which some care assistants are aware of their own emotions and how they use them in the workplace. Some explained situations involving emotional support or emotional labour in some detail but with little reference to their own feelings. For example, Lynn describes in detail how much a resident enjoys chatting in the bath and how they talk about each others’ families, but does not refer to her own feelings.

So yeah, so we talk about all sorts of things and she actually knows my husband, so we talk and I talk about her sons and she loves it, absolutely loves having a conversation. And um, I think she knew my grandparents because when I mention she always says, 'yes I remember him'. So it's sort of, you know, going a long way back through (town), cos I'm local and so was she. (Lynn)

It could also be that some staff do not like to, or do not tend to, discuss their own emotions, either in general or with someone they don’t know well (the researcher).

Thirdly, differences in the language care staff use, how open and relaxed they were and their language skills all influenced on how they referred to their own use of emotions. It should be highlighted that especially for staff who spoke English as an acquired language talking about emotions in this way is quite advanced linguistically and also relates to different cultural norms and understanding of emotions. Lastly, there were many references made to staff building a rapport or relationship with residents or knowing them well. In this case care assistants applied the knowledge they had of the resident, but did not refer to empathy. However it is likely that empathy is used both to build and maintain relationships and it is also the case the empathy tends to increase as knowledge of a person increases. There is therefore some overlap between the relationships staff have with residents and how empathy is used.

Easy residents, you get a rapport with all of them, you can read them like a book. You know when to back away, you know, when, you know you can give them a big hug. You know some of them you can cheer them up by making
them a cup of tea, or giving them a hug or dancing with them or being an absolute prat and singing, stuff like that. (Jackie)

It is likely that engagement in empathy was under reported by care assistants as it was not specifically asked for. It should not be assumed that people that are emotionally very skilled and aware will want to discuss their emotions with a relative stranger. Therefore comparisons between care staff regarding empathic engagement will be limited to those characteristics which are explicitly connected to empathy by the care staff themselves (eg previous experiences of caring). The examples of empathy given will be used to explore the use of empathy in an interpretative manner.

Types of Empathy Used

A range of types of empathy were used by care assistants. These can be arranged into three dichotomous constructs: Direct and Indirect Empathy, Group and Individual Empathy, General and Situational Empathy. These constructs will be described in more detail before using them in combination in order to explain how and when care assistants engage in different types of empathy.

Direct and Indirect Empathy

Care Assistants engaged empathically with the residents either directly, putting themselves in the situation of the residents, or indirectly, by placing a loved one in the situation of the resident.

Direct Empathy

Care assistants thought about how they might feel or how they would like to be treated if they were in the situation of the resident. This was either explicitly stated by describing how they would feel or what they would want in that situation, or more implicitly stated by describing the feelings or situation of the resident in a manner which strongly suggested the care assistant understood, or was trying to understand the perspective of the resident by engaging empathically.
There's some people, and as I say this isn't saying that anybody is bad at their job. I not saying that, but, um, they won't necessarily have that chat with them. Do you know what I mean? Which I think's really important because if somebody's, you know, somebody's standing there, obviously going to have to take their clothes off, if they've go nothing on and they're just standing there and they've just got this person doing this to them, if it was me I would be like, 'oh my god' you know. And I know I would be embarrassed and afterwards I would think about it, if it was me. (Anna)

Indirect Empathy
Care staff also engage in an indirect form of empathy whereby they think about how they would like their loved ones to be treated if they were in the position of the resident. Essentially they are placing themselves in the place of the resident's family. This form of empathy appears to be used for two main reasons. Firstly, if the care assistant has personal experiences of caring for a member of their own family or a family member entering care, they may use these experiences to motivate them to provide better care while at work.

"Yeah, I always try, you've got to give them...what's the word I'm looking for...quality. Quality of life, which is what I think, I think my Dad, he was in a home and I don't think he had the quality of life and care that he deserved. And I think that's really what's made me feel that I'd like to give more quality and care to this lot, you know." (Jackie)

Secondly, it may be too difficult for a staff to put themselves in the position of the resident if the situation is too unfamiliar to them. For example, it can be difficult to understand the perspective of a person with dementia or chronic illness or someone whose behaviour can be unpredictable. Using indirect empathy allows them to engage emotionally with the resident or motivates them to provide the best care they can.

"First I have to tell you that um, it's new job for me, I used to be a journalist in Poland, so it's a new experience for me. Um but I like this job, I really like this job, and, um, yeah, it's a big surprise for me because when I am thinking about this, in Poland I only look after my grandparents um, but now I have 11 or 12 new people, I don't know them, but I have to treat them like my grandparents or my parents. I have to try, like them, love them sometimes." (Kate)

The indirect method of placing themselves in the position of a resident's relative could be argued to be a different emotional response altogether, outside the construct of
empathy. However, the purpose of indirect empathy is very similar to that of traditionally understood empathy. It is used to better emotionally engage with a resident to try and find the most appropriate response in order to, for example, reassure them. A similar cognitive process is likely to be undertaken by placing a loved one in the position of the resident instead of oneself as it can be argued the care assistant is trying to understand the perspective of a loved one in the same situation, rather than the resident.

**Group and Individual Empathy**

Care assistants were found to engage empathically with the residents either as a group or with specific individual residents.

**Group Empathy**

Care assistants either referred to all the residents as a group or a particular sub group of residents, and used similarities in their situation to engage empathically with all or some of the members. For example they may refer to the confusion felt by residents with dementia or how difficult it must be for residents not to see their family very often.

*It can be distressing because they are distressed, and sometimes they don't know what's going on themselves, depending on their mental state and their physical state. And, you know, if you're quite an aware person, you're picking up that they are distressed, but you can sympathize, but you can't sometimes put things right.* (Elaine)

Group empathy could also be used as a way to avoid breaching the confidence of a specific resident. When describing a specific situation, some care assistants would talk about residents in general when it was at times more likely they had a specific resident in mind. It should also be noted that at times overseas staff who spoke English as an acquired language referred to residents in general or all residents as 'he' due to their own linguistic skills and their own cultural norms based in their own language. It was not always clear if 'they' referred to residents in general or one individual. Despite some ambiguities the distinction between group and individual
empathy is still a useful one to make as care assistants respond differently to these
different types of empathic engagement as will be discussed when group and
individual empathy are understood in combination with the other forms of empathy.

*Individual Empathy*

Care staff used individual empathy when describing a specific incident with a resident
or when referring to a specific resident in more general terms. In doing so they
appeared to take the perspective of the resident in terms of their unique situation, life
story or needs. This form of empathy was referred to more frequently when
describing day-to-day aspects of care, for example, to understand how a resident liked
things done or what might cheer them up. Individual empathy was also used in
specific situations, often if a resident was angry or distressed to try to understand their
behaviour and so respond appropriately.

Well there is this lady in particular that I got up this morning who whenever I'm
on a night shift... I normally give her a second cup of tea. Because she loves
a second cup of tea but she don't normally ask for second cup of tea. So
because, but she can be overbearing. But then, I kind of have a soft spot for
her because I can imagine going into a home with people just coming in your
room all the time and I had people hovering and you know, so I can
understand. (Arlene)

*General and Situational Empathy*

Care assistants either referred to specific situations or referred to empathy in general
terms without reference to specific examples or situations.

*General Empathy*

Care assistants sometimes spoke about caring for residents in general without giving
specific examples. General empathy is a relatively broad concept, mainly discerned
by what it is not (a reference to a specific type of situation) than what it is. However,
there were some themes that emerged. General empathy, as will be further discussed
in the next section, was only used in combination with group empathy and not with
individual empathy. In general it is used to describe a moral basis for providing good
care, or a 'philosophy of care' as the care assistant understood it. This was also
closely linked to indirect forms of empathy, particularly regarding memories of caring for loved ones. This general empathy could be used by some care assistants in order to motivate them and to set a general care standard that they would wish to follow as that is how they themselves would like to be treated or have a family member treated.

*I don't know, I see it as sort of helping somebody. You know, they, they looked after people when they were parents, and still are parents, but I just think, they need looking after as much as everybody else does. Everybody needs looking after don't they, one way or another. And it must be quite hard work for their families, it's just sort of nice to do something like that I suppose.*

(Claire)

In the above example, Claire demonstrates that she has thought about the past caring roles of residents in general and how this has changed to the residents being the ones needing care. No specific examples of situations in which residents need care are given, but rather a more general philosophy that she uses to understand her own role as a care assistant.

**Situational Empathy**

Care assistants referred to a specific situation or types of situations when describing empathic engagement. Most commonly referred to were personal care situations, washing, going to the toilet or incontinence and bathing or showering.

*But you can see by the end of the bath that she's actually moving a bit better, she feels good, she feels happy, she feels clean and she thoroughly enjoys it and it does make them happy. Whereas another person can't stand going in the bath, gets really scared, gets really worried, whereas a shower, they will like a shower they feel clean, refreshed, happy. Again, I mean, if I was in this place I'd want a shower every day, but I know it wouldn't happen.*

(Sophie)

Sophie refers to the specific situation of helping residents to have a bath and uses her understanding of resident’s emotions to treat them as individual, while also reflecting on her own preferences.

**Familiar and Unfamiliar Situational Empathy**

Care assistants' descriptions of situational empathy could further be regarded as related to either familiar or unfamiliar situations. Familiar situations were those with
which care assistants had some kind of life experience, such as having a bath. Other situations were far more unfamiliar, for example they had never experienced memory loss or confusion so had no life experience to draw upon to better understand how the resident might feel. This is more of a continuum than a dichotomous concept as some situations such as going to the toilet are very familiar, but incontinence far less so, but embarrassment and privacy are very well understood in everyday situations.

Also if, you know, they... I don't know, say their husband died 3 years ago and they've forgotten that, and they're asking where their husband's going to come in. That's very difficult, you know. You can generally distract them from that, you know, because you can't say 'love, he's dead'. You can't say that and you wouldn't want to say it. ...Because you've got to imagine that every hour then they're grieving for their husband, you know, um and that can be very hard because you think, oh how sad, you know, she's sitting there thinking that he's just not bothering to come and see her, um or vice versa. (Anna)

In the above example, Anna describes the relatively common situation of a resident who is asking for her husband who has died some years previously. Anna does not have any experience of memory loss or losing her husband, but she uses her imagination, as opposed to drawing on past experience to empathise with the resident so she can try and respond appropriately. Anna refers to her own emotions, not wanting to tell the resident her husband has died and thinking how sad the situation is. While Anna has engaged empathically to a certain extent, it is also possible her own emotions prevent her from talking with the resident about her husband any further. From Anna’s perspective, engaging empathically in this difficult situation has an emotional impact on Anna herself, and this in part guides her response.

Anna later describes her embarrassment when getting undressed at a tanning salon as a life experience she draws on to understand the resident’s embarrassment during personal care. Other care staff used examples of visits to hospital or childbirth to try and understand some of the feelings of the residents. Empathy related to familiar situations was more likely to involve comparisons with carers’ own experiences, whereas unfamiliar situations required a greater reliance on imagination.
The Different Uses of Direct and Indirect Empathy

Indirect Empathy

By looking at direct and indirect empathy in combination with general and situational empathy, and individual and group empathy, a picture begins to emerge as to how care assistants engage in direct and indirect forms of empathy. Indirect empathy is striking for how it is not used as much as for how it is. Care assistants do not engage in indirect empathy when referring to individual residents. That is, they do report thinking about how they would like a loved one to be treated when talking about how they responded to individual residents.

"I like to see people happy. I like to see them clean and tidy and I just like to know that they're being looked after. Because I know I had a nan that was in a home that wasn't, she wasn't terribly well looked after and it used to upset me. And I'd like to think that if ever it got to the situation for my mother or my mother-in-law in particular who is 84, to go to somewhere, I would like to think that they would get the same sort of care that I would give myself to somebody. (Lynn)"

Lynn clearly outlines her philosophy of care and the motivation behind it; her own experiences as a family member of a resident. This experience has not only motivated her to provide what she feels is good care for residents, but is linked to the hope that someone else would provide the same care to her loved ones in the future. Lynn's use of indirect empathy is therefore highly emotionally driven, linked to both past experiences and hopes for the future.

There are only a few examples of a care assistants referring to specific situations when describing indirect empathy. Most, like Lynn's example above, referred to care in general and not specific aspects of care.

"I just like caring for the elderly. It's just like caring for your own mother and father, and I think for your later years in life you should be, sort of be cared for. As best as can be. ...Because um, though I also cared for my father, seeing carers come in to care for him, doctors and the nurses and so many things I'd change, you know. And you might just get one or two that were really caring. It's just that special little touch, and they, they remember that. It's a bit of respect, dignity."
It's a very close contact kind of thing isn't it. It's just the touch of a hand and listening to what they're saying, having the time to sit with them if you can. It's a very one to one thing I think, like when you're, do, giving personal care, talk to them. Don't just get on with the job and ignore them. (Wendy)

In the above example, Wendy's personal experiences of seeing others caring for her father influenced how she thinks about the care she gives to residents. Her underlying philosophy of care that it should be compared to caring for your own parents, not only serves to guide her own care work, but highlights what she felt her father's carers sometimes failed to do. This is another example of a carer's personal experiences relating closely to indirect empathy, but it also describes how Wendy implements this empathy in practical terms, although she does not do this with reference to a particular resident. This example is unusual in that it starts as a description of care in general, but finishes with specific details. Wendy later described how her time spent caring for her father motivated her to become a care assistant. Therefore her understanding of her role as a care assistant and the value of the work she does appears to be closely bound to her personal experiences.

The interview data lack concrete examples of care assistants using indirect empathy when working with an individual resident, for example, describing how they thought about their own grandmother when helping Mrs T in the bath. Staff reported that they did implement indirect empathy in their care (such as Wendy above) but described this in general terms and not specific. Several examples of indirect empathy, such as that of Tina below, referred to residents with dementia as a group. It seems likely that when caring for residents with dementia, care staff find it more challenging to engage in direct empathy and place themselves in the resident's position. Thinking about how a loved one should be treated provides care staff with an emotional tool with which to make, sometimes difficult decisions as to how best to respond. In this example, Tina is describing the difficulty of encouraging some residents with dementia to have a wash or bath.

There's no, I don't force anybody to do anything, because I wouldn't like it done to myself, so I wouldn't do it to them. It's just no, not fair. You know, you're sort of looking, I look back on and think, well you could be my Gran or you could be my granddad or something like that. And I always put the
residents in my position, if you see what I mean, me in their position. And would I like it be done to my family? (Tina)

In the above example, Tina uses direct and indirect empathy interchangeably. This example also highlights the common shared purpose of direct and indirect forms of empathy in that they are both used to form a general rule relating to care, in this case not making residents do things they do not wish to do. This general rule making was more common in examples of indirect empathy than direct empathy.

The majority of references to indirect empathy are both general (not relating to a specific situation) and refer to residents as a group. These statements either refer to care they have given or they have witnessed being given to a vulnerable loved one, or refer to hypothetical situations involving loved ones. In the following example, Claire has not had any experiences of a loved one entering care, but thinks about how she might feel should this happen.

You know, I always think that, I mean I hope that one day my dad never comes into a care home, not because I don't like it or anything, just because I think that must be something that's really hard. And I always think (..) you know, I'm sure if these people could, they'd help you if you needed them to, so, it's just sort of doing something nice for them I suppose. I think that is one of the reasons why I become a care assistant. I mean you all sort of look at your grandparents and your nans don't you and you think, oh, I hope they never go in a home. But it would be nice to know that if they did, then, you know, the staff there would be similar to what they are in any home I suppose (Claire)

Care staff who did not have any life experience caring for a dependent loved one or a family member living in a care home, also engaged in indirect empathy by using their imagination as opposed to drawing on actual life experiences. This is similar to the use of imagination used when trying to understand the residents’ feelings when in unfamiliar situations as previously discussed. Claire's motivation to work as a carer is linked to her feelings towards her older family members, but also wider ideas of reciprocation; the residents would reciprocate the care if they could and other care staff will hopefully look after her family if needed in the future.
It is not clear from these examples how indirect empathy is implemented by care staff when working directly with residents, although care staff report that they do think about their loved ones when caring for the residents 'on the floor' and not just hypothetically. There is strong evidence however, that staff engage in indirect empathy to understand their role as a care assistant and to form their own philosophy of care. Care staff spoke more frequently about the care of loved ones influencing their perspective of good care than about how they themselves would like to be treated.

Direct Empathy

Direct empathy, in contrast, is more varied, with care staff referring to both individuals and groups, and also both specific situations and in general terms. However, as discussed above in the general empathy section, general statements that did not refer to specific situations, referred to residents as a group and not as individuals.

Care assistants use direct, general empathy relating to residents as a group for a variety of reasons. Firstly, they used them to try and understand the behaviour, usually negative, of residents as a group or a sub-group of residents. Most commonly it was used to refer to residents considered to be 'grumpy' or 'demanding' as in Arlene's example below.

And I think that what we tend to forget sometimes that we're coming in their home to help them, but then (.) probably to them this is just like a holding place for them to die. Because there's no place like your house where you can just put your feet up, you can do whatever you want. So I think it is also hard for them to accept where they are, that's, that's what I think. (Arlene)

By thinking of the wider context of resident's negative behaviour and trying to understand why residents might have cause to be in a bad mood, care staff motivate themselves to cope with negative behaviour from residents. In the context of emotional labour, staff may try to understand the perspective of residents who are responding negatively in order to feel more positive emotions towards the resident and respond to them in an appropriately caring manner (deep acting). Secondly, care
assistants use general, group empathy in order to relate the residents’ perspective to situations they have had in their own life when they have needed to be cared for or supported. For example, care assistants verbalised how they had needed support in the past during hospital stays, recovering from alcoholism and with learning difficulties at school.

Yeah because you know, at the end of the day, you know, it’s all about vulnerability isn’t it. All these people are vulnerable people, you know what I mean. I was a vulnerable person myself like, in my addiction which was alcohol, you know. And I was lucky enough to conquer my addiction with the help of people that knew what they were doing, you know what I mean. (Mark)

Some of these care assistants were motivated to do care work in order to ‘pay back’ the help they themselves had received. By relating their own experiences of help and support to the needs of the residents, care staff could also gain insight into the positive impact care work could have on the lives of others. Finally, at times care assistants did not express their empathy for residents in order to better understand the residents, but to express their own emotional distress at work.

I find (...) how they are demented I find difficult to cope with, the way they are. And I think being my age as well, I don’t think I should know half the stuff that goes on, you know what I mean. When you’re young you don’t really want to think about what it’s like to get old, but, like, I know, and it’s quite scary really. And I think that’s the negative thing about it at my age. (Sophie)

In this example Sophie does appear to empathise with the difficult or distressing situations of residents, but finds it difficult to cope with. Her reluctance to think about what it could be like to grow old could be related to concerns that some of the more negative aspects of ageing, such as dementia, could also happen to her one day. She is not trying to explain the needs of the residents but her own difficulty in coming to terms with her own feelings about ageing. Similarly, other care assistants also used these types of statements to relate their empathy with residents in difficult situations to their own negative emotions. Relating this to emotional labour, it suggests that at times, engaging empathically with residents can evoke negative or upsetting emotions on staff which they must then work to control.
Care assistants sometimes referred to the residents as a group but described specific situations common to some or all of the residents that they could empathise with. These situations were often those that can be said to pose emotional challenges for the care staff. These situations could be emotionally distressing for both residents and staff. The most commonly referred to sub group of residents were those with dementia, as care staff described difficult situations when residents wanted to ‘go home’, find a loved one or get the other residents to leave ‘their’ home. In the following example, Elaine highlights one of the commonly reported situations where a lady with dementia was looking for her deceased husband. She understood that from the perspective of the resident her husband had been there that morning, but found it hard to comfort her.

Yeah, there are a couple of times where, um, a resident has been quite distressed and quite, very, very agitated. And they are saying that, they are in a way they’re like telling you a story. They’ve obviously got this like picture in their mind and it is very hard for you to break their cycle of thought, because they are in this thought. And they would say for instance, want to leave the building, they would want to see their husband, and husband might have passed away 30, 40 years ago. But they’ve seen their husband, he’s here. And, you know, he’s clearly not here and it’s extremely difficult when, in and also it’s the correct wording and how you approach somebody like that as well. (Elaine)

For Elaine, this situation poses an emotional challenge. While she has engaged empathically and tried to understand the perspective of the resident (the affective component of empathy), she is not sure how best to respond (the behavioural component of empathy). Care staff often understood what it was the resident ideally wanted in these situations, but were unable to provide it for them. These concepts will be further discussed in Chapter 6 from an emotional labour perspective.

Group empathy referring to specific situations was also used to explain a care assistant’s general caring rules regarding specific aspects of their work. Most commonly they referred to personal care.

But we have to be very gentle because um, in the morning we give them first, we are first person they can see in the morning, so we make their day, um, good or bad, you know what I mean. When they have radio in the room, I put
Kate felt that how a resident was first approached in the morning would impact on them for the rest of the day, and so she applies how she herself likes to be treated and how she likes things done in the morning to her care of the residents. It can not be discerned whether the residents do indeed like to listen to music in the morning, however, or if Kate is basing her care on her own likes rather than her knowledge of the resident’s preferences. This type of empathy was also referred to when care assistants were describing what they did with a specific resident. They frequently moved from talking about an individual to how they thought residents should be treated as a group.

Anna tries to provide residents with the option of having a longer bath and encourage them to relax. She begins by explaining how she engages empathically while bathing a specific resident, but later reveals this is part of her more general understanding of how, based on her own preferences, care during baths should be given.

Care assistants described engaging empathically with residents as individuals using direct empathy and with a specific situation in mind. This form of empathy was most commonly referred to when care assistants were giving specific examples of care they had given to a particular resident. Often this type of empathy was referred to when care assistants spoke about a time when they had made a difference to a resident and had felt good about it. For example Elaine describes visiting a resident in hospital who had broken her leg.
Because she had a plaster, she was catheterised, and. You know like I said, fiercely independent. But I went in and she was very upset that she was no longer. She felt that she wasn’t progressing as much as she should do. But because she’s such a strong, determined woman I said, ‘You’re doing remarkably well’. And then that made her cry more. Initially I was trying to come forward and say, ‘look, you’re doing really well’. But by the end of the conversation she was nodding and she was smiling and she said ‘thank you very much’. And I walked away and I was feeling quite choked up really because I could understand, you know, I could understand how frustrated she was, and I could understand the need to remain independent, and why she was crying. (Elaine)

In this example, Elaine herself is emotionally affected by the situation of the resident, however Elaine’s own emotions are not the main focus of this description in contrast to some of the earlier examples. She appears to have engaged empathically and was able to provide emotional support for the resident while controlling her own emotions (engaging in emotional labour). These examples provide insight into how care assistants use empathy ‘on the floor’, when working directly with residents, and also the emotional impact empathy can have on the care assistants themselves when they become so emotionally involved with residents.

Obstacles to Engaging Empathically

Obstacles to engaging empathically refer to the obstacles in the emotional experience of empathy and not the behavioural response to these feelings. Obstacles to providing the appropriate emotional response to residents once their perspective has been understood will be discussed later in this chapter. These obstacles can be grouped as staff choosing not to engage, staff being unable to engage when trying to, and environmental factors suppressing empathic engagement. These obstacles are discussed below.

Choosing Not to Engage

A care assistant may choose not to try and understand the perspective or behaviour of a resident by using empathy. Particularly when working with residents that have dementia and who behave in a manner that has a negative emotional impact on the carer (rudeness, racism, physical aggression), a care assistant may effectively
dehumanise the resident by assuming they do not have any understanding or control over their own actions. The carer therefore does not see the need to understand the perspective of the resident, if it is assumed that the resident has no understanding of their situation or actions. For example, Habiba describes her past and current reactions to residents who were frequently physically aggressive.

\emph{At first maybe, I use to get like upset. But then after some time, I thought, this is just something to do. It’s a problem to them, they can’t help it yeah. It’s, they are with it, it’s just like a disease anyway. So you get to, you get used to those things, and then you don’t get bothered, you just say ‘she doesn’t even know what she’s saying, she doesn’t know what she’s doing’. So I don’t get bothered now.} (Habiba)

While this description appears to expose a lack of understanding of both individual residents and also dementia, it is also an example of how care staff may protect themselves and their emotions when working with residents who are physically aggressive towards them. Habiba does not blame the resident for their reaction and she does not blame herself, instead she blames the resident’s dementia. However, by diminishing the understanding of the resident in difficult situations, there is a risk that this will be applied to every aspect of the resident’s life. For example, assuming the resident does not know what they like to eat or if they want to go to bed. It is likely that from the resident’s perspective their needs and anxieties are not being addressed. However, from the care assistant’s perspective she is responding in a way that enables her to both protect herself emotionally and continue working with residents who respond aggressively.

Care assistants may also choose not to engage empathically with residents that do not have dementia, usually if they find them rude or offensive in some way.

\emph{He’s just, he’s just grumpy, very grumpy. I think that, he’s a doctor and he knows… he wants us to help him, but at the same time, he wants to be telling us how he thinks it should be done. And I find that very difficult. …You have to sort of say ‘Look, I’m trained, I’ve been doing this for 5 years, I have my way of doing things. Let me do it and then if I miss something or I’ve forgotten something you tell me’. And generally they’re fine with it. It’s just getting residents used to doing it themselves in their particular routine to do it a different way.} (Emma)
Emma finds it difficult working with a resident who tends to be critical of the care staff. However, while in previous examples care staff have tried to understand why a resident may be grumpy, this does not appear to be the case here. Emma goes on to reveal a more general rule she has in encouraging residents to fit into her own, or the home’s routines, rather than trying to accommodate the resident’s wishes. In contrast to earlier examples, Emma’s care rule is based on her own preferences rather than forming a ‘philosophy of care’ based on trying to understand the residents.

**Unable to Engage**

Empathy relies on a person being able to imagine themselves in the situation of the resident, however care assistants may not always be able to do this even when they try. If the resident’s behaviour is unpredictable or does not relate to how the care assistant could envisage themselves responding, they may struggle to see the situation from the resident’s perspective. For example, Jennifer described trying to understand a resident with speech problems and unstable diabetes.

> And because they still haven’t resolved it, she is having a lot of these, um (...) I don’t really know what to say. Like a little, not like a fit, but like um (...) ‘cos she can’t get out what she wants to say, she just like starts shaking the frame and goes to fall over and all the rest of it just because she gets so frustrated. And you can’t, you can’t get through to her and it, it. You know I get cross because I can’t get through to her and I don’t know what else to do. And I then feel that, you know, I’ve not achieved anything and you know, I really should be able to understand where she’s coming from and I just, I can’t. When she’s like that it’s just, what’s the best thing to do? (Jennifer)

In the above example, Jennifer knows this resident quite well but the resident’s physical health and ability to communicate have deteriorated rapidly. Jennifer appears to be annoyed with herself for not being able to understand and calm the resident despite trying to. It was later revealed during interviews with other care assistants that several of the care staff and senior staff struggled to understand and respond to this resident. In situations where the resident behaves in a way which the carer can not imagine they themselves would act, it can be hard for them to fully understand why the resident is responding in this way. For example, care staff understood that being unable to effectively communicate was frustrating for this
resident, but not why she tried to throw herself on the floor. Difficulties in understanding the perspective of residents with dementia were more commonly reported.

*It can be exasperating, particularly if you have somebody with dementia, and you try and try all day to try and understand their behaviour, and try and understand what they’re trying to communicate to you. And you can go home and think, oh I just didn’t do that right, I just can’t fathom (the resident) out.*

(Jan)

Similarly to Jennifer, Jan is negatively affected by being unable to understand a resident and feels responsible for being unable to do so. Guilt was a common reaction of care staff when they were unable to calm or comfort a resident as will be discussed in the emotional labour analysis (in Chapters 6 and 7).

**Impact of Situational Factors**

Situational factors can impact on how likely it is that a person will engage empathically. Empathy requires the carer to focus on the resident, but stress or pressures of time can draw attention away from the individual resident and towards the tasks at hand. However, no examples of this were given in the interviews, presumably because none of the interview questions directly related to empathy, and care staff described what they actually did, not what they did not do. The impact of situational factors on emotional labour are discussed in Chapter 8, many of which are also likely to be of relevance to empathic engagement.

**Barriers to Emotional Support (behavioural empathy)**

As discussed in Chapter 2 (Part C), empathy is formed of an affective and a behavioural component. In this research, the behavioural component is described as one aspect of emotional support. On feeling emotions relating to direct or indirect empathy, the care assistant then tries to respond to the resident based on those emotions. There can however be barriers between understanding a resident’s perspective and acting on this understanding. As both empathy and emotional labour are closely associated with emotional support, these concepts are discussed fully in the final emotional labour analysis (Chapter 8), and only briefly described here.
As previously discussed, there are some relatively common situations that can arise when caring for residents with dementia, for example searching for a deceased loved one or wanting to return home. In the example previously given by Elaine, she describes understanding that a resident believes they have just seen their deceased husband, but not knowing how to best respond. Elaine understood the situation, but the correct response was ambiguous. This is one barrier to providing emotional support based on emotional empathy. Ambiguous responses are further discussed in chapters 6 and 7.

Constraints of time or materials could also be a barrier to empathic behaviour. For example, staff knowing residents might like a shower everyday or a long bath, but being unable to actually provide this for them. Staff did not provide many clear examples of empathising, but not responding to residents. They did however refer to being understaffed or very busy and so not being able to provide the level of care they would like. This could presumably include understanding what a resident would like or needs, but being unable to provide it due to practical constraints. The environmental factors contributing to staff workload and the impact on staff and residents will be discussed in Chapter 8.

**Empathy and Emotional Labour**

Empathy and emotional labour are qualitatively associated in two different ways. Firstly, empathy can be used as a motivation for emotional labour. Secondly, empathy can be regarded as a form of emotional labour. The quotes already given in this chapter contain examples of care staff engaging empathically to try and understand a resident and then engaging in emotional labour in order to respond appropriately and provide emotional support. Elaine’s description of visiting a resident in hospital who had a broken leg, strongly suggests that her understanding of the resident’s perspective motivated her to undertake emotional labour in order to try to comfort the resident. This was at an emotional cost to Elaine who was upset by the incident, but had gone out of her way to support the resident. Similarly, care staff
who engage in direct or indirect empathy in order to guide their philosophy of care, engage in emotional labour in order to actually implement this care.

Empathy can also be regarded as a form of emotional labour, particularly when care staff deliberately engage in empathy to try and understand the best way to respond to a resident. The care staff are undertaking the emotional work of understanding the feelings of the resident or of a loved one in order to undertake their paid care work. This empathy can therefore be said to be a part of their emotional labour. Evidence of the emotional effort involved in empathic engagement can be found in the care staff's descriptions of their own emotional distress in some situations involving empathy. Care staff purposely worked with their own emotions to guide their care of residents.

**Empathy and Emotional Support**

This analysis has shown that empathy influences emotional support of the residents. This occurs both directly and indirectly through emotional labour.

When care staff try to understand the perspective of residents directly, or imagine the resident to be a loved one, the care staff often directly responded to these emotions when working with the residents. For example, Anna thinks about how she might feel if she had to take her clothes off in front of someone else, and tries to reduce the resident's embarrassment by chatting to them and taking their mind off it. In this way, her empathic engagement directly influences her response to the resident. Emotional support also occurs indirectly through emotional labour. As already discussed, empathy can motivate care staff to undertake emotional labour. Empathy can also be used to form a 'philosophy of care' which requires emotional labour to implement. In both situations the emotional support of the resident can be positively influenced, but emotional labour must be undertaken in order to do so. Emotional labour and the association between emotional labour and emotional support are discussed in Chapters 6-8.
Conclusion

This chapter has outlined the different types of empathy undertaken by care staff when working with residents. It is apparent that empathy is not only used when working one-to-one with residents, but also used to think about and try to understand residents as a group or sub-group, something which did not arise in the review of the literature (Chapter 2). The most striking finding has been about the use of both direct and indirect forms of empathy. Care staff not only engage in the normally understood form of empathy where they place themselves in the position of the resident, but also a second form whereby they imagine the resident to be a loved one. In doing this they effectively place themselves in the position of the resident's family. Direct empathy was most commonly used when referring to personal care. Indirect empathy was strongly influenced by care assistants personal experiences of caring for a loved one or seeing others care for a loved one. Indirect empathy also appeared to have a stronger role in forming care staff's philosophy of care, that is, their own understanding of their role as a carer and the quality of care they would like to give.

This analysis has supported previous findings that suggested empathy positively influences the emotional support care staff provide for care home residents (eg. Reynolds and Scott, 1999; MacKay et al. 1990 and Fleuren et al. 1998). Empathy and emotional labour are closely associated with empathy either motivating staff to undertake emotional labour or being a form of emotional labour in itself. Furthermore there was some evidence that empathy can be distressing for staff so could be related to emotional exhaustion or burnout supporting previous clinical literature (Larson and Yeo 2005).

In conclusion, this analysis has supported some of the previous research findings relating to empathy, but has also added to current literature providing a richer understanding of the types and uses of empathy within the important context of care work within care homes. The following three qualitative analysis chapters explore the much broader concept of emotional labour.
CHAPTER 6

THE EMOTIONAL LABOUR ASSOCIATED WITH EVERYDAY WORK
CHALLENGES OF CARING FOR RESIDENTS

Introduction

Working directly with residents was the main source of emotional labour for most care staff. The emotion work undertaken by care assistants can be broadly divided into two categories; caring situations and resident characteristics. This distinction is one that was made by the care staff, who, during the interviews, either gave examples of emotional labour that they described as being related to particular types of situation common to care, or to characteristics of a resident or group of residents. This chapter will analyse the first category, describing those types of care situations that often arise when caring for residents that require emotional labour from the care staff, which can also be described as emotional challenges. Chapter 7 will focus on the impact of resident characteristics on the emotional work of staff. These categories exhibit a great deal of overlap. For example the emotional labour of providing personal care to a resident who can be very rude, involves both the emotion work of the situation of providing personal care and also relates to the characteristics of that resident. This chapter aims to address those situations that pose emotional challenges for staff and understand the emotional labour of these situations from the perspective of the care staff.

When describing types of situations in which they undertook emotion work, care assistants tended to describe particular activities or tasks, such as serving food or taking someone to the toilet. Personal care was particularly important. The analysis of carers’ descriptions however shows underlying patterns in relation to the emotional work involved, that do not relate to the physical task, but to the emotional understanding, response and outcome of the particular situation. This chapter will focus on more physical based activities, such as personal care, and palliative care, but this will be set within an emotional labour and emotional support framework. The
emotional support of residents is integrated into the analysis of the care staff’s emotional labour where relevant as, from the perspective of the care staff, their emotion work is integral to the emotional support they provide.

The chapter will first describe the main emotional perspectives that emerged from the interview analysis before exploring the emotional challenges posed by personal care, responding to distress, and responding to pain and death.

**Emotional Perspectives for Different Care Situations**

When describing different caring situations, general themes emerged from the details given by care assistants regarding how these experiences were emotionally perceived. A framework based on the most common themes has been used to try and understand the emotion work undertaken and also the emotional outcomes for staff. These themes will be very briefly described and then further explored within examples of emotional challenges.

*Understanding*

Firstly, the care staff varied in their perceived understanding of a situation, either due to the complexity of the situation or the care assistant’s own emotional abilities and experiences. The care assistant either found the situation ‘understandable’ or ‘difficult to understand’. Understanding of a situation involves understanding both the physical and emotional aspects of a resident’s situation and how this relates to a resident’s wellbeing and behaviour.

*Response*

Secondly, the care assistant needed to respond to the resident in any given situation and what to do was either ‘unambiguous’, it was clear to them what to do, or ‘ambiguous’, they were not sure of the best or correct way to respond. Ambiguous situations were more common when working with residents with dementia.
**Outcome**

The outcome of the care assistant's action in any given situation was generally either positive or negative. Usually if it was positive for the resident, it was also positive for staff. Positive outcomes often related to emotional support for the resident, but negative outcomes could also include the rejection of support by residents, despite a care worker's best efforts.

The combination of perceived understanding the situation, how staff responded and the outcome highlights different aspects of emotional labour and also the emotional impact of this labour on staff.

The following sections will focus on the most common emotional challenges described by care staff. These include providing personal care, responding to distress, and responding to pain and death.

**Personal Care**

Personal care includes helping residents up in the morning and to bed in the evening, bathing, showering, helping to the toilet and changing after incontinence or sickness. This is the least observable aspect of care work for researchers, as it occurs in private spaces, yet it is one of the most important. Care assistants described a range of different types of emotional work when helping residents with personal care. Personal care is a complex area as not only is it the specific aspect of care that care staff had most direct empathy with, but also the aspect of care about which most explicit examples of emotional support were given.

**Incontinence and Sickness**

The body work involved when a care assistant washed and changed incontinent or sick residents stood out as emotionally significant for care staff. When dealing with bodily fluids, staff must manage automatic emotions, particularly disgust. There are two significant emotional challenges involved in dealing with bodily fluids. The staff
member's emotional response to the bodily fluids themselves, and their response to
the residents.

Most care staff were disgusted by some bodily fluids, mainly diahorrea and vomit. The body work involved in dealing with incontinence differs from other aspects of working with residents in that care assistants nearly always understand the situation, what needs to be done is not ambiguous, and the outcome tends to be positive; a cleaner, more comfortable resident. However it can still require high levels of emotional labour to cover up negative feelings. Most care assistants did get used to washing and changing residents who had been incontinent as highlighted by Emilia. She had only been working at the home for a few months and was asked to describe some of the more difficult aspects of care work.

"Oh it maybe the more obvious things, like not pleasant bits of it. Like dealing with um, how to say it politely, dealing with all these unpleasant smells I would say, something that it's not nice to, deal with."

"RL: So maybe the incontinence side, the physical...?"

"Yes yes, all these body fluids, that's not the nice part of it. But it needs to be done, so after a while we just do it without paying attention to it really. (Emilia)"

Emilia does not express feelings of resentment, but those automatic emotional responses that most people have in relation to incontinence. These feelings tended to be covered up for the benefit of the resident, but the staff member still felt disgusted despite their outward appearance, a classic example of 'surface acting'.

Although there were more extreme instances when care staff were disgusted or stressed by the physical labour of incontinence, most staff got used to it as described by Emilia, above. The main emphasis of emotional labour for this aspect of personal care moved from being almost entirely concerned with the care staff coping with the physical unpleasantness, towards the care assistant being more concerned about the resident's wellbeing. For example, when asked to describe a stressful shift, Shiela spoke about a recent outbreak of sickness and diahorrea.
Um, I suppose one recently was when we had the diahorrea outbreak, cos the lady concerned didn't know what was happening to her and she couldn't, couldn't grasp it at all. Then it's difficult because they feel they're dirty, they don't understand and you can't explain to them that they're not dirty it's just one of those things. But they can't, they find it quite distressing when things like that happen. (Shiela)

Shiela not only describes the distress of residents with diahorrea, but also has some insight into the reasons for this distress. This shows how care assistants engage on an emotional level with residents while still dealing with a heavy physical workload. Shiela understands both the physical and emotional situation in terms of emotion work, however, the best response in order to comfort the resident is more ambiguous.

Mostly, care staff were not emotionally affected by bodily fluids once the situation had been dealt with and the resident was clean. However, in some instances care staff found that working with incontinent residents had an effect on other aspects of their work or home life.

It was hard the first month for me, not with the care, it was hard with the accidents, you know, with urine, with this. Because it's different, I mean it was a different job, yeah. It was different because I was not used, I couldn't eat and drink anything in that home for more than one month. But then I got used, with the smell and with [faeces] and everything, you know. (Nadia)

Other care assistants reported being very concerned about hygiene and showered and washed much more frequently even when they were at home. During outbreaks of diahorrea and vomiting, staff were very careful to wash their hands, but remained concerned that they or their families could be infected. This tended to have an emotional impact after a shift had ended when staff had time to think about implications for their own health.

The emotional impact of incontinence and sickness was not all negative, particularly the long term effects. A number of care assistants felt that many people would be unable to cope with the physical aspects of care work. Care assistants did not express that this was in any way a negative reflection on themselves. Instead they argued that other people 'couldn't do' this job as opposed to 'wouldn't do' this job. This is an
important distinction for the care assistant and their own sense of self worth. This opinion is described by Anna.

...There's a lot of people that wouldn't be able to work with that, wouldn't be able to work with people being sick, wouldn't be able to work with people going to the toilet, you know. And to begin with that can be quite (takes deep breath) ok, ok, hang on, take a few deep breaths. You know, that can be quite hard, but as you know, once you've done it a few times it's just another part of the job. I mean some people wouldn't be able to say that, but, it is just like... there comes a point where if somebody dropped their dinner on the floor it would feel the same to you, you see what I mean, as if they had toileted themselves. (Anna)

Anna highlights that while there are negative emotional effects of dealing with incontinence, it can also be a source of self-esteem in knowing you did something many others could not do.

Providing Personal Time During Personal Care

Care assistants gave examples where they used the one-to-one time spent with residents during personal care to provide the resident with personal time, specific to the likes and needs of that resident. This involved several aspects of emotional labour. Firstly, the care staff got to know the resident and had built up a relationship with that resident. Secondly, many of the care staff recognised the importance of the time spent with residents during personal care and tried to make it as positive an experience as possible, directly providing emotional support to the resident. Consequently the outcome was more likely to be positive for both the resident and the care staff.

For example Jackie has found it difficult to organize activities for groups of residents with dementia so she tries to undertake activities with residents during personal care.

...When you change Mavis she doesn't speak, she hasn't got conversation. But for the last few weeks we've been singing, every time I change her pad I sing twinkle twinkle little star, and she can sing it now. That to me, that is an activity. So you're doing a job, you're changing her pad, but at the same time you're involving her by singing to her and you're getting a response from her
because she's singing. And she actually holds my hand and does the time as well, so that to me is an activity. (Jackie)

Not only does singing provide Mavis with a more positive experience, and so emotional support, but Jackie also gains job satisfaction from seeing Mavis' reaction. This is a clear example of emotional labour resulting in a positive outcome for both the resident and staff.

In some situations, care assistants used personal care as a tool to try and cheer up a resident and to give them some individual attention. For example, Teresa decided that a resident was looking down and could benefit from Teresa spending some time with her. During a quiet time of the day she washed and changed the resident, gave her hands and arms a massage and did her hair.

So she's looked much better and I said 'oh you really lovely' gave her a hug, you know. And then I said 'hopefully you'll feel alright today' and then she was, I hope so, she was very uplifted and that I took interest in her and spent some time... She didn't have make-up, she didn't have anything else, you know, but just clothes, we changed clothes and then, bit of rubbing muscles, you know, just to make it circulation improved and you feel better yourself like. (Teresa)

As with any group of people, older people living in care homes vary in the extent to which they are concerned about their physical appearance and how much time they like to spend on it. Once they are less able to do things like apply make-up and do their hair themselves, they must rely on care staff to do this for them. By spending this time with the residents, Teresa provides emotional support for the resident but also job satisfaction for herself.

Humour was an important aspect of personal care that made it into a more individual experience for residents. Knowing a resident and what makes them laugh or what could offend them was useful knowledge during personal care.

One, you enter, start with a joke, because he is, his, you know, his sense of humour is high.... 'Oh hello, Mr so so, hope you not in the mood this morning,
if you are I have a nice treat for you. Today's Monday, the breakfast is wonderful, and if you're late, your friend [is] likely going to pinch your food'. That really gets him up....You try to help him to put his feet down, the moment he puts his feet down you try to remove his jacket, and give him a scratch on the back. That makes his day. If he says 'oh that's good' you tell him to tell you when you are pulling the skin off, you know, and if you start out that way definitely he'll cooperate with you. (Adam)

In this example, the resident had been described as aggressive so it can be assumed that due to his dementia he exhibits some 'challenging behaviour'. However, Adam appears to know him well and enjoy working with him, later describing how he visits this resident in his breaks when he is working on other units. He knows the resident well enough to understand that he doesn't mind a bit of gentle teasing and uses this as an emotional tool. The outcome for Adam was that the resident cooperated, thus making his physical and emotional work easier. While the positive emotional outcome for the resident was one of Adam's goals, he was also motivated by his own need to complete the task within a time limit and with the least stress.

Care staff also tried to find shared interests or knowledge with residents so they could have conversations during personal care, including topics not related to the care home, for example places they had both been to, TV programmes and news items. In a few cases the care staff had a relationship with the resident that extended beyond the care home, usually because they had lived in the same area or the resident had known the carer before entering the care home. These relationships were important to both staff and residents, often providing a more interesting and intimate level of conversation.

... I've known her a long time so we get on quite well. I would say she's probably one of the better ones I get on with. Some of the other ones you chat, but you just chat and it's pass the time sort of chat. Where this is like, because I know her a lot better we do chat. And she always tells me if she's got any family worries and things like that. So we do, sometimes we have quite a deep chat, this, especially this time of year, she lost her husband, so she sort of sometimes talks about him. (Janet)

In this example, Janet had known the resident and her husband outside the home many years previously. This is an example of a deeper level of conversation and relies on a meaningful relationship that usually comes with time and a genuine interest in each
other. Other care staff struggled to talk to residents about loved ones that had passed away, but this particular relationship enabled both the resident and staff member to feel comfortable talking about what could be a difficult subject. While Janet does engage in emotional labour during these 'deep discussions' the relationship appears reciprocal and based on a caring relationship rather than being purely work based. In comparison, for those care staff that do not already have some links with a resident, personal time was seen as an important time for staff to get to know the resident.

Many care staff were highly motivated to provide individual personal care. However, it is not clear from the interviews what proportion of residents benefited from this type of care. It is very likely that the types of resident and their personality greatly impacted on how motivated staff were to support them in this way. All of the examples given included a positive response from residents or an equal contribution to the personal time. Residents that do not often respond positively or are more difficult to understand are more difficult to form a relationship with as will be discussed in the next chapter. Using personal care as personal time is a very positive example of the emotional support care assistants can provide. In this way, care staff not only demonstrate they understand the importance of personal care, but that they do not find the most appropriate response to be ambiguous. Instead they engage in a range of emotional responses and appear to both seek and enjoy the positive feedback from residents.

**Persuasion and Personal Care**

Care assistants at times needed to persuade residents to wash, have a bath, go to the toilet or accept help during personal care. This is an example of care work in which the physical and emotional needs of residents may conflict and so staff must balance the two. This area of care could be ambiguous for staff and relates to ideas of agency and power of residents as well as the responsibilities of staff. Residents should have the right to choose when they are washed or changed, but if they have been incontinent and it is noticeable by other residents, is it dignified to leave them? This
is just one example of the complex ethical situations care staff need to respond to, especially when working with those with dementia.

This analysis is from the perspective of care staff and not the resident. It is not possible to know the thoughts or feelings of the residents being persuaded and whether this was always the correct course of action for care staff to take. It should also be noted that care plans for residents can include the need to encourage residents to maintain personal care and hygiene. Therefore, this aspect of care is made explicit by health care and mental health professionals. Forcing a person to get ready for bed before they would normally like to is clearly not good care, but letting someone wear the same clothes day and night for several days is also regarded as poor care. Allowing a resident to remain in a wet incontinence pad so they develop sores is regarded as abuse. There is not the scope to explore in detail all the theories, concepts and ethics surrounding decisions taken for residents regarding personal care and whether care staff should persuade older people in their care. For the purpose of this analysis it is assumed that care assistants view personal care as essential to residents and persuasion is therefore regarded as sometimes necessary.

In the following example, Susan persuaded a resident to let the chiropodist attend to her feet. She referred to getting the resident in 'the right mood' and was then asked to explain how she did this.

> Well I just explained to her, and she's got her cuddly toy there. And I said, '[cuddly toy] would like to watch you having your feet done'. And I said 'can you take your stockings off', she said 'now', and I said 'yes'. She said, 'you're not to', and I said 'no no, you'll take them off', because I know she's very personal. So I said, 'you go in the bathroom and take them off', and she did. And then I beckoned the [chiropodist] to come in and she come in and she was absolutely fine. (Susan)

Susan’s response demonstrates how well she knew the resident and that she did not find her response ethically ambiguous. She later explained that the outcome was frequently not so positive and the resident would refuse care. Instead of continuing to persuade her once she’s refused, Susan tried to maintain a balance between
encouraging her when she saw the resident was in a good mood, and not badgering her.

Care staff also persuaded residents to get up by checking on them and then leaving them, and then returning to them again. This could be done several times throughout the morning. In this way residents could wake up more slowly and were also more in control of when they got up.

I came again and said 'oh would you like a sip of water' and then I said 'oh she's slowing down, leave her longer, don't rush her'. Because she's, you can't, you'd be forcing, you'd be forcing...I said 'very soon I am going to come and wash you and dress you'. And then I finished one others and I came again, just popped in. So I think I've done my best, when I have others, and um so I came and I washed her. And I said 'oh I know you don't like this but I try to wash, don't you be cross with me'. You know, anticipation. And then [she was] smiling, she was happy, she said I am nice person. (Teresa)

Teresa balanced her workload with the wishes of this resident and appeared to be pleased with the outcome, as she felt the resident had been given choice and was also in a better frame of mind than she might have been when she was being washed and changed. Staff often knew the resident well enough to know when they could be persuaded and when they needed more time or to be left.

There were also occasions in which care staff failed to persuade a resident to accept personal care. The negative outcome reduced their job satisfaction and led some staff to doubt their own skills.

I remember somebody has had incontinence of faeces, I've tried to get him to the toilet. He bluntly refused. There wasn't much I could do and uh, it is highly embarrassing for the whole, where he's sitting, because the odour is making the whole place unpleasant. And um, I couldn't, you know, one way or the other, get him out of his seat to cooperating with me. So sometimes you feel defeated and you know, there's nothing you can do about that.

R.L.: What did you do? Did you have to get someone else to come down?

Yes, of course I did, I did and the two of us had to, you know, encourage him to, yeah. Which most times is something I could have done alone, but then
involving somebody else means, to me I feel as if I didn’t do much, or I didn’t have enough impact that day. (Adam)

Adam describes a fairly common, but also difficult situation. Adam understands the situation in terms of the need to wash and change the resident, but it is not clear how well he understands why the resident does not wish to. This is one example of a situation where staff may find it hard to understand the perspective of a resident given it is their own dignity that is being compromised. The outcome could be considered positive as, with support, Adam was able to change the resident. However, Adam’s strong negative feelings reflect his attitude towards teamwork; that he expects to manage alone without help.

The role of persuasion in personal care is a complex issue, yet a common one in care homes. There are a range of ethical implications relating to the power balance between the resident and the carer. The carer may also lack autonomy or power within the care home structure or established routine which may well impact on how strongly they feel the need to persuade residents to fit into the routine. However, this analysis has tried to understand the perspective of care staff, and for them, persuasion can involve high levels of emotional labour, and using a range of tactics based on their knowledge of the resident. Staff appeared to vary in how negatively they felt if they were unable to successfully encourage or persuade a resident, with some, such as Susan accepting it is down to the mood of the resident, and Adam feeling as if he had failed, thus adding to his emotion work.

Responding to Distress

One of the greatest emotional challenges care assistants described was caring for a resident who was distressed. Most situations where a resident was distressed arose due to the residents declining mental health causing confusion or physical health causing frustration or despair. Distress in end of life care will be discussed in the next section. In situations where residents were distressed, care staff sought to calm them, usually by providing reassurance. The outcome of the emotional labour of providing
reassurance was either successful or not, and this impacted on both the resident and the care assistant involved.

**Confusion**

A large proportion of care assistants described some situations in which residents, usually with dementia, were distressed due to being confused. The situations which care assistants found most difficult involved emotional distress of the resident. For example, a resident wanting to go home was found to be a challenging situation for care staff, but a resident confused by the time of day was not, as the emotional impact on the care staff was not so great.

In the following example, Elaine described the difficulty she has in responding to a resident who wishes to see their husband and believes they have just seen him, but in reality her husband died some years previously.

> Cos you could say, 'oh but they're not here'. 'But they are, they are, I've seen them, I've seen them'. And you try to pacify them, but sometimes you can't pacify them because they're still in this mode of, they've seen their husband. And you, in some ways, not lie, but in a way yes. You've got to say, well, not necessarily, it's wrong to say that he will be back later. It's a very difficult situation isn't it? (Elaine)

As discussed in Chapter 5, Elaine engages empathically with the resident and understands that for the resident their understanding of the world is real to them. From Elaine's perspective, she understands the situation and the strength of the resident's emotions, but the correct response is ambiguous therefore making the outcome uncertain for both the resident and herself. In this situation, it can be deeply distressing for the resident to 'orientate' them to reality, but Elaine also feels unsure about the ethics of entering the resident's reality, and effectively lying to her. In these types of situation there can sometimes be no entirely positive outcome, only the least negative. Such situations involve high levels of emotional labour in order to try and work out the best response and then cope with the less than satisfactory outcome.

> For example one woman here, she every time when I see her, she asks me 'where's my baby?' I say 'I don't know, I think maybe your baby's in [the]
Kate describes two of the other very common situations involving residents with dementia which care assistants found difficult. Firstly, a resident looking for their baby or child. Kate finds these situations distressing and she appears very unsure of how to respond and when she does, this results in the negative outcome of the resident crying. Another common situation of residents wishing to leave the care homes and go to their ‘real’ home is equally challenging for Kate. While she gives an example of what she feels she can not say, she does not suggest what a better response could be. Kate had only been working as a care assistant for 2 months and so lacked experience, but many care staff also reported they did not always know what to do in these situations and found the distress of the resident upsetting or emotionally draining.

So it's harder for me I think when, um, when you've got the people who are confused and are doing it because they are confused. Um it's very difficult when you, when you, when somebody's getting angry with you. Not because of anything that you're necessarily doing that's horrible, I'd never be horrible to them. But um, if they say they want to go out the doors and you're saying 'well no I'm sorry, you can't'. They can get, you know, they can get violent, they can get abusive and they can call you names and say nasty things and, I've had that before. (Anna)

Responding to residents who are confused and distressed can be emotionally challenging for staff both in terms of wanting to comfort the resident, but also because the response of the resident may have a direct negative impact on the care assistant. Anna highlights that the outcome can be anger or aggression from the resident if the situation is handled insensitively, or because it is impossible for the carer to provide what the resident wants. Anna finds anger directed at herself difficult and upsetting. This is a very negative outcome and is likely to be remembered by the care assistant for some time. It can be difficult for care staff to understand the reactions of some residents even if they understand the initial cause (not being allowed outside) as from
One of our new ladies who's obviously got dementia, and she gets very repetitive. And you find with her sometimes, you know you (sighs) your patience does sort of run thin a little bit. And if she doesn't hear what [she wants] to hear, or you don't say what she wants you to say, then she will start, the tears will start and it's suddenly 'why are you so horrible to me' and everything. And you go home thinking, I should have tried harder sort of thing. And the next time you go to her it's like, 'oh darling, you're so wonderful', you know. And that, but yeah, I sometimes feel that I could have tried a little bit harder, but you know, it's sometimes difficult. (Zoe)

Zoe describes the effort that can sometimes be involved in caring for a resident with dementia who may have 'fixed ideas' and so has become repetitive. In Zoe's situation it is unclear what the particular details are, but she is either unable or unwilling to repeatedly provide the response the resident wants. Zoe then goes home feeling guilty, either because she lost her patience and did not respond to the resident as she should have done, or because she wishes she could have found a better response even though she was trying.

Other care staff reported that listening to constant repetitive words or sounds made by residents, especially those they did not understand, could make them feel quite tired and even depressed. It is likely that without breaks care staff do become drained and so do not respond in the best way to emotionally support the resident. Other situations, which when they occurred frequently, care staff could become irritated or drained by were; lost items such as handbags, hidden items (such as jewellery) that were then reported missing, and residents going into other resident's room or through other's belongings. Care staff often felt guilty if they lost their patience, even if they covered this up in front of the resident by engaging in 'surface acting'.

**Frustration of Residents**

Care assistants also found it sometimes difficult to calm a resident who was frustrated. The cause of the frustration tended to be not being allowed or able to do what they wanted, being physically unable to do things they used to do, and being unable to
communicate or be understood. In the example below, Janet is describing a resident that she finds can be quite challenging to work with.

But when he does start, he can be quite rude and aggressive, but you just need to tell him firm and straight, um, sort of, his tone, his language, isn’t appropriate.

R.L: Does he have dementia or....

He’s, most of it’s frustration, he’s had a lot of illnesses, he’s had a lot to deal with in the last couple of years. But I would say the main problem is he’s frustrated. And that’s what you’ve got to bear in mind. And I think that because he knows I understand where he’s coming from, he does simmer down. But I know some staff, they don’t listen to him or they can’t understand him, and it just escalates. But um, I’m not really here enough, because I’m only here, um, I’m not here enough, I don’t see him all the time. I suppose if I was seeing all the time and he was having a go at me every day it might be a different story. (Janet)

Janet interprets the cause of the resident’s behaviour as frustration. She does not appear to find the response ambiguous and combines letting the resident know his behaviour is not appropriate with trying to listen to the cause of his frustration. Janet describes the situation of the resident instead of attributing the resident’s behaviour entirely to his own characteristics or personality. This is possibly because she had known him previously, before he became ill. Other care staff lack this knowledge and this could be why, according to Janet, they failed to understand his frustration.

However, Janet also makes the important point that if she were working with the resident every day, she could get worn down by him, but currently she works part-time. For care staff, the difference between what is seen as a difficult situation with a resident, from a resident who is themselves difficult, is often the regularity with which they are exposed to negative behaviour from the resident.

[During lunch] she couldn’t find her napkin ring. So I explained, when I have a minute I’d go and look for it, though she had the napkin, but she didn’t have the actual napkin ring. So with that she just lunged herself back from the table and she was just in such a temper, she was fuming. And so another carer had to take her out to try and calm her down, and it took a long time. But, it’s and outburst like that, I find quite hard. Because she has difficulty talking anyway so you can’t always understand what she’s saying, so she’s getting frustrated and you’re getting frustrated, but you don’t, you can’t show
From Wendy’s perspective, a napkin ring in the middle of serving lunch would have appeared a very minor issue. Unfortunately, Wendy has not fully understood the situation from the resident’s point of view, so her response was not what the resident wanted. Wendy found this situation particularly emotionally difficult for a number of reasons which were also common to other staff. Firstly, the resident’s reaction was out of all expected proportions, and could not have easily been predicted. Secondly, Wendy was concerned that the resident could physically hurt her or another carer. It is hard for a carer to focus fully on the best way to calm a resident when they are also concerned for their physical safety. The resident found communication difficult, thus adding to her frustration as well as making it difficult for the care assistants to fully understand the problem and respond to it. Wendy states that she was covering her negative emotions in front of the resident. Finally, Wendy felt responsible for the incident, even though it is likely that other care assistants would have responded in the same way. All these factors combined made this a challenging situation, one which also had a negative impact on Wendy as she was still bothered by it some weeks later.

But last week we couldn’t calm her down... Up and down, she came up and down the stairs, sat down, wasn’t happy and almost sort of had a paddy with her zimmer frame. And so one of the night staff took her up. And I think it was all she wanted was a cup of tea. But that was one thing that I hadn’t, she’d had a drink earlier on, and I thought that’s what she needed. But obviously she wanted another cup of tea, but it’s not always easy to understand what she’s saying so it can be a bit of a problem. (Jean)

Communication barriers, generally as a consequence of dementia or a stroke are common in care homes and were a common cause of care staff not being able to understand a resident’s distress. Jean explains that as she only infrequently worked on this lady’s wing, another member of staff may have been better able to understand her. Although this example shows an initial lack of understanding of the situation and not knowing how to respond, the outcome was ultimately positive for Jean. Importantly, instead of feeling she had to cope on her own when she knew she did not have enough
knowledge of this resident, Jean felt able to ask others for help. The outcome would probably not been so positive if Jean did not have this support from other care staff.

Last night, I went to get this lady into her night dress...I took her top bits off, I was going to put her nightdress on because I like to get her top bit off, put her nightdress on, then stand her on the stand aid, wash her bottom, take off the bottom and just put a nightdress on. Because I just think it's less standing up you know...She didn't want to do it. I put her nightdress on and she chuck it out. I said 'sweetheart, I'm just try..,' 'I am not your sweetheart!!'. 'Ok, I'm only trying to help you'. Then I explain it to her. She say 'no'. I just walk out. I said 'well if you don't want me to do it I'm going to have to leave you I'm afraid and go and get someone else'. And she said 'just leave me then!' So I just leave her and go and tell another staff, I say 'whenever you're ready..' yeah. (Arlene)

Arlene became task focused when giving personal care to the resident and the resident became frustrated and was possibly offended. From Arlene’s perspective, planning the care so the resident only had to stand once was helpful to the resident. Arlene thought she had understood the situation, but had not, and her actions contributed to the resident’s frustration. Arlene knew she shouldn’t have called the resident ‘sweetheart’ and it is possible she used this term as she herself began to get frustrated. Arlene realised she had not approached the resident in the best way, but was able to ask another member of staff for help.

Despair of Residents

Many of the same events and medical problems that can cause a resident to become frustrated, may also cause despair. Trying to comfort or cheer up a resident who feels despair is an extreme challenge for care staff as often there is no simple solution that can improve the resident’s problems.

In the following example, Gillian describes a resident who has recently returned from hospital, following a fall.

Um, but yeah, seeing, trying to deal with her now, it's hard cos I just feel so sorry for her. Cos her motivation is just gone, completely gone for her now, that's it, knowing that she can't walk. Talking about my holiday, I've just been away on holiday, earlier this morning she said, 'I used to love it, I'm never
Gillian found the resident’s distress about her deteriorating health upsetting. She understands why the resident has lost her motivation, but is unable to improve her physical situation. Instead of avoiding what can be a difficult emotional experience, Gillian tries to do as much as she can for this resident. Working with this resident results in a mixed emotional outcome for Gillian as she gains satisfaction from the positive feedback from the resident and the support she feels she can provide, but also feels very sad about the resident’s distress.

I think as people, sometimes we want to put it all right. You know, because they’re distressed and because they’re old and because they’ve got, I don’t know, because a part of them is still there, and there’s another part that’s not. You, you try to put it right. You try to say the right things, but still you come back to basically, they’ve got to deal, or we’ve got to also deal with their needs. And we’ve got to encompass all that, but it can be quite hard, it can be definitely quite hard. (Elaine)

Elaine argues that while care assistants can do all they can to comfort a resident who is distressed due to their physical frailty, it is ultimately the resident who has to cope with the situation. She realises that care assistants cannot always make things better and these situations can be difficult to cope with. The despair of a resident can also make staff feel helpless as they are unable to improve the wellbeing of the resident to the extent they would like to. Care assistants reported that they often receive very little positive feedback from residents who feel despair or who are depressed, and this can be emotionally exhausting. While care assistants may well understand that a resident had depression they still found it hard to cope with.

Providing Reassurance

There are many instances where care assistants recognise a resident’s distress or confusion, and many are very skilled at providing reassurance. Instances where care assistants provide reassurance include:

1. **Physical Comfort**: Ensuring the resident is comfortable physically can go a long way in providing reassurance. This includes adjusting the bed, providing a warm bath, or simply holding the resident’s hand.

2. **Emotional Support**: Reassuring the resident that they are not alone and that staff are there to help can provide emotional comfort.

3. **Clear Communication**: Simple and clear communication can help reduce confusion and provide reassurance.

4. **Routine and Familiarity**: Maintaining a routine and familiarity can help reduce anxiety and provide a sense of reassurance.

5. **Stimulating Activities**: Engaging the resident in stimulating activities can help distract from distress and provide reassurance.

Providing reassurance is an essential part of care work, and care assistants must be skilled in doing so to provide the best care possible.
assistants had successfully calmed or cheered up a resident had provided them with job satisfaction.

Adam recognised that the resident was feeling down and used his knowledge of the resident and her family to remind her of the positive aspects of her life. Adam felt he had done well and was pleased with her response. Talking about family visits was a common form of reassurance for those who have become disorientated regarding time or have short term memory problems as they often forget family visits and feel abandoned even when they see family regularly.

Wendy describes providing reassurance for a resident who has a fear of falling, a relatively common anxiety amongst care home residents. Wendy later describes herself as being fond of this particular resident and this was apparent in her descriptions of the range of conversations they have and how well she appeared to know the resident. This is a positive example of care staff understanding the
residents' concerns, providing reassurance and both the resident and staff member benefiting from the outcome. Wendy also describes the poorer care given by some other carers, but later explained that she did not feel confident in addressing these issues with staff.

This section has discussed some of the emotional challenges involved in responding to different forms of resident distress. Care assistant's understanding of the situation and cause of distress and whether the best response was ambiguous both strongly related to positive outcomes for the resident and so usually the staff member. However, care staff also had to work with their emotions, such as their own distress at seeing a resident who was upset, frustration at not being able to understand a problem or emotional exhaustion from frequent negative feedback by resident.

Response to Pain and Death

One of the emotional challenges associated with care work was coping with residents becoming very ill and also passing away. Care staff regularly see the most distressing aspects of ageing. As well as the emotional labour of caring for the residents, many also reflect on what the future holds for themselves and their families.

...She was self caring, self medicating, doing everything for herself. Now she can't do any of that in just the space of a month. She can't do all that. So I just want to help her you know, as she's just sort of going down hill, she's going to die which I don't want to think of that. I just want to make her better so she can just go and look after herself and do things she was sort of doing a month before. (Nina)

Nina finds it difficult to watch a resident who has declined in a short space of time. In this case the care assistant understands the situation but they are unable to 'fix' it and so can only respond in the best way to comfort the resident at that time. As with many situations in which residents are distressed, the care assistants can feel helpless in not being able to improve their health or situation. Nina went on to describe her reaction to residents passing away.
And, when I used to work in a nursing home they used to sort of, if they died today, tomorrow someone can just move in [to their room], as quick as that. So I didn’t want them to just replace them and forget about they existed. I find it difficult, but now I know the procedure, that’s why they’re here. That’s why I try to make, to do as much as I can. When I go home, because sometimes you come in and someone has just gone during the night. So if I make sure I’ve done my bit, when I go home I won’t feel guilty. (Nina)

Nina has found the experience of residents passing away easier to cope with over the years, and this supports the general findings from the interviews, that younger and less experienced carers are more distressed by experiences of death. Several other care staff also expressed that they found the residents empty room to be upsetting or that a new resident moving in too quickly was difficult. In my own experience it is not uncommon for a particular room to be referred to as the deceased residents’ room, or old room for some time, even if there is another person in it. Finally, Nina uses her experience of residents dying, to motivate her to do the best for those she cares for. By providing them with good care, she avoids feeling guilty or can feel more positive when they die.

Well the lady that um died, last week...She had a lot of breathing difficulties. And just being in her room and sitting with her and holding her hand, you know, is uh, very, you feel as if you’re um, just being with somebody really. Spending that bit of extra time chatting to them.

R.L.: So how was that for you?

Oh it’s sad. Yes, very sad when you see people, you know, you realise someone’s coming towards the end of their life, you know, an uh, that they have to suffer. And obviously, you know, lived in a rosey coloured world, everybody would just go to bed one night and just not wake up again. But um, when you see them suffer, I do think, oh, I wish they didn’t have to. (Carol)

From Carol’s perspective it is important for her to be able to spend time with a dying resident and to ‘be there’ for them. Even though she felt she had done her best she was still understandably upset that the resident was in discomfort at the end of her life. Although the passing away of an elderly person tends not to be seen as tragic in the same way as the death of a younger person, the actual physical process of dying can be equally as distressing for the resident and so for the carers.
Many care assistants had strong opinions about being able to give residents a ‘good death’. By doing the best they can to ensure the comfort of the resident, care assistants feel far less upset than they otherwise might have done when a resident passed away.

Back in November we had a lady and she actually died that evening. And I was sitting with her and I was holding her hand. And she said, ‘please don’t leave me’, so I didn’t leave her. And I spent a lot of the time with her that day. Yes, alright, you do have to come out the room, you do have other residents and I did, and her other obviously family and friends were there. But when they needed me I went in... So I felt I’d done my bit throughout the day to just make her last day with us more comfortable really.

(Lynn)

Lynn was not upset after the death of the resident she was caring for, she felt pleased that she had been able to help give the woman a comfortable last day and peaceful death. This ‘good death’ was in contrast to Carol’s earlier description of a resident who she felt had suffered. This aspect of palliative care is not under the control of the care staff and so the emotional outcome for them does not just depend on how they cared for the resident, but the manner and place (i.e care home or hospital) of the resident’s death. While Carol was still upset by her experience, Lynn felt much more positive. Lynn also describes another aspect of emotional labour related to palliative care in residential homes. While she spent a lot of time with this resident, she also had other residents to care for who also had a range of emotional needs. Moving from quietly caring for a woman who is dying to serving meals or dealing with what are comparatively minor problems of other residents requires a great deal of emotional labour. The care assistant not only experiences extremes of emotion, but must manage how she displays her emotions and who to.

Yeah, I’ve been here 4 years. And um, one of our residents, when I was on holiday last week, we have Mavis died. And was like crying and I was like filling up and [senior staff member] sort of looked at me and I’m thinking, well, it’s sad. Cos she always used to, she always sort of, ‘hello my darling’, and ‘how are you’. And I always used to give her what she needed and she always used to make me laugh. But that was sad, that was really sad. You know, the couple of years that I’ve been here, we’ve lost about 3 or 4. And it’s
been sad actually. Cos you get attached to them. You shouldn’t do really, but you do. You can’t help it. (Rosemary)

Rosemary highlights the sometimes contradictory expectations on care staff. Rosemary had developed a meaningful relationship with the resident, something which is encouraged as it promotes good care, but was then not expected to express her emotions when the resident died. Some care assistants may have known a resident for years, and have spent a great deal of time with them, so particularly miss residents when they die. In this example, Rosemary’s feelings were dealt with insensitively by senior staff.

While death is an unavoidable part of care work, acknowledging staff feelings and allowing them to express them should be an accepted part of managing a care team. This is especially important if the resident did not have what the staff would class a ‘good death’. Palliative care work is not only important to care staff, but also to residents and their families. Unfortunately there is little acknowledgement of this highly emotional aspect of caring for older people in care homes. During my research one manager specifically stated that she thought research into emotions and care work was important as some of her staff had been so upset by recent deaths. She was even thinking of arranging some outside support or counselling. Of those care assistants who spoke about death, most had been distressed about the death or suffering of a resident in the past couple of years, although the extent to which staff were effected greatly varied.

Conclusion

This chapter has highlighted some of the most common emotional challenges involved in care situations when working with residents, that require high levels of emotional labour from care staff. Care staff mainly understood their work in terms of physical tasks, such as personal care or palliative care, but also in terms of some general emotional responses of the residents. Analysis has revealed that care staff’s
understanding of the emotion work involved in caring for residents is broader than the management of their emotions.

Firstly, the emotion work undertaken by staff relates to their understanding of the situation. It was care staff's understanding of situations that guided their emotions, and also responses including emotional labour. In terms of Hochschild's (1982) concept of emotional labour, this may be viewed as a precursor to that labour. Care staff's skills, experience as a care assistant and knowledge of that resident could all contribute to care staff's understanding and perspective in a given situation. As previously discussed in chapter 5, empathy appears to motivate care staff to undertake emotional labour and it makes conceptual sense that empathy would be involved at this stage in order to gain insight into the resident's position. Understanding the situation reflected not only the complexity of the situation itself, but the care staff's own emotional skills, of which empathy could be regarded as one. Complex situations were more common in relation to residents with dementia, or where communication with the resident was difficult. The type of situation impacted greatly on the type and intensity of the emotions experienced by staff and so the emotional labour required to respond.

While care assistant's understanding of a care situation guided their response, this was not always straightforward. In some circumstances, the 'correct' or 'best' response was ambiguous. This was more common when caring for residents with dementia, often as a result of the resident's understanding of the world conflicting with 'reality', for example, searching for a deceased loved one. These situations could require high levels of emotional labour while the care staff not only tried to provide emotional support for the resident, but they worried about whether they were acting appropriately. Particularly if staff were unable to calm or reassure a resident when the best response was ambiguous, staff could feel defeated or guilty. In contrast with Hochschild's initial study where air stewardesses had to work hard to manage their emotions and try to appear constantly calm and happy, care staff can work hard at managing their emotions without knowing if this is the correct way to react, adding a
new dimension to their emotional labour. This ‘extra’ emotional labour is reflected in the higher stress reported by staff when responding to ambiguous situations.

Balancing resident’s immediate wishes with their physical wellbeing or that of other residents was also difficult. Issues of resident power and autonomy are important but complex issues within a care home and for wider society. However, the interviews show that care staff often believe that a certain course of action, such as changing someone who has been incontinent, is in the resident’s best interest, and will engage in emotional labour to ensure this is done. The issue of what is in the resident’s ‘best interest’ also relates to the findings of the empathy data. The tendency for care staff to respond to a resident as they thought they would like a loved one to be treated, or indirect empathy, could well explain how care assistants assess and respond to some of these types of ambiguous situations.

Care staff responded to residents using a range of different approaches, many of which relied on emotional labour. In terms of managing dissonant emotions (those which are viewed as socially inappropriate), staff undertook deep or surface acting. However, while it is relatively simple to discern examples of surface acting, especially in relation to dealing with incontinence and irritation, deep acting was more difficult to identify. That is not to say care staff do not undertake deep acting, but that how they manage their emotions is less important in their understanding of their emotion work, than the context within which this acting was undertaken. This analysis supports the argument that non-dissonant emotions are indeed an aspect of emotional labour. There were clear examples of staff feeling appropriate emotions, but still managing these emotions to display them appropriately, for example being upset when a resident is distressed but managing these feelings so that genuine concern is displayed to the resident.

Care staff further understood situations to have a generally positive or negative outcome, usually the outcome for the resident coincided with the outcome for the care staff. The analysis reveals that care staffs’ emotion skills in understanding and
appropriately responding to residents are important for a positive outcome. However, very complex situations and unexpected reactions posed an emotional challenge for all care staff, and no care staff reported that they always achieved a positive outcome in their work with residents. In terms of emotional labour then, care staff work in an environment where high levels of emotional labour quite frequently do not result in a positive outcome. It is likely that this lack of 'emotional reward' can add to staff's negative feelings and can contribute to emotional exhaustion. However, staff can be supported in these situations by their colleagues and the organisation they work in, as will be explored in Chapter 8.
CHAPTER 7

THE EMOTIONAL LABOUR ASSOCIATED WITH 'CHALLENGING' RESIDENTS

Introduction

This chapter will focus on those resident characteristics that required higher levels of emotional labour from staff when working with them. The resident characteristics discussed in this chapter are a biased representation of residents given that they are all negative. For example, when asked if there were some residents they found more easy or difficult to work with, care staff almost always focused on the negative aspects in their response. However, these descriptions usually referred to a minority of residents, but the characteristics perceived as negative tended to be similar for all care staff. Positive characteristics were not often specified, but residents were referred to in general terms, such as 'lovely', or 'great'. Staff described positive, meaningful relationships with residents including those that they also described as having some negative characteristics. As this analysis is from the perspective of the care staff and it is more negative characteristics that contribute to higher levels of emotional labour, they will be the focus of this analysis. This chapter uses the language and distinctions made by care staff, which the researcher is well aware are not the 'correct' way to refer to older residents, but are nevertheless relevant to the emotion work of care staff.

While residents with dementia were more likely to be regarded as having certain characteristics, such as aggression, and also more likely to become distressed due to confusion (as discussed in Chapter 6), staff did not tend to refer to dementia as a characteristic in itself. Therefore, residents with dementia are discussed within the context of various characteristics.

Care staff tended to describe their working day in terms of the physical tasks and daily routine of the care home. However, when referring to the emotional aspects of their
work that they either enjoyed or found difficult, situations that they felt they had handled well and those that had not gone to plan, or residents they found easier or harder to work with, they tended to refer to the characteristics of individual residents as opposed to the physical aspects of the job. The personality, mood, mental health and happiness of the resident impacted on the emotional labour of staff to a great extent. The following sections will outline some of these characteristics and how these related to the emotion work of the care staff. The terminology reflects the language and descriptions used by staff in order to understand their perspective.

**Demanding Residents**

The majority of care assistants referred to some residents as 'demanding'. This term usually referred to two particular characteristics of a resident. Firstly, it was perceived that the resident took up more time or energy than was expected for their level of physical and/or mental health needs. Secondly, the attitude of the resident towards staff and the way in which residents spoke to them could be seen as demanding. These two main aspects of a demanding resident are described by Nadia below.

> They’re different characters you know. Some of them they are very demanding, some of them they don’t say please or they don’t say thank you, they treat you like a slave, their slave, you know. And some of them they want carer one-to-one, and it’s not possible because you need to look after other residents as well. Some of the family, they encourage them to demand one-to-one, which is not possible. (Nadia)

Nadia finds demanding residents to be both impolite and to expect more time than the carer feels she can provide, given she also has other residents to care for. Several care staff made comments to the effect that some residents treated them, or made them feel like slaves or servants. Care staff found demanding residents increased their emotional labour as they tried to remain calm when residents were impolite or increased their time pressures, presumably engaging in ‘surface’ or ‘deep’ acting to manage their negative emotions.
Understanding of Demanding Behaviour

Depending on the staff member and the individual resident, the behaviour of the resident was either assumed to be a part of their personality that had not changed, or a result of being older and being in a care home or having dementia. Using these types of distinction the care staff tried to make sense of the residents' behaviour. This is related to the 'understanding' care staff have of a given situation with a resident as described in the previous chapter.

There are some that um, you know, they're just, you just know that they've always been like that. The tea's never quite right, the food's never quite right, but you know that that's not anything that's happened in later years, that's just how they've always been. You could imagine them at 20 sitting there and saying exactly the same things. And obviously you never get annoyed, well I don't, I never get annoyed with residents. I never show them, cos that's not the right thing to do, you're here to help them no matter what, you know. Um, but you do find yourself sometimes thinking,' oh for goodness sake!' (Anna)

Anna tries not to show her irritation with a resident even when she thinks they are being unreasonable, this example appears to describe the use of surface acting to cover her emotions. She attributes the behaviour of some demanding residents to be a part of their personality and as such she is unable to change it and so will be unlikely to ever satisfy some residents. In contrast, Corina tries to remind herself that most of the residents she works with have dementia.

And um (...) I've never complained about the physical side of the things, because there you can always ask for another, an extra pair of hands, it's uh, what is tiring is those who are really demanding and let's say screaming, shouting, constantly um (...) Those who are never happy, those who want immediately, right now, things to happen. So they wont have the um, you must, I mean, I bear in my mind all the time that, they don't have the perfect understanding, but it gets you at times. (Corina)

Corina describes the emotional labour of working with very demanding residents as more tiring than the physical aspects. She also makes the distinction that for physical work she can get help from other staff, but this is not the case for emotionally demanding residents. Corina knows that many of the residents she cares for have dementia, but she still finds their expectations of an immediate response tiring and possibly irritating at times.
Responding to the 'Buzzer'

Most examples did not refer to residents shouting as in Corina's example, but several referred to residents frequently 'buzzing' staff. All the care homes had some form of buzzer or pager system whereby residents could press a button and alert staff that they required assistance. Residents who were thought to buzz too often, expect staff to attend to them immediately or buzz for small matters were seen as 'demanding'.

Yeah, if yeah, one of the residents, I mean I've got one that can buzz anything up to 60 times in a day. Um, that can be hard cos obviously other people all go, oh god it's her again, you know, nobody will rush. And I'm like, that's not fair.

R.L.: ...Is the buzzer mostly for things that the resident needs or is it for the company or..

Um, she'll just buzz for, 'pick my pen lid up', in the middle of lunch, that sort of thing. Things that can wait, most of the time, they can wait. (Gillian)

This resident was well known to other staff as someone who buzzes a lot as others also spoke about her. According to Gillian, other staff do not quickly attend the resident, and Gillian feels she gains little support from other staff in caring for this resident. Therefore she has her physical workload greatly increased and so also her stress levels and emotional labour increased as she tries to remain calm and support the resident. Gillian also gives an example of the resident buzzing during lunch, to highlight that was busy and, presumably had other residents to help during that time. There is no evidence that the reason behind the resident buzzing has been thought about or determined by staff, or any interventions have been made to improve the situation for both the resident and staff.

There's some that, you know, they press the buzzer and (clicks fingers) you've got to be there just like that. And they're not, you know, respectful of you, but we have to be respectful towards them, it doesn't always work the other way round. And that's quite upsetting I find sometimes. It's demeaning. (Wendy)

Wendy finds resident who expect an immediate response to be demanding. As with buzzing frequently, increased time pressure adds to her stress. Similarly to Nadia above who described being treated like a slave, she finds residents that are impolite to her undermine her status as a care assistant and actually describes their attitude as
'demeaning'. Emma also finds she gets stressed by residents who expect an immediate response from staff as they can take her away from other residents who she feels have a higher level of need.

*When you've been with a resident for an hour because they can't move and they're dying or whatever and then you get someone buzzing and you go into them and they're like, 'you're 5 minutes late with my cup of tea', it makes me want to throw things (laughs)... Like, don't you have a go at me, you don't have a clue what I'm doing. (Emma)*

Emma highlights a common situation that can arise in care homes. While care of an individual with high or immediate care needs should take priority, other residents can be inflexible around the established routine. Therefore both residents and staff can contribute to maintaining a rigid routine that does not allow for the varying needs of residents. Having gone from a highly emotional situation, such as caring for a resident with palliative care needs, care staff may well find the seemingly less important expectations of other residents as irritating, although in a different situation they may have appeared quite reasonable. This is an example of the varying emotions staff can experience in a short space of time and the difficulty they can have in managing these emotions.

**Critical or Insistent Residents**

Care staff also described residents who appeared to tell them what to do or criticised their work. This was particularly so in areas where staff felt they had been trained and so had greater knowledge, for example using hoists.

*Maybe you would walk in and you'd get a list of could you get me this or could you get me that, or could you sort out this and sort out that. And then you get like the, if you're moving and handling somebody, the person might say, 'oh no, shouldn't you have put that on that strap', and 'oh but shouldn't we have the commode there?' And we're like, well no, we'll get the commode once.. you know. And sometimes it's a balance, it's a bit of a battle between you and a particular resident. But uh, you get through it. You've just got to be calm and in control of the situation. (Elaine)*

Elaine did not like residents to question her work when it came to particular areas. Using hoists can often be a source of conflict as some residents do not like them and different staff may use the same hoist in different ways. Elaine refers to the emotion
work of staying calm, but also staying in control. This could refer to control of her emotions in the situation, but it seems more likely that she means control of the resident. From the staff member’s point of view, they are entirely responsible for the correct physical handling of a resident both for the resident’s and their own safety, so may be caught between these legal requirements and the residents’ wishes. However it is also likely that residents are seen as demanding when their routine or way of doing things conflicts with a staff member’s preferred routine.

In some situations, such as that described by Olga below, residents appeared to deliberately manipulate staff and have unreasonable expectations of them. In this example, Olga had not been at the home for long when she was attending to a resident she did not know well.

But I didn't know her, well I didn't know how mobile she is, what shall I do? ...And she was, she knew that I don't know and she was pushing me sort of, you know, sort of taking the piss. ...And in the end I left her and just told her I'd be back in a second. I was standing outside her door like, bloody hell...She really upset me.

R.L: So what was it you were upset about?

I don't know, she was so really demanding, she was really, sort of, I don't know. It's weird, sometimes, when the way she like spoke to me and stuff she was really like nasty to me and really sort of, asking for things she didn't really need me to do, or just silly stuff. I spent there like 40 minutes just sort of doing everything she wanted and you know, you've still got a lot of other residents, you know. (Olga)

In this example, Olga had been upset by this resident who she felt had taken advantage of her inexperience. She was distressed by this incident when she went home and it still effected her for some time after. At the time, Olga clearly did not know the resident or their needs and so did not understand the situation she found herself in. She did not now how best to respond as she lacked experience and support from other staff. The outcome was therefore very negative for Olga, although it is not clear how the resident felt. Olga did eventually gain a good relationship with this resident. As with many aspects of emotional labour, care staff did gain job
satisfaction when they were able to persevere with a resident and build a relationship with them.

Yeah, so some residents really 'oh go and do this do that', they want everything to be done in the proper way. Even though they know you are there most of the time, you know what they want, they still tell you one by one, you know, so you still have to do those things. And in the end if you... the goodness is that if you keep on helping that person, even though she may be or he may be demanding, in the end if you do what she likes or what he likes every day, and then he tends to like you and you like him. That's it. (Habiba)

Habiba viewed meeting the 'demanding' instructions given by the resident as part of building a relationship, as opposed to something to be changed. While she doesn’t describe this in detail, it is possible that by not engaging in a power struggle with the resident and by trying to do as they ask, Habiba then saw some of the more positive characteristics of the resident and so began to like them. This is in contrast to previous examples where care staff focused on how demanding a resident was and did not try to build a relationship based on their other characteristics.

In conclusion, care staff found residents they perceived as demanding increased their emotional workload. Residents who expected more assistance than staff felt they needed increased the time pressure and physical workload of staff. This in part reflected the challenges of caring for a group of residents and their needs and wants conflicting. Care staff rarely appeared to understand the resident’s perspective and why they behaved in a ‘demanding’ manner. The emotional labour involved in remaining calm when stressed and also covering negative feelings towards the resident were at times necessary. The perception of a resident being demanding was also related to concepts of power, with the staff trying to maintain control over the resident, such as when using the hoist. Staff also felt irritated or upset by the attitude of some residents who they felt treated them with a lack of respect or like they were servants.
Rude Residents

Staff found residents who were rude to them, or very negative in general, more difficult and less enjoyable to work with than those who were found to be helpful or more positive. A distinction was made between those residents with dementia who were generally thought to have less understanding of a situation or less intent to cause offence, and those who did not have dementia.

The following extract highlights some of the overlap between residents perceived as 'demanding' and those perceived as 'rude'. In the following example Elaine describes how she is sometimes unable to answer a buzzer for some time as she is with another resident and that a particular resident was, in her opinion, quite rude to her about this.

*And she [resident] would say, ‘oh well I’ve been waiting half an hour’. And I’d say ‘Oh I’m very sorry, but I’ve been held up. I’ve been in doing a bath’ or whatever. Yeah, but in the end she was quite argumentative and then saying to me that basically I didn’t know what I was talking about. And she said, oh, she said, ‘if that went to a court of law, that you wouldn’t, that wouldn’t stand’. But I said, ‘it would never go to a court of law would it’. And she sort of, ‘hm hm’, she started laughing. And she was trying to imply that I didn’t know what I was talking about. And I just had to leave at that point. I was beginning to. Not, lose my temper totally, I would never lose my temper totally, because I’ve got to remain calm and professional, but, she just didn’t want to see my side of my point of view. (Elaine)*

Elaine found this resident’s insinuation that she did not know what she was talking about to be particularly rude. This could be seen as just a disagreement between two people as can happen in everyday life, but as discussed in the previous section, issues of power are also apparent. The resident was annoyed at having to wait so long, and Elaine, who felt she was justified in being late was irritated as she felt the resident was talking down to her. However, instead of placing the resident’s comments in the context of her frustration at having had to wait, the care assistant took this disagreement personally. Staff described residents who criticized their work as both demanding and rude. Although Elaine does not expand on her feelings here, throughout the interview she was keen to stress that she was both capable and intelligent. It is possible that Elaine was sensitive to the low status given to care staff
and does not feel it reflects their work or their abilities. Therefore Elaine finds comments, such as those made by the resident more upsetting than may be expected, and had to engage in surface acting not to lose her temper.

Understanding of and Reactions to Rudeness

Care staff reacted to residents they found to be rude in different ways. Often they just put up with it and tried to maintain a calm and relaxed appearance.

Um, with me, I find it difficult when, um, when people aren't 'please and thank-yous'. I find that really hard to deal with because in their days they were always brought up to be so polite and all the rest of it, and, and they're not. And you spend like an hour in with them and then you come out and it's like there was no thank you, there was no appreciation whatsoever. I really struggle with that, just being appreciated. I don't have a problem doing the work, doing hard work and all the rest of it, I'll put in the hours, I'll even do over-time and not get paid for it, I'm fine with that. But at the end of the day I just want that thank you... (Jennifer)

Jennifer feels strongly that residents should at least say ‘thank you’ and finds those that do not can lower her morale. However she does not address this with residents or other staff. Instead she tries to care for each resident as well as she can, but often feels quite despondent if she does not get any positive feedback from the residents. It is very possible that some residents expect to receive care as they are paying a great deal for it, and do not, therefore, feel thankful when they receive it. However, from Jennifer’s perspective, not even engaging in common courtesy is rude, and it is likely to also suggest that the resident is not interested in building any form of relationship with her.

Other staff are affected by impolite residents, but they avoid taking the behaviour of the resident personally by making medical or other excuses for them.

I suppose when I first came here, not understanding the dementia completely. I'd have a lady that would chuck things at me, you know, that sort of thing. And say really hurtful things. But then as the time got on, you know, I got to realise it wasn't her, you know, it was her dementia. And that can be a bit of a strain. (Gillian)
Gillian has become less upset by the actions or comments of residents as she gained more experience. Instead, she reasons that it is not the resident who is meaning to be offensive, but it is the effect of their dementia. This enables Gillian to work with the resident without feeling that either she, or the resident, are responsible for the negative response of the resident, something which will be discussed further in the next section. Similarly, Claire admits she still does get offended by some things residents say, but tries not to worry about it, as she doesn’t think the resident will remember it.

\[
\text{I have had a few and um, I mean, a few of them do say a few hurtful things.} \\
\text{But then (..) I don't think most of them actually realise who you are and what} \\
\text{you do and that. It does, they do sort of hurt you a bit but then you just sort of} \\
\text{get over it to be honest. Half the time it's not really worth worrying about is it,} \\
\text{I mean they probably don't even remember they've said it, do they so it's...} \\
\text{(Claire)}
\]

Claire highlights some common problems in relation to caring for residents with dementia, as some of these residents do not remember staff or know that they are carers. Staff obviously know the resident, but do not fully appreciate that they are strangers from the perspective of the resident. Claire tries to feel better about negative responses from residents by focusing on their dementia, and residents being unable to remember events later.

Alternatively, staff felt that everyone can potentially be rude when they’re having a bad day and that as care staff they just have to accept that sometimes they will be the object of a resident’s bad mood or frustration.

\[
\text{We’ve got one lady, she’s ex-teacher and um she is quite rude to staff, but it} \\
\text{is alright, we are all different. But um, you know and she is rude to you, and} \\
\text{she shouts as well, because she can’t hear herself so it’s funny like} \\
\text{conversation, and visitors might think, oh what’s going on here....So it’s a bit} \\
\text{difficult....She can be very nice at times, but uh, like everybody else we’ve got} \\
\text{moods haven’t we, so when she’s in a mood she’s quite rude. But that’s one} \\
\text{of the things you need to tolerate and just get over it and, you know, I think it’s} \\
\text{nothing personal, it’s just, you know.} \text{(Dominik)}
\]

Like Dominik, a number of care staff referred to residents having an ‘off day’ and argued than in this way they were like any other section of the population. Dominik sees this resident as having both positive and negative characteristics and also
understands her deafness can make her appear as if she is shouting at staff, when she
may not intend to. Dominik still did not like the experience and found it to be
difficult, but accepted it was part of his job and tried not to feel personally offended.

And then, another down side, you have them saying ‘(tuts) your hair isn't
looking very nice’, or ‘you’ve gained a bit of weight haven’t you?’ Or ‘you
smell’.

We were taking care of this lady, two staff, and I, she say ‘were you
eating garlic?’ I found that very offensive. You, but then, I just (..) When I
just started into care work it used to annoy me, but then as you grow you get
wiser, yes, so it just go over my head. (Arlene)

Arlene gives specific examples of residents being rude, either because they intended
to, or they had not thought about what they were saying. With experience, Arlene had
grown more used to such comments, but newer staff described being surprised as they
had not thought residents (or older people) would be rude in this way.

Responding to ‘Rude’ Residents

In the examples given so far, staff have described mainly their emotional reactions to
rudeness from residents, and focused less on their actual response to the residents.
Staff frequently appear to undertake either deep or surface acting to give either a
positive or neutral response to the resident and continue the task at hand. Although in
the previous example Arlene tries not to be offended by resident’s comments she later
described a situation where she directly addresses a resident instead of ignoring their
comments.

Last week this lady says to me ‘oh, your hair isn't very nice’. And I said ‘well I
like it, thank you very much’. But I don’t really say (in baby voice) ‘Oh come
on now, you shouldn’t be saying that’. Because that is patronising. And I’m
not here to patronise them because they are adult. I mean, I mean [you]
probably think I’m nasty, but they’re not children….If it’s getting too much, I
just walk out, yeah, cause I’m not going to argue with them, I can’t be
bothered. (Arlene)

As with many care staff Arlene is trying to find the balance between residents being
treated just like any other adults and accepting that residents will at times be rude due
to their mental health or situation. She was offended by personal comment and
instead of ignoring the comment or coaxing the resident to be more polite, she
responded more like she would have done had any adult made such a comment.
However, she makes a distinction between making it clear she is not going to ignore the resident’s rudeness and actually engaging in an argument with them. She feels it is reasonable for her to leave a resident if they are insulting her to a great extent, suggesting that from her perspective, protecting her own dignity and emotions are important at work.

Similarly Jean tries to encourage a resident to be more polite and is partly successful. She also leaves a resident if they are being very rude, as she does not wish to lose her temper.

So I suppose it’s um, I suppose the ones that sort of treat us a bit like maids, or, you know, can’t be bothered to find out our names, or ‘oi’ or, you know, who don’t have sort of respect for us. I find that a bit, I mean, one particular lady wouldn’t say thank you at all, you know. And so I tried to get her to, no, she wouldn’t say please but she would say thank you after you’d done it, so it was sort of a battle and I’ve given up on that. But I do think manners makes such a difference, whatever age you are really....I mean sometimes when people are rude and you find yourself beginning to boil up, it’s best really to just walk away out of the situation, then come in when you’re cooled down and they’ve cooled down, so nothing is said that, you know, you’re going to regret or be sorry about. (Jean)

Many care assistants removed themselves from a resident if they felt themselves losing their temper, becoming too drained or if they wanted to make it clear that the resident’s behaviour was not acceptable without engaging in an argument. While this seems at face value, a very sensible response, and one that prevents the situation escalating, it is also a reflection of the staffs’ power that they are the ones who can walk away and ‘temporarily withdraw’ their care. Care staff were aware of their own limits and knew they could not always contain their emotions. Unlike in deep or surface acting where staff cover their emotions in front of residents, in this situation, staff physically move so they can then release their emotions, or manage them in a less demanding environment. In the following example, Emma is aware that it is not always the resident, but her own ability to cope with the resident that impacts on her response to him.
R.L: So is he like a chatty person or is he quiet?

Um, I think he would chat if it was a different situation. He talks all the time but all he does is moan about everything you’re doing. He's very sarcastic about what you do, you know. Sort of 'I could have done it better' all the time. It's very draining with Michael.

R.L: How do you respond to that, or is there a response you can give Michael?

Um, well, sometimes I just ignore him and I get on and do it and let him just talk and the only thing I can do is just block him out. That's when I know that if I don't block him out I'll be leaving the room and just leaving him to it because I'm just getting to that point. Sometimes, I'll, I'll, you know, I'll come in and if it's, if I'm fresh, I've had a day off or something, I'll go in and I'll be like 'Ok then Michael, I'm sorry about that' and just keep on top of it. (Emma)

Emma uses the method of 'blocking out' the resident in order to get on with the physical tasks at hand while trying to manage her emotions. It seems unlikely this is particularly satisfying for either Emma or the resident, as Emma is barely tolerating the situation and the resident is effectively being ignored. This is an example of poorer care, but from a carer who had previously described examples of very good care. However if she is in a positive frame of mind and rested herself, she feels better able to respond to his comments and stay calm. This suggests that when working with 'rude' residents, the care staff's own emotional state is also important to how they respond and cope with the situation. Staff tiredness, both physical and emotional could impact on how they respond to rude residents. In all the care homes, staff were either required to, or had the option of working 'long days' of around 12 hours. Presumably at the end of a long day, staff were less patient and had less energy with which to control their emotions than at the start of the day. Emma also refers to the positive effects of having a day off, suggesting that this tiredness is cumulative, both physically and mentally or emotionally.

Racism

The majority of overseas staff reported some instances of racism by residents. This was particularly so for black care assistants. In some cases racism was used as a form of rudeness. It could be that a resident would also have been rude to another member of staff, but chose to use racist comments with black and overseas staff. Other
residents displayed negative behaviour and made racist comments to overseas staff only.

Yes, and sometimes some of them can be damned rude, they can be very rude. They say 'oh, I don't want this black man to touch me', you know. Even though you know that in ordinary circumstances probably wouldn't have said it so bluntly that way, but then, it makes you feel... still you feel, you just feel it just like any other human being. (Adam)

As with some examples of rudeness, Adam believes the residents may not have spoken to him in that way if it was not for their situation or their mental health, however, he still feels upset. Female residents refusing personal care from a man is understandable and socially acceptable, but refusing care due to Adam being a black man is offensive and upsetting. Those staff that were white and from the UK and so not open to racism from residents also reported witnessing incidents of racism.

There's one lady who, um she doesn't, she only really really likes English people. Um, it's just on of those, she' you know, she's older, it's just how she was brought up. And um, I remember one day, she's fine with me obviously cos I'm English. But because one day I was busy doing something and it was like 3 o'clock when they're due for their tea, a drink of tea. I said to a girl who's Polish, I said 'can you please take her tea to her'...Next thing I know she's running out, and I'm saying 'what's happening?' And she's calling her a bitch and all this stuff. So I went in there and said, you know, 'what's up', you know 'are you all right, are you sure you're.. ' 'No, I'm not talking to you either', 'why not? What have I done?' 'Well you let her come in here'. (Anna)

In this example, care staff try to avoid overseas staff having contact with this particular resident as she is known to be very rude to them. Staff referred to older people being unable to help being racist, implying that because in the past racism was acceptable, they did not know any better. Even so, racism can create a very awkward social situation for all staff so most try to avoid these types of situations. Overseas staff may be upset or offended by the reactions of residents and 'UK' staff feel embarrassed on their colleagues or the resident's behalf. Most homes are aware that residents can be racist, but in general care staff were left to cope with this without support from senior staff, usually by creating unofficial rules whereby the racist resident was not cared for by overseas staff. In the example above Anna sought the help of senior staff but it was not forthcoming, so she dealt with the resident on her
own. Only in one example did a senior member of staff go and speak to the resident involved to tell them racist comments were unacceptable. As with many other situations, allowances were made for those with dementia, but in general, no action was taken by any member of staff, including the target of the abuse, when residents were racist.

Racism in care homes is an example of negative behaviour from residents that is offensive to staff, but not easily changed and creates emotion work for the care staff. Care staff did try to prevent overseas staff from having to work with particularly racist residents, but this appeared to be the only form of support these staff received. This is one example where the rights of the resident outweighed those of the staff, to the extent that care homes accepted staff would be racially insulted and did not offer any intervention. The rights of the staff not to be abused, were therefore seen as less relevant than the rights of the resident. This feeling of imbalance was also highlighted in staff’s experiences of aggression by residents and is discussed in the following section.

Physical Aggression

Over half of the care staff reported incidents of physical aggression. These incidents were much more common amongst residents with dementia and so occurred with more frequency and severity in EMI homes or units. However they did not only involve residents with dementia. Situations that involved physical aggression were particularly memorable for staff and so readily reported. Staff still vividly recalled incidents that had occurred over a year previously or in a different home.

Understanding of and Reactions to Aggression

While there are some similarities between the emotional labour of caring for a resident who is being rude and a resident who is being physically aggressive, there are also some emotional challenges and reactions that are unique to physical aggression.
Um, as I said with abuse as well, I can be abused, that is not nice. Some of the residents can be aggressive, verbally aggressive or physical, less physical we have 1 or 2 here which are. But we don’t take it personally, at least I don’t take it personally, you know.

R.L: Is that something you’ve learnt over time, or...

Yeah, yeah, during the life I learnt that people they don’t do things because they want to do, they are frustrated, they can have, you know, mental disease or something, or you know. Me I try to know them better, the better I know their past life, you know, the better I know how to deal with them. Because usually if you respect their character, the way they were as well. I mean you can deal better with them. But even so there are some aspects, you know, that people they are aggressive or they all their life, they were aggressive. So they are aggressive with you, I mean swearing or rude, being rude. Mm, I don’t agree with this at all. And I don’t allow them. That doesn’t mean that I’m aggressive. (Nadia)

Nadia highlights a number of issues relating to physical and also verbal aggression. Firstly there are some similarities with rudeness, in that care staff try not to take it personally and also seek reasons for the aggressive behaviour, such as dementia or frustration. Nadia seeks to protect herself from aggression by knowing how best to deal with each resident as an individual. This implies that she accepts that her own behaviour towards residents impacts on their response, including aggression. She argues however that some residents have always been aggressive and that it is not always due to their health or circumstances. Nadia also argues that staff can be abused as well as the residents. Several care assistants who had been hurt by a resident felt that they had no protection at work and argued that residents have all the human rights but staff have none. While care staff felt that instances of rudeness were unreasonable they were more likely to accept them, but being physically attacked crossed a line.

In contrast to Nadia above, Teresa does not seek to understand a resident’s physical threats in relation to her own behaviour towards the resident. She feels that she was the victim of an attack by an unreasonable man.

He’s got dementia and he’s a very very strong chap, and very, well, powerful with his stick. And he never gives up he’s always right, type of person, he’s a man. So, I think his personality maybe.... He came to the toilet and he not supposed to come, I said ‘I’m cleaning, can you go to another one?’ And he
got antagonised and, he was in door. You know, he’s opened the door, it was sticking, staying there by the frame, and I was in the toilet tidying up. And he used his stick and he said he’s going to thrash me with the stick, mm hmm. Very aggressive

...And then he waved that and I said ‘ah well, I’m just trying to finish, do you mind leaving because I need to finish it off’, and then I pulled the cord. I tried to talk calmly, you know, not to give in, and um. Several people came by [and] I said ‘help’. He said ‘you don’t call for help because I mean to thrash you and I will thrash you’. I was threatened, yeah. And then eventually help came, yes, they got him. (Teresa)

Teresa does not speak English as a first language and so her description of the incident may be quite blunt. However it is also likely that she spoke quite bluntly to the resident who tried to hit her with his stick. In this situation the care assistant was focusing on the task of cleaning the toilet and did not respond appropriately to the resident even after it was clear he was becoming agitated. It is likely that many care assistants will at some time handle a situation badly and upset or anger a resident, however, Teresa appears to believe the incident was entirely due to the nature of the resident. Her comments regarding him being a man could also suggest she feels more threatened by men or believes men are more likely to show these negative characteristics. This is another example of poorer care, but also of an extreme reaction by the resident. Teresa was obviously still distressed by the incident and was also angry that the other care staff had not done more to support her and make sure she was alright. Teresa did not learn how she could have managed this situation better in the future. Instead, Teresa reported not wishing to work with this resident as she was very wary of another physical attack.

Emma described how a resident with dementia became aggressive and staff struggled with her for several months before she was eventually given anti-depressants, which she responded well to.

*It was very difficult with her because we had to do our job with her hitting us and things. We just had to do it. It was when we got to a point when the carers were frightened of doing it and she wasn’t getting her care. You know, she wasn’t getting washed everyday because you had to assess her. I mean if one day you went into her and she was alright, you could wash her, give her a strip wash... But some days, you just couldn’t. You’d go in there and you’d*
be like, 'right we’re just going to put on your trousers and your top and leave you to it'. And that’s when we had to start talking to the doctor cos there’s only so much of walking out of the room and leaving her to it that you can do before it becomes neglect isn’t it? (Emma)

Emma tried to judge the mood of the resident in order to give her personal care, but it was not always possible. Although she did not feel responsible for the behaviour of the resident, she did feel responsible for her welfare. She previously described how she argued against this resident being sedated as she did not feel this was fair to the resident. Instead of blaming the resident she felt frustrated at the situation. She described staff as being frightened of working with this resident, presumably because they were concerned for their own physical safety. Emma later expressed how hard she found the situation herself.

....The thing is it takes a very very strong character to be able to brush it off. Like I said the carers personality is that they care. And when you're doing something for someone because you're caring for them and they're doing that, it takes, it's a different personality that can put up with that. (Emma)

In Emma’s opinion, the emotional sensitivity she feels as part of being a carer is in juxtaposition with the emotional hardness required to cope with frequent aggression from a resident. In terms of emotion work, the type of emotion work required to be ‘caring’ is very different to that required to cope with aggression, therefore, it is something care staff struggle with.

Another response by care staff to situations involving aggression was to blame themselves. Jackie describes a situation involving a respite lady who had a urine infection (UTI) and was particularly anxious and confused as to where she was. Jackie had tried to explain to her where she was and reassure her that everything was ok.

But shortly after that I went back onto the unit, was just walking through to go and help another resident and she turned round and she punched me right in the stomach, full force. And she winded me, I actually was really hurt and for three days I was in agony because she’d got me right on the ovary, right on the soft part of my lower abdomen there. And one of the other residents who was renowned for being aggressive, actually stood up, put his arm round me and said ‘don’t cry’. Now, that night I went home, not only was I in agony, this
woman had really hurt me, but I felt I'd failed. I felt really awful and I was in a lot of pain as well.

R.L: Do you think another member of staff, someone else would have been able to deal with it any better?

I don't know, because she had a raging UTI, I don't think that anyone could have got through to her. But, you see she's got POVA protecting her. I had nothing protecting me and I was in agony for three days. (Jackie)

This example contains many details of the perspectives and experiences of care staff in relation to physical aggression. Although Jackie doubted that another member of staff could have done any better in calming and reassuring the resident, she still felt as if she had failed. She did not blame the resident or her illness, but felt that she must have done something wrong in order to get such a response. She went home and continued to feel emotionally distressed as well as being in physical pain, something which strongly suggests that she did not receive adequate support from the care home following this incident. Jackie ended up going to hospital due to her injury. She felt let down by the care system as she argues that residents are protected by POVA (Protection of Vulnerable Adults, a legal framework designed to prevent abuse of vulnerable adults), but that she had no protection or rights even though she was quite seriously injured. In a wider context, Jackie is aware that she will receive no protection or support should another similar incident occur. Had she received better support she would still have found the experience negative, but may have felt that her distress was recognised by the home, not taken for granted.

...I find it difficult when people are confused and they're getting upset about it, that's what I find difficult. Because I think, I feel sorry for them, I feel bad for them. Um, but really that's, and obviously the kind of thing 'are you going to smack me with that stick?' you know. And you have to be careful, you do have to be careful because you sit there and you think that they're, they'll give you a little bit of a push or a little bit of a tap, but they can hit hard. They are strong people you know. Um, that can be hard, yeah, when you're a bit worried about what they're going to do next if you know what I mean. You know it's quite unpredictable sometimes, the job, you know. (Anna)

Anna describes how care staff commonly feel when assisting residents known to be verbally or physically aggressive, especially if their behaviour is hard to predict. Care staff are concerned that they may be hit by a resident but still continue to give them
Care workers. Concealing fear or anxiety is very difficult and it is likely that staff do not always successfully manage their emotions with these residents and so appear tense or nervous. Anna also highlights that while older residents are indeed vulnerable adults, they can also be physically strong and therefore capable of injuring staff.

While care staff found aggression to be a negative part of their work, they did not necessarily have a bad relationship with residents that were more frequently aggressive. For example, Nadia describes caring for a resident who does not like personal care and tends to try to hit care staff. However, Nadia likes this resident and describes herself as having a 'soft spot' for her, that other care staff do not share.

She has quite a good sense of humour... And she tells me, I hate it when, I take her to the toilet, and she hates this. She doesn't like to be undressed and, you know, she hates this. And she begins to smack and, 'I hate you, you know that I hate you when you do this'. And then the rest 'I love you'...And she said, 'I hate you', and I begin to smile and she said, 'you don't believe me'... (Nadia)

For Nadia the resident's tendency to hit her during personal care relates to her strong dislike for the situation and not her entire personality. Instead of labelling the resident as aggressive and focusing on this one aspect, Nadia finds her to be humorous and interesting and enjoys trying to make her laugh.

Conclusion

Care staff found that many physical aspects of care were made more or less enjoyable and required differing levels of emotional labour, depending on the personality and behaviour of the resident. The three most common negative characteristics of residents, as perceived by care staff were that they were demanding, rude or aggressive. Care assistants had to work hard at managing their emotions when working with these residents. They tried to suppress their dissonant negative emotions of annoyance, offence, distress, or fear and remain calm when with the resident. This form of emotional labour most closely relates to Hochschild's (1983) 'deep' and 'surface acting', although it was not always clear which form of acting
staff undertook. Working with these ‘challenging’ residents could increase the physical workload of care staff, as well as increase their stress levels and ultimately their emotional labour.

Responding to demanding, rude or aggressive residents posed an emotional challenge for care staff, one which they responded to in a number of ways. Some stoically accepted the resident’s behaviour, remaining calm but without addressing the possible reasons for this behaviour, while others described ‘ignoring’ the resident’s behaviour. These methods require high levels of emotional labour, most likely in the form of surface acting, but do not provide residents with good emotional support. This finding supports Lopez (2006) argument that remaining ‘professional’ rather than addressing the resident’s behaviour is emotionally draining for care staff. Furthermore, in the current research, descriptions given by some care staff suggest that meaningful interactions between the resident and staff do not occur in these situations.

Some care staff tried to negotiate a balance between their own needs and that of the resident by making it clear they would not accept certain behaviours. For these care staff, the expression of some negative emotions towards residents was acceptable within their ‘feeling rules’, again in contrast to Hochschild’s air stewardesses. In terms of emotional support, it would presumably depend on how care staff responded to the resident as to whether this could be considered supportive. Lopez (2006) described how care staff would make the boundaries of acceptable behaviour clear to residents in order to then start to form a meaningful relationship with them. In the current study some care staff did try to understand individual residents and their reactions to try and improve the situation for both themselves and the resident. However, in other cases it is more likely care staff were more concerned with protecting themselves physically or emotionally than in their longer term relationship with the resident.

Many care staff said they would remove themselves from a situation, usually by leaving the residents room, if they were struggling to cope or felt the resident had
been unreasonably rude. This could be seen as purely a coping mechanism to prevent a situation escalating out of control or care staff becoming emotionally exhausted. It also serves as a signal to the resident that their behaviour was not acceptable to that staff member. However, this action can also highlight the relative lack of autonomy for residents in that staff can walk away from them, but they are less likely to be able to do the same, especially if they need assistance with personal care. As will be described in Chapter 8, the outcome in situations where staff left a resident was strongly related to support from other staff.

Ideally, care staff must engage emotionally with residents and build up a relationship in order to know how best to work with individual residents, to provide emotional support, and to increase their own job satisfaction. However when residents do not give them any positive feedback or are rude or aggressive, this can leave care staff emotionally vulnerable. Staff therefore try to balance the emotional support of residents with their own emotional wellbeing. Care staff are sometimes expected to have a meaningful relationship with residents while overlooking, or not being offended, by their negative behaviour. This is not a ‘normal’ relationship and so care staff can struggle to build up a rapport or understanding with these residents. Some staff were better at providing emotional support for these difficult or demanding residents than other staff as they were better able to focus on positive characteristics of the resident or appeared to enjoy the challenge of working with particular resident. As argued by Campbell (2005) in her study of resident ‘attractiveness’, resident characteristics do impact on the care, or in this case emotional support, they receive from care staff. However this study has shown that working with ‘challenging’ residents requires high levels of emotion work by care staff and requires them to navigate a complex and atypical social situation.

This chapter has also described the emotional impact of racism on some overseas staff, usually black care staff. The differing emotional labour of overseas staff is further explored in the next chapter. Those staff towards whom some residents were
racist could be insulted, upset or embarrassed by the comments, thus adding to their emotion work.

For all care staff involved in situations involving threatening or aggressive behaviour, they had to work hard to control their emotions. Fear and anxiety are both strong emotions that take a great deal of effort to control. In some examples, care staff were more focused on themselves than on the needs of the resident, and this could be related to staff feeling the need to protect themselves, emotionally or physically. If the resident had dementia, staff often ‘blamed’ the resident’s reaction on the dementia. These reactions are unlikely to emotionally support the resident. If the staff’s reaction is viewed within the context of emotional labour however, these responses are understandable given the extreme effort required to control feelings of fear or anxiety. Without support or intervention it seems unlikely that these staff will gain a greater understanding of these residents and learn more effective ways of responding to them. Therefore, it appears that some staff and residents remain trapped in a situation where neither of their needs are being met and both feel upset and vulnerable.

This chapter also highlights issues of power, control and respect within resident/staff relationships. Residents who were seen to lack respect for staff, were seen as rude or demanding, and residents who sought control by telling staff what to do, or criticising them were also seen as demanding. Presumably, however, staff who wished to be in control of residents, for example during personal care, were also likely to be seen as rude and demanding by residents. However, while staff actions and perceptions do impact on the care they provide for residents and so the resident’s own reactions, this is not always the case. Care staff are not to blame for all negative behaviour from residents. To assume this is so is to undermine both residents and staff. Some people are more difficult to please, some people tend to moan, some people like a great deal of attention and some have learnt to use aggression as a response throughout their lives. In this respect, older people are not different from the rest of the population, they are however usually in a more difficult life situation, therefore more likely to exhibit negative behaviour.
In conclusion, this chapter has highlighted some of the emotion work care staff undertake when working with residents who display ‘demanding’, ‘rude’ or ‘aggressive’ behaviour. By placing these concepts within the context of emotional labour, it has been argued that these ‘challenging’ residents pose an emotional challenge for care staff, requiring higher levels of emotional labour. A lack of support and guidance when working with these residents can result in care staff ‘coping’ with these situations but not seeking to address or improve them. However, it is also the case that some resident’s behaviour is unlikely to be changed even with a great deal of effort, thus acknowledgment for care staffs’ hard and at times emotionally unrewarding work is essential.
CHAPTER 8

STAFF CHARACTERISTICS AND ORGATIONAL FACTORS IMPACTING ON EMOTIONAL LABOUR

This chapter will address the social factors, both environmental and relating to individual staff characteristics, that impact on the emotional labour of care assistants. The previous chapter has already explored some of the resident characteristics, as perceived by care staff, that influenced the emotion work they undertook, and the mix of residents can be regarded as one aspect of the staff’s working environment. This chapter will focus on the organisational factors within care homes, including the effects of other staff, time pressures, support from senior staff and personal problems. Within this organisational analysis, some of the factors also relating to individual staff characteristics also emerge. Staff characteristics impacting on emotional labour, including personal experiences of caring, overseas staff and staff experience will then be addressed.

Colleagues of Care Assistants

The care assistant’s colleagues were perceived as impacting on their emotional labour. Care staff found it relatively easy to describe colleagues that they did not like to work with, and general and specific situations that increased their workload, put them in a bad mood or made them feel uncomfortable. It was these negative aspects that produced emotional labour. Positive attributes of fellow care workers were not so easily described (similarly to the positive characteristics of the residents), often being an absence of the negative attributes or a friendship that was not related to care work specifically.

Care assistants described how their colleagues impacted on their emotional labour in two ways. Firstly by causing the care assistant to do emotional labour with their colleague, by managing them, trying to remain calm around them, or needing to care
for them in some way. Secondly, by impacting positively or negatively on the general mood of the care assistant. Care assistants whose mood was negatively impacted by their colleague were then required to manage their emotions. Ultimately the effect staff have on each other’s emotional work can be regarded as an effect of teamwork, which is an important organisational factor within a care home. It will be argued that staff communication and teamwork can have as great an impact on care assistant’s emotional work and wellbeing as do the needs of the residents.

Similarly to the way in which many care staff referred to residents as rude or demanding, labels were also given to their fellow care workers. These characteristics, as perceived by the care assistants describing them, are outlined below.

‘Lazy Staff’

Care assistants widely reported that some colleagues increased their workload, thus increasing the time pressures placed upon them and ultimately increasing their stress levels. The most commonly criticised group of care staff were those believed to be lazy. Care assistants often referred to working with staff who did not do enough work as frustrating and felt annoyed that their own workload had been increased, or that they would be unable to complete all their work as a result. Care staff perceived to be lazy also increased the physical and emotional workload of staff in some less obvious ways, as will be discussed.

Whereas if you get someone who’s like couldn’t care less kind of attitude, which unfortunately there are, but um, there’s only a few, most of them here are really good, really good, but you only have to get one that you think ‘oh god’, you know. And then you feel like you’re having to work even harder to get what you want done. And then you feel bad if you can’t get what you want finished by 8 o’clock, you go home and you feel a bit down, you feel like a bit sort of, oh damn you know, I didn’t do this right and I didn’t do that right, or I could have done this and I could have done that. But at the end of the day you can only do so much in twelve hours. (Jackie)

In the above example, it is clear Jackie’s emotional labour is increased by the extra workload and stress and her negative feelings towards particular staff members. Jackie also implies that as a result, the residents do not receive the level of care she
feels they ought to, thus impacting negatively on the residents and also Jackie’s job satisfaction. Her description also suggests that the workload is high at this home and staff are left to negotiate between them what work they do, and the standard to which they do it.

When staff felt that they were being put upon ‘unfairly’ it understandably had a negative impact on their mood, thus increasing their emotional labour as they managed these negative emotions. In the example below Dominik describes how when he started working at the care home he was keen to be seen as a hard worker by senior staff, but that he felt some care staff took advantage of this.

So obviously, it depends, it's up to you what kind of character are you, but I don't like people taking advantages of other people too often. Sometimes it's excusable if someone is not feeling well, ok, no problem, I will have extra from your part of job. But if it's too often, obviously you will talk to senior, openly. Not to be nasty or anything, but you want to come to job to work, you want to be in good mood because that's important in the job. And if member of staff wants to, mm, I'd say again, take advantage of you then that's annoying. So it's difficult to stay calm and in good mood and do your job properly if someone is annoying you. (Dominik)

Supporting staff on a ‘bad day’ did not appear to require the same degree of emotional labour as working with ‘lazy’ staff as Dominik only felt strong negative emotions when he felt he was being taken advantage of. Dominik does sometimes speak to senior staff if he feels another staff member is too frequently not doing enough work, although he does not say what the outcome of this is. The majority of staff did not report their colleagues to senior staff.

One girl I find, sort of, irritates me, because I don't think she does necessarily, you know, helps a lot really. You know, she doesn't play as part of a team member, but others recognise that and so we just have to, you know she's a bank staff, so we just have to sort of put up with it, but she's not often on so (laughs), you now.... Well I suppose I should address it with her really, but I suppose I'm afraid of, well not the backlash, but what she would say. (Jean)

Jean equates staff that do not appear to do enough work as not being part of the team. Care assistants not only found working with ‘lazy’ people increased their workload and put them in a bad mood, but how they responded to the staff member in question
could also be a source of emotional labour. Jean does not feel comfortable speaking to a member of staff who she feels does not do enough. It would appear that other care staff also feel the same way, so they compensate between themselves rather than confronting the 'lazy' staff member. As a result, the situation is not being resolved. These types of staff problems should be known to, and addressed by senior staff, but usually were left to care staff to deal with. However, this description suggests that, in general, Jean is used to having support from other staff and they do usually work as a team.

... So naturally you want to work with people who are motivated, who want to do this without being told to do it. And you feel more relaxed with those people because when you keep reminding them stuff you want done, 'do this, do that' it feels like you are bossing them which is not the case. (Adam)

In the above example, Adam describes the added emotional work of having to 'manage' staff who he feels do not work hard enough otherwise. Although some staff like a more managerial or team-leader role, many did not feel comfortable or felt stressed when they had to tell other staff what to do. Adam is concerned that the staff member he is instructing will take offence and feel he is being bossy.

Working with staff that were perceived to be 'lazy' involved several types of emotional labour. Firstly, as the workload increased, the quantity or frequency of emotional labour also increased. Their emotion work also increased if they felt they had to manage the other staff member, effectively meaning there was another person for them to care for and not offend. The increase in workload also increased their stress as time pressures increased. Care staff had to manage their stress and remain calm with residents and possibly other staff. Similarly, the mood of care staff may be negatively impacted on as they felt taken advantage of, and this negative mood also had to be controlled when with residents. Finally, staff had to decide what action to take regarding the lazy staff member. Most commonly no action was taken as opposed to talking to the staff member directly or speaking to senior staff.
Witnessing Poorer Care

Many care assistants felt that other care staff did not care for residents as well as they themselves did. The more extreme cases consisted of clear examples of poor quality care. This care was of a low standard and involved situations that care homes would like to avoid. Less extreme or more general situations tended to be described as different working styles or different care standards. This did not just include direct work with residents but household tasks as well. The more extreme cases of witnessing poorer care will be discussed before the broader statements regarding working styles.

Many care assistants felt anxious or awkward when they witnessed poor care by other care staff. On a few occasions it was directly stated that the care given to a resident by another member of staff was poor or even abusive. In the example below, Kate talks about witnessing poor care in general and later describes a specific situation with a resident.

Another difficult thing is when you’re working with another carer and he or she treats residents in a very bad way. For me it’s very difficult because sometimes I have to work with another carer who are very bad for them. I don’t want report because, you know when I report for somebody, um, I think he said, ‘oh no, she treats them in a bad way not me’, or something, so. I know that they shouldn’t be a care assistants because they don’t have a patient, um, (...) But I don’t know what I can do, nothing sometimes.

...And sometimes she (resident) can’t help us, or she won’t help us. But I know that she can stand up but sometimes she doesn’t want. And some, some members of staff, um, I don’t know how to say in the English, you know they don’t be gentle for her. They push everything (mimes) you know, and sometimes she’s crying. Yeah, um some, some of them they can speak so they tell us ‘oh be gentle please’ or ‘what are you doing, it hurt’, but she can’t say this because it’s dementia so she doesn’t understand that somebody treat her in a very bad way. (Kate)

Kate is upset by how she sees other care assistants treating a particular resident. However, she does not feel that she can say anything, either to the care staff at the time or to the senior staff afterwards fearing she could be accused of poor care herself. She appears to experience feelings of fear and also helplessness in this situation. In these more extreme situations it seems likely that staff witnessing poor care, but
feeling powerless to do anything about it, may feel guilty as they did not act on behalf of the resident. Ultimately though, the resident will continue to receive very poor care unless there is some form of intervention.

In the following example, Jennifer describes how staff sometimes enter a room when asked not to and so invade the privacy of the resident concerned. This care assistant does report these incidents to senior staff, but finds it awkward to do so.

_Cos like I could even say something to, you know Laura the receptionist, if I say something to her, like if I've had someone in the stand-aid or something and I say 'can you just hang on a minute' and they go in. That, it's not fair on the resident because of um privacy and things like that. So then later on if I go and speak to her [Laura], people can um not appreciate what I'm saying, they just take it the wrong way, which is a shame cos I'm saying it for the resident's sake, not because I want to say it to deliberately offend you or whatever. I'm saying it because, you know, it's something that has to be said and sometimes people take it the wrong way._ (Jennifer)

Jennifer is not concerned about the reaction of the senior staff member as Kate is, but is worried about the response of the care staff she complains about. She prioritizes the needs of the resident above the feelings of other staff members, but finds it difficult to do so. Unlike Kate, Jennifer is not left with feelings of helplessness and guilt regarding the residents. She is however concerned the staff member will not understand her motivations in complaining.

Witnessing poorer quality care creates a complex situation in terms of emotional labour and the emotional wellbeing of staff. Initially they may be distressed or angry when they witness the poor care. Following this, many feel they are in a difficult situation in terms of how they can either confront the staff in question or report them in order to prevent the poor care occurring again. For some staff this is not a problem, they will directly speak to the staff member concerned, or report them to senior staff and not feel emotionally stressed by this experience, indeed for some it could relieve their negative emotions. Some staff do report these incidents but either feel guilty about getting a colleague in trouble or feel worried about the reaction of the staff member concerned. Other staff lack confidence or feel powerless to intervene in any way. It is likely that they will experience guilt for not doing anything to help the
resident. It is likely that if staff are unable to respond in these more extreme situations then they are also unable to speak up in a whole range of less serious situations, either in the home as a whole or with specific care staff. Overall their job satisfaction and self efficacy could suffer leading to high emotional labour. Alternatively they may only feel this high emotional labour with specific staff members, thus making shifts with those staff emotionally stressful and negatively impacting on teamwork.

In terms of care home organisation, the action of care staff in choosing to report or not to report poor care also reflects on the senior staffs’ relationship with and knowledge of the care assistants they manage. Presumably, some senior staff are more approachable than others or respond to complaints in more or less effective ways. In all the examples given, the onus was on the care assistant witnessing the poor care to go to speak with senior staff or address the issue themselves. There were no examples where problems were shared with senior staff as part of a conversation initiated by senior staff where they sought to find out if the staff member had any problems. It could be that this does happen, but there was no evidence of this in the homes.

**Different ‘Working Styles’**

Care staff in all homes expressed that they found it harder working with people who had different working styles to themselves. This sometimes related to how they liked domestic tasks to be done or the times they liked things done by, and the speed at which they worked.

*It's easy to work with someone if (...) if they're like me. I like to be busy, I mean I like to have a little break every now and then, but I like to constantly be doing something, whereas you get a few people that, I don't know, I suppose aren't as fussy as me I suppose. So I find it easier to work with people who are like me. Whereas people who aren't like me, I find it quite hard work, cos you, you're constantly saying 'oh can you do this, can you do that' kind of thing, so.* (Claire)

From Claire’s perspective, she is hard working and has high standards, so finds it hard when working with staff who are not like her in that respect. This relates to perceptions of staff being lazy, but highlights that this perception can be largely based on individual staff’s own understanding of how work should be done. Claire appears
to be quite inflexible in her working style, assuming that if another staff member does not work as she does, she’ll have to tell them what to do.

_Um (..) I'm a bit of a perfectionist, I've sort of, I like things, I'm particular about how I do things. And I sometimes can be a bit over, wanting other people to work the same way which isn't going to happen but that's just me (laughs)._ (Zoe)

Similarly, Zoe is quite aware that she likes things to be done in a certain way. It is not clear if they are referring to domestic tasks (such as laundry and setting the table) or resident care. For example, some care staff can have set ideas as to how they think laundry should be folded, beds should be made and tables should be laid, due to their own life experiences. These examples of working styles could indicate frustration at others not thinking in the same way as them and not necessarily relate to lower work standards. Care staff preferred to work with people who did things more like them, but that did not necessarily mean they found working with other staff a particularly negative experience, just not so good. Staff were more concerned with what they saw as a poorer standard of work or care by other care assistants.

_Some people I find they don't do stuff to what I would say is the same standard as myself. Um, and I just have to remind myself that everyone's trying to do their best and to not let it bother me. I'm not going to go and get my knickers in a twist and start getting stroppy with them. I just try and bite my tongue and just leave it. If it's really bad I will go and say something to the senior, but it's not my place to pick them up on their work. I'm not gonna sort of get temperamental on the shift and start getting funny, I just get on with it and stay the same. Cos at the end of the day if you start getting stroppy the residents are going to pick up on I and then it'll go through the place like a wild fire._ (Janet)

Janet makes it clear that she feels other care staff do not do their work to as high a standard as she does. As a result, her emotional labour is directed at covering her annoyance with the other care assistants, but her reasoning behind this emotional labour is related to the residents and the possible impact of arguing between staff on the atmosphere in the home. In the earlier quote, Janet had no concerns about reporting staff when she witnessed poor care when residents had their call alarms taken from them. However, she makes the distinction between poor care and lower work standards which could relate to any aspect of their work. In this situation the
feelings of other care assistants and the impact of a staff argument on the residents are prioritised above picking up staff on less important aspects of their work.

And another thing I find difficult is; I try to give people choice. 'So do you want jam on your toast or marmalade?' Whereas I think some people are very, sort of, if it's written down in a list that you have to get them up and get them dressed, give them breakfast and sit them down, that is what they'll do. And they won't waver from that. Whereas obviously you are supposed to, because you've got to try and give them choice, you know, this is their home, this isn't a prison or anything like that. It's their home and so they should be able to do pretty much, as long as they're safe, they should be able to pretty much do what they want, when they want. Um and some people don't do that, but it's not them being horrible, they just want to go by the rules. Not that giving them choice isn't a rule, do you see what I mean? (Anna)

Anna makes the distinction between task based and resident focused care, and as she feels she tries to give a more resident focused care, she finds it hard when others do not. She partly excuses the care standards of other staff by assuming they do not mean to be horrible and that they are just following rules. However, by justifying their behaviour, she does not seek to confront or change it in any way. While Anna feels frustrated by other care staff's actions, the residents are left not receiving choice, without any intervention. On a wider organisational level, Anna appears to believe that some rules are more important to follow than others. The fact that the work is getting done, is more of a 'rule' than the manner in which that work is being carried out.

Some care staff often have high expectations of their colleagues and find it difficult when others do not have the same standards or priorities. While care assistants are more likely to be understanding towards a resident that has annoyed or upset them, they are much less likely to excuse a member of staff who does the same. Therefore care assistants do engage in emotional labour with each other, but in a different way to that undertaken with residents. Care assistants generally wish to avoid upsetting or angering another member of staff by pointing out mistakes or speaking to senior staff. However, this is not usually due to worrying about the other care assistant's feelings, but more related to how the other care assistant might react and if this could put the person who complains in a difficult situation. Care assistants, feel a duty of care for
residents, but far less for some of their colleagues. The reluctance of many care assistants to speak to senior staff also reflects on management or leadership within the home. How open senior staff are to problems, how they respond and their awareness of how staff are working on the floor all contribute to how likely it is they will be aware of any problems.

Communication Between Staff

The manner in which staff spoke to each other, particularly when giving instructions or pointing out a problem, was an area that could potentially cause a lot of negative feelings and stress. Staff found it difficult to point out a problem to their colleagues, but also found it difficult to receive criticism from other care staff. In the following example, Emma is in her 20s and is a team leader, which in her care home means she is between care staff and senior staff. She still works as a care assistant, but she is responsible for some extra tasks including keeping senior staff informed of any issues relating to residents or staff on a particular unit. She therefore has some seniority over other care staff while still working with them as a member of the team.

...but it's telling them when they're doing something wrong, I find that really difficult. I mean I don't find it difficult with the ones that are my own age, or even the very friendly ones that are older, it's the ones that are very set in their ways, that... You know they're just not going to take it from you, you know it's just going to cause an argument.

R.L: mm. Is it usually just little practical things that you might have to pick people up on, or is it related to the care they're giving the residents or...?

There's one lady who's probably in her 50s. She's only worked in care for about 2 years and she doesn't care for her residents, to a standard that I would like. That's an issue for me, because I have to (...) it's my job to pull her up on it and I find that really difficult. Um, but, the rest of it is just silly little things like having your mobile phone on you, or having your break when you're not supposed to be having your break. And if I see them I have to tell them to come off it. Oh, I hate doing that, I just hate it. (Emma)

Even though part of her job is to speak to staff when she feels their work is not good enough, she still finds it very awkward, expressing very strong negative emotions in relation to this aspect of her work. In terms of power relations between care assistants, they are not just based on Emma's slightly senior role, but on other aspects
such as age and maybe time worked at the home. This highlights how difficult criticising other care staff can be when staff have an equal level of seniority, highlighting the need for good support from management.

Care staff found that accepting criticism was also difficult. However, they reported that it was the way in which staff spoke to each other that could cause offence and not just being asked to do something or being criticized.

But I know, I’m very careful (... ) with some staff because there could be some, not all in general, just one or two, could be very blunt. So, sometimes I work ahead of them, or, if they come out with something blunt or what say abrupt, I don’t. I don’t try to put words to it. I prefer put the action. ...Like one sentence, one morning, one lady says to me, ‘Oh can you leave, make that your last tea and come and help me’, and I though that was a bit abrupt, so I goes (shrugs). (Ruth)

In this example Ruth, tries to organise her work so that she can not be criticised by other staff who she feels are blunt in how they speak to her. Instead of getting stressed, Ruth remarks that she tries to ignore how the other staff speak to her. However, as she also appears to go to some lengths to avoid criticism from some staff, it is likely that it does bother her and she has to work to cover her emotions. There were also some more extreme cases where staff felt they, or their colleagues, were bullied by other care assistants.

Let’s say it in another way, um. Maybe (...) well it’s a bit harsh, but it’s bullies? So they pick up on the soft ones, lets say it and then it’s that constant nagging, ‘oh you’re not doing that right’. I mean as long as everybody’s doing his own job I think I should mind my own business, doing my own group. Of course if there is something major that the other one is not doing right, you have the right to say it, but there is always 2 ways of saying things, a nice way and a not nice one. But unfortunately what I hear is mainly the less nicer one. (Corina)

Corina feels that some staff at her work are being bullied, although she does not feel she herself is a victim. She makes a distinction between people doing their work differently, who should be left alone, and also those who are doing something wrong. Again, this relates to staff perceptions as to what is acceptable and what is not, different staff members make different judgements regarding when they feel they
should intervene. However, it is also possible that some staff members do behave in a bullying manner towards other staff, possibly highlighting the difference in how staff behave towards residents and each other.

In the following example, Arlene describes a day where she felt very annoyed by how another member of staff had spoken to her over what should have been relatively minor issues.

"... They were buzzing in the middle of lunch but I normally like to go and help if it is something that can wait I say 'can you wait a bit because we are just doing lunch'. So I went to go and help this person. When I came back into the dining room, the senior staff said, when she had just got her seniorship, 'can you wear an apron please?' That was fine. Now she said 'can you wear an apron in the future in the dining room'. I say 'ok that's fine'. So then I walk off to finish up. 'Well as a matter of fact can you go and put it on now?' I found that very rude because she didn't have to speak to me in that manner because I am not a child. (Arlene)"

Arlene appears to have comparatively little patience with the staff compared to residents. It seems likely that she does not easily accept criticism, however, it is the delivery of the criticism that Arlene felt was the main cause of conflict. In this example, a relatively minor matter left the care assistant feeling angry and resentful towards another member of staff. She struggles to control her temper with the other care assistant and is then left in a bad mood as she goes back to care for the residents, presumably adding to her emotional labour and the quality of emotional support she provides for the resident. In this example, Arlene and also the care assistant she refers to, both speak English as an acquired language and it could be that the way in which they communicate appeared abrupt or blunt due to linguistic differences or difficulties.

Situations where staff are angered or upset by each other increase the emotional labour of the care staff. Poor staff communication has a negative impact on team work, which is vital to providing staff with support when they are very stressed, distressed or struggling with a resident. Essentially, if a carer is struggling with a situation with a resident or is emotionally distressed, relying on team members to
notice your problem and provide support when asked is vital. Poor communication and team work that actually increases the emotional workload of care staff and puts them in a position where they are unable or unwilling to ask for help, leaves them open to struggling with challenging situations on their own. Ultimately, a lack of, or poor quality communication between care staff negatively influences the emotional support they provide for residents.

Language and Culture Barriers

Relating to communication problems between care staff, the mix of staff from overseas or different parts of the UK, could create some challenges when staff worked together. Some UK and overseas staff reported finding working with a mixture of people of different nationalities to be more difficult. Staff found communication more difficult with some staff who did not speak English very well or had a strong accent. However, staff often found it difficult to express their thoughts on this area as it is a sensitive issue and UK staff in particular were concerned about sounding racist.

I feel sorry um sometimes for the new ones that can’t speak very good English. Because you’re trying to show them how to do things and you don’t know really if they’re understanding 100% of what you’re trying to tell them. I think um, culture and language barriers are somewhat, are sometimes in the offing and it can make, it can make a difficult situation. I’m not prejudice, never have been never will be, you know, we’re all equal as far as I’m concerned but I do feel sorry for them if they can’t understand what you’re trying to show and teach them. So sometimes I think yeah that does sort of come into it. (Jackie)

There were no reports by overseas staff of racism by other staff. While Jackie is referring to feeling sorry for the staff who do not speak good English, underlying this are her own negative experiences of some staff not understanding her. Presumably, trying to teach someone who is struggling to understand her also has an impact on Jackie’s emotional work. Some UK staff did report that they found working with some overseas staff more difficult and more stressful and that their workload was at times increased by the communication problems.

I don’t mind working with the foreign people, whatever you want to call them, I mean I get on with them quite well, but some of them they have different ways
and, um they don't understand. I mean if they're kind of coming in our country they need to work the way we work and not the way they work, and I find it quite hard to do things their way. Because they can be quite pushy, bossy. But that might just be the way, because they can't speak English, that might just be the way they come across. (Sophie)

Sophie clearly has very negative feelings towards working with some overseas staff, possibly based on prior experiences. In terms of ‘how things are done’, Sophie could be referring to what she sees as cultural differences, although as already discussed, perceived working styles vary between staff anyway. She also recognises that language barriers can make people sound more blunt than they may intend, however, she still appears to be annoyed at the situation.

Staff that had more recently come from overseas and staff that grew up overseas but have lived in Britain for many years also found the mix of accents and cultures to be difficult at times.

We have Irish, we have Irish people, they have different accent, you know. They have um problems speaking, you know like speaking, speech not very good, we have some of them. And it takes a little bit of time, because of a stroke or something that their speech it isn't good. But it is, it is hard and it's frustrating, and for the staff as well, you know. You try to cope with everything. (Nadia)

Nadia is from the Caribbean and finds some accents more difficult to understand and also recognises it can impact on communication with some residents as well. Communication problems caused by the mixture of first languages of staff could increase their workload as they had to work harder at understanding each other.

Communication problems between staff from different cultural backgrounds can be a barrier to effective teamwork. As teamwork is vital to the emotional support of care assistants this has a negative effect on their emotional labour and wellbeing, impacting on the emotional support they provide for residents. However, it is also likely that given the appropriate time and support, language barriers can be overcome and linguistic skills of some care staff improved. If workloads are already high however, staff may lack the time, energy or patience to invest time in communication.
Teamwork

In conclusion, the emotional labour associated with working with other members of staff, largely reflects effective or poor teamwork. In effective teamwork, care staff could rely on being able to ask for support from another member of staff, could communicate effectively, give and accept constructive criticism, and express their emotions. In this way, staff did not have to struggle alone with situations which they found distressing, or which they did not have the ability to respond to alone. In homes where staff readily helped others and expected help themselves, situations were less likely to escalate, and staff felt supported. Equally staff that feel they can admit to having made a mistake, or to not understanding what a resident wants, without being criticised are more likely to use the support of other staff and learn from other staff, thus utilising the mix and experience of care assistants within a home. In contrast, in some homes there was a lack of teamwork. Some staff were physically unable to find others to support them while some chose not to ask for help, or were refused help. Some staff did not seek help as they felt it reflected badly on them, but others lacked confidence in their colleagues (such as with ‘lazy staff’). Where there was little or no perceived teamwork, staff dealt with emotional challenges alone, potentially effecting the outcome for both the resident and the staff member. Teamwork is often a buzzword within organisations, but within care homes, effective teamwork both reduces the incidence of excessive emotional labour and provides emotional support to staff, which may then enable them to provide a better quality of care to the resident.

Time Pressure

Many care assistants reported feeling stressed due to pressures of time. Staff are usually expected to have completed a certain amount of work, for example getting most of the residents ready for bed, before they finish their shift. Particular times of day, such as mealtimes are also busy. Staff shortages or unforeseen circumstances that increased their workload could increase pressure on staff so they felt stressed.

*I think you can get stressed, I think you can get stressed. When you’ve got so much to do and you’ve got, as I say, say for instance 10 to 1 ratio and you’ve*
got a couple that are being very demanding, and you've still got to do what you gotta do, like with the feeding and stuff like that and you have to like split yourself in three and keep everyone happy. There's a saying isn't there that you can not keep everyone happy all of the time which is very true. (Jackie)

Many care staff felt stressed when they felt they had to do several things at once, for example during busy periods, such as meal times when another resident was buzzing for them to come. Care staff can feel torn between the needs of different residents when they all want or need attention at the same time. Pressures of time also relate to perceptions of residents being demanding, as discussed in the previous chapter, as care staff felt some 'demanding' residents took away time they needed to spend with other residents. Pressures of time also relate to staff perceiving others as 'lazy', as they felt they had to do more work in the same amount of time, and this had a negative impact on both the standard of their work and their job satisfaction.

Support from Senior Staff and Management

A number of situations already discussed have related to the support care assistants receive from senior staff or managers. When responding to challenging situations, care assistants either required help from senior staff, or support after the event. Care assistants also felt varying levels of confidence in speaking to senior staff regarding problems, particularly relating to witnessing poor care by other care staff. Senior staff also set the tone regarding how strict routines were and encouraging care staff to express their emotions or not.

The majority of examples care assistants gave when asked about senior staff, related to medical concerns regarding a resident or practical help in completing paperwork or giving out medication. It appears then that care staff in all the homes found the senior staff approachable regarding some matters, especially regarding medication.

In the following example, Nadia works both as a care assistant and as a senior member of staff on different shifts. As senior staff she gave out medication and
organised the care staff’s work, but also worked ‘on the floor’ alongside the care assistants.

But working on the floor I know that if you are organised you can finish all the residents to be washed and dressed and to have them at breakfast. But maximum, you know, half past ten in the morning. By 10 o’clock everybody has to be down when I’m working. And as I said the morning medication need to be given before 10 o’clock, because they need to eat something and then to have the medication. (Nadia)

Nadia sets quite a strict time frame on the care staff when she is working as senior staff. Presumably this could add to the ‘pressures of time’ experienced by care staff. However, from her perspective, she is responsible for giving out medication and feels the time constraints related to medication are important.

Senior staff did generally come and help carers with residents when asked and care staff felt confident they would be supported. As with effective teamwork between the care assistants, knowing they could step away when struggling with a difficult situation was very important. The care assistants did not have to endure the emotional labour of trying to handle a situation in which they were ‘out of their depth’ and as a result, resident care was also improved. However, in the following example Anna asked for advice following an incident (already discussed in Chapter 7) in which a resident had racially insulted a member of staff and then refused care from Anna.

So in that, you know, I went and asked the team leader. And um, and they said well you have to just keep, you know, persevering. Took me 2 hours to sort of, you know. But I just need to know, you know what do I do, do I send one of you in? And they said, well, you know, we can go in. I think they were doing medication or something at that point. We can go in, but if you try and persevere, otherwise another time when we really can’t help you, what are you going to do? (Anna)

From Anna’s perspective, she did not receive any support from senior staff, for what did appear to be quite a serious incident. The racist abuse of the resident was not acknowledged by the senior staff, and Anna’s Polish colleague could not support her because of the resident’s racist views. Anna therefore experienced considerable stress and undertook emotional labour over an extended period of time, to care for this resident. The team leader’s comments also failed to reassure Anna that she could
expect support in future situations. Lack of support, such as in this example, not only make the outcome for the resident and staff more negative at that time, but also indicate to staff they can not expect support in future, so they may be more likely to try and cope with very difficult situation on their own.

In this example of racism, as in most others, and in examples of physical abuse by residents (i.e Jackie being punched in the stomach), emotional support by senior staff following these incidents was important. However, it often seemed to be lacking, leaving care staff to understand the situation alone, often continuing their emotion work when they returned home. Some staff blamed the resident, labelling them as difficult or aggressive, some blamed themselves and felt guilty, while others focused on a resident’s dementia. Without support and guidance from senior staff, care assistants were sometimes unable to gain a new, and more helpful, perspective on events or on the resident’s situation.

Secondly, care staff felt that this lack of support reflected their lack of rights, compared to those of the resident. While they accepted that at times a resident may be racist or aggressive, the lack of acknowledgement and effective support by senior staff, indicated to staff that their experiences were largely irrelevant. In contrast, there are laws aimed at protecting the residents from these same types of abuse. Some care staff felt strongly that this imbalance was a particularly negative aspect of their work and left them feeling vulnerable to abuse.

The negative feelings many staff had in relation to reporting poor care by other staff have previously been discussed. Senior staff play an important role in being open to staff, being seen to respond in a sensitive manner and also actively speaking to staff to ask about any problems rather than placing all the emphasis on care assistants to come forward.
Staff Characteristics

This section will look at some of the individual staff characteristics which emerged as important to the emotion work they undertook. Many aspects have already been discussed within the analysis. The main characteristics were; overseas staff, having cared for a dependent relative, experience and personal problems.

Overseas Staff

Staff who spoke English as a second language, particularly those whose language skills were not strong or who had more recently moved to the UK, experienced communication problems with other staff and also residents. This has already been partly discussed in ‘language and culture barriers’ above. Effectively, this increased the workload for overseas staff as they were required to make more effort with communication than other staff. Especially when new to the job, they simply had to work harder than those who spoke English as a 1st language. However, some positive methods of compensating for this were also found.

Yeah sometimes, especially the, most of them are very old and some of them don’t understand my accent or some from physical impairment, they may have difficulty in even getting the information in… And sometimes I do think differently which is not what they’re used to. You know, I don’t have the names, I may not have the names of some foods for instance, and they ask me ‘what is it?’ I have no clue (laughs). So sometimes I have to show them the food, and uh, they teach me also (laughs). (Adam)

Adam found that by asking residents for help, many responded positively and were pleased to be able to help him. He does acknowledge however, that communication can be a particular problem, especially as some residents already struggle to comprehend and communicate.

Overseas staff, particularly black staff with accents, were often found to have experienced racism from the residents. This has been previously discussed (Chapter 7). This form of abuse had a negative impact on care assistant’s emotions, but usually they ignored the comments, or overseas staff tried not to not work with residents
known to be racist. This is a source of emotional labour that is unique to overseas staff.

Well, now I've got some roommates cos there are 2 people who are living with me, because they live here in the lodge. But they only came 2 months ago and I've been here for almost a year alone. And it's really not very nice if you're, if you're used to busy lifestyle. (Isabela)

Some overseas staff, especially those relatively new to the UK, also had an extra emotional burden relating to being in an unfamiliar country and often away from family and friends. In the example above, Isabela was leaving the home and returning to Poland as she felt very homesick. However, she did feel that the home she worked in had been supportive and she had enjoyed being there, but outside the home she was unhappy.

So I felt really welcome and comfortable and everything, so that helped me a lot because if you come somewhere and then on the top of it you feel that you are not very welcome or no one really cares about you that must be. Like some of my friends are telling me, because I go to university, quite a lot of people from abroad, um, it's exceptional for them to hear this. That you go there, you get all the treatment and the care given. So it was quite, I was very happy, very lucky in this job. And I do appreciate it, so I'm trying to give my best now to, you know, repay all the kindness I received. (Dominik)

There were also some very positive examples with one care home in particular making the effort to understand and support new overseas staff. They provided accommodation, meals and also provided an introduction to the UK and the town in which they were based. The home introduced overseas staff to others living in the area, and tried to stagger the courses staff took in the home so they were not overwhelmed with information when they started and before they had time to learn more English.

Personal Experiences of Caring

About half of the care staff interviewed had personal experiences of caring for a dependent adult family member, and some had known family members move into care homes. The impact of these experiences has been previously discussed in Chapter 5 in relation empathy. It was found that these experiences were strongly related to in-
direct empathy as these care staff often thought about loved ones being in the resident’s position. This indirect empathy and the positive and negative memories of their loved ones care, contributed to care staff’s ‘philosophy of care’. This philosophy of care encapsulated care assistants understanding of their role as a care assistant and how they felt residents should be cared for, something which they then tried to implement in their daily work. Care staff whose philosophy of care included a strong ‘emotional support’ element were more likely to engage in emotion work in order to achieve this quality of care.

Understanding the impact of life experiences on emotion work also provides insight into the relationship between empathy and emotional labour in a caring context. This has been discussed in Chapter 5, where it was argued that empathy both motivates care staff to undertake emotional labour and can also be a deliberate form of emotional labour in itself.

*Length of Experience as a Care Assistant*

In several situations relating to resident care, less experienced staff engaged in different or higher levels of emotional labour. In particular, when dealing with sickness and incontinence, newer staff tended to focus on the unpleasant bodily fluids involved and less on the resident (see Chapter 6). However, as they gained experience and became desensitised to the physical aspects of the work, they began to focus more on the emotional needs of the resident they were washing or changing.

Less experienced staff were also more distressed or worried about residents who were very ill or when residents passed away. Part of this related to their fear over finding a resident who had died, and not knowing how they would react. Newer staff may have had little experience of death, and tended to express that they were emotionally upset by a resident dying, as opposed to more experienced staff whose emotions were related to whether the resident was perceived to have had a ‘good death’ (see chapter 6). Overall however, while newer staff did in some situations focus more on
managing their own emotions than those of the resident, not many differences emerged in terms of the emotional support they tried to give to residents.

**Personal Problems of Care Staff**

Care staff reported having ‘off days’ when they had problems or worries from outside the home that impacted on their emotions when at work. Kate explains how problems arising outside the home impact on her work.

*I think it’s normal because sometimes you know, sometimes you have good day and you, you are very good for everybody, and sometimes you have bad day, you have a headache, you are tired, you are, I don’t know, you’ve fought with your boyfriend or something. And then you give them only basic mmm service, yeah?* (Kate)

Kate’s emotional labour is high, just trying to get through the day, so less emotion work is focused on the emotional support of residents. Similarly, Susan described how she found out her Aunt had passed away one morning before she came into work.

*I mean I’ve just had an aunty die actually. And I was on at the weekend and she’s very special to me, but I still didn’t let any of them sort of know, still carried on. I’m quite good at doing that.*

*R.L:* So you made sure that other people didn’t see, but you must have felt…

Oh I did, yeah. But it didn’t seem to, they didn’t seem, it didn’t show to them. But when I got home, my grandchildren, cos my daughter come round cos she was upset, when I got home from work and that, we all. The grandchildren picked up on it, cos they do don’t they children. You know, I don’t think they any of them did, cos I just carried on as normal, I even made one or two of them laugh, I mean although I didn’t feel particularly good myself. But um, no I’m quite good at doing that. (Susan)

Susan engaged in emotional labour with the residents to try and hide her distress following the death of her Aunt. It is not known the extent to which she was successful in this, but she feels that she did manage to behave as she normally would. This example appears to be one of prolonged ‘surface acting’. Susan also later recalled that the shift had been relatively smooth, but that had the shift involved a ‘difficult’ or distressed resident, she did not know if she would have been able to cope. In terms of limits of emotional labour, it makes sense that if care staff are already working hard to control their emotions due to personal problems, they may
not have the energy to effectively cope with challenging situations, or may wish to
avoid certain emotions (such as not seeing a very ill resident when already feeling
upset). Susan did feel that if such a situation had arisen, other staff would have taken
over as the staff were aware of her recent bereavement, again highlighting the
important role of communication and teamwork amongst the staff.

Many care assistants have problems and stresses in their personal lives, elderly parents
they were concerned about, family members with disabilities, caring for grandchildren
and financial problems. Care staff engage in emotional labour in order to cover their
emotions with residents and sometimes other staff. Undoubtedly different staff do this
with varying success. In extreme cases, for staff to complete even the most basic
tasks at work may take a great amount of emotional work. Combined with all the
stresses that can arise inside the care home, without support these staff could suffer
emotional exhaustion or burnout.

Conclusion

This chapter and the previous two chapters on emotional labour, have provided some
insight into the impact of emotional labour on the care staff that undertake this work.
This chapter has addressed some of the social factors, specifically those relating to
teamwork, support from senior staff and staff characteristics, that influence the
emotion work undertaken by care staff.

Firstly, teamwork has emerged as very important to both the emotional wellbeing of
care staff and also in their provision of emotional support for the residents. It is
evident from the interview analysis that care staff who were able to effectively
communicate and also support one another with challenging situations or residents,
effectively shared their emotional labour, thus offering some protection against
emotional exhaustion. Furthermore, as discussed in the previous chapters, care staff
experience a range of emotional challenges in their work, from caring for a resident
who is dying to coping with a resident who is being aggressive. These challenges
require staff to use a range of emotion skills with some care staff being better in some areas than others. A skills mix within the care staff workforce is therefore essential, however, this mix of staff can only be effective with teamwork. Staff being able to gain support for situations they find particularly hard, but also to give advice and support in areas they are more adept at, would provide better emotional support for the residents involved in these challenging situations.

Staff perceived some of their colleagues to be ‘lazy’, have different working styles or provide poorer care to residents, all of which increased the care staff’s emotion work. These descriptions not only suggest a breakdown in some staff relationships, but also in teamwork. Additionally, some staff found cultural and communication barriers when working with staff from different countries to be difficult, and to add to their workload. These barriers to teamwork impacted on the care staff’s emotional labour as they had to undertake emotion work when with that staff member or as a result of their negative feeling about that staff member. Care staff may struggle to cope with the emotional challenges of their work with residents when already coping with ‘extra’ emotional labour from their colleagues. This is likely to impact on the emotional support of residents.

It was apparent from the analysis that care staff found it difficult to solve some problems they had between themselves. They did not like confronting or criticizing other care staff directly, and many regarded approaching senior staff to be a last resort. Being good at caring for residents does not make staff good at working with each other or ‘teaching’ new staff. It is care home managers and senior staff who should manage care teams and respond to any problems within them. However, this aspect of management appeared to be largely absent. Similarly, it is care home managers who should seek to understand and address the difficulties of staff from different countries working together, such as ensuring there is enough time for effective communication, and focusing on cultural differences such as those regarding mealtimes. This support was apparent in one home in particular and the positive impact on all the care staff especially those from overseas was apparent.
The role of senior staff in emotionally supporting care staff following difficult incidents, such as when a resident was physically aggressive, was also highlighted. As discussed in chapter 6, whether an outcome was positive or negative for care staff was usually dependent on whether the outcome was positive for the resident. However, following negative outcomes, staff were often left to cope with their worries or distress alone. Intervention by senior staff could be valuable in these situations to support the care assistant, recognise their work and emotions and also to enable staff to reflect on, and possibly learn from what happened. Staff who work with residents who are verbally or physically aggressive can feel vulnerable and this vulnerability is further compounded by the lack of organisational recognition or support they often receive. This analysis has shown that it is not just the emotional labour when working directly with residents that impacts on staff wellbeing, but the emotional outcome. Consistently negative outcome could result in burnout, something which could be mitigated by recognition of their work by senior staff.

This chapter and also the empathy analysis (Chapter 5) have highlighted the important role of personal experiences on care staff’s emotion work. In particular the experience of caring for a dependent loved one. This experienced influenced empathic engagement by care staff, especially ‘indirect empathy’ where staff thought about how they would like a loved one to be treated if they were in the position of the resident. This life experience also influenced emotional labour, with care staff striving to provide emotional support for residents based on their own ‘philosophy of care’. Overseas staff reported additional sources of emotional labour when working with residents and other staff. In particular, communication barriers and cultural differences could negatively influence teamwork with other staff, and also make communication with residents difficult. Racism from residents was also common, especially toward black staff, who then had to work hard to manage their negative emotions. In simple terms, overseas staff often had to work harder than UK staff, both mentally and emotionally, especially when they had not long been living in the UK or when they were not fluent English speakers.
This chapter has also shown that staff can struggle to manage their emotions relating to personal problems when they come to work. The idea of 'leaving troubles at the door' when coming to work is unrealistic. Care staff are expected to work with their emotions as a part of their job, and they face many emotional challenges, so care homes must accept that their own private emotions will have impact. It could be seen as equivalent to someone who has sustained a physical injury at home and is then told to 'leave it at the door' and continue physical labour at work. Effective teamwork, staff feeling able to say when they are emotionally vulnerable, and senior staff understanding those situations and resident characteristics that require high levels of emotional labour, could support staff and help avoid emotional exhaustion.

While much of the analysis relating to emotional labour, especially that involving intense emotions was negative, staff enjoyed and actively sought the emotional interactions involved in their work. Some explained that they had been unfulfilled in previous jobs and gained satisfaction from working with older people. Positive outcomes as a result of care staffs’ emotional labour provided them with satisfaction, as did positive feedback from residents, something which was evident in chapters 5 and 6. In contrast, when the outcome of their efforts was negative, or when they received no feedback or criticism from residents staff could feel worn down. Emotional labour can therefore be viewed in a similar way to stimulation. Too little stimulation (or emotional labour) can result in boredom and loss of satisfaction, but too much leads to stress and fatigue. There is an optimum level within which care staff not only gain satisfaction from working, but are able to maintain the energy to work effectively. Staff are, therefore able to undertake the emotional challenges required in their work, but, in order to prevent emotional exhaustion, this work needs to be recognised and supported through teamwork and senior staff support.

The qualitative chapters have explored the emotion work of care staff from their own perspective. The following chapter presents the quantitative findings from the questionnaire analysis before the qualitative and quantitative findings are integrated and discussed in Chapter 10.
CHAPTER 9

QUANTITATIVE ANALYSIS: EMOTIONAL SUPPORT, EMOTIONAL LABOUR AND EMPATHY

Introduction

This chapter contains and discusses the quantitative analysis of the questionnaire data. This analysis essentially explores the theoretical model of emotional support (See Figure 4.1). Firstly any associations between empathy, emotional labour and emotional support are presented, before examining associations between the range of variables on the questionnaire, and each of the three constructs. Appendix 8 describes the scales in detail before presenting the missing data analysis and reliability and validity testing of the scales. Missing data were imputed and unreliable items removed where appropriate. The current chapter uses the adjusted scales from that analysis to explore each of the three constructs. A brief literature review of the scales used is given below before outlining the methodology.

Literature Review

Two scales from Davis’ Interpersonal Reactivity Index (IRI; Davis, 1980, 1983b) were selected for this research. As already outlined in Chapter 2 (Part C), the affective and behavioural components of empathy are separate, that is one can engage in emotional empathy and not act upon it. Davis (eg 1980, 1983b, 1994) outlined a comprehensive theory of empathy that made this distinction explicit. Davis presented an organizational model of empathy that described the antecedents, the processes involved and both the intrapersonal and interpersonal outcomes. Within the antecedents of empathy, Davis argued that there are individual differences in how likely it is that a person will engage empathically, and that this trait is relatively stable throughout adulthood. Davis’ IRI is designed to measure this trait empathy. This scale has been widely used in both the UK and USA (eg Davis 1994) and also tested for reliability (see below). The scale was also used by prominent emotional
intelligence (EI) researchers and has been found to positively correlate with measures of EI (Mayer and Salovey, 1997). As this scale is based on a detailed model of empathy and seeks to measure trait empathy relating to the affective component of empathy, it was ideally suited to the current research. Furthermore, trait empathy is described as only one of the antecedents to empathic engagement, making the influence of other social and situational factors on empathic engagement explicit.

Unlike empathy, the construct of emotional labour is relatively new, and has only recently been introduced within the psychological literature. Although popular within sociology, researchers within this discipline were not concerned with developing quantitative measures of emotional labour. The scale designed by Brotheridge & Lee (2003) was the only previously used and tested measure of emotional labour found in the literature that not only focused on deep and surface acting, but also non-dissonant emotions (management of emotions that do not conflict with what is socially acceptable) which has previously been argued to be an essential component of emotional labour (see Chapter 2). Although not so well established as Davis' IRI scale, the EL scale has been used in a number of recent studies including Austin et al. (2008) and Mikolajczak et al. (2007) which explored personality and EI and work related stress respectively.

There has been no scale developed on emotional support for use within care homes. In the context of this research, emotional support is defined as the emotional aspects of care provided by care assistant for care home residents. Given that this research aims to gain understanding of the care assistants' perspective of the emotional aspects of their work, the Emotional Support scale is designed to provide an indication of emotional support as reported by the care staff. This scale is therefore designed as a useful indicator only, and as a useful tool for care homes to understand the emotional aspects of their care staff's work. This has practical value as it is not only quick, but also does not include residents, removing complex practical and ethical issues. The items and the reliability and validity testing of the Emotional Support scales are detailed in Appendix 8.
Methodology

All quantitative analysis was conducted using SPSS version 13. Field (2005) was used as a reference relating to both the statistical analysis and a practical guide to using SPSS. The specific criteria, such as p-values and effect sizes are those commonly applied in social sciences, as outlined in Field (2005). The specific tests used will be outlined alongside the results, and a brief methodology given here.

The Empathy, Emotional Labour and Emotional Support scales were tested for reliability and factor analysis to explore subscales was undertaken. Following this analysis adjustments were made to the scales (unreliable items removed) and some subscales were found to be reliable while others were not. The following scales were selected for the current analysis, with unreliable items removed. Full details of the analysis and the decisions relating to removing items and the formation of subscales following factor analysis are found in Appendix 8.

**Empathy**

Empathy full scale (13 items)

This scale was not split into the Empathic Concern and Perspective Taking subscales from the IRI (Davis 1983b) as these did not emerge in factor analysis and the EC scale was unreliable with staff who speak English as an Acquired language.

**Emotional Labour**

Surface Acting (SA; 3 items)
Variety & Intensity (V&I; 4 items)
Deep Acting & Frequency (DA&F; 5 items)

Following factor analysis these three subscales emerged which combined some of the original 5 subscales designed by Brotheridge and Lee (2003). The variety and intensity of emotions experienced at work combined to form one scale, as did deep acting and the frequency of emotional labour at work. The DA&F scale was found to be unreliable with staff who speak English as an acquired language.
Emotional Support
Emotional Support full scale (17 items)
Factor 1: Prioritising emotional support (Prioritising; 6 items)
Factor 2: Knowledge of and relationship with resident (Knowledge; 9 items)

Two factors emerged from factor analysis of the Emotional Support scale which did make conceptual sense. Factor 1 related to whether care staff prioritised emotional support within their work, and Factor 2 related to how well care staff knew residents and the relationships they had built with them. However, Factor 1 contained positively coded items and Factor 2 predominantly negatively coded. Factor 2 was also unreliable for staff who speak English as an acquired language. Therefore it was decided to explore these scales further by including both the full scale and the two subscales in the analysis.

The abbreviations used in this analysis are given next to the relevant scale above. Staff that spoke English as a 1st language are also abbreviated to E1stL staff. Staff that spoke English as an acquired language are abbreviated to EAL staff.

Normality of Scales
These scales were first assessed for normality (skew and kurtosis) in order to select the best types of tests for the analysis. The normality of the totals on the scales was tested using a conservative, z>3.29, p<0.001

All scales were found to be normally distributed except for ‘Factor 1: Prioritising Emotional Support’, which was negatively skewed, abs error = 3.68. There were no outliers, but the majority of care staff scored high on this scale. While the skew was outside the limits it was not grossly outside. In order to maintain comparisons between the analysis of the scales, parametric analysis was undertaken with all scales including Factor 1.

The main body of the analysis was separated in to two sections: Part A and Part B as briefly outline below. The main findings are given first, and then discussed at the end of each section.
PART A: Empathy, Emotional Labour and Emotional Support
The associations between the three constructs (empathy, emotional labour and emotional support) were tested using regression analysis. To test for effects relating to whether staff spoke English as a 1st language, this variable was also tested, by introducing it as a ‘forced entry’ variable.

Some of the items of the Emotional Support scale were then further explored. Firstly, items relating to covering or expressing emotions were compared to responses on the ‘surface acting’ and ‘deep acting & frequency’ subscales, using regression analysis. This was to discover whether these items distinguished between the two different types of acting, and therefore were of theoretical value. Secondly, two items relating to direct and indirect empathy were compared with the full empathy scale also by using regression analysis. This was again to assess the theoretical value of these items, and of interest due to the strong emergence of indirect empathy in the qualitative analysis.

PART B: Staff Characteristics and Differences Between Care Homes
The staff characteristics were then tested for any associations with the scales. Dichotomous variables were tested using Independent t-tests, and categorical variables with one-way ANOVAs. Any differences between the scores from each care home on each of the scales was also tested using a one-way ANOVA. As only non significant differences were found, no further quantitative analysis relating to organisational differences between the homes were conducted.

Initially, it had been hoped that more complex analysis, such as path analysis could be conducted. However, due to the relatively low sample size and the added complications of whether staff spoke English as a first language or an acquired language, this was not possible. However, using multivariate analysis, a quantitatively based predictive model of emotional support was formed, to clearly display all of the significant associations. This model was then used to structure the integrated analysis and discussion in the next chapter (Chapter 10).
Part A: Empathy, Emotional Labour and Emotional Support Results

Descriptive Statistics for Scales

Table 9.1: The Mean, Standard Deviation, Minimum score, Maximum score and range for the scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>52.95</td>
<td>8.21</td>
<td>34</td>
<td>65</td>
<td>31</td>
</tr>
<tr>
<td>Surface Acting</td>
<td>7.91</td>
<td>2.27</td>
<td>3</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Variety &amp; Intensity</td>
<td>11.74</td>
<td>3.10</td>
<td>4</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Deep Acting &amp; Freq</td>
<td>17.92</td>
<td>3.43</td>
<td>11</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>70.99</td>
<td>8.17</td>
<td>49</td>
<td>84</td>
<td>35</td>
</tr>
<tr>
<td>F1: Prioritising em sup</td>
<td>26.82</td>
<td>3.04</td>
<td>18</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>F2: Knowledge of res</td>
<td>36.15</td>
<td>5.14</td>
<td>17</td>
<td>45</td>
<td>28</td>
</tr>
</tbody>
</table>

Regression Analysis of Scales

This analysis aimed to explore any associations between the scales and subscales of the three constructs, empathy, emotional labour and emotional support. Linear regression analysis of the selected scales and subscales was conducted. Emotional Support and its factors ('prioritising emotional support' and knowledge of and relationship with resident) were the dependent variables. In analysis of Empathy and the Emotional Labour subscales, emotional labour was the dependent variable. The variable 'speaks English as a 1st language' was entered as a 'forced entry', second block independent variable for each regression. In doing so, the effect of those participants who spoke English as an acquired language (EALs) on the relationships between the scales could be ascertained. Pearson’s correlations were also conducted on EAL, ElstL and all staff as separate groups in order to better understand any differences between these groups. These correlations are only reported where relevant differences were found.
Empathy Scale

Table 9.2: Overview of linear regression with Empathy as the Independent Variable and Emotional Labour subscales as Dependent Variables

<table>
<thead>
<tr>
<th>DV</th>
<th>$R^2_{ad}$ (%)</th>
<th>$F$ (p)</th>
<th>Effect of English as 1st language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surface Acting</td>
<td>-0.9</td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td>Variety &amp; Intensity</td>
<td>-1.1</td>
<td>N/S</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Deep Acting and Frequency</td>
<td>0.3</td>
<td>N/S</td>
<td>N/S</td>
</tr>
</tbody>
</table>

Table 9.2 shows the Adjusted R-Square ($R^2_{ad}$) which is an estimate of the percentage of the variance accounted for by the regression. This small, negative $R^2_{ad}$ actually shows that the ‘fitting’ the Emotional Labour subscales into a model using Empathy is actually accounts for less of the variation than fitting it to a horizontal line. It is clear then that there were no significant associations between Empathy and the Emotional Labour sub scales. This finding suggests that empathy does not impact on emotional labour. However, the variable English as a 1st language had a significant effect on the association between Empathy and V&I.

The regression for V&I and English as a 1st language was still a very poor fit, ($R^2_{adj} = 4.9\%$), but the overall relationship was near significance ($F(2,60) = 2.61, p = 0.082$). EAL staff tended to have a lower score, by 1.88. Only the effect of English as a 1st language was significant ($t(60) = -2.21, p < 0.05$), the effect of empathy was not.

Pearson’s correlation of Empathy and V&I were conducted for all participants, E1stL staff only and EAL staff only.

Table 9.3: Pearson correlation for Empathy and ‘Variety & Intensity’

<table>
<thead>
<tr>
<th></th>
<th>Pearson Correlation</th>
<th>Sig</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ppts</td>
<td>0.07</td>
<td>N/S</td>
<td>63</td>
</tr>
<tr>
<td>E1stL</td>
<td>0.29</td>
<td>&lt;0.05</td>
<td>47</td>
</tr>
<tr>
<td>EAL</td>
<td>-0.33</td>
<td>N/S</td>
<td>16</td>
</tr>
</tbody>
</table>

The correlations show a positive association between empathy and V&I for the E1stL, but a negative association for the EAL. As there are only 16 EAL, the lack of significance is not surprising, however the effect size and direction suggests that for
EAL staff, as empathy scores increase the Variety and Intensity (V&I) scores tend to decrease. This finding is discussed in more detail following the t-tests for EAL and E1stL staff for empathy and V&I (Part B).

The results in table 9.3 suggest that there is no significant association between empathy and emotional labour using these scales. This is supported by small effect sizes on the Pearson’s correlations. However, there is a difference between EAL and E1stL on the Variety and Intensity scale and/or on the Empathy scale, which impacts on the direction of the association between Empathy and V&I.

**Table 9.4: Overview of linear regression with Empathy as the Independent Variable and Emotional Support scales as Dependent Variables**

<table>
<thead>
<tr>
<th>DV</th>
<th>$R^2_{ad}$ (%)</th>
<th>F</th>
<th>$F (p)$</th>
<th>Change in DV for 1 point increase in empathy</th>
<th>Effect of English as 1st language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
<td>15.9</td>
<td>12.87</td>
<td>&lt;0.01</td>
<td>0.41</td>
<td>N/S</td>
</tr>
<tr>
<td>F1: Prioritising</td>
<td>10.3</td>
<td>8.23</td>
<td>&lt;0.01</td>
<td>0.13</td>
<td>N/S</td>
</tr>
<tr>
<td>F2: Knowledge</td>
<td>13.1</td>
<td>10.51</td>
<td>&lt;0.01</td>
<td>0.24</td>
<td>N/S</td>
</tr>
</tbody>
</table>

All of the regressions for empathy and emotional support and its 2 factors (‘prioritising emotional support’ and ‘knowledge of and relationship with resident’) were significant and showed a reasonable association. The variable ‘English as a 1st language’ did not have a significant effect on any of the associations, therefore it can be assumed that there was no effect of EAL staff.

The results for empathy and emotional support suggest that empathy does have a significant impact on emotional support. However, this only accounts for a small/moderate amount of the variance (between 10.3% and 15.9%), suggesting other variables have a greater impact on emotional support. ‘Prioritising emotional support’ had the weakest association with empathy.
**Emotional Labour Subscales**

The association between each of the emotional labour scales, ‘Surface Acting’, ‘Variety & Intensity’ and ‘Deep Acting & Frequency’ were tested separately against the emotional support scales.

*Table 9.5: Overview of linear regression with Surface Acting as the Independent Variable and Emotional Support Scales as Dependent Variables*

<table>
<thead>
<tr>
<th>DV</th>
<th>R² adj (%)</th>
<th>F</th>
<th>F (p)</th>
<th>Change in DV for 1 point increase in empathy</th>
<th>Effect of English as 1st language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
<td>2</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td>F1: Prioritising</td>
<td>3.5</td>
<td>3.30</td>
<td>0.074</td>
<td>-0.3</td>
<td>N/S</td>
</tr>
<tr>
<td>F2: Knowledge</td>
<td>1</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
</tr>
</tbody>
</table>

Only the regression for surface acting and Factor 1: Prioritising emotional support, approached significance, and this was a poor fit. Interestingly, for every 1 point increase in Surface Acting, Factor 1 decreased by about 0.3. The Pearson’s correlations for Surface Acting were studied to gain more insight into the negative relationship between surface acting and the Emotional Support scales.

*Table 9.6: Pearson’s correlation for Surface Acting and the Emotional Support Scales*

<table>
<thead>
<tr>
<th>Full EmSupp Scale</th>
<th>All ppts</th>
<th>E1stL</th>
<th>EAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pearson Correlation (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>F1: Prioritising</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pearson Correlation (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>F2: Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pearson Correlation (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>39</td>
<td>16</td>
</tr>
</tbody>
</table>

Only ‘Surface Acting’ (SA) produces consistently negative associations for all participants and for both E1stL and EAL staff. Although these effect sizes are small and not statistically significant, this indicates that the association between SA and Emotional Support is very different to that of the other two Emotional Labour scales.
The Pearson’s correlations also show that the results for EAL staff show larger negative effect sizes for ‘Surface Acting’ and Emotional Support than for EIstL, although this effect was found not to be significant in the regression. In particular EAL staff showed a strong negative association between ‘Factor 2: Knowledge of residents’, and ‘surface acting’. Therefore overseas staff that felt they knew the residents and had built a relationship with them, were less likely to engage in surface acting. This association makes sense, but it is not clear why this should be so for overseas staff and not for all staff.

Table 9.7: Overview of linear regression with ‘Variety & Intensity’ as the Independent Variable and Emotional Support scales as Dependent Variables

<table>
<thead>
<tr>
<th>DV</th>
<th>(R^2_{ad}) (%)</th>
<th>F</th>
<th>(F(p))</th>
<th>Change in DV for 1 point increase in empathy</th>
<th>Effect of English as 1st language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
<td>6.5</td>
<td>5.39</td>
<td>&lt;0.05</td>
<td>0.75</td>
<td>N/S</td>
</tr>
<tr>
<td>F1: Prioritising</td>
<td>4.9</td>
<td>4.21</td>
<td>&lt;0.05</td>
<td>0.25</td>
<td>N/S</td>
</tr>
<tr>
<td>F2: Knowledge</td>
<td>5.9</td>
<td>4.94</td>
<td>&lt;0.05</td>
<td>0.46</td>
<td>N/S</td>
</tr>
</tbody>
</table>

All of the regressions with V&I and the emotional support scales are significant, but account for very little of the variance. The variable ‘English as a 1st language’ did not have a significant effect on any of the associations, therefore it can be assumed that there was no effect of EAL staff.

Table 9.8: Overview of linear regression with ‘Deep Acting & Frequency’ as the Independent Variable and Emotional Support scales as Dependent Variables

<table>
<thead>
<tr>
<th>DV</th>
<th>(R^2_{ad}) (%)</th>
<th>F</th>
<th>(F(p))</th>
<th>Change in DV for 1 point increase in empathy</th>
<th>Effect of English as 1st language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
<td>3.9</td>
<td>3.53</td>
<td>&lt;0.1</td>
<td>0.56</td>
<td>N/S</td>
</tr>
<tr>
<td>F1: Prioritising</td>
<td>0.2</td>
<td>N/S</td>
<td></td>
<td>N/S</td>
<td>N/S</td>
</tr>
<tr>
<td>F2: Knowledge</td>
<td>4.0</td>
<td>3.56</td>
<td>&lt;0.1</td>
<td>0.35</td>
<td>N/S</td>
</tr>
</tbody>
</table>

None of the regressions with DA&F and the emotional support scales are significant, although the Emotional Support scale and ‘Factor 2: Knowledge of residents’ were near to significance. They account for very little of the variance. The results suggest
that Deep Acting & Frequency have a very small positive effect on emotional support and Factor 2: knowledge of resident.

Discussion of Associations Between Scales and Subscales

Figure 9.1: Model of associations between Empathy, Emotional Labour and Emotional Support

There was no significant association between empathy and any of the emotional labour scales. There is therefore no quantitative evidence of an indirect effect of empathy through emotional labour. These findings do show a difference in the relationship between empathy and V&I for EAL and E1stL staff. E1stL staff showed a medium positive correlation and EAL staff showed a medium, negative correlation. This finding is supported by the t-test results for ‘English as a 1st language’ (see PART B below) which show that on average E1stL staff tend to score lower on
empathy, but higher on V&I than EAL staff. This finding is discussed in the summary of the t-test results.

There was a reasonable and significant association between empathy and all three emotional support scales, suggesting that as empathy increases, so does emotional support. As there were no significant associations between empathy and emotional labour, these findings suggest that empathy impacts directly on emotional support and not indirectly through emotional labour. The empathy scale does not measure how good a person is at engaging empathically with another, but how likely they are to engage empathically. In the context of this research, empathy is being viewed as an emotional skill at which some are better than others. If emotional support is viewed as an emotional competency it makes sense that this is partly predicted by core emotional skills, as represented by the empathy scale.

The association between empathy and emotional support only represented a small amount of the variance in emotional support. This suggests that other variables such as staff characteristics and care home organization have a greater role in predicting levels of emotional support.

The ‘surface acting’ subscale showed only a poor fit, approaching significance with ‘Factor 1: prioritising emotional support’. This was a negative association. Although not significant, the correlations between ‘surface acting’ and the emotional support scales were all negative with the greatest effect sizes, medium and approaching large for EAL staff. Surface acting is a qualitatively different concept to the other emotional labour subscales. This supports previous findings by Brotheridge and Lee (2003), that surface acting is negatively associated with staff satisfaction and well being, but positively associated with burnout. The current findings show that surface acting could also have a negative effect on emotional support of residents, an interesting finding as it could be argued that surface acting is engaged in precisely to avoid showing negative feelings and improve the emotional support of residents. However, another, larger study would be needed in order to confirm this as none of the regressions were found to be significant.
Further evidence that surface acting could be negatively associated with emotional support comes from the reliability testing of the emotional support scale from Appendix 8. It was found that the following items did not load on either factors, and that item (s) was unreliable overall and so was removed from the scale. Item (s) clearly refers to surface acting. Item (o) refers to dissonant emotions which are then expressed.

o) If I feel annoyed with a resident I tend to show my feelings
s) I feel irritated at times by some residents but I cover my feelings

Further regression analysis showed that item (s) was significantly associated with the SA subscale, but not with DA&F. Item (o) was not associated with either. There was some link then, between this surface acting item and the SA subscale.

Items (o) and (s), above, also show that there are two separate concepts involved in surface acting. Firstly, a situation must arise in which a care assistant feels inappropriate, negative emotions (in this case irritation). It could be that some care assistants are less prone to feeling irritated with residents or engage in deep acting to avoid feeling irritated. It could also be that some residents or some organisational features in care homes are more likely to create situations in which a care assistant could become irritated. Secondly, surface acting involves covering feelings. Of those that are in a situation in which they feel inappropriate emotions, some may then cover these emotions whereas others may show them. When responding to this item, it is difficult to determine if a care assistant responded to the ‘feeling irritated’ part or the ‘covering emotions’ part.

As previously discussed, surface acting appears to be negatively associated with emotional support. Therefore it could be that those who more frequently become irritated have to use surface acting. Those who do not tend to become irritated, have less need to use surface acting. It follows that a person who more often feels inappropriate emotions is less emotionally supportive of residents.
In contrast to the surface acting findings, there was a positive association that was approaching significance, between ‘deep acting & frequency’ and emotional support, and also ‘Factor 2: knowledge of and relationship with residents’. There was no association between DA&F and ‘Factor 1: prioritising emotional support’. Assuming that a significant finding would have occurred with a larger sample, this suggests that those who engage more frequently in deep acting to feel appropriate emotions may also have a better understanding of the residents they care for. It makes sense that residents would respond better to those who tried to feel the appropriate feelings towards them and engaged emotionally with them more frequently. Therefore a better relationship would develop. Conversely, care workers who know residents well and have developed a relationship with them would be more likely to be able to engage in deep acting as they could use their understanding of the resident to feel the appropriate emotions when caring for them.

There was a small but significant association between ‘Variety and Intensity’ and all of the Emotional Support scales. Those care workers who were more emotionally engaged with residents were also more likely to feel and display a greater range of emotions, more frequently. V&I refers to non-dissonant emotions, that is, emotions that are in accord with what is socially appropriate, but which may still need to be managed to express them to an appropriate degree. Interestingly, both surface and deep acting, which refer to dissonant emotions did not yield significant results (although near significance). This suggests that staff who reported using their emotions to a great extent, but not covering or altering their emotions also felt they provided better emotional support.

In conclusion, this research has produced significant and positive association between Empathy and each of the Emotional Support scales, and between ‘Variety & Intensity’ and each of the Emotional Support scales. Overall then, both empathy and non-dissonant aspects of emotional labour are associated with emotional support. However, empathy does not appear to act indirectly though emotional labour.
Empathy Items on the Emotional Support Scale

Given the positive association between empathy and emotional support as previously described, and also the emergence of indirect empathy as a relevant construct in the qualitative analysis, a brief analysis of the direct and indirect empathy items on the Emotional Support scale was undertaken. The Empathy scale itself only referred to direct empathy. On the Emotional Support scale, item (g) refers to 'direct empathy' and item (m) to 'indirect empathy'.

\[
g) \quad \text{I frequently think about how it would feel if I was in the position of the resident}
\]
\[
m) \quad \text{I sometimes think about how I would like a resident to be treated if they were my parent or loved one.}
\]

Regression analysis was conducted using the empathy scale as the IV and item g (direct empathy) as the DV. The regression was a good fit, \( R^2_{adj} = 24.5\% \), and the positive relationship was significant \( F(1,64) = 22.04, p < 0.01 \).

Regression analysis was conducted using the empathy scale as the IV and item m (indirect empathy) as the DV. The regression was a good fit, \( R^2_{adj} = 35.6\% \), and the positive relationship was significant \( F(1,64) = 36.87, p < 0.01 \).

Therefore, on average, those that score higher on the empathy scale also tend to score higher on both the direct and indirect empathy items, which both refer to working directly with residents. This represented a good proportion of the variance for both items. These results also suggest that the association is strongest with indirect empathy. The mean score on these items also show that the average score on m (indirect) was higher than on g (direct), suggesting care staff are more likely to engage in indirect empathy than direct empathy, thus imagining how they would feel if the resident were a loved one as opposed to how they would feel if they were the resident themselves. This brief analysis has provided some quantitative support for the regular use of indirect empathy by care staff and that this form of empathy does indeed strongly relate to the direct form of empathy as indicated by the empathy scale.
Part A: Conclusion

This analysis supports previous findings (eg. MacKay et al. 1990) that empathy is directly associated with emotional support, but does not support the indirect influence of empathy through emotional labour as proposed in the theoretical model (Figure 2.1). There is also some evidence, using items on the Emotional Support scale that indirect empathy, as outlined in Chapter 5, is associated with direct empathy and that both forms are important in the emotional support of residents.

The analysis of the scales and also items from the Emotional Support scale also revealed that the use of non-dissonant emotions (Variety & Intensity) were associated with emotional support, but that the use of deep and surface acting to cope with dissonant emotions (those which are not appropriate in a given situation) was not. The possible negative association between Surface Acting and Emotional Support would be an interesting area for future study, as it suggests that relying on this form of emotional labour is not supportive for residents.

This analysis (and the reliability analysis in Appendix 8) has revealed that there are differences in how E1stL and EAL respond to some items and scales. It is difficult however to know whether this is related to actual differences in terms of empathy and emotional labour, cultural differences in how the items are understood, or linguistic differences or difficulties. These relatively short and simple scales reveal the complexity of data analysis for this heterogeneous group and the challenges involved in using self-report scales with care staff. These differences could also have a bearing on how EAL and E1stL staff relate to training materials for care staff, many of which rely heavily on reading and writing, as well as culturally complex terms such as ‘dignity’ and ‘respect’. This is further discussed in Chapter 11.

Part B: Analysis of Staff Characteristics

This analysis aimed to explore any associations between the three constructs, empathy, emotional labour and emotional support and the staff characteristics from
the questionnaires. Any differences between the staff in each of the 8 care homes on the Empathy, Emotional Labour and Emotional Support scale were also explored.

The variables, gender, ‘completed TOPPs 5’ and ‘completed NVQ3’ were not analysed as there were too few cases in one of the categories. There were only 6 males, and very few care assistants had completed either TOPPs5 or NVQ3.

The following variables did not yield any significant or near significant results in the t-tests or ANOVAs and did not show anything greater than a small effect size:

- Number of homes currently worked in
- Full-time/Part-time
- Years working as a care assistant
- Years working at current home
- Other job other than as a care assistant
- Working towards a qualification (eg NVQ2)
- Highest level of education
- Have any children
- Known a friend or family member enter residential care

The descriptive statistics for these variables can be found in Appendix 10.

**Descriptive Statistics for Staff Characteristics**

Tables of the descriptive statistics for the significant and near-significant variables are given below.

### Table 9.9: Table of the care assistant sample from each care home

<table>
<thead>
<tr>
<th>Home Number</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15</td>
<td>22.1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>7.4</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>23.5</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>11.8</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>14.7</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>10.3</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>5.9</td>
</tr>
</tbody>
</table>
As can be seen from Table 9.10 the majority of participating care staff were permanent staff. The agency staff who did participate were all working regularly at the care home, 2 of them only worked at that one home.

These findings suggest that homes in general have not yet met the criteria of 50% staff qualified to NVQ 2 even in a sample dominated by permanent staff.

As can be seen, staff came from a range of ethnic backgrounds. However, analysis of the different backgrounds was difficult due to the small numbers in some categories.
Table 9.14: Frequency table for Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>24</td>
<td>35.8</td>
</tr>
<tr>
<td>30-39</td>
<td>14</td>
<td>20.9</td>
</tr>
<tr>
<td>40-49</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>50-59</td>
<td>16</td>
<td>23.9</td>
</tr>
</tbody>
</table>

The median age group was 30-39. Examining age as a continuous variable, the mean age is 37.4. The youngest care assistant was 19.

Crosstabulations

Crosstabulations were conducted between a range of variables to give an indication of how some of the staff characteristics related to one another. The variables age and English as a 1st language were found to differ the most when explored within the context of other variables and are briefly outlined below. (Refer to tables in appendix 9 for full crosstabulations)

Age

Care Home: Homes 1 and 5 had the highest percentage of under 30s care staff, both around 60%, compared with between 10% and 25% for the other homes. Home 5 contained 60% of staff aged over 50.

Education & Training: The 18-29 age group were most likely to still be in education, with almost 30%. In general the older groups were more likely to have completed manual handling and also NVQ2, probably reflecting amount of time they had been working at the home. However, the youngest age group was also more likely to be working towards NVQ2, with 37.5% currently training.

Life Experiences: The older groups were also more likely to have cared for a dependent relative, 34.5% of under 30s, and 68.8% of those over 50. In general the likelihood of having known a friend or relative enter residential care increased with age, although the 40-49 group was lowest.
English as a 1st Language: The percentage of EAL staff decreased with age. 34.5% of those aged 18-29, but only 12.5% of those aged 50-59. Those under 40 account for 71% of those who do not speak English as a 1st language and 51% of those that do.

Overall then, there are clear age differences on a range of variables which include training, life experiences and also whether the staff speak English as a 1st language.

### English as a 1st Language

#### Table 9.15: Percentage of EALs and E1stLs in each home

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1stL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>66.7</td>
<td>60</td>
<td>93.8</td>
<td>37.5</td>
<td>80</td>
<td>50</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>10</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>EAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>33.3</td>
<td>40</td>
<td>6.3</td>
<td>62.5</td>
<td>20</td>
<td>50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Education & Training: 61% of those that do not speak English as a 1st language were still in education compared 8% of those that do. Approximately 88% of EAL staff had not completed NVQ2, compared with 53% of E1stL staff. These findings reflect that either the staff uptake or the offer of training for EAL staff is lower than for E1stL staff.

Life Experiences: About 50% of both EAL and E1stL staff had cared for a dependent relative. 93% of EAL staff had not known a relative enter residential care, compared with 52% of E1stL staff. This finding is perhaps not surprising considering care homes are not prevalent in the countries of origin of many of the EAL staff, something which also emerged in the interviews.

### T-tests of Dichotomous Variables

The aim of this analysis was to explore any differences between groups of care staff on how they responded to the Empathy, Emotional Labour and Emotional Support scales.
Independent samples t-tests were conducted using the dichotomous staff characteristic variables. These detected differences in the mean scores for empathy, SA, V&I, DA&F, Emotional Support, Factor 1 (prioritizing emotional support) and Factor 2 (knowledge of resident). Levene’s test of equal variances was used and corrections were used for those samples of unequal variance.

Table 9.16: T-test for ‘Still in Education’

<table>
<thead>
<tr>
<th></th>
<th>t-value</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>2.90</td>
<td>&lt;0.01</td>
<td>0.41</td>
</tr>
<tr>
<td>SA</td>
<td>0.22</td>
<td>N/S</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>V&amp;I</td>
<td>0.37</td>
<td>N/S</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>DA&amp;F</td>
<td>1.43</td>
<td>N/S</td>
<td>0.18</td>
</tr>
<tr>
<td>Em Support</td>
<td>1.34</td>
<td>N/S</td>
<td>0.17</td>
</tr>
<tr>
<td>Factor 1: prioritising</td>
<td>1.53</td>
<td>N/S</td>
<td>0.19</td>
</tr>
<tr>
<td>Factor 2: Knowledge</td>
<td>1.04</td>
<td>N/S</td>
<td>0.13</td>
</tr>
</tbody>
</table>

On average, those still in education scored higher on the empathy scale (M= 56.68) than those not in education (M= 51.49) (see Table 9.16). This difference was significant $t(42.4) = 2.90, p<.01$, and also represented a medium to large effect size. It is not clear why those still in education should be more empathic. It could be that as with those who had other jobs, those still in education are more aware of the emotional work they do as they have a comparison outside of care work. Those still in education were both more likely to be younger and also EAL staff, which could be related to these findings.

There were no significant differences between those who were and were not still in education on any of the other scales.

Table 9.17: T-test for ‘Completed Manual Handling’

<table>
<thead>
<tr>
<th></th>
<th>t-value</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>0.93</td>
<td>N/S</td>
<td>0.12</td>
</tr>
<tr>
<td>SA</td>
<td>1.94</td>
<td>&lt;0.1</td>
<td>0.25</td>
</tr>
<tr>
<td>V&amp;I</td>
<td>0.76</td>
<td>N/S</td>
<td>&gt;0.1</td>
</tr>
<tr>
<td>DA&amp;F</td>
<td>0.38</td>
<td>N/S</td>
<td>&gt;0.1</td>
</tr>
<tr>
<td>Em Support</td>
<td>0.19</td>
<td>N/S</td>
<td>&gt;0.1</td>
</tr>
<tr>
<td>Factor 1: prioritising</td>
<td>1.06</td>
<td>N/S</td>
<td>0.13</td>
</tr>
<tr>
<td>Factor 2: Knowledge</td>
<td>0.89</td>
<td>N/S</td>
<td>0.11</td>
</tr>
</tbody>
</table>

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On average, those who had completed manual handling scored lower on SA (M=53.63) compared to those that had not (M=51.71). This finding was not significant t(58.2) = 1.94, p=0.058, but was close to significance. This difference represented an effect size that was approaching medium. No other significant or near significant effects were found.

**Completed NVQ2**

There were no significant differences found between those who had and had not completed NVQ2 on any of the scales. All of the effect sizes were small. This is perhaps a surprising finding as NVQ2 is the standard care qualification across all homes and almost 40% of staff had completed it.

**Table 9.18: T-test for ‘Cared for Dependent Relative’**

<table>
<thead>
<tr>
<th>Scale</th>
<th>t-value</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>1.75</td>
<td>&lt;0.1</td>
<td>0.22</td>
</tr>
<tr>
<td>SA</td>
<td>0.77</td>
<td>N/S</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>V&amp;I</td>
<td>2.63</td>
<td>&lt;0.05</td>
<td>0.32</td>
</tr>
<tr>
<td>DA&amp;F</td>
<td>1.72</td>
<td>&lt;0.1</td>
<td>0.21</td>
</tr>
<tr>
<td>Em Support</td>
<td>1.93</td>
<td>&lt;0.1</td>
<td>0.24</td>
</tr>
<tr>
<td>Factor 1: prioritising</td>
<td>1.67</td>
<td>&lt;0.1</td>
<td>0.21</td>
</tr>
<tr>
<td>Factor 2: Knowledge</td>
<td>1.43</td>
<td>N/S</td>
<td>0.18</td>
</tr>
</tbody>
</table>

Those who had the experience of having cared for a dependent relative scored higher on the following 5 scales in comparison to those who did not have this life experience:

Empathy (M=54.69) compared to (M=51.12). This finding was approaching significance t(62) = 1.75, p=0.085 and represented an effect size between small and medium.

‘V&I’ (M=12.72) compared to (M=10.75). This finding was significant t(62) = 2.63, p<0.05 and represented a medium effect size.

‘DA&F’ (M=18.71) compared to (M=17.27). This finding was approaching significance t(62) = 1.72, p=0.091 and represented an effect size between small and medium.
Emotional Support (M=72.81) compared to (M= 69.00). This finding was approaching significance $t(63) = 1.93, p=0.058$ and represented an effect size between small and medium.

'Factor 1: prioritising emotional support' (M=27.42) compared to (M= 26.18). This finding was approaching significance $t(63) = 1.67, p=0.099$ and represented an effect size between small and medium.

The experience of having cared for a dependent relative was significantly associated with 'V&I', but, taking the findings as a whole, it would appear to be associated with empathy, emotional labour and also emotional support. It did not relate to surface acting or Factor 2: knowledge of residents. It seems likely that the experience of caring for a loved one has a positive impact on the emotion skills and emotional support of those care staff. It could be that those who had this experience and then started care work did so as they felt they were good at it and had something to offer. This is an important finding and supports qualitative findings relating to both empathy and emotional labour. This will be discussed in greater detail in the integrated analysis and discussion (Chapters II and 12).

**English as a 1st language**

There were no significant differences between those that did and did not speak English as a 1st language but a near significant difference for 'Variety and Intensity'. On average, those who spoke English as a 1st language scored higher on V&I (M=12.27) than those who did not (M=10.24). This difference was approaching significance $t(21.4) = 2.41, p=0.058$ representing a medium to large effect size (0.40).

The possible reasons for these findings are not clear. E1stL care staff reported expressing a greater variety and also intensity of emotion, this could relate to communication skills in general which may make the expression of emotions easier for E1stL staff. This finding could explain why the association between Empathy and V&I was significantly effected by the variable 'English as a 1st language' in the earlier regression analysis (Table 9.2).
**ANOVAs for Categorical Variables**

The aim of the one-way ANOVAs was to explore any association between those variables with 3 or more categories and the empathy, emotional labour and emotional support scales. Tukey’s test of homogeneity of variances was used. If the assumption of equal variances was broken, the Welch and Brown-Forsythe adjustments were used (Field, 2005). Post hoc multiple comparisons were conducted to determine significant differences between each pair of categories. The Games-Howell procedure was used as it is more accurate when sample sizes are unequal (Field, 2005).

**Table 9.19: ANOVA for ‘Age’ and Factor 1: prioritising emotional support**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Factor 1: Prioritising Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>25.32</td>
</tr>
<tr>
<td>30-39</td>
<td>27.36</td>
</tr>
<tr>
<td>40-49</td>
<td>27.38</td>
</tr>
<tr>
<td>50-59</td>
<td>27.75</td>
</tr>
</tbody>
</table>

There was a significant effect of age on Factor 1: Prioritising emotional support $F(3, 61) = 2.81, p<0.05$ with care staff in the youngest age group scoring lower than the other age groups who had more similar scores. Multiple comparison’s using the Games-Howell procedure did not reveal any significant differences between each pair of age groups.

**Table 9.20: ANOVA for ‘care homes’ and ‘SA’, ‘V&I’ and Factor 1**

<table>
<thead>
<tr>
<th>Home</th>
<th>SA Mean score</th>
<th>V&amp;I Mean score</th>
<th>Factor 1: Prioritising Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.77</td>
<td>10.64</td>
<td>26.07</td>
</tr>
<tr>
<td>2</td>
<td>7.00</td>
<td>10.00</td>
<td>27.40</td>
</tr>
<tr>
<td>3</td>
<td>6.69</td>
<td>12.07</td>
<td>26.94</td>
</tr>
<tr>
<td>4</td>
<td>7.62</td>
<td>12.37</td>
<td>25.62</td>
</tr>
<tr>
<td>5</td>
<td>8.20</td>
<td>13.50</td>
<td>28.40</td>
</tr>
<tr>
<td>6</td>
<td>10.00</td>
<td>9.33</td>
<td>24.20</td>
</tr>
<tr>
<td>7</td>
<td>7.33</td>
<td>14.33</td>
<td>28.00</td>
</tr>
<tr>
<td>8</td>
<td>8.00</td>
<td>12.5</td>
<td>29.25</td>
</tr>
</tbody>
</table>
There was no significant effect of care home. There was a near to significant effect for SA, V&I and Factor 1. However, there were no significant differences between pairs of homes for SA, V&I and Factor 1.

It would appear that there could be an effect of care home on some aspects of emotional labour and also on Factor 1, prioritising emotional support. There is not a clear relationship between the findings for the three scales for each home. As these findings were not significant and also showed no obvious pattern, no further quantitative analysis was undertaken to explore differences between care homes.

**Type of Care Staff**

There was no significant effect of type of care staff (permanent, bank or agency) on V&I, DA&F, Emotional support, Factor 1 or Factor 1. There was a significant effect of care staff type on empathy using the Welch adjustment $F(2, 12.5) = 9.06, p<0.01$ and a near significant effect using the Brown-Forsythe adjustment. Agency staff scored highest on empathy ($M=58.67$), followed by bank staff ($M=53.5$) and the lowest being permanent staff ($M=52.63$). Multiple comparison’s using the Games-Howell procedure revealed a significant difference between agency and permanent staff $p<0.01$.

There was a significant effect of care staff type on surface acting, $F(2, 63) = 4.58, p<0.05$. Agency staff scored highest on SA ($M=9.91$), followed by permanent staff ($M=8.07$) and the lowest being bank staff ($M=6.00$). However, there were no significant differences when pairs of staff types were compared.

**Ethnic Background**

Indian, Asian-other and Black-Caribbean cases were removed from the analysis as they contained 2 or fewer cases and could not be analysed.
There was a significant effect of ethnic background on V&I, $F(3, 57) = 3.214, p<0.05$. White UK/Irish staff scored highest, followed by White-other (mostly South African), then White European and lastly Black-African. This suggests that either the expression of a variety and intensity of emotions at work differ between these groups, or interpretation of the questions differ. Multiple comparisons using the Games-Howell procedure did not reveal any significant differences between each pair of ethnic backgrounds.

The t-tests showed a near significant difference between E1stL staff and EAL staff on V&I, with E1stL staff scoring higher. This is supported by the ethnic background findings. It is not possible to determine whether this was an effect of how people understood and responded to the questions or if this finding relates to actual variety and intensity of emotions displayed within care homes. As suggested previously, those who speak English as an acquired language may display fewer emotions as their overall level of communication with residents and some other staff is reduced.

**Discussion of Analysis of Staff Characteristics**

Many staff characteristic variables, did not show a significant association with the Empathy, Emotional Labour or the Emotional Support scales. This discussion will focus on the significant, near significant and larger effect sizes.

Those still in education tended to score higher on empathy. Those still in education tend to be part-time and also 50% spoke English as an Acquired language (EAL). Both part-time and EAL staff tended to score higher on empathy, although this was not significant. It is not clear if the effect of education related to empathy or the joint effects of working part-time and speaking English as an acquired language.

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**Table 9.21: Mean scores for V&I for different ethnic groups**

<table>
<thead>
<tr>
<th>Ethnic background</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black-African</td>
<td>9.33</td>
</tr>
<tr>
<td>White-UK/Irish</td>
<td>12.63</td>
</tr>
<tr>
<td>White European</td>
<td>11.60</td>
</tr>
<tr>
<td>White-other</td>
<td>12.02</td>
</tr>
</tbody>
</table>

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Staff who had completed a manual handling course tended to score lower on surface acting. As manual handling courses are entirely practical, teaching staff how to safely move residents, it is highly unlikely the course itself impacted on surface acting. However, manual handling could be an indication of staff training or other organizational features in the home as it was also found that which of the 8 care homes staff worked in was also associated with surface acting.

Care staff who had cared for a dependent relative tended to score higher on empathy, ‘Variety & Intensity’, ‘Deep Acting & Frequency’, Emotional Support and ‘Factor1: prioritizing emotional support’. This is a clear indication that those who have caring experience in the private sphere tend to undertake more emotional labour and also prioritise emotional support. This relates to the findings from the interviews where those who had cared for relatives spoke about how it impacted on how they cared for residents and what they understood their role as a care assistant to be. Having children or knowing someone who had entered residential care did not have the same impact. Caring for a dependent relative was more likely to represent hands on care of an adult or older person and therefore was most similar to working with older people. The higher scores on empathy could be a reflection that the type of person who either cares for a dependent relative or who has had this experience and then decided to enter or continue with care work, tended to be more empathic.

Those who spoke English as a 1st language (E1stL) tended to score higher on V&I. There was also an effect of ethnic background on ‘Variety & Intensity’ with white-UK/Irish scoring the highest, followed by White-other (all E1stL staff), white European and then Black-African. Variety and intensity of emotion could relate to communication relating to English language skills, or it could relate to social differences in understanding of what is an ‘intense emotion’ or differences in emotional engagement. The interviews revealed that overseas staff were more likely to see working as a care assistant as ‘a job’ rather than a vocation, but it is not clear why this would only impact on V&I and not other scales as well.
The age of care staff was associated with ‘Factor 1: prioritising emotional support’, with the youngest age group scoring the lowest. This younger group were also less likely to have cared for a dependent relative. It seems likely that experiences relating to emotional support are gained throughout life which is why younger staff reported that this is less of a priority. As there were no effects of NVQ 2 or years of experience as a care assistant, it appears that personal experiences are more relevant to younger staff than formal work and training. However these differences were only found on that subscale, suggesting there are also many similarities between the age groups.

The staff types (permanent, bank or agency), was associated with empathy and surface acting. Agency staff scored highest on empathy, followed by bank and then permanent staff. This also follows the pattern of distribution of EAL staff, which are represented most highly in agency staff. Agency staff scored highest on surface acting, followed by permanent and then bank staff. It is not clear why this would be.

There was an effect of care home on ‘Surface Acting’, Variety & Intensity’ and ‘Factor 1: prioritising emotional support’ that was near significance. The care home worked in and therefore organisational factors would appear to impact on both emotional labour and emotional support. In particular, ‘Factor 1: prioritising emotional support’ could also relate to the ‘feeling rules’ at a given care home, whereby emotional work is either encouraged or suppressed by the care home.
Conclusion

Figure 9.2: Model of Statistical Associations Between the Empathy, Emotional Labour and Emotional Support Scales and Subscales, and Staff Characteristics

Figure 9.2 highlights the main statistical findings from this analysis. The model shows all of the significant associations and also the near significant associations which were further supported by an overall trend in the findings. Specifically, ‘deep acting & frequency’ showed an overall trend of near significant positive associations with both emotional support and factor 2 (knowledge). The variable ‘cared for a dependent relative’ showed near significant positive associations with four scales as well as a significant association with one (V&I). Where only one near significant association was found for a variable, this was not included as it poses a higher type 1 error risk.

Looking at the Emotional Support scales, it is clear that ‘Factor 1: prioritising emotional support’ is separate to the other emotional support scales in that tests do
discriminate between the Emotional Support scale and its two factors. Factor 1 does appear to have theoretical value, despite care assistants tending to score high on this subscale. The variable ‘cared for a dependent relative’ was only associated with ‘Factor 1: prioritising emotional support’ and not with Factor 2: knowledge of resident’. Of further interest was the possible association between the care home worked in and Factor 1. Although this was only approaching significance, it could suggest an organizational element to prioritizing emotional support. Conversely, ‘deep acting and frequency’ was only associated with ‘Factor 2: knowledge of resident’ and not ‘Factor 1: Prioritising emotional support’, suggesting that individual relationships with residents were related to staff engaging in deep acting. These findings suggest there is theoretical value in looking at the two scales separately.

The associations between the scales show that there is no statistically significant association between empathy and the emotional labour scales. It does not appear that increased empathic engagement increases levels of emotional labour. If empathy is taken to be an emotional skill, then it would appear that high levels of emotional ability do not relate to the amount or type of emotional labour undertaken in care home work. This will be further explored in Chapter 11 when the qualitative and quantitative findings will be discussed together. This finding does not provide support for empathy acting indirectly on emotional support through emotional labour. Empathy was however, positively associated with all three emotional support scales, suggesting that empathy plays an important and direct role in emotional support.

The three emotional labour scales were differently associated with a number of variables, supporting the qualitative differences between the subscales. Most striking is that of the ‘Surface Acting’ scale which is negatively associated with the Emotional Support. While ‘Variety & Intensity’ provide good associations with each of the emotional support scales, ‘Deep Acting & Frequency’ is only correlated with Emotional Support and ‘Factor 2: knowledge of resident’. The stronger and also statistically significant association with ‘Variety & Intensity’ and the Emotional Support scales suggests that non-dissonant emotional labour is more important in influencing emotional support than are the dissonant deep and surface acting.
Only five of the staff characteristics were found to have a statistically significant or near significant impact on the Empathy, Emotional Labour and Emotional Support scales. The most striking of these is the variable ‘cared for a dependent relative’, with those who have done so on average scoring higher on 5 of the scales: Empathy, ‘V&I’, ‘DA&F’, Emotional Support and ‘Factor 1: Prioritising emotional support’. This finding strongly suggests that the experience of having cared for a dependent loved one influences both the emotion work undertaken by care staff and the emotional support they provide for residents. When compared to the lack of impact of formal training (NVQ2), this is quite a striking outcome. This finding will be discussed in greater detail in Chapter 11 where both the findings from the questionnaire and interviews will be discussed.

A positive association was also found between age and ‘Factor 1: Prioritising emotional support’, with the youngest age group scoring lower than the other three groups. As already discussed there was a strong effect of having cared for a dependent relative, a life experience which older care staff were more likely to have than young. This combined with the finding that there were no effects of training or ‘years of experience as a care assistant’, it seems likely that life experiences such as caring for a relative are related to these age differences.

The positive associations between ‘being currently in education’ and ‘type of care staff’ with empathy are not easily understood. As empathy is supposed to be a relatively stable trait, it is not apparent why a care assistants’ employment status or their being a student would influence their empathy score. Furthermore, type of care staff also influenced surface acting, although not in the same order. Agency staff scored highest on both empathy and on surface acting but these findings should be treated with some caution given only 3 agency staff participated.

Ethnic background was associated with ‘Variety & Intensity’, with ‘White UK/Irish’ scoring highest followed by ‘White other’, ‘White European’ and then ‘Black-African’. This could be related to linguistic or cultural differences in how items related to variety of emotions or intense emotions were understood and responded to.
The results from the ANOVA showed that there were effects relating to which of the 8 care homes staff worked in for 'Surface Acting', 'Variety & Intensity' and 'Factor 1: Prioritising emotional support'. This suggests organizational factors may influence aspects of both emotional labour and emotional support. However these effects were not significant and there was no obvious link between homes that scored high on one variable and how they scored on another. As there were only 68 care assistants and these were spread unevenly across 8 homes however, this method was not, in retrospect, well suited to understanding differences between care homes. A higher number of participating care staff in each home would have been required to detect any effects.

Overall, despite a small sample size (n=68), there have been a number of interesting and significant or near significant findings. The statistical model in Figure 9.2 shows the relationship between empathy, emotional labour and emotional support differs from that predicted. A relatively small number of the staff characteristics predict empathy, emotional labour and emotional support, these primarily relate to personal experiences of caring and also ethnic background. However, without the interview data and qualitative analysis, the statistical model would provide little understanding of these variables and how they interact. As will be discussed in the next chapter, the qualitative analysis also brings to light some limitations of the questionnaire questions, such as residents being referred to as a homogenous group when the qualitative analysis suggests that individual care staff have very different experiences and relationships with different residents.
One of the aims of this research was to understand the relationships between empathy, emotional labour and emotional support of care assistants in a care home setting and also in a wider theoretical sense. These three constructs have been analysed both qualitatively and quantitatively, both sets of data providing different perspectives on the constructs themselves and how they relate to each other. The research has involved the integration of sociological and psychological constructs and theories in order to appreciate the emotional aspects of care work and also to ascertain how the understanding of emotion from these two discipline's relate to and compliment each other. Integration refers to a type of mixed method where the differing methods retain their own specific features but are used together to study a particular area (Moran Ellis et al. 2006). In the current integrated chapter, the findings from the qualitative and quantitative methods have been brought together after separate analysis of each and so at the end of the analytical process.

At the start of the research a theoretical model of the relationship between empathy, emotional labour and emotional support was introduced, based on the literature and an assumption that these three constructs would be associated (Figure 2.1). Quantitative analysis, however, produced a differing model (Figure 9.2). This integrated chapter will discuss each of the three main constructs; empathy, emotional labour and emotional support, before using the quantitative model of associations between the three constructs as a starting point for further exploration of the qualitative and quantitative findings. The qualitative analysis strongly supports aspects of the model but also highlights that the statistical analysis of the scales lacks both depth and social context in relation to the emotional work of care staff.
The second part of this mixed analysis chapter will explore those social factors that were found to influence empathy, emotional labour and emotional support. Those staff characteristics that were found to be statistically significant will be used to structure the discussion of the integrated findings before focusing on those social factors that only emerged in the qualitative analysis.

**Emotional Labour, Empathy and Emotional Support**

This section of the integrated analysis will discuss both the qualitative and quantitative findings for empathy, emotional labour and emotional support separately, before discussing the relationships between the three constructs in the next section.

**Empathy**

Research into empathy has previously been conducted predominantly within the discipline of psychology and also psychiatry or counselling. In the context of the present research it was the most easily defined construct, and more readily identified within the qualitative interviews.

The empathy scale used in the quantitative analysis provided an estimate of how likely care staff were to engage empathically in general, thus providing some information as to the differences between staff in their use of this emotional competency or skill. In contrast the qualitative analysis explored the use of empathy within care staff’s work with residents, revealing staff undertook several ‘types’ of empathy which they used for a range of purposes. The qualitative data also provided some insight into why care staff sometimes fail to engage empathically.

**Empathy and Staff Who Speak English as an Acquired Language**

Quantitatively, the empathy scale had been widely used and consisted of two separate subscales. Reliability analysis showed that care assistants who spoke English as an acquired language (EAL staff) did not respond to the two subscales, perspective taking and empathic concern, in the same way as care assistants who spoke English as
a 1st language (ElstL staff). The empathy scale was therefore only analysed in its complete form. It is not possible to determine if these differences in reliability related to social differences or the linguistic understanding of the items. The interview data do not, unfortunately, provide any clarification as to these differences between EAL and ElstL staff. Not all staff spoke directly about empathy, but those who did were roughly proportionally represented in the EAL group. However, ElstL staff, not surprisingly, were more articulate when relating their empathic feelings or situations in which they had responded empathically. Therefore, the ElstL interview data were richer. However, it should be made clear that linguistically, discussing emotions in this way is complex and language barriers are very likely to play a role.

Approximately half of both EAL and ElstL staff had cared for a dependent relative, which was also positively linked to empathy, so in terms of life experience there were similarities.

**Direct and Indirect Empathy**

One of the most striking findings from the interviews was the importance of both direct and indirect empathy. Direct empathy occurred when the care assistants put themselves in the position of the resident, and indirect empathy occurred when the care assistant thought how they would like the resident to be treated if the resident were a family member or loved one. The Empathy Scale did not differentiate between direct and indirect empathy, but only related to direct empathy. However, analysis of the 2 items from the emotional support scale that specifically related to direct and indirect empathy when working with residents were both strongly correlated with the full empathy scale. This supports the qualitative assertion that indirect empathy is indeed an aspect of empathy and is not better placed within another construct. Indirect empathy fulfils many of the same goals as direct empathy, that is engaging emotionally with the resident and using this emotional guidance to respond in the most appropriate way to support the resident. Both the quantitative and qualitative findings suggests that indirect empathy is widely used and an important emotional tool for care assistants.
Qualitative analysis further determined that care staff did not describe using indirect empathy when caring for an individual resident (although they did report that they did this), but rather they tended to talk about residents in general and their own thoughts of how they felt residents should be treated, often stemming from their own experiences with loved ones. In contrast, direct empathy was more varied and included both references to individuals and groups, and to specific and general situations. It would appear that care staff do frequently use direct empathy as a way of understanding situations and responding to them, particularly those involving personal care. This will be described in more detail when considering the relationship between empathy and emotional labour, as empathy is one of the tools used to understand, often emotionally challenging situations. The interviews did not specifically refer to empathy and so it is difficult to gauge the extent to which the analysis reflects how care staff use empathy on an every-day basis. However, it is clear that indirect empathy relates to experiences with loved ones and this helps to shape the care assistant’s ‘philosophy of care’, that is, how they understand what their role is and how they provide care. Analysis of the interview data relating to emotional labour highlighted the difficult decisions care staff made when conflicts arose between what the care staff felt needed to be done, and what the resident wanted to do. For example, a resident who had been incontinent, but did not wish to get changed. It is likely that in these types of situations, care staff engage in indirect empathy to try and decide what is best for the resident and how to approach them. By thinking of how they would want a loved one to be treated, care staff still respond to the resident on an emotional level when they may find it very difficult to understand the resident’s perspective. However, although care staff suggested in general terms that they did this, no specific examples were given.

The empathy scale referred to empathic responses in general terms and not relating to specific situations or individuals. The interviews revealed that at times care staff are either unwilling or unable to engage empathically with residents. This was often as a response to negative behaviour or responses from the resident and most commonly associated with residents with dementia. For example staff could be unwilling to
empathise with a critical resident or unable to understand the root cause of upset for a resident with dementia or communication problems. Therefore, by combining a psychological and sociological perspective, individual care staff do differ in their general empathy, but even the most empathic person can struggle to engage empathically in some of the situations they experience with residents.

**Emotional Labour**

Emotional Labour is a sociological construct first described by Arlie Hochschild (1983). She described separate forms of emotional labour relating to when felt emotions conflicted with what it socially appropriate to display (dissonant emotions). According to Hochschild, in surface acting, the worker maintains the conflicting emotion and alters their emotional display, such as when a care assistant is disgusted by incontinence, but covers this up for the resident. In deep acting, the worker alters their emotions to bring them in line with the socially appropriate emotional display such as when a care assistant is finding a resident difficult, they may try and think about the situation from the resident’s perspective in order to feel more positively about them. These concepts are both relevant in a care home environment. More recently, psychologists Brotheridge and Lee (2003) argued that not all emotional labour related to conflicts between felt emotions, but that emotions that are in line with what is deemed socially appropriate must also be managed in order to get the best response from another person. For example, in a care home, it is appropriate to feel upset when a resident is ill or in distress, but it may not be appropriate to fully display these emotions, but rather use them to comfort the resident. They created an Emotional Labour scale that included ‘frequency’, ‘intensity’ and ‘variety’ of emotional display, as well as ‘surface’ and ‘deep acting’. They found that surface acting was strongly associated with loss of job satisfaction and burnout, whereas deep acting was related to personal accomplishment and identifying with one’s role. These studies related to customer service type jobs, such as sales assistants.

Analysis of the Emotional Labour scale completed by care assistants showed that Brotheridge and Lee’s subscales were valid, although ‘Variety’ and ‘Intensity’ as well
as 'Deep Acting' and 'Frequency' were combined into 2 scales in factor analysis, instead of the original 4 separate scales. However the qualitative analysis was conducted using an interpretative approach, and while the concepts of empathy, emotional labour and emotional support were used as a basis for coding, the perspective of the care assistants was the main focus, especially how they understand their working lives and emotions within them. The care staff did not understand or talk about emotional labour in a way that these different subscales of emotional labour (ie SA, DA&F, V&I) could readily be determined, although it was generally possible to distinguish dissonant from non-dissonant emotions. Rather, their understanding of the emotional work they undertook with residents was separated into common situations requiring emotional labour and types of residents who required varying levels of emotional labour. Together these could be conceptualised as emotional challenges for care staff. While the challenging situations were varied in term of the type of emotional labour undertaken, responding to 'challenging' residents who were perceived as rude, racist, demanding or aggressive, was primarily focused on dissonant emotions, requiring the staff to engage in surface of deep acting.

Particularly in relation to those situations that staff found challenging, including aspects of personal care and responding to distress or confusion of a resident, further distinctions were made. The ease of understanding of the situations involving residents, whether they felt the correct response was ambiguous, and the emotional outcome for the resident and care assistant were all important to care staff. When trying to provide emotional support for residents involved in difficult situations, care staff first needed to understand the situation, for example knowing what had just happened, what the resident's perspective was, what the resident wanted or was trying to do. This particular aspect is likely to relate to how well staff know residents as well as how 'predictable' a resident is and how well the staff member and resident can communicate with one another. Some situations were particularly complex and so difficult to understand, especially when communication was difficult. Care staff's understanding guided their response, however, sometimes the 'correct' response was found to be ambiguous.
Sometimes care staff found that they understood a situation, such as a distressed resident looking for their deceased loved one, but did not know how best to respond in order to calm and support the resident. Care staff did think about how distressing it would be to be in the position of the resident, as emerged from the empathy analysis. In terms of emotional labour, not being confident in how best to respond was a concern for care staff and added to their emotional labour. In contrast, the emotional support scales relate to the type of emotional labour undertaken, but lack context. Therefore the quantitative analysis does not reveal that care staff must work with their emotions in ambiguous situations, but shop workers are less likely to, or that this uncertainty could relate to stress or burnout more than which type of ‘acting’ staff undertake.

Following care staff’s response, which involved emotional labour, either using dissonant or non-dissonant emotions, the outcome of their emotional labour was of high importance. Usually the outcome for the care staff related to the outcome for the resident, that is if the resident was distressed or angry, the care staff also felt negatively about the outcome. The outcome is conceptually complex as it involves the emotional support of the resident, how the staff felt about the situation and how they had responded, how the staff felt about the resident and also the effect of any support from colleagues and senior staff. All of these issues are discussed within this chapter. However, in terms of emotional labour, negative outcomes for the care staff meant staff had to work to control or cover these negative emotions. Repeated negative outcomes, where care staff received no ‘emotional reward’ could leave staff feeling drained or exhausted and doubting their ability as a care assistant or the usefulness of their role. In contrast, positive outcomes where a resident was comforted or was thankful for the help they received acted as an ‘emotional reward’. Care staff may have worked hard with their emotions, but the positive effect of this hard work was apparent. Care staff gained job satisfaction from these positive outcomes. Therefore the qualitative analysis has revealed that it is not just the type or ‘amount’ of emotional labour that is important to staff and impacts on their wellbeing,
but whether this emotional labour results in positive or negative feedback for the staff member.

Although the interpretative analysis did not focus on the different ‘types’ of emotional labour as outlined in the quantitative subscales, some general findings regarding these concepts did emerge. Surface acting could at times be identified, especially regarding dealing with incontinence and also when a staff member was irritated or frustrated with a resident (challenging residents). Deep acting was far more complex as care staff did not talk about the stages they went through to manage their emotions. Many references were made about suppressing or dampening emotions, particularly ‘remaining calm’. Suppression of emotion is in general terms one aspect of deep acting, but when referring to ‘remaining calm’ it was not clear how this was achieved. Staff may well talk themselves into feeling calmer, they may just manage to cover it up (surface acting), they may generally be relaxed people who rarely feel stressed or they may have become emotionally disengaged. In relation to negative behaviour such as rudeness or aggression by residents there were some examples of care staff either ‘ignoring’ the behaviour of the resident, trying to ‘block it out’ or arguing that the resident did not know what they were doing due to dementia. All of these methods are used by care staff to emotionally protect themselves and to be able to cope with the difficult situation. However, it is not clear how ‘blocking out’ a resident fits into deep or surface acting as it refers more to trying to disengage emotions rather than alter or cover them.

While different types of positive and negative emotions could be identified, specific labelling of the variety and intensity of emotions was not viable. What was more relevant were identifying those situations termed ‘emotional challenges’ that tended to involve high levels of emotional labour. What became evident during analysis was that careful coding of different aspects of emotional labour was, with a certain amount of assumption, technically possible but it would have required a very different approach. It was not however, theoretically advantageous as it did not represent the understanding of the care staff. Not knowing how to best respond or having their
emotional labour effectively rejected was of greater import than what type of 
emotional labour they were engaging in. It was also very evident that a great deal of 
emotional labour was not directly related to the residents but to other staff, stress of 
time and personal worries or concerns. Many staff immediately spoke about other 
care assistants and not residents when asked what were the more difficult or negative 
aspects of their job. Emotional labour relating to other staff is discussed later in this 
section within ‘Feeling Rules’.

The analyses of the emotional labour data provide an excellent example of qualitative 
and quantitative methods, both contributing some unique aspects to the understanding 
of a construct. The quantitative analysis supports the validity of the different aspects 
of emotional labour as determined by Hochschild (1983) and then expanded by 
Brotheridge and Lee (2003). Not only did the quantitative analysis identify these 
subscales, but, as will be later discussed, it also distinguished between them, 
especially providing insight into surface acting and also highlighting some differences 
between EAL and ElstL staff. However, the qualitative analysis suggests that unless 
prompted to do so, care staff do not think about or talk about their emotions in terms 
of these constructs. It could be suggested that the care staff had been partly primed, 
given they had all completed the questionnaire with the emotional labour items prior 
to the interview, but even so they rarely incorporated these emotional constructs into 
their interviews. In determining how care staff understand their own working lives, 
these quantitative constructs are less useful than the themes that were determined by 
the qualitative analysis, which include the care staff’s understanding of a situation and 
also the outcome. Therefore in future analysis an emotional labour scale reflecting 
how often staff feel they deal with complex situations, how often they find the 
‘correct’ response ambiguous and how often the outcome is positive or negative, 
could better reflect care staff’s emotional labour. This could be of value to compare 
between homes, for example those homes that specialise in caring for people with 
dementia and those that do not.
Emotional Labour and Staff Who Speak English as an Acquired Language

The Emotional Labour scale had been designed for English speakers. As previously discussed, factor analysis of the scale resulted in very similar subscales to those outlined by Brotheridge and Lee (2003), but unfortunately there was not a large enough sample of staff who spoke English as an acquired language (EAL staff) to see if this was the same for the EAL staff as a separate group. EAL and E1stL staff varied in both the reliability of ‘Variety & Intensity’ and ‘Deep Acting & Frequency’, and their overall responses to them. There were no significant differences in Surface Acting. EAL staff showed greater reliability on the V&I scale, but tended to score lower on it than E1stL staff. This was supported by a significant effect of ethnic background, with ‘White UK/Irish’ scoring the highest on V&I. The reliability of the DA&F scale for EAL staff was very poor suggesting either social or linguistic differences for these items. These items were the longest and probably the most linguistically difficult on the scale so language difficulties are likely.

In contrast, no obvious differences in the ‘variety’ of emotions felt by EAL staff or in the ‘intensity’ of felt emotions were apparent from the interview data. Overseas and UK care staff tended to find the same types of situations challenging and all felt a range of positive and negative emotions in relation to their work. Both EAL and E1stL staff referred to remaining calm with residents. The qualitative analysis revealed some differences in the emotional labour undertaken by overseas staff in comparison to UK staff that would not be detected in the questionnaires. Firstly, overseas staff were quite likely to have racial abuse directed at them from some of the residents and secondly the added burden of communication problems due to language barriers.

Some of these residents were in general rude to all staff, but used racist comments to be rude to overseas staff. Other residents specifically targeted overseas staff, especially black staff. Many overseas staff accepted this racism as part of their job and did not respond to it. Others found it more difficult to deal with and could at times be upset or offended. Only in one case did senior staff or management speak to
a resident to tell them that racist comments were unacceptable. In 2 homes the staff made sure that overseas care assistants did not work with particular racist residents, thus acknowledging the problem and avoiding conflict. No overseas staff felt that the other care assistants were racist though and some had been very pleasantly surprised by the warm welcome they had received in the care homes.

Communication was another area in which overseas staff often had to work harder. Especially when they were relatively new to the UK, their linguistic skills, pronunciation and understanding of spoken English was not advanced, and they did not know the words for some areas relating specifically to care. Most learnt quickly and their language skills dramatically improved in the first few months. The added task of improving language skills as well as navigating the cultural differences added to their cognitive and emotional labour as they simply had to work harder than new UK staff. Care homes varied in how they addressed this, some did not at all, leaving UK care assistants to train the overseas staff on the job and this added to the stress for both overseas and UK staff. Other homes had a very thorough introduction for new overseas staff, provided accommodation and some meals, showed them the local area and shops and made allowances for the extra learning they had to do. These new overseas staff felt valued and welcomed to the homes and as a result were more likely to stay for several years or longer.

The interviews with some care assistants who spoke English as an acquired language were difficult due to the language barrier. As an interviewer I found the high levels of concentration in order to fully follow what some care assistants were saying, and also rephrasing questions, to be quite demanding. It is likely that this reflects how EAL and E1stL staff can feel communicating with each other, and it also gave some insight into the extra cognitive and also emotional labour required by EAL staff to constantly communicate in a second language. Furthermore, this also reflects how difficult it must sometimes be for residents to understand some EAL staff and the effort of EAL staff to be understood. However it was not as simple as vocabulary and grammar, some care staff were better at communicating altogether, with voice expressiveness
and body language being as important as the spoken words. When recruiting participants to complete the questionnaires and then to take part in the interviews, it is clear that the care assistants were a self-selecting group, thus creating a positive bias in my sample, in terms of how confident staff felt at participating in an interview conducted in English. Having had contact with and spoken to more care staff than I interviewed, there were indicators that those with poorer English language skills, or those lacking confidence in their skills did not participate. The language barrier did impact on both the completion of the questionnaire and also the participation in interviews. While this is not an unexpected finding, it does suggest that some overseas staff are likely to have less or different understanding in relation to training materials which are heavily based on reading English and also British culture, an issue which will be explored in Chapter 11.

Feeling Rules

Another aspect of Hochschild’s (1983) emotional labour, was the concept of ‘feeling rules’, which she described as socially appropriate ways of acting and expressing oneself. Pam Smith (1992) in her ethnographic study of student nurses, found that feeling rules could vary greatly between wards in a hospital and also between shifts. Emotional work was recognised to a greater or lesser extent by staff, who also varied in how emotionally supportive they were of each other. Smith argued that the emotional rules on wards were influenced by the role of the ward, for example oncology wards being more ‘emotionally focused’ than general wards, but also by the ward leadership and a range of organisational factors. In the current research it was possible to identify differences in feeling rules from the perspective of the care staff.

The interview analysis highlighted the differences between the emotional support shown to residents by care staff and that given to other staff, indicating a difference in the ‘feeling rules’ for the two groups. It was possible for staff to be very emotionally aware of the needs of the residents, while being critical and unsupportive of other staff. The feeling rules between staff are discussed here, and those related to the residents within the following ‘emotional support’ section.
The most prominent social factor affecting staff 'feeling rules' appeared to be teamwork. How staff worked together as a team was primarily influenced by how they were physically arranged in the home and how many staff were on duty, but also by how staff interacted. Staff perceived as lazy, giving poorer care, having different working styles and communicating in an 'unpleasant' manner, were barriers to good teamwork. In terms of the feeling rules, in 'effective' teams, staff felt they could ask for help, would not be left to cope with difficult situations alone, could admit to making mistakes and could overall express their emotions and needs in relation to challenging situations. In 'ineffective' teams, staff did not feel able or were unwilling to ask for help, tended to try and manage situations alone, and did not express problems to other staff. In the latter environments, the staff were not emotionally supported themselves. While it was not possible to accurately compare between homes based on the interview data, it did appear that teamwork was most effective in homes 3, 4 and 5 and least effective in homes 1 and 2. Homes 1 and 2 were EMI homes, therefore their emotional workload was high and it was more difficult to organise the 'group living' environment of the residents. The research suggests that in homes where the workload is particularly high and there are a great number of emotional challenges relating to dementia, the staff were least effective at working together and supporting one another.

A second organisational factor relating to the feeling rules was the nature of support by senior staff and management. Support from senior staff involved help and advice with difficult situations relating to the residents and also support or action following negative incidents. Similarly to teamwork, if care assistants felt senior staff would help them if they were having difficulties with residents, staff did not feel they had to struggle alone. Support following incidents such as racism of aggression from residents served two purposes. Firstly, to emotionally support the care staff and to try to reduce their negative emotions such as guilt. Secondly, the seriousness with which these incidents were treated reflected the extent to which the welfare of the care staff was thought by management to be important. Staff who were supported when working with 'challenging' residents, or following a difficult situation tended to feel
less negatively about the situation as a whole and therefore less negatively about the resident and how they might be able to respond in a similar situation in the future. Not only did this improve the emotional wellbeing of the staff, but also the emotional support they provided to the resident.

This section on feeling rules has predominantly focused on the emotional support and welfare of the staff. However, the emotional tone set in terms of how the staff work together and how their emotional needs are met, directly impacts on the emotional labour they undertake. Staff undertaking higher levels of emotional labour to cope with negative unsupportive feeling rules are likely to have less 'emotional energy' when caring for residents. If staff feel they will not be supported when dealing with 'challenging' residents, this could impact on how they approach and care for those residents.

The questionnaire did not include how staff worked as a team and the extent of perceived support from senior staff. Therefore, only qualitative data were available, as well as the data on each care homes about staffing levels and mixes. However, it was clear from the interviews that it was not just the staffing levels, but how staff worked together and assumptions they made about one another, such as staff being 'lazy' or having 'different working styles', that influenced teamwork.

**Emotional Support**

Emotional Support of the residents is a broad term, which for the purpose of this research has been divided into 'day to day' support and support during times of stress. The emotional support of residents with dementia has also been highlighted as the needs of those with dementia can differ to those of other residents. As with empathy and emotional labour, the emotional support scale was relatively discreet and easily defined. The factor analysis of the scale revealed two subscales, 'prioritising emotional support' and 'knowledge of and relationship with the resident'. Care literature highlights the need for care staff to know the residents, their backgrounds, care needs, likes and dislikes, in order to provide individualised care for each resident.
The current trend towards 'person centred care' would also strongly advocate this position. How care staff understand their role and the emphasis they place on emotional support is less well identified in the literature. In general terms, care staff being 'task focused' would presumably be the opposite to prioritising emotional support. These scales give a good insight into two important aspects of emotional support. The fact that these two separate factors have emerged suggests it is possible for a care assistant to give emotional support a high priority, but not know the residents very well. This would apply particularly to new staff or part-time staff and therefore has an impact on homes with a high staff turnover. It is also possible for care staff to know the residents well, but not choose to, or not be able to prioritise emotional support. However, some caution regarding the two subscales is also needed given that Factor 1 (prioritising) is made up of positively coded items and Factor 2 (knowledge) of negatively coded items. This may suggest an effect of language and wording of the items. Further testing with the wording of some items being changed would be useful to better understand these subscales. The qualitative differences between the two subscales will be further discussed in relation to the impact of other variables on emotional support.

The emergence of emotional support from the interview data is far more complex. It was not possible to separate emotional labour and to a lesser extent empathy from the emotional support provided by care assistants. As the analysis has been conducted from the perspective of care staff, their own understanding of situations and how they dealt with them, could not be disentangled from the assumed emotional impact this had on the residents. Often there was not enough information to reliably discern how a resident responded and if this was a good response or poor in relation to the resident's usual state. Emotional support of residents also assumes that good emotional support, a result of emotional labour and skills, results in a positive outcome for the resident. This is not always the case. It was clear from the interviews that at times, care staff put in a great deal of emotional labour with some residents and in some types of situation, but the resident still remained distressed or angry. Where the outcome was not positive, is that to say the resident was not well supported?
positive outcome is sometimes the result of good emotional support, but not the only outcome. The emotional support of residents has therefore remained embedded within the emotional labour analysis.

Validation of the emotional support scale and the two subscales involved comparing scores on the scales to ratings of emotional support given to each interview (see Appendix 8). The method of triangulation relied on the assumption that if the two methods produced similar findings in relation to emotional support rating, then this would reflect positively on the validity of the Emotional Support scale (Campbell & Fiske, 1956, cited in Moran-Ellis et al. 2006). This analysis revealed that there was a significant association between the interview ratings and the full emotional support scale and also the ‘Knowledge of Resident’ subscale. There was no association with ‘Prioritising Emotional Support’. Only specific examples of providing emotional support to residents were rated, and the knowledge staff had of the resident they were describing was quite evident within these examples. In comparison, prioritising emotional support is an aspect of care assistant’s ‘philosophy of care’ and this was talked about in more general terms and was not therefore rated. In qualitative analysis, the feeling rules regarding residents were closely liked to emotional support, particularly ‘prioritising emotional support’.

**Emotional Support and Feeling Rules**

Staff differed in how they perceived their role as a care assistant and so the emotional work that they expected to undertake with residents. This is complicated however by the needs of the residents and the individual approaches of staff. In each home there were some staff who were very emotionally engaged with residents. The general feeling rules of each staff member could not be directly, accurately measured, but rather the emotional labour scale, the emotional support scale and the interviews all provided insights.

Probably the closest scale in relation to ‘feeling rules’, is the ‘prioritising emotional support’ subscale as this indicates how important emotional aspects of caring for
residents are for staff. This scale emerged after factor analysis and so lends credibility to the concept of feeling rules. The interview data also provided strong evidence as to the differences in the social rules of individual staff members, what they deemed appropriate and how they understood their work. For example, some felt they should never show a resident they were annoyed, whereas others felt that a normal part of any meaningful relationship was to respond emotionally to both positive and negative behaviour.

The quantitative data showed differences between care staff in those subscales relating to 'feeling rules' and also differences between homes. One limitation of the scales however was that they referred to residents as one homogenous group, therefore assuming staff responses to all residents were the same, or forcing staff to think of particular residents when completing the questionnaire. The interviews however suggest that the emotional response of care staff to, and the emotional support of residents varies, sometimes greatly, between residents. It was clear that some residents were favoured by some staff or that staff had built up better relationships with some than others. Sometimes this was due to the home's organisation, such as key worker schemes of the tendency for staff to work on the same units, but it was also strongly related to perceived characteristics of the residents themselves.


The Relationship Between Empathy and Emotional Labour

Empathy in this study has been taken to mean the emotional act of placing oneself in another’s position, and has not included the behavioural response to these feelings. It was therefore predicted that the behavioural response to empathy would either directly impact on emotional support or would be mediated by emotional labour (see model of emotional support, Figure 2.1). That is, those who were more likely to engage empathically would use emotional labour as a way to respond to their empathy and so also tend to report higher levels of emotional labour. This was not found to be the case in the quantitative analysis. As shown in Figure 10.1 there was no significant statistical association between empathy and emotional labour. Both were associated with emotional support however, and both were associated with ‘Having cared for a dependent relative’ and ‘type of care staff (permanent, agency etc)’. This suggests that there is some benefit to understanding the contribution of both of these constructs.
in relation to emotion work and emotional support. This assertion is supported by the qualitative analysis.

Analysis of the interviews has highlighted that most care staff have their own 'philosophy of care'. Indirect empathy, that is care staff thinking of how they would like a loved one to be treated if they were a resident, was an important aspect of forming this philosophy of care. In simple terms, care staff each have an understanding of their role as a care assistant and the extent to which this involves the emotional support of residents and the feeling rules as to which emotions are appropriate to display to residents. This philosophy of care is one of the factors that guides the emotions they feel at work and how they manage these emotions when working with residents. Therefore, while empathy is involved in the formation of this philosophy of care, emotional labour is used to implement it in the workplace. However, this is not a simple association, there are many factors that influence the care that staff provide on a given day, not just their philosophy of care, and there are more determinants of emotional labour than just those that involve trying to follow a given philosophy of care.

Empathy could also be seen as an aspect of emotional labour, one of many tools used to manage emotions. By actively attempting to understand the perspective of the resident and by trying to emotionally engage with that resident, care staff can gauge what the most appropriate emotional response may be. For example, care staff may be working with a resident who is very critical. By thinking of how they might feel if they were unable to do small things for themselves, care staff can use this understanding to manage their own emotions and prevent them becoming annoyed. In this way, empathy could be one part of emotional labour, specifically related to deep acting. However, empathic engagement is not the only way in which care staff manage their emotions, they may remain calm when a resident is being very critical because they have learnt from experience that the resident will be much more positive once they have finished. The qualitative analysis highlights that there are links
between empathy and emotional labour, but these are not straightforward as there are many factors that impact on emotional labour.

**The Relationships Between Emotional Support, Empathy and Emotional Labour**

The statistical relationship between the Empathy scale and the Emotional Support scale was straightforward and statistically significant. Empathy was directly associated with emotional support, and the two subscales. In general, care staff who reported higher levels of empathic engagement also reported a greater level of emotional support. The qualitative analysis showed that direct empathy was particularly relevant during personal care, where care staff thought about how they might feel if they had to receive intimate care. This directly impacted on the care they provided with staff explicitly stating that they try to treat residents as they would like to be treated. Indirect empathy related to their philosophy of care which encompasses the priority they give to emotional support. Empathy and 'knowledge of and relationship with' the residents are likely to have a reciprocal association as empathy is important in getting to know someone and also building a relationship with them, but also it is easier to empathise with people we know and we have positive feelings towards. There was also some quantitative evidence from comparison of scores on the direct and indirect empathy items from the Emotional Support scale with the Empathy scale, that indirect empathy is statistically associated with the more traditional form of direct empathy, and is also widely used by care staff.

The relationship between emotional labour and emotional support was more complex. The three emotional labour subscales were differently associated with the emotional support scale and subscales. Therefore 'Surface Acting', 'Variety & Intensity' and 'Deep Acting & Frequency' will be discussed separately.

**Surface Acting**

Firstly, Surface Acting was not significantly associated with Emotional Support or the subscales. However, although none of the findings were significant, they were all negative. The higher care staff scored on 'Surface Acting', the lower they scored on
the Emotional Support scale. Although it should be treated with caution, this trend supports previous findings by Brotheridge and Lee (2003) that ‘Surface Acting’ is negatively associated with some outcomes, particularly job satisfaction. A larger sample may have given a statistically significant result and would be useful to explore in the future. The surface acting item on the emotional support scale (I feel irritated at times by some residents but I cover my feelings) was significantly associated with the surface acting subscale (but was found to lack reliability in the emotional support scale and was removed). This item highlights that part of the difficulty with analysing surface acting is that it involves two separate stages. Firstly the care assistant must feel a negative emotion, such as irritation, and secondly they must respond to this emotion by covering it up. The qualitative analysis shed more light on both of these stages.

Most care staff reported that they quite often felt negative emotions, particularly disgust in relation to body fluids, irritation, frustration, or upset in relation to residents. Some did not seem to feel these negative emotions as often as others, either they weren’t bothered by body fluids (usually more experienced staff) or they did not tend to feel annoyed. These care staff engaged less frequently in surface acting as they had less need to. The second aspect, of covering the emotions was most easily determined in relation to bodily fluids. It is clear that if the care staff had shared their true emotions to the residents, they could well have caused the resident distress, therefore surface acting did increase emotional support. However, it was clear from examples involving bodily fluids that those people who felt disgusted tended not to focus on the resident’s emotions to the same extent as those who did not. The energy required to maintain the surface acting associated with disgust meant that they had less emotional energy for thinking about the resident’s emotions. In this way, surface acting appears to provide only the bare minimum of emotional support for residents. Care staff who more frequently engage in surface acting are therefore less likely to provide ‘good’ emotional support, more likely ‘adequate’ emotional support.
Variety and Intensity

The ‘V&I’ scale was positively associated with the emotional support scale and its’ two subscales. All these associations were statistically significant. Those care staff who reported feeling a wide range of emotions while at work and also feeling some intense emotions, also reported providing a higher level of emotional support. The interview data do not distinguish variety and intensity as specific constructs, but instead recognises the emotional challenges of care work. However, some care staff did appear to be more emotionally engaged in their work, whereas others either focused less on their own and the resident’s emotions or purposely disengaged from the emotional aspects of their work. It makes sense that those people who experience more emotion in relation to the residents are more likely to provide better emotional support. An important qualitative finding was the emotional impact on those staff members who set themselves high standards in care, including emotional support, and who had built up meaningful relationships with residents. These staff appeared to experience strong positive and negative emotions. For example, a care staff member who saw an improvement in the health of a resident they knew well would feel happy and satisfied as a result. However, when these residents became very ill, left the home or passed away, the staff member would be more distressed than when they did not know the residents so well. This was particularly striking in the homes where residents had a lower level of need and so the turnover of residents was lower. The staff had in some cases known the residents for many years. It was clear from the interviews that the positive impact of the emotional engagement with residents was an increase in emotional support and also job satisfaction for staff. There was an emotional price for the care staff however as they were left open to feeling helpless and distressed when residents were in distress or passed away. It is understandable therefore that some care staff are less emotional than others and less emotionally engaged as they wish to protect themselves from these negative experiences.

Deep Acting and Frequency

The DA&F scale was positively associated with the emotional support scale and also the ‘knowledge of and relationship with the resident’ subscale. These were near
significant associations. It was not associated with the ‘prioritising emotional support’ subscale. This highlights that there are distinct differences, not only between the Emotional Labour scales, but also the Emotional Support scales. Unlike ‘Surface Acting’, ‘Deep Acting’ appears to be a more positive form of dissonant emotion management that results in better emotional support for the residents. It also makes theoretical sense that if care staff know a resident well and have a meaningful relationship with them, they will be more able to manipulate their own emotions in order to try and feel what they need to display for the resident. Care staff can use their knowledge of a resident to empathise with them and also to form tactics that will enable them to perform their care tasks more smoothly. This relates to care staff understanding situations and knowing how to respond to them. If the care staff know the resident they will be better able to understand situations and adjust their emotions so they can give the most appropriate emotional response.

Empathy, Emotional Labour and Emotional Support Summary
In conclusion, this section has discussed the qualitative and quantitative findings relating to empathy, emotional labour and emotional support as well as the associations between the three constructs. In a number of important respects, the Empathy and Emotional Labour scales used in the statistical analysis represent the current research literature relating to these constructs. Therefore this integrated section has highlighted how the qualitative research which focused on the perspective of care assistants has added to the current understanding of empathy and emotional labour and two important findings have emerged. Firstly, the use of indirect empathy as well as, the more traditionally understood, direct empathy in everyday care work with residents. Secondly, care staff did not understand their emotion work in terms of the ‘types of emotional labour measured in the scales. Instead the context of the emotional labour they undertook, including how ambiguous the correct response was and the outcome of their emotion work, were more important to care staff’s wellbeing.

Both the qualitative and quantitative findings have highlighted the important role of empathy in the provision of emotional support for residents. However the qualitative
findings suggested no indirect influence of empathy through emotional labour, in contrast to the qualitative findings that suggest empathy can motivate staff to undertake emotional labour or can be viewed as a form of emotional labour in itself. This reflects the lack of context of these two scales and also the complexity of the emotional labour care staff undertake.

**The Social Factors that Impact on Empathy, Emotional Labour and Emotional Support**

This research aimed to understand those social factors that related to care homes and their staff which influenced the emotion work of care staff and the emotional support they provide for the residents. This section will address the staff characteristics and organisational factors, that influenced empathy, emotional labour and emotional support. The statistical findings are based on the Empathy, Emotional Labour and Emotional Support scales as well as the demographic information relating to each staff member. As has previously been discussed in this chapter, the empathy and emotional labour scales lack context in relation to working in a care home, in contrast to the interview analysis which is contextually rich but is not readily comparable between care staff. This analysis of social factors, not only highlights some important findings using each method, but also reveals the strengths and weakness of each when exploring differences between staff and between care homes.
Statistical analysis revealed that three variables were associated with the Empathy scale. Firstly, those still in education scored significantly higher than those who were not. Secondly, those who had cared for a dependent relative scored higher than those who had not. Lastly, the type of care staff was significantly associated with empathy scores with agency staff scoring highest, then bank staff and permanent staff scoring the lowest. It is not clear why those in education should have scored higher, except that possibly they were more likely to be working as care assistants as a particular choice, especially if they were training in a health care area. It is also not clear why the type of staff should impact on empathy and why in this particular order. It is possible that as more people who were in education were also bank or agency staff, these staff characteristics are associated, but the sample size is too small to distinguish the influence of each. However, due to the low numbers of participants in some groups (such as only 3 agency staff), these findings should be treated with some caution. The interview analysis did not highlight any differences in empathy between the different types of care staff. A few part-time care workers referred to having more energy or being more fresh for shifts than permanent staff, but this does not specifically relate to empathy.
The most consistent findings relate to the care staff who had cared for a dependent relative. Qualitative analysis also showed this to be an important factor. Having cared for a dependent relative impacted on the indirect empathy of care staff. These staff were more likely to relate their own experiences to those of the residents. Instead of placing themselves directly in the position of the resident, they thought about how they would want the residents to be treated if the residents were their loved one. Their experiences of the good and poor care received by their own loved one helped influenced their understanding of their role as a care assistant. These personal experiences were used to form their ‘philosophy of care’.

![Diagram](image)

**Figure 11.3: The statistical associations between Emotional Labour and staff characteristics**

The Emotional Labour scales were associated with two of the same variables as the Empathy scale. Again the type of care staff was a significant variable with agency staff scoring highest on surface acting, followed by permanent staff and then bank
staff. It is not apparent why agency staff who scored highest on empathy, would also score highest on surface acting. Surface acting may well be used more by staff who did not know the residents very well, which could include agency staff. However, there were no qualitative findings relating to the staff type and surface acting.

As previously discussed in the 'Emotional Labour' section of this chapter, those staff who spoke English as an acquired language scored higher on V&I than those who spoke English as a first language.

Once again the variable ‘cared for a dependent relative’ was an important factor. Those who had cared for a dependent relative scored higher in both V&I and DA&F. These staff reported feeling and expressing a range of emotions and also intense emotions and also more frequently engaging in deep acting. As will be discussed later, having cared for a dependent relative relates to a wider philosophy of care and may also have motivated staff to work as care assistants. As can be seen from Figure 10.4 below, those who had cared for a dependent relative also scored higher on the emotional support scale and the subscale ‘prioritising emotional support’.

![Diagram showing Emotional Support, Prioritising Em Support (Factor 1), Knowledge of Resident (Factor 2), and Age. The 'Cared For Dependent Relative' node points to 'Emotional Support' and 'Prioritising Em Support (Factor 1)'. The 'Age' node points to 'Knowledge of Resident (Factor 2).]
The staff characteristic of having cared for a dependent relative was the only variable to have a significant statistical association with each of the constructs empathy, emotional labour and emotional support and was one of only two variables to have a direct association with emotional support. Of all the statistical findings from analysis of the variables, this is the most robust and strongly suggests that caring for a dependent relative is an important predictor of the emotion work of care assistants and the emotional support they provide. This finding was also supported by the qualitative data independently of the statistical analysis, as the qualitative analysis was carried out prior to the quantitative analysis. The experience of caring for a loved one and in many cases watching that person be cared for by others, impacted on the care staff’s philosophy of care and their emotional engagement with the residents. Neither having children or knowing someone who had entered residential care were associated with empathy, emotional labour or emotional support. While staff did report in interviews that experiences of knowing a relative who entered residential care had influenced them, these staff had a significant caring role in their family member’s lives. It is possible that others that also knew a friend or family member who had entered residential care had not been so involved in their care and this is why ‘having known a friend or relative enter residential care’ was not a predictor in itself.

The life experience of having cared for a dependent relative impacted on the indirect empathy of care staff, helped them form a philosophy of care and as a result determined their own personal feeling rules as to which emotions they did or did not feel were appropriate to display. When asked about why they had started work as a care assistant, some staff with this experience had been motivated by the caring role they had undertaken to seek paid care work. This was related to their desire to help others who were in a similarly vulnerable position to their loved one and because they felt they had gained important skills in caring. The influence of this life experience is in stark contrast to the apparent lack of influence of staff training, including NVQ2. This formal training does not appear to influence the emotional aspects of care work.
Age was statistically associated with 'prioritising emotional support' with care staff in the youngest age group (18-29), scoring lower than the older age groups. This suggests that younger staff do not place as much emphasis on the emotional aspects of their work. However, this was the only statistical finding relating to age. This younger age group was the least likely to have cared for a dependent relative and had on average, worked as care assistants for fewer years. The qualitative analysis did reveal some general differences between less experienced (although not necessarily younger) and more experienced care staff. Those with less experience found coping with incontinence more difficult and also were more concerned about residents dying. Both of these issues could relate to emotional labour, but less so to prioritising emotional support. No obvious differences arose in the interviews between the different age groups regarding emotional support. There were excellent examples of care staff working hard to emotionally support residents from all age groups.

**Organisational Factors**

There were no significant statistical differences between the average scores of care assistants in each care home for any of the scales. Therefore none of the homes scored significantly higher or lower on emotional support. In some respects this is a surprising finding. However, the qualitative analysis showed that emotional labour and emotional support were complex constructs with many contributing factors.

The homes varied in the levels of dependency of the residents that lived there, notably the two EMI homes cared for more residents with dementia, and that dementia was more severe than in the other three homes. The level of need of the residents is an important contributing factor to not only emotional labour but the physical work care staff need to undertake to care for the residents. Comparing the EMI homes to the other three homes, there are some clear differences. There were fewer examples of reciprocal relationships and conversations relating to matters outside of the home in the EMI homes and staff appeared to have a heavier workload. These differences are understandable in the context of caring for people with more severe dementia. It can be more difficult to communicate with residents so meaningful relationships are
harder to build. Caring for a group of residents with dementia also tends to require more physical, as well as emotional work than caring for residents without. The qualitative analysis revealed that one of the most important organisational factors was team work. Team work was influenced by how staff were organised within a home and the staffing levels and also by how senior staff managed these teams and responded to any problems between staff. However, effective team work was heavily influenced by how staff perceived one another, for example some staff were regarded as 'lazy' or as having 'different working styles'. How staff communicated with one another when they disagreed with each other or needed help was also important, something which could also be influenced by language barriers and cultural differences. Effective teamwork within a home could be promoted by senior staff understanding the needs and strengths of their staff and encouraging staff to support each other, in part by leading by example and being supportive themselves. The influence of teamwork has been previously discussed in this chapter under 'feeling rules'.

Both the quantitative and qualitative method had weaknesses in relation to exploring the organisational influences on emotion work. The quantitative sample size was not large enough to detect subtle differences, and the structured interview with senior staff in each home did not gather data pertinent to those areas that have emerged as important, such as teamwork. While the interview analysis did reveal some important organisational aspects, it was not possible to accurately compare between each home based on these data.

Conclusion

In conclusion, this analysis has revealed the separate contributions of both the qualitative and quantitative findings. In some important aspects, such as the direct contribution of empathy, the importance of indirect empathy and the influence of having cared for a dependent relative, the two sets of data complemented and supported each other. In relation to emotional labour however, it was clear that while
the quantitative analysis supported previous findings, the constructs such as ‘Deep’
and ‘Surface Acting’ did not reflect how care staff understood their own emotion
work. How staff understood situations, if the ‘correct’ response was ambiguous and
whether the outcome was positive or negative were all important to staff in relation to
the emotion work they undertook.

This integrated analysis has also revealed weaknesses in the methodologies used. In
particular, the scales treated residents as a homogenous group and differences,
especially in reliability for EAL staff were a problem. Similarly, the depth of
response on interview questions differed between EAL and EIstL staff given that
speaking about emotions is linguistically complex. The relatively small sample size
for the questionnaires also meant that smaller effect sizes were very difficult to detect,
especially when the group sizes were uneven. Neither method provided a clear
understanding of the specific organisational differences between the homes and how
these impacted on the emotional aspects of care work. These limitations are fully
discussed in the concluding chapter.

The concluding chapter will focus on the most important findings from this research
and relate these to the previous literature, highlighting how this research has
contributed to both theoretical and more practical understanding of the emotion work
of care assistants. Implications for care home practice and policy will also be
discussed. The methodological strengths and weaknesses will also be addressed.
CHAPTER 11

CONCLUSIONS

Main Findings from Analysis

Introduction

This research aimed to explore the emotion work of care assistants, working with older people living in care homes. It has provided insight into the use of empathy and emotional labour from the perspective of care staff, and how this influences the provision of emotional support for the residents. This thesis has built on both psychological and sociological theory and research in order to investigate this complex topic. By addressing the use of empathy, a traditionally psychological construct, and emotional labour, a sociologically based construct together, the emotion work within a care homes context was explored. A mixed methodology was used, involving interpretative analysis of interviews with care staff and also self-completion questionnaires. These two sets of data were analysed separately, with the qualitative data forming the principal part of the analysis. The findings from the two sets of data were then integrated and discussed together (Chapter 10).

This research has highlighted the importance of both empathy and emotional labour in terms of both the emotional support of residents, and the wellbeing of the care staff who undertake this emotion work. The analysis has provided insight into the emotion work of care staff from their own perspective, a previously little researched area, including how they engage in different forms of empathy and also the importance of the context in which they undertake emotional labour. The findings have broadly supported the model of emotional support (Figure 2.1) proposed based on previous literature, that the emotion work of care staff was influenced by staff individual characteristics, the attributes of the residents the staff care for, and also organisational factors relating to the care home. However, this research has added to current understanding of the relevance of these social factors. In particular, this research has
added to the previous literature, by providing insights into the emotional challenges of care staff, those aspects of care work which require high levels of emotional labour.

This section will address some of the main findings relating to emotional labour, empathy, emotional support and also the social factors associated with these three constructs within the context of the previous literature. The relevance of this research to care home policy and practice will then be discussed before focusing on the methodological issues relating to this study.

*Emotional Labour*

This thesis has highlighted both the importance of emotional labour in relation to the emotional support of residents and also the wellbeing of the care staff, but also the complexity of this emotion work from the perspective of care staff. It has added to the current understanding of emotional labour by situating emotional labour within the wider emotional demands of caring for residents living in a care home.

This part of the research built on previous, mainly sociological literature relating to emotional labour. Hochschild (1983) first introduced the concept of emotional labour, in particular she argued that when staff felt dissonant emotions, that is those emotions which conflicted with what was socially appropriate to display, they undertook a form of acting in order to display acceptable emotions. Surface acting involved simply changing their outwards expression while still feeling the conflicting emotions, whereas in deep acting, staff changed their felt emotions to bring them in line with what was appropriate to display. The current findings do support the use of both deep and surface acting by care staff, many of whom quite regularly feel negative emotions which they need to cover or manage when working with residents. In particular, responding to 'rude', 'demanding' or 'aggressive' residents often involved staff managing their negative emotions through a form of acting. Coping with incontinence often required surface acting. The current findings also support the assertion that emotional labour not only involves managing dissonant emotions, but also non-dissonant emotions (those which are in line with what is appropriate to display;
Brotheridge and Lee (2003). Brotheridge and Lee constructed a model of emotional labour which included not only deep and surface acting, but also the variety of felt emotions, the intensity of felt emotions, the frequency of emotional labour and also the duration of emotional labour in the workplace. It was this model of emotional labour which formed the basis for their Emotional Labour scale which was used in this research. The quantitative analysis largely supported this model of emotional labour, but the qualitative analysis revealed it was not only the type of emotional labour that care staff undertook that was important, but rather the context in which the labour was undertaken and whether the outcome was positive or negative.

Previous findings suggested that surface acting, unlike the other forms of emotional labour, was associated with higher levels of emotional exhaustion, depersonalization and negative affectivity (Brotheridege & Lee, 2003; Goldberg & Grandey, 2007; Johnson & Spector, 2007; Martinez-Inigo et al, 2007; Naring et al, 2006), a finding that has been supported by this research. In the current research ‘Surface Acting’ was the only Emotional Labour subscale to be negatively associated with the Emotional Support scales. Although these negative associations were not significant this findings suggests surface acting does not influence emotional support or may even negatively impact on it. As with measures of job satisfaction, surface acting is associated with emotional support in a different way than the other forms of emotional labour. Naring et al (2006) in their study of teachers found that only ‘emotional consonance’, not engaging in either deep or surface acting, was related to feelings of personal accomplishment. In this research ‘emotional consonance’ has been represented quantitatively by the ‘Variety & Intensity’ subscale of the Emotional Labour scale. This subscale was the most strongly associated with Emotional Support, with a significant positive association with the full scale and the two factors. This provides some evidence that emotional labour that did not involve altering or covering emotions that were thought to be inappropriate was most strongly associated with emotional support.
In contrast, the qualitative analysis did not focus on the constructs as outlined above. While the quantitative findings suggest care staff do engage in the different types of emotional labour as outlined by Hochschild (1983) and Brotheridge and Lee (2003) the qualitative findings explored the wider context of the emotional labour undertaken by care staff, thus complementing previous finding but also adding to them. As this analysis was interpretative, that is, trying to understand the perspective of the care staff, it suggests that care staff do not understand their emotions in terms of these different ‘types’ of emotional labour. More relevant to care staff was the ‘source’ of the emotional labour which they organised into challenging situations with residents (eg. Providing personal care or responding to confusion or distress), challenging resident characteristics (eg. Demanding, rude, racist or aggressive residents), and staff and organizational issues (eg. Lazy staff). Staff responded differently depending on their perception of who or what was impacting on their emotion work. This research has provided insight into the most commonly reported challenging situations from the perspective of the care staff, which, it will be argued in the ‘policy and practice’ section is of value in order to provide care staff with support in these difficult situations.

In terms of responding to these emotional challenges, care staff varied as to how well they understood a given situation, for example knowing what had upset a resident and why. In general it was care staffs’ understanding of a situation that guided their response and so their emotional labour. Some situations were complex or unexpected and these were difficult for staff to understand. Sometimes, even when care staff understood a situation, they found the ‘correct’ response to be ambiguous. This more commonly related to caring for residents with dementia, for example a resident wanting to ‘go home’; a situation which staff understood, but did not always know how best to respond to in order to calm or comfort the resident. The complex ethics of dementia care are an important issue within the gerontological literature (e.g. Hertogh, 2003; Jones & Mieses, 2004). The current research however provides some insight into how the care staff feel about these complex problems, the high level of emotional labour that responding to residents can require and the emotional impact on
the staff themselves. How well a situation is understood or whether the 'best' response is ambiguous is not reflected within the emotional labour constructs such as deep acting and 'variety & intensity' of emotion, as they do not relate to types of emotional labour, but rather the situation in which the emotional labour is undertaken. For example, care staff feel differently about engaging in deep acting when they are confident they are responding in the correct way, than when they engage in the deep acting when they are not sure if this is the best way to respond. Therefore, the context in which emotional labour is undertaken relates to both the successful emotional support of the resident and also a positive or negative outcome for the staff.

The outcome of emotional labour for staff was related to the perceived outcome for the resident. If their emotional labour resulted in a positive perceived outcome for the resident, care staff often felt satisfaction in their work and enjoyed any positive feedback from the residents. In contrast if the outcome was negative, particularly when the staff member had engaged in a great deal of emotional labour, staff could feel upset or exhausted. Therefore job satisfaction and burnout were not only related to the type or amount of emotional labour staff undertook as found in previous studies (Goldberg & Grandey, 2007; Johnson & Spector, 2007; Martinez-Inigo et al, 2007; Naring et al, 2006; Brotheridge and Lee, 2003), but to whether their emotional labour resulted in a positive or negative outcome. Chappell and Novak (1992, 1994) argued that burnout was more commonly experienced by staff working with people with dementia. This research has demonstrated that some emotional challenges, such as responding to confusion and also aggression from residents, are more prevalent amongst residents with dementia and that ambiguous situations are also more common in relation to residents with dementia. Therefore, it can be argued that caring for residents with dementia is more likely to be associated with some of the emotional challenges staff often found most difficult and emotionally demanding. However, Cole et al. (2006) argued that it was effective support for care staff that was more important than the care needs of the residents. This finding has also been supported and will be discussed under the section on 'social factors'.
One emotional challenge which is both more prevalent in the care homes literature and which care staff expressed particularly strong emotions about, were incidents in which a resident was physically aggressive towards staff, and so this will be briefly discussed. Aggressive behaviour was more common amongst residents with dementia and is often referred to in the literature as 'challenging behaviour' (Fetherstone et al. 2004, Jones & Mieses, 2004, Marshall, 1990). In line with previous findings (Bair et al. 1999; Long-Foley et al. 2003), staff understandably found working with residents who were more frequently aggressive or whose behaviour was unpredictable to be more difficult and frequently stressful. The current research however, further revealed that care staff commonly respond to aggression by either feeling guilty, or by attributing the resident's behaviour entirely to their dementia and assuming the resident did not know what they were doing. It is perhaps surprising that care staff who have effectively been assaulted at work feel guilty about this. It is maybe less surprising that some staff focus on or 'blame' the dementia of a resident who is being aggressive as this enables care staff to continue to do their job while protecting themselves emotionally from the aggression they encounter. By understanding care staff’s emotions in relation to aggressive behaviour, care homes can better support their staff and help them to respond in a more emotionally supportive way towards residents. Staff also expressed their dismay and frustration that following incidents where they were hurt by a resident, their needs did not appear important to the care home. Whereas poor care is regarded as 'elder abuse' there is no such comparable notion of 'staff abuse' within care homes. Taken together, these findings suggest that care staff can be both physically and emotionally vulnerable in their work, a situation which is not readily acknowledged and for which little support is currently available.

The current care homes standards set out in the National Service Framework for Older People (DoH, 2001) express the importance of person-centred care for residents. To achieve this, care staff must know the residents, their history, likes and dislikes, and what is important to individual residents in order for them to maintain their identity while living in a care home. This requires care staff to build up meaningful relationships with residents. There were some excellent examples of care staff who
had good relationships with the residents they cared for, with a number of staff who had known some residents for many years. These relationships were rewarding for staff, who often enjoyed the time they spent with these residents. However, when residents were very ill, distressed or when they died, care staff with these closer relationships were vulnerable to feelings of distress. There may be a limit then to the depth of relationship care staff wish to, or are able, to develop with residents when this could potentially leave them emotionally vulnerable. There were also examples of care staff working with residents with whom they did not have a good relationships. Some of these poorer relationships related to residents whom staff perceived as being challenging, in particular rude, racist or demanding residents.

One of the major sources of emotional labour from the perspective of the care assistants, related to the negative characteristics, such as rudeness or racism, of some of the residents they cared for. This aspect of the findings bears some similarities to Campbell's (2005) study into, what she termed, resident 'attractiveness'. Campbell outlined resident features which can make them 'attractive' or 'unattractive' to care staff, including physical appearance, cognition, communication and behaviour. She argued that the perceived attractiveness of residents impacts on how care staff approach them when providing care and so the outcome for the resident. In the current research there was evidence that care staff found some residents were preferable to work with than others, and this often related to the care staff having to undertake higher levels of emotional labour when working with some residents. Care staff described working hard to manage their emotions when working with residents who were rude or racist or aggressive usually engaging in deep or surface acting or trying to 'ignore' the resident's behaviour. This could relate to Campbell's 'behaviour' component of attractiveness, in which she argued that resident responses to others and to their care made them more or less attractive to care staff. The current research strongly suggests that care staff do approach the care of these 'challenging' residents differently.
In relation to the communication or cognition components of Campbell’s description of ‘attractiveness’, the current findings do not support her assertion that staff respond to these residents differently because of how they perceive them, but rather staff can find responding to these residents more difficult due to the difficulty of understanding and then ‘correctly’ responding to the resident. Therefore, the emotional support received by these residents related to the complexity of responding to them, rather than staff not making as much effort to provide them with emotional support as suggested by Campbell. The current research has partly supported Cambell’s (2005) research, but has also revealed that staff’s emotion work in relation to residents is more complex than simply finding them more or less ‘attractive’.

**Empathy**

This study has built on previous research into empathy by exploring its use by care staff (as well the association between empathy, emotional labour and emotional support) in a care homes context. In general terms, empathy has been mainly studied within psychology, with a particular focus on the individual differences in empathy, using mainly quantitative methodologies. This research aimed, not only to understand empathy within a caring context, but also to emphasise empathy as an important ‘emotional skill’ which varied between care assistants, and to relate this to the emotion work they undertook.

Davis (1983a, 1994) model of empathy provided the basis of this research’s conceptualisation of empathy, and referred to the affective and behavioural components of empathy separately. In the current research ‘empathy’ referred to the empathic emotions felt by care staff and the care assistants’ behavioural response to these emotions were conceptualised as one aspect of emotional support for the residents, thus assuming that empathy directly influenced emotional support. This research has supported the previous findings that empathy is an important aspect of a caring relationship and does have a positive influence on resident care (Reynolds & Scott, 1999; Gladstein 1977; Coffman 1981; MacKay et al. 1990 and Fleuren et al. 1998). This finding was supported both qualitatively and quantitatively. In the
quantitative analysis a self report measure of 'likelihood to engage empathically' was used (Davis, 1983b). Assuming then that this measure of empathy does relate to a person’s emotional competency, this analysis has provided some support for the argument that care staff vary in their skills related to emotion work, and this impacts on the emotional support they provide for residents. The empathy literature tends to focus on the empathy undertaken when working directly with a resident or patient (e.g. Reynolds & Scott, 1999) Morse et al. 1992), but while this was also reported by care staff, the qualitative analysis further revealed that different types of empathy were used in a variety of ways by care staff.

Care staff described empathising with groups of residents as well as individuals, and in relation to specific situations (such as having a bath), as well as more general (living in a care home). Therefore they did not just use empathy in one-to-one situations, but to try and understand resident’s feelings and behaviour in a wider sense. They used insights gained from these more general forms of empathy to guide their care. One unique contribution to the empathy literature has been the emergence of 'indirect empathy' as an important form of empathic engagement. Care staff reported that they thought about how they would like their loved ones to be treated if they were in the position of the residents. In doing this they effectively took the perspective of the resident’s family members as opposed to the resident directly. This type of empathy was intrinsic to guiding care staff’s ‘philosophy of care’, that is their understanding of their role as a care assistant and the quality of care they would ideally like to give. Care staff more frequently referred to ‘indirect empathy’ when talking about residents with dementia. It is possible that care staff find it more difficult to imagine themselves in the position of a resident who has dementia. This would support Zaki et al.’s (2008) argument that empathy is interpersonal in nature, relying on both the resident’s ability to express their emotions as well as the care staff’s ability to interpret them. Where resident’s struggle to effectively communicate and staff find it difficult to understand their perspective, indirect empathy could be a valuable tool for guiding care staff’s responses. The quantitative analysis also provided some support for the argument that indirect empathy is indeed a form of
empathy and care staff report frequently undertaking this form of emotional engagement. This broader understanding of the empathic engagement of care staff and how this influences their work is an important contribution to both the empathy and caring literatures.

It was within the empathy analysis that another important finding initially emerged. Care staff who had experience of caring for a dependent loved one, and had often also witnessed the care of that loved one by others (care staff, doctors and nurses), used this experience to engage in indirect empathy. Previous literature had related the large numbers of care staff in their 40s and 50s and the wealth of experience, gained throughout their lives (Platt, 2006), but had not detailed what this experience might be or how it impacted on their care work. The current research has demonstrated both quantitatively and qualitatively, that the experience of caring for a dependent loved one directly related to care staff’s emotion work. In terms of empathy, this experience was closely linked to indirect empathy and the care staff’s philosophy of care. This finding supports Davis (1983b, 1994) model of empathy, in that the antecedent ‘strength’ of a situation, in part relates to a person’s individual prior experiences which either increase or suppress their empathy in a given situation. Thus a person who has experience of caring for and watching the care of a vulnerable loved one is likely to relate this experience to the care of other vulnerable adults and their families. The contribution of care staff’s personal experiences to their care work is important for homes to recognise and value, as opposed to only focusing on formal training.

This research aimed to explore the association between empathy and emotional labour. Previous literature had either implicitly (Reynolds et al. 2000) described empathy as a form of emotion work, or explicitly (Larson & Yeo, 2005) described empathy as a type of emotional labour. Following the literature review, a theoretical model of emotional support was presented in which empathy influenced emotional support indirectly through emotional labour (Figure 2.1). This link was not supported in the quantitative analysis. There was however some evidence in the interview analysis that empathy and emotional labour were associated in two ways. Firstly, staff
spoke about purposely engaging in empathy, suggesting that it can be a form of emotional labour in itself. Care staff used empathy as an emotional tool in order to guide their care, particularly for ‘understanding’ aspects of challenging situations. This is not new in that previous researchers (e.g. Davis et al. 1999; Campbell-Yeo et al. 2007) have argued that many forms of empathic engagement are undertaken consciously and purposely, but these authors had not specifically linked this to emotional labour. Larson and Yeo (2005), specifically linked empathy to deep and surface acting, although this association did not emerge in the current research.

Secondly, empathy contributed to care staff’s ‘philosophy of care’ which included their understanding of the emotional support they would ideally like to provide for residents. In order to implement this care, emotional labour was necessary. On a practical level it is important to understand that for care staff empathy can involve a great deal of effort and is a form of emotion work, but that engaging empathically also encourages staff to provide a higher quality of care.

Schell and Kayser-Jones (2007) outlined some barriers to care staff engaging empathically when caring for residents who were dying. These were mainly focused on organisational factors such as support from senior staff. The current research has built on the concept of barriers to empathic engagement. The qualitative analysis revealed the barriers to emotional empathy included choosing not to engage, for example if residents were rude or critical, and being unable to engage when a carer tried and failed to understand a resident’s perspective. In contrast, staff also reported that they did engage in emotional empathy but were then unable to act on it either due to constraints of time and materials, or because the ‘correct’ response was ambiguous (e.g. a resident with dementia searching for their deceased loved one). The analysis of the empathy data has not only confirmed the importance of empathy, but also provided insight into the diverse forms of empathic engagement undertaken by care staff. Furthermore, empathy has been argued to be a form of emotion work associated with emotional labour, and some of the situations in which care staff find it very difficult to engage empathically have been highlighted.
Understanding Emotional Support

Emotional support in this research refers specifically to the emotional aspects of care that care assistants report providing for older people living in care homes. This research has confirmed that both empathy and emotional labour are essential to care assistant’s provision of emotional support.

The literature review outlined some of the components to emotional support; day-to-day support, support during times of stress, and also dementia care. The qualitative research specifically addressed the personal care of residents, an important element of the daily care that staff provide. When giving examples of personal care, many staff demonstrated how well they knew the residents they were referring to, and the thought that went into trying to make personal care as positive an experience as possible for the resident, thus providing emotional support. As with Lopez (2006) there were also examples of how care staff managed to provide emotional support for residents within the home routine. Similarly to Smith’s (1992) research with student nurses, care staff did refer to the ‘little things’ with respect to the daily care of residents, such as holding their hand or taking them another cup of tea when they went to bed. As well as the more daily aspects of care, care staff also reported trying to provide emotional support in a range of situations in which residents were stressed, including responding to confusion, despair and also caring for residents who were very ill or dying. These formed many of the most common situations that posed emotional challenges for care staff. Finally, some forms of emotional support, such as responding to confusion were more common when caring for residents with dementia and the ‘correct’ response in these situations was more likely to be ambiguous.

The quantitative analysis showed that both empathy and emotional labour (although not surface acting) were positively associated with emotional support. It appears then that a combination of emotional skills and also hard work in relation to managing emotions, both influence the emotional support care staff provide to residents. The qualitative analysis however, revealed that in highly stressful situations, such as when a resident was aggressive, staff’s emotional labour was particularly high, but this work
was mostly linked to staff trying to remain calm, as opposed to them particularly thinking about emotional support of the resident. Therefore the associations between empathy, emotional labour and emotional support are not always positive and direct. It is possible for care staff to exert high emotion work and fail to provide good emotional support for the resident. This research has also revealed that care staff have limits in the emotion work they can do, and can not maintain high levels of emotional labour over long periods of time. Hochschild (1982) argued that emotional labour could lead to negative emotional consequences for workers and Smith (1992) and Lopez (2005) have both described nurses/care staff becoming emotionally tired by their work. It is readily accepted that people have physical limits, but a greater awareness is required regarding emotional limits. A person who is emotionally exhausted is more likely to make mistakes or to employ methods (such as ‘blaming the dementia’) that enable them to work, but do not encourage good care practices. The qualitative analysis highlighted that the relationship between emotional labour of the staff, and residents responding positively, thus suggesting they were emotionally supported, were not always direct. This was either because the emotion work of the care staff was not related to the resident (eg. it related to other care staff), or the emotion work related more to staff trying to ‘cope with’ the resident or situation rather than focusing on the emotional support of the resident. However, from their own perspective staff sometimes ‘provided’ the support, both thinking about how best to respond and exerting emotional labour to do so, but the outcome was still not positive. Therefore, it was not just the types or intensity of the emotional labour that staff undertook that was important to the outcome for the resident as there were two other important factors. Firstly, whether the emotion work was directed towards the emotional support of the resident or towards other factors, such as the staff member trying to cope with the resident being rude or already being upset due to matters unrelated to the resident. Secondly, negative outcome could relate to factors relating to the resident themselves (such as illness or depression) which the care staff had little power to influence. It could be that the care staff’s emotion work made the situation ‘less negative’ for a resident, but this may not be obvious to staff. A number of social
factors were also important to the emotion work of care staff and so to the emotional support of residents.

Social Factors Impacting on Emotional Support

The current research identified two important social factors in relation to emotional support. The first was the staff characteristic of having cared for a dependent relative. This variable was both quantitatively and qualitatively associated with empathy, emotional labour and emotional support, in stark contrast to the lack of influence of other variables. For example formal training (including NVQ2) had almost no influence. This finding is concerning for policy makers. While there is value in formal training, such as improved methods of moving residents and preventing back injuries and better understanding of conditions such as Parkinson’s disease, this training lacks emotional awareness. It is not only the training material that is relevant however, but also the training environments, as in Nolan et al’s. (2002) findings relating to ‘enriched’ or ‘impoverished’ learning environments. Nolan et al. (2002) described these learning environments using the ‘six senses framework’ (Davies et al. 1999; Nolan et al, 2001, 2006), which included ‘a sense of purpose’, ‘a sense of continuity’ and a ‘sense of achievement’. It could be that if all care staff completed training in ‘enriched’ environments there would be a positive effect of training, but this is not currently the case. Some of the most difficult situations for care staff were emotionally challenging, such as ambiguous situations where staff were not sure how best to respond to a resident. Care staff directly reported that the training they had received did not help when they were confronted with these difficult situations.

The second social factor found to be particularly important was teamwork. This was found from the qualitative data, and supports that of other researchers. In particular Davies (2001a, 2003) argued that effective teamwork amongst staff is vital for a positive community within a care home. The six senses framework (Nolan, 1997; Davies et al. 1999; Nolan et al, 2001, 2006) emphasises that the needs and wellbeing of the care staff are intrinsically linked to the quality of care they provide for the residents. In the current research teamwork was essential for the wellbeing of care
staff. However, teamwork was not a simple concept, but related to many aspects of care home organization and staff mixes. Ineffective teamwork was related to poor staff relationships, poor communication, language barriers, staff physically working alone, low staffing levels and lack of trust.

Teamwork emerged as central to the ‘feeling rules’ within care homes, with some similarities to Smith’s (1992) study on student nurses. In homes where staff did not work together, staff did not feel able to, or did not try to, gain support from colleagues when they were in difficult situations. Staff were both critical of each other and feared criticism for making mistakes or not being able to cope alone. In this way staff could not rely on support from others when it was most needed, thus adding to their emotion work, forcing them to deal with situations they were ill equipped to cope with alone, and presumably negatively impacting on the emotional support of the residents. In contrast, in effective teams, staff expected to help out other staff and felt readily able to ask others for support. These staff tended to be organized so they worked at least in pairs, and it was accepted that sometimes staff would make a mistake or not be able to cope alone. These staff felt greater security in that they were unlikely to be left alone in very difficult situations, thus reducing their emotional labour. Importantly, these staff were also more likely to learn from others as they could see how different people approached residents.

Teamwork within care homes is not therefore just another buzzword, but vital to the wellbeing of staff and residents. While this research has provided some insight into the differences between effective and ineffective teams, this is an area that would be particularly useful to further explore in the future. This research was not very successful in determining organizational differences between the 5 care homes, in part because the area of ‘organisational factors’ was too broad, and the care homes were very different. However, a future study could specifically address teamwork in relation to different care homes and focus on how staff are physically situated in the home, the mix of staff, how much time staff have to spend together and how readily they ask for help. Without a more specific idea of how good teamwork can be
encouraged and sustained, there is a danger that teamwork will remain as just another buzzword.

A staff characteristic that emerged as relevant in terms of the emotion work of care staff was whether staff were from overseas. The findings support some of the findings of Winkelmann-Gleed's (2006) research into overseas nurses, in that communication between staff, some cultural differences and also racism by residents were all relatively common problems for overseas staff who spoke English as an acquired language. However, no care staff reported racism by their colleagues in contrast to Winkelmann-Gleed's research. Problems of communication between staff negatively impacted on teamwork particularly if staff were under pressures of time. Communication problems with residents resulted in higher workloads for the overseas care staff and presumably less emotional support for residents if they could not make their wishes known or did not understand what was happening. However, communication skills were not limited to linguistic ability, but to a range of methods of expression which some overseas staff were adept at. Some overseas staff also encouraged residents to help them learn English or about specific cultural practices particularly relating to meals, thus not only learning but building a reciprocal relationship with some residents. The findings also supported those of a report by Anchor Trust (Jones & Mosley, 2007) that racism amongst residents was quite widespread, especially towards black care staff. As with Anchor's findings, many staff ignored racist comments or did not respond to them, even though they reported sometimes feeling upset by them. Generally racism was not reported to senior staff. In some homes all the care staff were aware of racist residents and organised themselves so overseas staff would not work with those residents. In terms of emotional labour, overseas staff frequently had to work harder to manage their emotions than 'UK' staff, as they had to cope with racism and also a higher workload relating to communication difficulties.
Policy and Practice

This section will discuss how some of the main research findings could be used to influence care homes policy and practice. This research has provided insights into care assistant’s working lives and the emotion work this involves, particularly some of the most common aspects of care work that care staff found to be emotionally challenging and could benefit from being supported with. This research supports several important arguments. Firstly, that care work is emotionally challenging, involving complex situations. Secondly, in order for care staff to respond to these emotional challenges they need to be emotionally skilled, therefore care work is not 'unskilled labour' and many care staff do already possess a range of emotional abilities to support residents. Thirdly, care staff undertake a great deal of emotion work when caring for older people and this can be tiring, therefore, as with physical work, there is a limit to how much a person can, or should be expected to undertake. Finally, care homes need to recognise and support care staff with the emotional aspects of their work, both to improve the wellbeing of staff and reduce burnout, and to enable them to provide further emotional support for residents. These issues will be outlined in this section.

This thesis provides a fuller understanding of the more common ‘emotional challenges’ staff regularly encounter when working with residents. Staff tended to conceptualise into either ‘challenging situations’ or ‘challenging resident characteristics’, therefore staff made the distinction between situations/problems that can arise when working with residents that required high levels of emotion work by the staff and those particular residents or resident characteristics which regularly required more emotion work by staff.

In relation to ‘challenging situations’, many care staff reported that they did not always know the best way to respond to the resident, finding the correct response to be ambiguous. This was more commonly found when working with residents with dementia, particularly when the resident’s understanding or wishes, conflicted with
reality, health concerns, or the needs of other residents. Staff reported that their training did not prepare them for these situations, strongly suggesting staff need better training and also good role-modelling within care homes. It was clear that some staff in a care home were better at approaching residents in these situations, but in most cases no advice was passed onto other staff who were not so good at responding.

Care staff did perceive some residents or resident characteristics to be more difficult to respond to, often creating preferences as to which resident’s care staff favoured working with. If a resident frequently responded in a negative way, for example being rude or aggressive, care staff would ‘label’ the resident in this way. This is in conflict with care policy which strongly suggests care staff avoid referring to residents in this way. However, simply not allowing staff to use certain words does not improve the care staff’s feelings towards these residents and does not improve the emotional support they provide for them. It could be more helpful for care staff to be able to openly talk about their concerns or distress in relation to a resident in order to reflect on this and try new approaches regarding their care. In some cases improved care would change the resident’s negative behaviour, but not always. In these situations, care staff’s difficult work needs to be recognized, supported and rewarded by senior staff. This research has highlighted the importance of positive emotional feedback for many staff, something which they do not receive from some of the residents they care for despite working hard. Senior staff should recognise care staff’s work and thank them for it, noticing and praising good work. This is a simple, inexpensive, yet effective way of ensuring care staff’s work is valued. Staff who receive no positive feedback are more prone to burnout and emotional exhaustion, something which is in the care home’s interest to avoid.

The analysis revealed there were no obvious effects of formal staff training on their emotion work, but yet life experiences, particularly that of having cared for a dependent loved one, influenced empathy, emotional labour and emotional support. Therefore, this research has not just revealed a weakness of staff training, but also provides some suggestions as to how these could be addressed. Important aspects of
these personal experiences, particularly the understanding of what a positive impact good emotional support could have, the distressing effects of negative care, and how it might feel if it were your loved one being cared for could be used during training to encourage staff to be more emotionally engaged with residents. The regular use of indirect empathy could also be a valuable training tool, by asking staff not only to think of how they would like to be cared for themselves, but also their loved ones. The research also highlighted the value of continued training and support for staff when at work, not just on training courses. Especially when staff were struggling with a particular resident, or with particular types of situations, discussing their experiences as a team and sharing information as to how best to respond, or working with senior staff to address problems would be more appropriate in many situations than generalised training that does not help with individual residents.

This research has demonstrated how much emotion work staff are required to do as part of their work. It is this emotion work that can be greatly rewarding for staff, but too much, or constant negative feedback leads to exhaustion and burnout. One important way to negate the effects of negative feedback and high emotion demands is to ensure effective teamwork. This requires homes to make sure staff are able to work at least in pairs, but also by promotion and encouraging staff to ask for support as well as offering help to their colleagues. In some homes an attitude prevailed whereby staff did not like to ask for support, did not trust other staff not to criticize them if they needed help, and staff struggled to cope alone with difficult situations, often resulting in a great deal of stress. Homes should make explicit the importance of staff working well together and ensure they have time to communicate with each other as well as being aware of and addressing problems between staff. Currently, care home managers rarely manage the care team, but rather expect staff to organise themselves, something which they struggle to do.
Methodological Discussion

Two separate methods, quantitative and qualitative, were used and then integrated at a later stage to try to understand the emotional aspects of care work. Overall the approach was successful and provided many insights into the emotion work of care staff as well as contributing to more theoretical understanding of empathy, emotional labour and emotional support. However, there were also some limitations in using these two methods and a number of challenges.

Quantitative Method

The main weakness in the quantitative method was an overestimation as to the number of questionnaires that would be completed by care assistants. Not only was access to care homes difficult and could take many months, but within some participating care homes, the return rate of questionnaires was lower than had been hoped. Therefore a relatively low number (n=68) of questionnaires were completed. As a result, small effect sizes could not be detected, and especially in tests where group sizes were uneven, even medium effect sizes were unlikely to yield significant results. However, some important outcomes were still detected, but ideally a sample size of over 100 would have been needed to more fully explore all the variables.

The inclusion of staff who spoke English as an acquired language (EAL staff) was also challenging (n=16). The empathy and emotional support scales had been originally designed for and tested with participants who spoke English as a 1st language (ElstL staff). Therefore the data was tested very carefully for reliability and, overall, most scales were adequately reliable, and relevant findings were still obtained. The differences in the reliability of scales did highlight linguistic difficulties and also possible cultural differences within the emotions constructs. In particular the deep acting items were unreliable for EAL staff. The analysis has highlighted the relative complexity of conducting self-completion questionnaire research with care staff. While this method of data collection is relatively quick and easy in comparison to longer interviews or observations, the statistical analysis is not
straightforward. However, it could also be argued that these challenges in terms of the questionnaire responses could also reflect some of the difficulties care homes must overcome when integrating and training EAL staff. It is possible that care staff understand written material less well or differently to E1stL staff. Therefore any training schemes need to bear in mind and cater for staff from many backgrounds.

One of the aims of this research was to develop an Emotional Support scale for use within a care home setting. This has been achieved to a certain degree although further testing is needed. As has previously been described, two subscales emerged from factor analysis: Factor 1 'Prioritising emotional support' and Factor 2 'Knowledge of and relationship with resident'. However, while these factors did have theoretical value, factor 1 contained all positively coded items and factor 2 predominantly negatively coded. This is a problematic finding and one which would need to be further explored by rewording some of the items and retesting with other samples. However, the analysis differentiated between the scales and this suggested there was theoretical value in the subscales. There was also some evidence that the Emotional Support scale and also Factor 2 were positively associated with interview ratings and so were partly validated in this way. Overall this scale could be of use in the future as care staff responded positively to this scale suggesting it had face validity, and it is quick and simple to administer.

Another limitation in the quantitative method, which also affects the interview data, is the sampling bias involved in the research. There was initially a bias in which care homes agreed to participate (those with enough time and staff, and positive management attitudes), and then a further bias in the self-selecting sample of care staff who agreed to take part. As was made apparent in the pilot home where senior staff accurately predicted who would take part, more enthusiastic staff with better language skills and more confidence or interest in paperwork were more likely to participate in completing the questionnaires. Those with poorer language skills, who were perceived as 'less dedicated' to their role as a care assistant, and who tended to avoid paperwork, were less likely to participate. Added to this is the likelihood that
some or most staff responded to the questionnaire and/or the interview in a 'socially desirable' manner. However, in undertaking research in care homes and with care assistants, some of this bias is inevitable. While a random sample would be ideal, it is not ethically feasible as each home and each staff member has the right to choose whether or not to participate. A good relationship was built with the care homes and care staff who participated reported having appreciated a researcher being interested in their work.

The sampling bias could be important for several reasons. Firstly, it suggests that this research has presented a more positive image of the emotion work and attitudes of care staff than would be represented across all care homes and care staff. The sampling bias also suggests that, in a more representative sample, language barriers or poor reading skills could have been even more of a problem in relation to completing the questionnaires. If the self-selecting sample were those who were more confident in reading and writing, this could also have further implications for both future research and staff training. Self-completion questionnaires alone do not fully reflect all care staff responses as a significant proportion either will not take part, or will not fully understand the questions due to poor English reading skills.

The quantitative method was successful in determining the statistical associations between empathy, emotional labour and emotional support, and also some of the social factors. These findings have been of value in supporting and also adding to previous findings relating to these constructs, particularly in determining the differences between 'surface acting' and the other forms of emotional labour. Of particular relevance were the strong associations between having cared for a dependent relative and empathy, emotional labour and emotional support, a finding which supported the qualitative findings and highlighted the lack of impact of formal training. The comparison of the quantitative and qualitative findings has been essential with the quantitative scales generally focusing on the current theories in relation to empathy and emotional labour, while the qualitative analysis was focused on staff perspectives. The quantitative findings suggest that care staff do undertake
and also vary in their use of 'classic' empathy, as examined by Davis (1983b, 1994) and also the types of emotional labour as outlined by Brotheridge and Lee (2003), which is of relevance to current understanding of these theories and important to understand within the broader context of care work. However these findings do not fully describe the emotion work of staff within a care homes context, only one aspect of it, which the care staff themselves do not generally relate to. The qualitative method has therefore complimented the quantitative findings by exploring these same constructs from the care staff's own perspective.

*Qualitative Method*

The qualitative methodology provided a rich source of data, which is of theoretical value within the emotions literature, but has also provided practical examples and suggestions which are of use to care homes.

As already discussed, there was a sampling bias in relation to the care staff sample and so those staff that participated in interviews may well have been more motivated in their work and also more confident communicators. Therefore the perspectives of some groups of care staff may not have been represented in this analysis, for example, those with poorer communication skills or those who are less enthusiastic about working with older people. Equally, the perspectives of staff working in those homes that did not participate due to staff shortages or management problems are also not represented. This likely bias suggests that in some other homes, and for other staff, the emotional challenges of their work may be more extreme. For examples, if in these 'good' care homes staff still felt unsupported at times or teamwork was ineffective, it is likely that this is even more so within a representative cross-section of homes. It was however, important that homes and staff did not feel pressured by the researcher to participate and that good relationships were built up with staff in the participating homes.

Interviewing EAL staff was also challenging due to language barriers and strong accents that were harder to understand. However, the data for these staff was still rich
and gave a good insight into some of the particular issues EAL staff face at work. The researcher found interviews with EAL staff were often more tiring and required higher concentration. This reflects the high levels of work that EAL staff undertake on a daily basis. By understanding that these language problems can simply require more effort from staff, care homes may be able to address some of the challenges associated with multicultural staff groups. For example, ensuring staff are encouraged to communicate with each other and have the time to do so, and being sensitive to some of the social norms that overseas staff might not be aware of. Currently care homes and staff are more concerned with appearing racist than tackling the practical issues relating to language and cultural differences.

Overall, the qualitative design was successful, and the integration of the quantitative and qualitative findings allowed a deeper understanding of empathy, emotional labour and empathy. While there were some limitations relating to the method, this is not unexpected or unusual within a population, such as care assistants, which can be difficult to access, and within care homes which are usually very busy.

Conclusion

In conclusion, this research has demonstrated that sociological and psychological perspectives both contribute important insights in the field of emotions, many of which are complimentary. This thesis has explored the emotion work of care staff and in doing so has made some important contributions to the fields of empathy and emotional labour, particularly in relation to caring environments. The study has contributed to the care homes literature by seeking to understand the perspective of care staff regarding their working lives and the emotion work they undertake, an understanding which is of both theoretical and practical value.

It was shown that care staff face many emotional challenges in their daily work with residents, including situations which require a high level of emotional labour to respond to, and also some ‘challenging characteristics’ of residents which require staff
to engage in high levels of emotion work. Care staff engaged in both empathy and emotional labour when responding to these challenges, but the association with this emotion work and the emotional support of the resident was not always straightforward. In general empathy did positively influence emotional support, but staff found there were some barriers to engaging empathically, such as struggling to communicate with the resident. Similarly, emotional labour did, in general positively influence emotional support, but sometimes in complex, or ambiguous situations, care staff did not know how best to respond, or factors, such as the resident’s poor health, were outside their control, resulting in a negative outcome.

The research has shown that care staff undertake a range of different types of empathy in their daily work, not only the ‘direct empathy’ focused on by researchers (e.g. Davis 1983b, 1994). Similarly, care staff do not understand emotional labour only in terms of the types proposed by Brotheridge & Lee (2003), but rather they focus on the context of that emotional labour, including the ambiguity of a situation, and also whether the outcome was positive or negative. Therefore, previous findings into emotional labour and empathy have been supported, but this research has provided further insight into these constructs within a care home.

This research has also provided a greater understanding as to those factors that influence empathy and emotional labour, highlighting the relative importance of both teamwork and personal experiences of caring, to that of formal training.

The emotion work of care staff could be draining or exhausting for them, especially when high levels of emotion work did not result in a positive outcome, when they did not receive any positive feedback, and when they were upset or distressed by a resident’s situation or behaviour. Support for staff, particularly through effective teamwork was vital both for the wellbeing of staff and also to enable them to provide emotional support to residents. Where teamwork was poor, other staff could actually increase emotional labour rather than reduce it. This and other findings are not only of theoretical value, but of practical importance to care homes.
REFERENCES


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Preferred Priorities for Care. from http://www.endoflifecareforadults.nhs.uk


Appendix 1a: Research Information Poster for Care Assistants

UniS

For All Care Assistants:
Research Information Sheet

Name of Researcher: Rebekah Luff

Research Institution: University of Surrey

e-mail: R.Luff@surrey.ac.uk

Thank you for your interest in this study. I am a social sciences researcher carrying out some much needed research into care assistants working in care homes. This page contains some information about the research and how you can take part.

About The Researcher
I am a PhD student at the University of Surrey. My research interests are in care of the elderly, particularly in residential care. I am currently working as a care assistant and have done so on and off for 9 years. I have worked in a range of homes as permanent, bank and agency staff. It was while working in care homes that I became interested in conducting research with care assistants.

The Research
Over the years there has been a lot of research into nurses in hospitals and nursing homes and their working lives. There has also been a lot of research into people caring for elderly family members at home. However, there is very little work with care assistants working in residential care homes. I will be looking at the daily work lives of care assistants including the care they provide for the residents and how staff work together. I am also interested in the range of people that are currently working as care assistants and their backgrounds. Lastly I will be exploring the type of work that care assistants do when caring for the elderly, for example, caring for those with dementia can require both physical work and also mental or emotional work.

How You Can Take Part
Care assistants will be asked to take part in the research by filling out a questionnaire. This should take about 15 minutes. If you need help or have any questions, I will be available at the home. The questionnaire asks you to tick boxes indicating how much you agree or disagree with a range of statements about care provision. At the end of the questionnaire you will be asked for some general information such as your age, any training you have done and your ethnic background.

You may also be asked to take part in a tape recorded interview. The interview takes up to 1 hour. The interview is about your own thoughts and experiences of working as a care assistant, there are no right or wrong answers.
Dear Participant,

Thank you for your interest in this study. I am a social sciences researcher carrying out some much needed research into care assistants working in care homes. This page contains some information about the research and how you can take part.

About The Researcher
I am a PhD student at the University of Surrey. My research interests are in care of the elderly, particularly in residential care. I am currently working as a care assistant and have done so on and off for 9 years. I have worked in a range of homes as permanent, bank and agency staff. It was while working in care homes that I became interested in conducting research with care assistants.

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You may also be asked to take part in a tape recorded interview. The interview takes about 1 hour and is about your own thoughts and experiences of working as a care assistant, there are no right or wrong answers.
Appendix 1c: Research Information Sheet (Homes 6-8)

Research Information Sheet

Name of Researcher: Rebekah Luff

Research Institution: University of Surrey

e-mail: R.Luff@surrey.ac.uk

Dear Participant,

Thank you for your interest in this study. I am a social sciences researcher carrying out some much needed research into care assistants working in care homes. This page contains some information about the research and how you can take part.

About The Researcher
I am a PhD student at the University of Surrey. My research interests are in care of the elderly, particularly in residential care. I am currently working as a care assistant and have done so on and off for 9 years. I have worked in a range of homes as permanent, bank and agency staff. It was while working in care homes that I became interested in conducting research with care assistants.

The Research
Over the years there has been a lot of research into nurses in hospitals and nursing homes and their working lives. There has also been a lot of research into people caring for elderly family members at home. However, there is very little work with care assistants working in residential care homes. I will be looking at the daily work lives of care assistants including the care they provide for the residents and how staff work together. I am also interested in the range of people that are currently working as care assistants and their backgrounds. Lastly I will be exploring the type of work that care assistants do when caring for the elderly, for example, caring for those with dementia can require both physical work and also mental or emotional work.

How You Can Take Part
Care assistants will be asked to take part in the research by filling out a questionnaire. This should take about 15 minutes. If you need help or have any questions, I will be available at the home. The questionnaire asks you to tick boxes indicating how much you agree or disagree with a range of statements about care provision. At the end of the questionnaire you will be asked for some general information such as your age, any training you have done and your ethnic background.
APPENDIX 2

Interview Schedule for Senior Staff

What is the maximum capacity of the home?
How many residents are currently in the home?
Does the home accept any nursing care residents? If so how many?
What level of dependency are the residents, what types of needs do they have?

How is the home organized in terms of units or floors?
Are some units heavier or lighter than others?
How many staff to a unit/floor?
Do staff tend to work in pairs/groups or alone?
How are staff allocated to a floor/unit

What are the shift times in the day?
How and when are staff breaks allocated?

How many staff should be on duty during a day shift?
Do you usually have the full number of staff?
How many permanent day staff are at the home?
Are these staff mostly FT or PT?
Are there any/many staff that have worked here for a number of years?
How many staff have done or are training for NVQ level 2 or 3?

Do you use bank or agency staff? How often?
Do you get regular bank/agency staff?

Do you employ many overseas staff (including bank and agency)?
Level of English?
Appendix 3a: Questionnaire Consent Form

Dear Participant,

Please read the following statements and sign and date below to indicate that you understand and accept the conditions of this study.

Your participation in this study is voluntary and you do not have to complete the questionnaire or answer all the questions if you do not wish to. You do not have to provide a reason for not completing the questionnaire if you do not want to.

All the completed questionnaires will be stored safely and kept separate from information about your identity. Only the researcher will know the identity of participants. Access to your data is restricted to the people involved in this research. If the data is used for publications we will ensure that no reference to your identity is made. The questionnaires are confidential. Information given by participants will not be passed on to anyone in the care home.

I give my permission for my questionnaire responses to be used for research purposes only (including research publications and reports) with strict preservation of anonymity.

I hereby assign the copyright in my contribution to Rebekah Luff (the researcher)

Date __________________________ Printed Name __________________________ Signature __________________________

ID Number: ___
Appendix 3b: Care Assistant Questionnaire

ID Number: 

Care Assistant Questionnaire
Part A

The following statements ask about your thoughts and feelings in a variety of situations, in everyday life. For each statement, indicate how well it describes you by circling the appropriate number. The scale is shown below.

ANSWER SCALE:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Not Describe Me Well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe Me Very Well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a) I often have tender, concerned feelings for people less fortunate than me. 1 2 3 4 5
b) I sometimes find it difficult to see things from another person’s point of view. 1 2 3 4 5
c) Sometimes I don’t feel very sorry for other people when they are having problems. 1 2 3 4 5
d) I try to look at everybody’s side of a disagreement before I make a decision. 1 2 3 4 5
e) When I see someone being taken advantage of, I feel kind of protective towards them. 1 2 3 4 5
f) I sometimes try to understand my friends better by imagining how things look from their perspective. 1 2 3 4 5
g) Other people’s misfortunes do not usually disturb me very much. 1 2 3 4 5
h) If I’m sure I’m right about something, I don’t waste time listening to other people’s arguments. 1 2 3 4 5
i) When I see someone being treated unfairly, I don’t often feel very much pity for them. 1 2 3 4 5
j) I am often quite touched by things that I see happen. 1 2 3 4 5
k) I believe that there are two sides to every question and try to look at them both 1 2 3 4 5
l) I would describe myself as a pretty soft-hearted person. 1 2 3 4 5
m) When I’m upset at someone, I usually try to “put myself in their shoes” for a while. 1 2 3 4 5
n) Before criticizing somebody, I try to imagine how I would feel if I were in their place. 1 2 3 4 5
I'd like you to think about the time you spend working directly with the residents and staff when responding to the following statements.

**ANSWER SCALE:**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

Each statement begins with the phrase:

*On an average day, when interacting with residents and staff, how often do you .....?*

a) Pretend to have emotions that you don't really have

b) Show some strong emotions

c) Express many different emotions

d) Show specific emotions required by your job

e) Try to actually experience the emotions that you must show

f) Resist expressing your true feelings

g) Hide your true feelings about a situation

h) Show many different kinds of emotions

i) Express intense emotions

j) Really try to feel the emotions you have to show as part of your job

k) Express particular emotions needed for your job

l) Make an effort to actually feel the emotions that you need to display to others when working
I'd like you to think about the time you spend working directly with the residents and staff when responding to the following statements.

**ANSWER SCALE:**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neither Agree or Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>a)</td>
<td>I often find that I don't know how residents like things done (e.g. during personal care)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b)</td>
<td>I sometimes think about how best to communicate with a resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c)</td>
<td>I am sure I notice when a resident is not themselves</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d)</td>
<td>I often find I don't know what to say to a resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e)</td>
<td>I make an effort to use non-verbal communication rather than just talking with some residents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f)</td>
<td>I usually know how much can be expected from each resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g)</td>
<td>I frequently think about how it would feel if I was in the position of the resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h)</td>
<td>There are often situations where I provide reassurance to a resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i)</td>
<td>I never just sit and chat with residents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j)</td>
<td>I don't tend to express sympathy for a resident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k)</td>
<td>I struggle to communicate with some residents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l)</td>
<td>It is an important part of my job to listen to a resident's worries or complaints</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>m)</td>
<td>I sometimes think about how I would like a resident to be treated if they were my parent or loved one</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>n)</td>
<td>I often chat with a resident while carrying out physical tasks, such as dressing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>o)</td>
<td>If I feel annoyed with a resident I tend to show my feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>p)</td>
<td>I rarely talk to residents about their past or their family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>q)</td>
<td>I often have a joke or make residents laugh</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Part B

Please complete the following questions which ask for some general information. Please tick the box which corresponds with your answer or fill in your answer in the space given.

1) Age: __________

2) Are You: Male ☐ Female ☐

3) Do you work as a care assistant: Part Time ☐ Full Time ☐

4) How long have you worked as a care assistant? __________

5) How long have you worked at this home? __________

6) Are you employed as:

- Permanent Staff ☐
- Bank Staff ☐
- Agency Staff ☐

7) How many other care homes do you currently work in?

- None ☐
- 1 ☐
- 2 ☐
- 3 or more ☐
8. a) Do you have another job other than being a care assistant?  
   Yes  
   No  

   b) If Yes, What is your other job ________________________________________

9. a) Are you in education (e.g. at college or university)?  
   Yes  
   No  

   b) If Yes, What course are you doing? ________________________________

Education and Training

10. What is your highest level of educational qualifications?

   None  
   G.C.S.E (G.C.E or O'Level)  
   A'Level (or AS'Level)  
   Degree  
   Other (please state) ________________________________

11. Please tick to indicate which of these care training courses you have completed.

   None  
   TOPPS 1-5  
   Backcare (manual handling) course  
   NVQ Level 2  
   NVQ Level 3  

   Any others, please list

12. Please indicate if you are currently working towards any of the following:

   TOPPS 1-5  
   NVQ Level 2  
   NVQ Level 3
Family Background

13) Do you have any children? Yes ☐ No ☐

14) Have you cared for a dependent, elderly or disabled relative? Yes ☐ No ☐

15) Have you known a close friend or relative that has entered residential care? Yes ☐ No ☐

Ethnic Background

16) Are you:
   - Indian ☐
   - Pakistani ☐
   - Bangladeshi ☐
   - Chinese ☐
   - Asian- other (please specify) ☐
   - Black-Caribbean ☐
   - Black-African ☐
   - Black-other (please specify) ☐
   - Mixed Race ☐
   - White-UK/Irish ☐
   - White European ☐
   - White-other (please specify) ☐
   - Any Other Group (please specify) ☐

17 a) Is English your first language? Yes ☐ No ☐

17 b) If No, What is your first language? ☐

Thank you for taking the time to complete this questionnaire.

Please post your completed questionnaire into the box found
Appendix 4a: Interview Consent Form

Dear Participant,

Please read the following statements and sign and date below to indicate that you understand and accept the conditions of this study.

Your participation in this study is voluntary and you can leave the study at any time without penalty or giving reasons. You can withdraw your consent at any time by contacting the researcher. At any stage of the interview you can ask the researcher to turn the recorder off or to erase anything that you have said. You are also free to decline from answering any questions or to stop the interview without having to give a reason for doing so.

All the interview data will be stored safely and kept separate from information about your identity. Only the researcher will know the identity of participants. Access to your data is restricted to the people involved in this research. All interview transcriptions will have people and place names removed or changed so no staff member, resident or care home can be identified. If your data is used for publications we will ensure that no reference to your identity is made. The questionnaires and interviews are confidential. Information given by participants will not be passed on to anyone in the care home.

I give my permission for my interview responses to be used for research purposes only (including research publications and reports) with strict preservation of anonymity.

I hereby assign the copyright in my contribution to Rebekah Luff (the researcher)

_________________________  ___________________________  ___________________________
Date                  Printed Name                  Signature
APPENDIX 4b

Interview Schedule for Care Assistants

a) General information about the home
   i. 1) Tell me a bit about the home you work in.

b) Information about the carer
   i. What for you are some of the positive aspects of working as a care assistant?
   ii. What for you are some of the more difficult (negative) aspects of working as a care assistant?
   iii. Do you find some residents easier/harder to work with than others?
   iv. In general are there some staff that you prefer to work with than others?

c) Experiences on most recent shift (shifts)
   i. Can you talk me through getting the 1st person up (helping the 1st person to bed) on your most recent shift?
   ii. Can you talk me through the most recent bath you helped a resident with?

d) Experiences in past month
   i. Can you think of and instance or a shift where you felt that you’d really made a difference to a resident by comforting them, helping them solve a problem?
   ii. Can you think of a shift where you were unable to calm, comfort or help a resident as you would have liked?
   iii. Can you think of a shift when you have been particularly stressed and explain why the shift was stressful and describe what you did?

e) Motivation & Plans
Why did you start work as a care assistant?
   i. Why continue
   ii. Future plans
Excerpt from Interview 1, Home 1 (Jackie)

R.L: Can you think back over the last month or so, can you think of a shift or situation where you felt you really made a difference to a resident, something where you went away and felt good.

Jackie: Yeah like the birthday party, yeah (female’s) birthday party, where they were all together and eating cake and they had white wine spritzers and balloons, yeah it was good.

R.L: So did you organise that or help organise it

Jackie: Yeah, I bought balloons in and birthday banner in and the kitchen got the cake and then we decided that we’d, activities lady came up and helped out. So yeah I think it was sort of, it happened, it just kinda happened.

R.L: So you went home and felt good,

Jackie: Yeah, oh definitely, yeah, yeah.

R.L: At the other end, um, can you think of a time when you were unable to calm or comfort or help a resident in a way that you would have liked, it didn’t go as you would have liked?

Jackie: Probably the worst, the worst experience that I’ve had was um a respite lady and she was (…) she was really awful this one night. She was arguing with everyone and saying that this was her house and how were all these people going to sleep in her house. And um she was telling everyone be careful of the stair carpet cos you know it’s loose and the rail’s not on properly, and she was totally, she was totally in a world of her own. And I’d said to her um, “it’s ok, um you’re in (home name) you’ve got nothing to worry about, your family know where you are” and tried to calm down all the things like this. And then because she was still vary agitated and arguing I walked away, because, um she was then talking to someone else, so I walked away. But shortly after that I went back onto the unit, was just walking through to go and help another resident and she turned round and she punched me right in the stomach, fall force. And she winded me, I actually was really hurt and for three days I was in agony because she’d got me right on the ovary, right on the soft part of my lower abdomen there. And one of the other residents who was renowned for being aggressive, actually stood up, put his arm round me and said ‘don’t cry’. Now, that night I went home, not only was I in agony, this woman had really hurt me, but I felt I’d failed. I felt really awful and I was in a lot of pain as well.

Example of coding

<table>
<thead>
<tr>
<th>Residents</th>
<th>Group, other staff and self</th>
<th>Emotion (Satisfaction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>Resident (Emotional Labour)</td>
<td>Dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
R.L: So why did you feel that you’d failed?

Jackie: Because, I think I felt like I’d failed because she didn’t, she couldn’t see, um, she couldn’t see that she wasn’t in her home, she couldn’t see that she was safe, she couldn’t see that she was in a protective environment, that there were other people around that were helping her. She was blinkered, all she could see was that this was her house, everyone was in her house. How could she feed everyone, how could she stop everyone falling down the stairs, and this sort of thing. So I felt that I’d failed because I hadn’t made her see that she was in somewhere safe, so yeah that made me feel bad.

R.L: Do you think another member of staff, someone else would have been able to deal with it any better?

Jackie: I don’t know, because she had a raging UTI, I don’t think that anyone could have got through to her. But, you see she’s got POVA protecting her. I had nothing protecting me and I was in agony for three days. In fact I was on holiday the day after and my husband wanted me to go to the doctors because I was in a lot of pain. So all you do is full out the accident-incident reports but nothing happens.

Initial coding was undertaken using NVivo7, and has been partially replicated above. All references to emotion were coded under ‘emotion’ before subgroups of empathy and emotion labour were used.

Following initial analysis of the first few interviews, new codes were added, such as ‘satisfaction’.

Following coding, the interviews were organised into ‘chunks’ using combinations of codes.

The example on the following page shows analysis for the combination: ‘negative experiences’, ‘emotional labour’ and ‘resident’.
APPENDIX 5b: Example of IPA Analysis

Excerpt from Interview 1, Home 1 (Jackie)

<table>
<thead>
<tr>
<th>Analysis of transcript ‘chunks’</th>
<th>Portions of Interviews coded as ‘negative’ AND ‘emotional labour’ AND ‘resident’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RL: At the other end, um, can you think of a time when you were unable to calm or</td>
</tr>
<tr>
<td>2</td>
<td>comfort or help a resident in a way that you would have liked, it didn’t go as you</td>
</tr>
<tr>
<td>3</td>
<td>would have liked?</td>
</tr>
<tr>
<td>4 Very -ve memory. CA doesn’t</td>
<td>Jackie: Probably the worst, the worst experience that I’ve had was um a respite</td>
</tr>
<tr>
<td>5 Awful- for res herself, CA</td>
<td>lady and she was (…) she was really awful this one night. She was arguing with</td>
</tr>
<tr>
<td>6 other res</td>
<td>everyone and saying that this was her house and how were all these people going</td>
</tr>
<tr>
<td>7 Tries to explain res</td>
<td>to sleep in her house. And um she was telling everyone be careful of the stair</td>
</tr>
<tr>
<td>8 perspective/behaviour-</td>
<td>carpet cos you know it’s loose and the rail’s not on properly, and she was totally,</td>
</tr>
<tr>
<td>9 confusion, anxiety.</td>
<td>she was totally in a world of her own. And I’d said to her um, “it’s ok, um you’re</td>
</tr>
<tr>
<td>10 CA tries to reassure res</td>
<td>in (home name) you’ve got nothing to worry about, your family know where you are”</td>
</tr>
<tr>
<td>11 verbally</td>
<td>and tried to calm down all the things like this. And then because she was still</td>
</tr>
<tr>
<td>12 Unsuccessful in</td>
<td>vary agitated and arguing I walked away, because, um she was then talking to</td>
</tr>
<tr>
<td>13 Someone else- res or staff?</td>
<td>someone else, so I walked away. But shortly after that I went back onto the unit,</td>
</tr>
<tr>
<td>14 Physical attack by res on</td>
<td>was just walking through to go and help another resident and she turned round and</td>
</tr>
<tr>
<td>15 CA. Unexpected</td>
<td>she punched me right in the stomach, full force. And she winded me, I actually</td>
</tr>
<tr>
<td>16 ‘actually’- makes clear</td>
<td>was really hurt and for three days I was in agony because she’d got me right on</td>
</tr>
<tr>
<td>17 she was injured by</td>
<td>the ovary, right on the soft part of my lower abdomen there. And one of the other</td>
</tr>
<tr>
<td>18 resident despite the res</td>
<td>residents who was renowned for being aggressive, actually stood up, put his arm</td>
</tr>
<tr>
<td>19 being old etc</td>
<td>round me and said ‘don’t cry’. Now, that night I went home, not only was I in</td>
</tr>
<tr>
<td>20 Male res labelled as</td>
<td>agony, this woman had really hurt me, but I felt I’d failed. I felt really</td>
</tr>
<tr>
<td>21 aggressive ( &amp; by other</td>
<td>awful and I was in a lot of pain as well.</td>
</tr>
<tr>
<td>22 staff)</td>
<td></td>
</tr>
<tr>
<td>23 Unexpected comfort/empathy</td>
<td></td>
</tr>
<tr>
<td>24 by male res (+ve)</td>
<td></td>
</tr>
<tr>
<td>25 Physical &amp; emotional</td>
<td></td>
</tr>
<tr>
<td>26 distress continues at</td>
<td></td>
</tr>
<tr>
<td>27 home.</td>
<td></td>
</tr>
<tr>
<td>28 Feelings of guilt/failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Describes perspective of resident in context of what Jackie wanted to change the res perspective to. Aims of reassurance that had failed.</td>
</tr>
<tr>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Feelings of failure in not reassuring res- this was cause of aggression.</td>
</tr>
<tr>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Medical explanation</td>
</tr>
<tr>
<td>33</td>
<td>‘Rights’ of care staff less important than those of res (regarding physical attack)</td>
</tr>
<tr>
<td>34</td>
<td>Impact on personal life</td>
</tr>
<tr>
<td>35</td>
<td>Org failure to support/understand CA. For CA her experience not seen as important to home.</td>
</tr>
<tr>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

RL: So why did you feel that you’d failed?

Jackie: Because, I think I felt like I’d failed because she didn’t, she couldn’t see, um, she couldn’t see that she wasn’t in her home, she couldn’t see that she was safe, she couldn’t see that she was in a protective environment, that there were other people around that were helping her. She was blinkered, all she could see was that this was her house, everyone was in her house. How could she feed everyone, how could she stop everyone falling down the stairs, and this sort of thing. So I felt that I’d failed because I hadn’t made her see that she was in somewhere safe, so yeah that made me feel bad.

RL: Do you think another member of staff, someone else would have been able to deal with it any better?

Jackie: I don’t know, because she had a raging UTI, I don’t think that anyone could have got through to her. But, you see she’s got POVA protecting her. I had nothing protecting me and I was in agony for three days. In fact I was on holiday the day after and my husband wanted me to go to the doctors because I was in a lot of pain. So all you do is full out the accident-incident reports but nothing happens.
APPENDIX 5c

Example of Themes and Clusters

Data coded as ‘negative’ AND ‘emotional labour’ AND ‘resident’

Theme: Aggression by resident

Cluster: Understanding of situation
Resident confused, agitated, distressed

Cluster: How to respond
Not ambiguous
Provide reassurance

Cluster: Outcome
Failed to provide reassurance
Physical aggression from res
Physically and emotionally –ve for staff
Guilt/blame self
Inadequate support by senior staff
Impact on home life

This example of ‘aggression from a resident’ was then filed with and compared to other examples of ‘aggression by residents’.
APPENDIX 6

Letter of Ethics Approval from the University of Surrey Ethics Committee

The following 2 pages contain a full copy of the ethics committee letter
9 September 2005

Miss Rebekah Luff
Department of Sociology/Psychology
School of Human Sciences

Dear Miss Luff

**The emotional support provided by care workers for elderly, care home workers (EC/2005/92/SOCIO)**

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **9 September 2005**

The list of documents reviewed and approved by the Committee is as follows:

- **Document Type: Application**
  - Dated: 09/08/05
  - Received: 23/08/05

- **Document Type: Research proposal**
  - Received: 23/08/05

- **Document Type: Senior staff interview schedule**
  - Received: 23/08/05

- **Document Type: care assistant questionnaire**
  - Received: 23/08/05

- **Document Type: Scales to be attached to care assistant questionnaire**
  - Received: 23/08/05

- **Document Type: Emotional support scale**
  - Received: 23/08/05

- **Document Type: Care assistant interview schedule**
  - Received: 23/08/05

- **Document Type: Information sheet**
  - Received: 23/08/05

- **Document Type: Questionnaire consent form**
  - Received: 23/08/05

- **Document Type: Interview consent form**
  - Received: 23/08/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research, and with the following condition:

- Could you ensure that this research excludes any NHS premises.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

I would be grateful if you would confirm, in writing, your acceptance of the conditions above.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

[Signature]
Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
    Professor S Arber, Department of Sociology
    Dr Victoria Senior, Department of Psychology
Appendix 7

Table of Interview Participants

<table>
<thead>
<tr>
<th>Pseudo name</th>
<th>Care Home</th>
<th>Age Group</th>
<th>Further Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackie</td>
<td>1</td>
<td>40-49</td>
<td>CA for 10 months, cared for own parent</td>
</tr>
<tr>
<td>Kate</td>
<td>1</td>
<td>19-24</td>
<td>CA &amp; in UK for 2 months, from Poland. Interview cut short as Kate needed by staff.</td>
</tr>
<tr>
<td>Habiba</td>
<td>1</td>
<td>30-39</td>
<td>From Central Africa, interview difficult due to language barrier and accent</td>
</tr>
<tr>
<td>Teresa</td>
<td>1</td>
<td>50-59</td>
<td>CA 16 months, previously teacher in Poland</td>
</tr>
<tr>
<td>Anna</td>
<td>1</td>
<td>19-24</td>
<td>CA 2 months, Part time with 9 month old baby</td>
</tr>
<tr>
<td>Adam</td>
<td>1</td>
<td>40-49</td>
<td>CA 2 years, from Africa where trained as medical doctor</td>
</tr>
<tr>
<td>Sophie</td>
<td>1</td>
<td>19-25</td>
<td>Would like to train as nurse, young baby, very shy</td>
</tr>
<tr>
<td>Claire</td>
<td>1</td>
<td>19-24</td>
<td>CA 5 years, sees self as ‘career CA’</td>
</tr>
<tr>
<td>Corina</td>
<td>2</td>
<td>30-39</td>
<td>Trained as nurse in Romania, CA in UK 4 years but new to home 2, critical of other staff</td>
</tr>
<tr>
<td>Shiela</td>
<td>2</td>
<td>50-59</td>
<td>At home 2 for 8 years, very guarded</td>
</tr>
<tr>
<td>Mark</td>
<td>2</td>
<td>Unknown (35-45?)</td>
<td>Agency staff from Ireland, at Home 2 for 6 months, did not want to stay in England</td>
</tr>
<tr>
<td>Arlene</td>
<td>3</td>
<td>30-39</td>
<td>Jamaican, in UK for 4 years, bank staff.</td>
</tr>
<tr>
<td>Jennifer</td>
<td>3</td>
<td>19-24</td>
<td>At home 3 for 3 years, very well thought of by manager and other staff</td>
</tr>
<tr>
<td>Ruth</td>
<td>3</td>
<td>50-59</td>
<td>West Indian, been CA in UK for 11 years, new to home 3. Occasionally hard to understand</td>
</tr>
<tr>
<td>Wendy</td>
<td>3</td>
<td>40-49</td>
<td>CA for 5 years after caring for own parent</td>
</tr>
<tr>
<td>Zoe</td>
<td>3</td>
<td>30-39</td>
<td>CA for 16 years, planned to leave care work until made ‘team leader’.</td>
</tr>
<tr>
<td>Jean</td>
<td>3</td>
<td>50-59</td>
<td>CA for 2 years after being carer for a friend.</td>
</tr>
<tr>
<td>Emma</td>
<td>3</td>
<td>19-24</td>
<td>CA 6 years, ‘team leader’ but not happy in role</td>
</tr>
<tr>
<td>Elaine</td>
<td>3</td>
<td>40-49</td>
<td>CA 1 year, care work is her new career</td>
</tr>
<tr>
<td>Gillian</td>
<td>3</td>
<td>30-39</td>
<td>CA 3 years, previously domestic staff in home 3, career CA</td>
</tr>
<tr>
<td>Nina</td>
<td>3</td>
<td>40-49</td>
<td>CA 15 years in UK and Africa, ‘Team Leader’</td>
</tr>
<tr>
<td>Emilia</td>
<td>4</td>
<td>19-24</td>
<td>CA in UK for 1 year, Polish, excellent English</td>
</tr>
<tr>
<td>Janet</td>
<td>4</td>
<td>19-24</td>
<td>CA 9 years, now part time around children</td>
</tr>
<tr>
<td>Olga</td>
<td>4</td>
<td>19-24</td>
<td>In UK as CA for 3 months, Polish, leaving that week</td>
</tr>
<tr>
<td>Dominik</td>
<td>4</td>
<td>25-29</td>
<td>In UK as CA for 2 years, Polish.</td>
</tr>
<tr>
<td>Nadia</td>
<td>4</td>
<td>50-59</td>
<td>In UK as CA for 4 years, Romanian. Sometimes senior on duty.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Years</td>
<td>Experience</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Melanie</td>
<td>4</td>
<td>25-29</td>
<td>CA for 6 years but new to home 4, part time around children</td>
</tr>
<tr>
<td>Lynn</td>
<td>5</td>
<td>50-59</td>
<td>CA for 32 years, at home 5 for 4 years.</td>
</tr>
<tr>
<td>Susan</td>
<td>5</td>
<td>50-59</td>
<td>CA for 11 years, many caring roles in personal life</td>
</tr>
<tr>
<td>Jan</td>
<td>5</td>
<td>50-59</td>
<td>CA for 17 years. Part time as CA and PT admin at home 5.</td>
</tr>
<tr>
<td>Tina</td>
<td>5</td>
<td>30-39</td>
<td>CA for 15 years, 3 at home 5. Tina struggled to understand some questions.</td>
</tr>
<tr>
<td>Liz</td>
<td>5</td>
<td>50-59</td>
<td>CA for 20 years. Quite shy, short interview.</td>
</tr>
<tr>
<td>Debbie</td>
<td>5</td>
<td>50-59</td>
<td>CA for 30 years, cared for own parent</td>
</tr>
<tr>
<td>Isobela</td>
<td>5</td>
<td>19-24</td>
<td>In UK as CA for 1 year but returning to Poland as homesick</td>
</tr>
<tr>
<td>Tendai</td>
<td>5</td>
<td>30-39</td>
<td>Ugandan, new to home 5, full time but also worked as agency staff in 2 other homes</td>
</tr>
<tr>
<td>Charlotte</td>
<td>5</td>
<td>50-59</td>
<td>CA for 48 years, at home 5 for 28 years, also senior staff. Short interview as Charlotte in rush</td>
</tr>
</tbody>
</table>
APPENDIX 8

RELIABILITY AND VALIDITY OF THE EMPATHY, EMOTIONAL LABOUR AND EMOTIONAL SUPPORT SCALES

Introduction

This appendix chapter will focus on the three scales used in the quantitative analysis, empathy, emotional labour and emotional support. Prior to using these scales to explore the associations between the three constructs and the impact of any social factors, tests of missing data, reliability and validity were first undertaken. This chapter will describe the process of these tests and the results, which impacted on how the scales were used in the multivariate analysis (Chapter 9). This stage of the analysis highlights some of the difficulties and limitations of using psychometric scales with different groups (i.e., care assistants) and also with participants who speak English as an acquired language. Problems, such as missing items on the scales are also explained, as well as the decisions taken in response.

One of the main challenges of using questionnaires containing psychometric or self-report scales with care assistants was the diversity of the care assistants' backgrounds. The Empathy and Emotional Labour scales in particular had not been designed or tested for those who speak English as an acquired language, although I gave some thought to this problem in the wording of the Emotional Support scale. Furthermore, care assistants vary greatly in their level of education and their literacy. The Empathy and Emotional Labour scales are also likely to have been predominantly used with undergraduates or groups with at least average levels of education. One of the aims of this research was to ascertain the reliability and validity of using such scales with care assistants, and if necessary to modify them to enable use within this heterogeneous group.
Methodology

Design of Scales

The Empathy Scale

The Empathy scale is based on the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983b). The empathy scale consists of two subscales of the IRI. The original IRI is a 28 item scale consisting of 4 subscales. Davis argues that trait empathy consists of a set of separate but related constructs and this scale measures 4 of those constructs. Firstly, the 'perspective taking' (PT) scale (“I sometimes try to understand my friends better by imagining how things look from their perspective”). The ‘empathic concern’ (EC) scale assesses the tendency to feel sympathy for unfortunate others (“When I see someone being taken advantage of, I feel kind of protective towards them”). The ‘personal distress’ (PD) scale looks at the emotions felt in response to extreme distress in others (“Being in a tense emotional situation scares me”). Finally, the ‘fantasy scale’ (FS) measures the tendency to “imaginatively transposes oneself into fictional situations”.

The subscales have been found to be reliable with the internal alpha coefficients ranging from .70 to .78 and the test-retest from .61 to .81 over a 2 month period (Davis 1983b). These reliability figures have been derived from studies whereby the participants spoke English as a first language.

For the purpose of this research the Perspective Taking (PT) and Empathic Concern (EC) scales were selected as the most relevant, as they most closely relate to aspects of care as well as to everyday life and to wider theories of empathy. The fantasy scale was immediately removed as it was less relevant to real life situations and also had lower face validity which could have affected response rates or encouraged participants not to take their responses seriously. The personal distress scale was also later removed as it was thought that participants may focus on situations that had occurred in their work as a care assistant rather than in life in general and so respond 'professionally' rather than emotionally. This could increase the social desirability of
responses and also encourage them to focus on specific distressing incidents rather than day to day life.

The Perspective Taking (PT) and Empathic Concern (EC) scales measure how likely a person is to engage in that particular type of empathic activity, but do not include a measure of behaviour relating to the empathic feeling. This corresponds to the definition of empathy being used in this research which focuses on affect and not on behaviour.

The PT and EC scales contain 14 items in total. Participants were asked to think about everyday life and indicate whether each statement does or does not describe them well using a 5-point Likert scale format. These PT and EC scales were piloted with a convenience sample of 5 care assistants from different homes. The scales were fairly well received and did not take long to answer.

**PT scale**
I sometimes find it difficult to see things from another person's point of view.
I try to look at everybody's side of a disagreement before I make a decision.
I sometimes try to understand my friends better by imagining how things look from their perspective.
If I'm sure I'm right about something, I don't waste time listening to other people's arguments.
I believe that there are two sides to every question and try to look at them both.
When I'm upset at someone, I usually try to "put myself in their shoes" for a while.
Before criticizing somebody, I try to imagine how I would feel if I were in their place.

**EC scale**
I often have tender, concerned feelings for people less fortunate than me.
Sometimes I don't feel very sorry for other people when they are having problems.
When I see someone being taken advantage of, I feel kind of protective towards them.
Other people's misfortunes do not usually disturb me very much.
When I see someone being treated unfairly, I don't often feel very much pity for them.
I am often quite touched by things that I see happen.
I would describe myself as a pretty soft-hearted person.

**The Emotional Labour Scale**
The Emotional Labour Scale (ELS) is based on a scale designed and validated by Brotheridge and Lee (2003). The original scale is a 15-item self-report questionnaire that measures six facets of emotional display in the workplace. These facets are the frequency of emotional display (Frequency), intensity of emotional display (Intensity)
and variety of emotional display (Variety), the duration of interaction, and surface and deep acting. The ELS was initially tested on samples of 296 and 238 respondents (Brotheridge & Lee, 2003). Estimates of internal consistency for the subscales ranged from .74 to .91. Confirmatory factor analysis results provided support for the existence of six unidimensional subscales. Evidence was also provided for convergent and discriminant validity.

The Surface and Deep Acting subscales, each consist of 3 items and are based on Hochschild’s (1983) study into how workers deal with emotional dissonance in their work. In this scale, as with Hochschild’s work, each are seen as fundamentally different. In surface acting only the emotional display is manipulated, whereas with deep acting it is the internal feelings that are changed. These two subscales were replicated exactly for the pilot study. The word ‘display’ was changed to ‘show’ on two of the items as the term ‘display’ was confusing to some care assistants, particularly those that did not have English as a first language.

Duration of interaction, frequency, intensity and variety of emotional display relate to management of appropriate emotions. The 4 subscales- frequency, variety, intensity and duration are based on work by Morris and Feldman (1996) who posited that the frequency, intensity, duration and variety of emotional expression would have positive, negative, or non-existent relationships with each other.

For the purposes of the current research, the single duration item has been removed as it was felt that the average time in minutes of a typical interaction with residents would not be valid in the case of residential care. The scale was piloted on 5 care assistants from different homes and the scale has been revised as follows. The 2 item scale for Intensity has been replicated exactly. However the subscales for Frequency and Display have each had one item removed and so have been reduced to 2 items each. The removed frequency item referred to how often workers ‘adopt certain emotions….’ and it was felt that this term could be difficult for some care workers to
fully understand. The removed Variety item was felt to be repetitive. The Emotional Labour Scale used in this research therefore contains 12 of the 15 original items.

Each statement in the ELS is preceded by the phrase ‘On an average day, when interacting with residents and staff, how often do you......?’ This is similar to the wording by Brotheridge and Lee (2003), but made more specific to care work. Participants respond to each statement using a 5-point likert scale ranging from ‘Never’ to ‘Always’. The items are given below under each of the 5 subscales. (See *appendix 3b Part A for order of items in questionnaire*)

**Frequency**
- Show specific emotions required by your job
- Express particular emotions needed for your job

**Intensity**
- Express intense emotions
- Show some strong emotions

**Variety**
- Show many different kinds of emotions
- Express many different emotions

**Surface acting**
- Resist expressing my true feelings
- Pretend to have emotions that I don’t really have
- Hide my true feelings about a situation

**Deep acting**
- Make an effort to actually feel the emotions that I need to display to others
- Try to actually experience the emotions that I must show
- Really try to feel the emotions I have to show as part of my job

**The Emotional Support Scale**
The Emotional Support scale was constructed specifically for this research project. The items in the scale were derived from the researcher’s own experiences working as a care assistant, and also data from pilot interviews conducted with a convenience sample of care assistants from separate homes unrelated to the sample of homes used for the main body of this research (See Chapter 4, Methodology)

The scale has not been divided into specific subscales although some general themes relating to emotional support were used to generate the items. These general themes were: Knowing the resident and understanding their needs, communication, empathising with residents, prioritizing emotion work and specific emotional labour.
The general themes and items derived from them are shown below:

Knowing the resident and understanding their needs:
- I am sure I notice when a resident is not themselves
- I usually know how much can be expected from each resident
- I often find that I don't know how residents like things done (e.g. during personal care)
- I don't really know how much each resident can do for themselves

Communication:
- I sometimes think about how best to communicate with a resident
- I often find I don't know what to say to a resident
- I make an effort to use non-verbal communication rather than just talking with some residents
- I struggle to communicate with some residents

Empathising with residents:
- I frequently think about how it would feel if I was in the position of the resident
- I sometimes think about how I would like a resident to be treated if they were my parent or loved one

Prioritising emotion work:
- I never just sit and chat with residents
- There are often situations where I provide reassurance to a resident
- It is an important part of my job to listen to a resident's worries or complaints
- I often chat with a resident while carrying out physical tasks, such as dressing
- I rarely talk to residents about their past or their family
- I often have a joke or make residents laugh

Specific emotional labour:
- I don't tend to express sympathy for a resident
- If I feel annoyed with a resident I tend to show my feelings
- I feel irritated at times by some residents but I cover my feelings

The scale consists of 19 self-report items. Participants indicate how well each statement describes them using a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree. (See Appendix 3a Part A for order of items in questionnaire)

This scale was positively received in the pilot home as participants felt it had face validity. It was also found to be more easily understood by those who speak English as an acquired language than the Empathy and Emotional Labour scales. This is likely to be due to the language used being more usual in everyday use, especially in care homes. This ES scale was reported as being the easiest to complete in terms of the language used and the questions being less abstract than the Empathy and Emotional Labour scales.
Data Analysis

As discussed in chapter 4, access to care homes was difficult and the return rate of questionnaires in some of the homes was lower than had been expected ($N = 68$). It became clear that not only were the care homes very much self selecting and therefore a biased sample, but the care assistants who responded to the questionnaires were also self selecting. Inferential statistics are based on probability sampling in which a random sample is gathered from a specific population. The current sample is far from being random, those who did not participate are likely to differ, in general terms, to those that did. Therefore, the absolute error and the p-values generated in any statistic must be treated very cautiously.

Missing Data

Missing values pose a problem in any statistical analysis. There are several methods for dealing with missing data, which will be briefly outlined before discussing the approach taken in this research. Several source materials were used in addressing the issue of missingness; Field (2005), Tabachnick and Fidell (2001), an ESRC supported website (www.missingdata.org.uk) and SPSS Version 13 ‘help and support’.

Firstly, cases with missing items could be deleted casewise. That is they are removed from all analysis on, for example, a correlation matrix. Secondly, cases can be removed pairwise, that is they are only removed from analysis involving that variable, for example in a correlation matrix values from each pair of variables are calculated from every valid case for those two variables. Casewise deletion makes the assumption that all the data is invalid for a case should a single item be missing. It also assumes the missing items and cases are random. Casewise deletion also assumes that the missing data is randomly distributed and that there are not patterns as to which cases have missing data. Pairwise deletion is not an option for all statistical tests as they rely on a true matrix.
A second option is to analyse the missing data in order to understand any patterns as to which items are missing and if this occurs randomly. Missing items can then be imputed using the other items that have been completed. This is known as EM (expectation-maximization). This is better than replacing a value with a mean score as it includes not only the other scores on the scale, but the demographic details as well. Therefore if those that do not speak English as a 1st language have tended to respond differently on a particular item than those that do, this will be taken into account. This method means that more cases can be used, ideal for the current sample which has a relatively small number of cases and even smaller subgroups. However it also leads to incorrect standard errors as it does not allow sampling variance in the imputed values. In this research, the biased method of data collection and the lack of random selection has already negated the assumptions of a genuine probability sample and the standard error is already inaccurate. Ensuring sample sizes are as large as possible in order to detect medium as well as large effect sizes is more important therefore than any concerns regarding the standard error as the p-value can now only be used as a guide.

In this research the reasons for items being missed are not known for any specific missing value. However, several reasons are likely. For the infrequent, individual missing item the participant either missed it accidentally, did not like the question or did not understand the question. Where several, most or all items on a scale have been missed it is likely that a page was accidentally missed out, the participant did not like or did not understand a number of the questions, the participant became bored with the questionnaire or the participant did not have time to thoroughly complete the questionnaire. It is those items that have been purposely missed due to not understanding or not liking the question that are of specific interest as this could point to a problem with a specific item or a problem that only effects some groups of care assistants.

Missing data falls into one of three categories. The values could be Missing Completely at Random (MCAR), that is, the reason for the missing data does not
depend on the observed data or any unobserved factor. The second type are Missing at Random (MAR) data, which means that the reason for the missing data can be explained by the observed data, and once accounted for, there is no effect of unobserved factors. If the missing values are not entirely accounted for by the observed data however, the missing data is Not Missing at Random (NMAR). The current data was expected to be MAR, that is, it would be possible to understand non randomly missing data by looking at the other observed variables.

A missing data analysis using SPSS was undertaken for each of the scales separately. The scales were treated as 'quantitative' data and all of the other variables were treated as categorical. 'Age', 'how long as a care assistant' and 'how long working at the home' were converted into categorical data. Tables of patterns of missing data were used to ascertain which cases has missed which items and if there appeared to be any pattern as to which items were most frequently missed. Differences in those that did and did not speak English as a 1st language were specifically examined for each scale.

Little’s test of missingness was used to determine whether the missing data was MCAR or MAR. If the result was insignificant it could be assumed that missing items on any given variable was MCAR and could not be predicted by any other combination of observed or unobserved variables. If Little’s test was found to be significant, the data was assumed to be MAR or NMAR. Further analysis of those cases that had missed items was than conducted to determine which variables accounted for the non-random missingness. Crosstabulations were used to determine those variables that had a higher than expected missingness frequency.

Missing values for each of the scales were then imputed using EM (expectation maximization). This method was derived using theoretical and practical information from www.missingdata.org.uk. Cases where more than 20% of items from any scale were treated as having missing items and so were removed from any analysis involving those items. They were not therefore included in Factor Analysis. These
cases could still be used for analysis those subscales that were complete, and for analysis of other scales.

Reliability tests were conducted using both the imputed data set and the data with missing values to determine the impact of the imputed values. It was ascertained that mostly minor differences occurred except where the sample size had been considerably increased (overseas staff on the emotional support scale in particular). The missing items did not form a high proportion of any subscale. The imputed values were therefore used in the rest of the analyses.

**Reliability Testing and Factor Analysis**

Cronbach’s Alpha was used as a basic test of reliability for the three scales. The full scales were tested using all the cases, followed by separate tests for those who speak English as a 1st language (N=49) and English as an acquired language (N=18). This was repeated using the subscale where appropriate. Sample sizes were too small to conduct confirmatory factor analysis using the Empathy and Emotional Labour subscales, so exploratory FA was instead conducted using maximum likelihood and the direct oblimin rotation. This was conducted for all the cases and also for those that spoke English as a 1st language. The group that did not speak English as a 1st language was too small for FA. One aim was to form one overall scale for Empathy, Emotional Labour and Emotional Support, that was reliable for all the groups. A second aim was to determine whether the subscales related to the previously determined subscales. Finally new subscales relevant to this research were determined.

The new scales and subscales were then also tested for reliability. Some subscales were found to be inappropriate for those who did not speak English as a 1st language. These were highlighted and not used in analysis for that group as will be described in the results section below.
The method and results for the validation of the Emotional Support scale is given towards the end of this chapter after the reliability analysis.

*English as a First Language*

A simple short hand will be used to describe staff who speak English as a first language (E1stL staff) and staff who speak English as an acquired language (EAL staff)

**Results**

*Empathy Scale*

**Missing Data**

*Table A8.1: Pattern of missing values for Empathy Scale*

<table>
<thead>
<tr>
<th>Case no</th>
<th>Number of missing values</th>
<th>Missing items</th>
<th>English 1st lang</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>g</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>3</td>
<td>f,m,n</td>
<td>Yes</td>
</tr>
<tr>
<td>57</td>
<td>3</td>
<td>f,k,m</td>
<td>No</td>
</tr>
<tr>
<td>60</td>
<td>1</td>
<td>g</td>
<td>Unknown</td>
</tr>
<tr>
<td>64</td>
<td>2</td>
<td>c,f</td>
<td>Yes</td>
</tr>
</tbody>
</table>

As can be seen from Table A8.1 above, only 5 cases had missing values on the empathy scale. Items f, g and m were the most frequently missed, with item f missing 3 times or 4.41% (*Please see the 1st scale on the questionnaire, Appendix 3b for items*). It appears that these items were not as well understood or were disliked by some care assistants. However the distribution does not appear to be based on language skills.

The items on the empathy scale were entered as 'quantitative' (representing interval data) on Little's MCAR test using SPSS. This test is a chi-square test for missing completely at random. The categorical variables from the questionnaire were also all entered.
The SPSS Missing Values Analysis (MVA) option supports Little's MCAR test, which is a chi-square test for missing completely at random. A non-significant p-value for Little's MCAR test means the data may be assumed to be MCAR.

\[ \chi^2 = 57.59; \text{ df } = 47; \text{ p } = 0.14 \]

This finding was not significant (p>0.05) and so it can be assumed that although some items were more frequently missed, they could not be predicted by any combination of the observed variables. It can also be assumed that no underlying unobserved variables could predict the pattern of missingness. Crosstabulations of all the variables against those with missing items and those with none were conducted to confirm this finding. No groups were found to be considerably more likely to have missing items.

Values on the missing items were imputed using EM (Expectation Maximization, as outlined above). In practice SPSS estimates the missing value, based on the pattern of scores for that item in relation to the other variables (in this case the other items on the empathy scale and the categorical information given on the questionnaire). A Maximum Likelihood estimation method is applied to test how well this estimated figure fits the data, and makes another estimation. This process continues until the estimated value which best fits the model is found. The 10 missing items were replaced with estimates, generated by SPSS. Reliability tests were conducted on both the original data and the imputed data.

Reliability
Reliability analysis revealed there were mainly very small differences between the data containing imputed values for missing scores and the original data set. These differences were very minor and so the imputed data was used. Chronbach's alpha was used as a test of reliability.

Empathy Scale: All Items
n = 68; \( \alpha = 0.814 \)
If remove item (b) \( \alpha = 0.830 \)
If only include E1stL staff  
n=49; $\alpha=0.865$  
If remove item (b) $\alpha=0.868$

If only include EAL staff  
n=18; $\alpha=0.647$  
If remove item (a) $\alpha=0.657$  
If remove item (b) $\alpha=0.733$  
If remove item (c) $\alpha=0.694$  
If remove item (l) $\alpha=0.662$

Item (b) is problematic, more so for EAL staff. It shall therefore be removed from the scale.

The total score on the complete Empathy scale can be used for the group as a whole or for E1stL and EAL separately once item (b) is removed.

_Perspective Taking (PT) scale_

n=68; $\alpha=0.731$  
If item (b) removed, $\alpha=0.789$

If only include E1stL staff  
n=49; $\alpha=0.783$  
If item (b) removed $\alpha=0.802$

If only include EAL staff  
n=18; $\alpha=0.582$  
If item (b) removed $\alpha=0.760$

This confirms that item b is a particular problem for those who do not speak English as a 1st language. With it removed the scale can be used for staff as a whole or the 2 groups separately.
**Empathic Concern (EC) scale**

n=68; $\alpha=0.651$

If item (e) removed $\alpha=0.659$

If only include E1stL staff
n=49; $\alpha=0.770$

If only include EAL staff
n=18; $\alpha=0.171$

If remove item (e) $\alpha=0.381$

The EC scale is not reliable for those who do not speak English as a 1st language. The PT and EC scales can be used together to form one total scale for all care assistants, but when using the EC scale alone it can only be used with E1stL staff. Item (e) shall not be removed as this does not improve the reliability for English speakers or the reliability of the scale as a whole.

**Factor Analysis**

A factor analysis (maximum likelihood, direct oblimin) was conducted for all cases on the Empathy scale (Field 2005). Items d,e,f,h,i,j,k,m and n all loaded on 1 factor, both when factors were formed using eigenvalues over 1 and when all the items were forced into 2 factors. This factor accounted for 34% of the variance. This factor does not relate to the EC or PT sub-scales, and no obvious connection between the items is apparent. The factors contain a mixture of positively and negatively worded items. As the subscales EC and PT did not emerge at all from factor analysis and due to the reliability problems outlined above with the separate subscales, the empathy scale will be used as one complete scale for analysis, with only the unreliable item (b) removed.
Missing Data

Table A8.2: Pattern of missing values for Emotional Labour Scale

<table>
<thead>
<tr>
<th>Case no</th>
<th>Number of missing values</th>
<th>Missing items</th>
<th>English 1st lang</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>a</td>
<td>no</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>d</td>
<td>yes</td>
</tr>
<tr>
<td>8</td>
<td>12</td>
<td>all</td>
<td>no</td>
</tr>
<tr>
<td>21</td>
<td>1</td>
<td>e</td>
<td>yes</td>
</tr>
<tr>
<td>28</td>
<td>1</td>
<td>e</td>
<td>yes</td>
</tr>
<tr>
<td>31</td>
<td>4</td>
<td>e,i,k,l</td>
<td>yes</td>
</tr>
<tr>
<td>49</td>
<td>1</td>
<td>e</td>
<td>yes</td>
</tr>
<tr>
<td>60</td>
<td>12</td>
<td>all</td>
<td>unknown</td>
</tr>
</tbody>
</table>

As can be seen from Table A8.2 above, 8 cases had missing items, 2 of these had missed the entire scale. Case 8 only missed the empathy scale and also took part in an interview. It is likely that this participant accidentally missed a page of the questionnaire. Case 60 also missed most of the emotional support scale having completed the empathy scale. It is likely this participant ran out of time or became bored or irritated by the questionnaire. As can be seen from the table, item e was the most likely to be missed with 4 cases (excluding those that missed the entire scale) missing this item or 6.06% of cases. It does not appear that language skills have impacted on the likelihood of missingness as the majority of cases with missing items spoke English as a 1st language.

The items on the emotional labour scale were entered as quantitative (representing interval data) on Little's MCAR test. The categorical variables were also all entered.

\[ \chi^2 = 53.42; \text{df} = 41; \text{p} = 0.093 \]

This finding was not significant and so it can be assumed that although some items were more frequently missed, this could not be predicted by any combination of the observed variables. It can also be assumed that no underlying unobserved variables
could predict the pattern of missingness. Crosstabs of all the variables against those with missing items and those with none were conducted to confirm this finding. No groups were found to be considerably more likely to have missing items.

Values on 5 missing items were imputed using EM (expectation maximization). Reliability tests were conducted on both the original data and the imputed data. Cases 8 and 60 were removed from all tests involving the emotional labour scale. Case 31 was left with missing values and was only included in those tests that did not include those items, for example reliability of some subscales.

*Reliability*

Reliability analysis was conducted with both the data containing imputed values for missing scores and with the original data set. There was little variation between the two data sets and the imputed data was used in all further tests. Chronbach’s alpha was used as a test of reliability

*All Emotional Labour Items*

\[ n = 65; \alpha = 0.712 \]

If remove item (f) \( \alpha = 0.719 \)
If remove item (g) \( \alpha = 0.716 \)

If only include E1stL staff
\[ n = 48; \alpha = 0.766 \]
If remove item (f) \( \alpha = 0.773 \)
If remove item (a) \( \alpha = 0.774 \)

If only include EAL staff
\[ n = 17; \alpha = 0.492 \]
If remove item (g) \( \alpha = 0.582 \)
If remove item (j) \( \alpha = 0.633 \)

The decision was taken to remove two items, G and J from the full scale as both were particularly unreliable for EAL staff. Having removed these items, and repeated reliability testing, item F was also found to be unreliable for all cases and E1stL staff in particular. This item was also removed.
All items. F, G and J removed

n = 65; \( \alpha = 0.731 \)

If only include EL staff

n = 48; \( \alpha = 0.716 \)

If only include EAL staff

n = 17; \( \alpha = 0.730 \)

To use a full Emotional Labour scale items F, G and J will be removed as this gives acceptable levels of reliability across all groups.

Factor Analysis

A factor analysis (maximum likelihood, direct oblimin, Eigenvalues over 1) was conducted for all cases. Three factors formed that were based on the merging of the original 5 subscales as follows.

Factor 1: SA (surface acting)
Items A, F and G.
26% of variance

Factor 2: V & I (variety & intensity)
Items B, C, H and I
18% variance

Factor 3: DA & F (deep acting & frequency)
Items D, E, J, K and L
15% variance

A second factor analysis only including those who speak English as a 1st language yielded the same 3 factors, although with 30%, 14% and 17% of the variance
respectively. The sample of EAL staff was too small for even exploratory factor analysis.

Reliability Subscales

Surface Acting (3 items)

n=66; $\alpha=0.683$
If item (a) deleted $\alpha=0.737$

If only include E1stL staff
n=49; $\alpha=0.696$
If item (a) deleted $\alpha=0.755$

If only include EAL staff
n=17; $\alpha=0.696$

Variety & Intensity (4 items)

n=65; $\alpha=0.820$

If only include English as 1st language
n=48; $\alpha=0.746$

If only include those who do not speak English as a 1st language
n=17; $\alpha=0.880$

Deep Acting & Frequency (5 items)

n=65; $\alpha=0.729$
If item (I) deleted $\alpha=0.735$

If only include E1stL staff
n=48; $\alpha=0.845$

If only include EAL staff
n=17; $\alpha=0.246$
If exclude e $\alpha=0.289$
If exclude j $\alpha=0.321$
If exclude l $\alpha=0.408$
All extremely non-reliable items for EAL staff are from Deep Acting scale. The Deep Acting and Frequency scale cannot be used for EAL staff, but can be used for E1stL staff and for all cases.

*Emotional Support Scale*

**Missing Data**

**Table A8.3: Pattern of missing values for Emotional Support Scale**

<table>
<thead>
<tr>
<th>Case no</th>
<th>Number of missing values</th>
<th>Missing items</th>
<th>English 1st lang</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>e</td>
<td>no</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>e,j</td>
<td>no</td>
</tr>
<tr>
<td>50</td>
<td>1</td>
<td>b</td>
<td>yes</td>
</tr>
<tr>
<td>51</td>
<td>1</td>
<td>a</td>
<td>no</td>
</tr>
<tr>
<td>56</td>
<td>17</td>
<td>all except r,s</td>
<td>no</td>
</tr>
<tr>
<td>57</td>
<td>2</td>
<td>c,d</td>
<td>no</td>
</tr>
<tr>
<td>60</td>
<td>17</td>
<td>all except r,s</td>
<td>unknown</td>
</tr>
<tr>
<td>64</td>
<td>1</td>
<td>j</td>
<td>yes</td>
</tr>
</tbody>
</table>

As can be seen from Table A8.3 above, 8 cases had missing items, 2 of these had missed the entire scale except the last 2 items which were on the next page. Case 60 had also missed the entire emotional labour scale. The other 6 cases missed 1 or 2 items each. Items e and j were both missed twice. The table also shows that those who do not speak English as a 1st language were more likely to miss items on this scale.

The items on the emotional support scale were entered as quantitative (representing interval data) on Little’s MCAR test. The categorical variables were also all entered.

\[ \chi^2 = 142.56; \text{df} = 108; \text{p} = 0.015 \]

This significant finding suggests that the missing items can be predicted by other observed or unobserved variables. The data are can not be MCAR (missing completely at random), but either MAR or NMAR. Statistical analysis to compare the mean scores of other items on the scale or the categorical variables for those who did and did not miss items were not possible due there being only 8 cases with missing items. The assumptions of both the t-test (roughly equal group sizes) and \( \chi^2 \) (no more than 20%
cells with assumed frequency of less than 5, no cells less than 1) were violated.
Crosstabulations of all the cases with missing variables and those with none, against
all the categorical variables were conducted.

**Summary of crosstabulations**

Those variables which could have predicted the pattern of missing values are briefly
outlined below.

**English as 1st language**

Those who did not speak English as a 1st language contained 71% missing cases
compared to 27% total cases. English as a 1st language is the strongest predictor of
missingness as it directly impacts on missing values as well as indirectly predicts them
through other variables.

**Table A8.4: Crosstabulations of Ethnic Background against missing data on
Emotional Support scale**

<table>
<thead>
<tr>
<th>Complete Scale</th>
<th>Indian</th>
<th>Asian-other</th>
<th>Black-Caribbean</th>
<th>Black-African</th>
<th>White-UK/Irish</th>
<th>White European</th>
<th>White-Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Scale</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>39</td>
<td>10</td>
<td>4</td>
<td>60</td>
</tr>
<tr>
<td>Missing values</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

As can be seen from table 9.4, the distribution of cases with missing values is not
equal across the different ethnic groups, however with such low frequencies for some
of the groups, percentages are deceptive. White-UK/Irish have a lower than expected
frequency of missing values. White European have about the expected number of
missing cases. Indian, Asian-other and Black-African have more than expected but
also very low total frequencies.

The following variables also contained unequal distributions of missing items:

- Home (which of the 8 care homes the care assistants was from)
- Age
- How long as a care assistant
- Still in education
- Completed manual handling
Completed NVQ2
Relative entered residential care

Summary

It was found that for all the variables with unexpected distributions of missing values, there were also similar unequal distributions of EAL staff. It is therefore likely that the missing values can be greatly predicted by the variable, English as a 1st language.

Although effects caused by unobserved variables can not be tested for, it shall be assumed that the effect of English as a 1st language strongly predicts missingness and so the data can be assumed to be MAR. Values of 8 missing items were imputed using EM (expectation maximization) which is suitable for MAR data. Reliability tests were conducted on both the original data and the imputed data. The imputed data set was used in all further analysis. Cases 56 and 60 were removed from all tests involving the emotional labour scale as they had almost all of the scale missing.

Reliability
Reliability analysis was conducted with both the data containing imputed values for missing scores and with the original data set. Chronbach's alpha was used as a test of reliability

All items
n= 66; \( \alpha = 0.827 \)
If remove item (e) \( \alpha = 0.835 \)
If remove item (s) \( \alpha = 0.839 \)

If only include E1stL staff
n=49; \( \alpha = 0.861 \)
If remove item (e) \( \alpha = 0.868 \)
If remove item (s) \( \alpha = 0.872 \)

If only include EAL staff
n= 17; \( \alpha = 0.679 \)
If remove item (e) \( \alpha = 0.686 \)
If remove item (i) \( \alpha = 0.734 \)
If remove item (k) \( \alpha = 0.711 \)
If remove item (p) \( \alpha = 0.690 \)
If remove item (s) \( \alpha = 0.692 \)

This scale is likely to be effected by English as a 1st language, not just because of issues of filling in the questionnaire, but because a number of the items refer to talking to residents. It is therefore possible that a person scores high on some emotional support questions, but then lower on the communication type questions due to the language barrier. Item I, K and P all related to verbal communication with residents which could be why these items were less reliable for EAL staff. This could represent the variation in language ability amongst this group.

It was decided that as items E and S were found to be less reliable in all of the tests above, these items would be removed from the full scale. This increases \( \alpha = 0.719 \) for those who do not speak English as a 1st language. This scale could them be used for all groups, although bearing in mind the issues relating to the verbal communication variables as described above.

**Factor Analysis**

A factor analysis (maximum likelihood, direct oblimin, Eigenvalues over 1) was conducted for all cases and also for those that speak English as a 1st language. As both analyses appeared to yield 3 similar factors as well as some unclear factors, the analyses were repeated extracting only 3 factors. The 2 sets of analysis, from all the cases and those that spoke English as a 1st language, were used together to form 2 factors that had a good theoretical basis.

**Factor 1: Prioritising Emotional Support**

Items g, h, i, m, n, q

- g) I frequently think about how it would feel if I was in the position of the resident
- h) There are often situations where I provide reassurance to a resident
- i) It is an important part of my job to listen to a resident’s worries or complaints
- m) I sometimes think about how I would like a resident to be treated if they were my parent or loved one
- n) I often chat with a resident while carrying out physical tasks, such as dressing
- q) I often have a joke or make residents laugh
Factor 2: Knowledge of, and relationship with residents
Items a, c, d, f, i, j, k, p, r

a) I often find that I don’t know how residents like things done (e.g. during personal care)
b) I sometimes think about how best to communicate with a resident
c) I am sure I notice when a resident is not themselves
d) I often find I don’t know what to say to a resident
e) I usually know how much can be expected from each resident
f) I never just sit and chat with residents
i) I don’t tend to express sympathy for a resident
j) I struggle to communicate with some residents
k) I rarely talk to residents about their past or their family
l) I don’t really know how much each resident can do for themselves

Items b, e, o and s did not load, or did not load consistently on any factors
b) I sometimes think about how best to communicate with a resident
e) I make an effort to use non-verbal communication rather than just talking with some residents
o) If I feel annoyed with a resident I tend to show my feelings
s) I feel irritated at times by some residents but I cover my feelings

Reliability Subscales

Factor 1
n= 66; α= 0.848

If only include E1stL staff
n=49; α=0.854

If only include EAL staff
n= 17; α=0.836

Factor 2
n= 66; α= 0.769

If only include E 1st L staff
n=49; α=0.830

If only include EAL staff
n= 17; α=0.474
If remove a α= 0.499
If remove c α= 0.541
If remove i α= 0.517
If remove k α= 0.528
Factor 1 contains all positively coded items and Factor 2 contains negatively coded items. While the factors do appear to fall into themes, this pattern also suggests that the language used in the items also impacts on how staff respond. The first factor was reliable for all groups, but Factor 2 was unreliable for EAL staff. No items will be removed, but Factor 2 will be regarded with some caution in relation to EAL staff. Although there could be some difficulty in overseas staff not understanding the questions, items I and k directly relate to talking to residents, so it would not be surprising if these items were different for overseas staff. However, it makes sense that to know residents and to build a relationship, care staff must be able to effectively communicate. These items will therefore remain.

In the main analysis (Chapter 10), the emotional support scales will be analysis as a full scale and also as two sub-scales, given the unreliability of Factor 2 for overseas staff and the concerns regarding the negatively coded items.

Assessing the Validity of the Emotional Support Scale

A method of triangulation was used to provide an indication of validity for the new emotional support scale. As all the care assistants who participated in interviews had completed a questionnaire, the interview data for these participants could be compared to their score on the emotional support scale, as described below. This method relies on an 'increased validity' model of triangulation (Moran-Ellis et al. 2006), which assumes that confidence in a measurement can be increased if it produces complimentary results, to another method. However, in order to do this, the interpretative analysis could not be practically used, so a more empiricist approach has been taken to analyse relevant sections of the interviews. This approach is not without flaws. Both the interview and questionnaire data are self reported by the care assistants, and therefore subjected to some of the same biases associated with that method (eg positive social presentation of the self).
Method and Results

The interviews were rated for level of emotional support provided for the residents. The question specifically asking to talk through a recent example of personal care for a specific resident was the focus of these ratings. However any specific example given was used, these being examples describing a particular example of care from memory, usually involving an individual resident. These types of examples were also frequently given when asked to described a time when a care assistant had calmed or comforted a resident in some way and also when they had tried to calm or comfort a resident but the resident had not responded as the carer would have hoped. The care was rated as good, adequate or poor for each example and then an overall rating given based on an 'average' score. While there were a couple of examples of poorer care, overall no care assistants were rated as poor. Most examples of poorer care were given when those being interviewed made references to other care assistants and were not about themselves. Some interview excerpts and their ratings are given in the Appendix 9.

14 care staff interviews were rated as describing 'adequate' emotional support, and 22 were rated as 'good'.

The range of scores on the emotional support scale, Factor 1 (Prioritising Emotional Support) and Factor 2 (Knowledge of, and relationship with residents) were divided into 2 equal groups using the median of the 36 care assistants that also participated in interviews. These were categorised as those scoring high or low.

Table A8.5: Frequency Chart for Full Emotional Support Scale

<table>
<thead>
<tr>
<th>Interview Score</th>
<th>Emotional Support Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Adequate</td>
<td>11</td>
</tr>
<tr>
<td>High</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

A significant association was found between the interview ratings and the full emotional support scale

\[ \chi^2 (1) = 8.24, p<0.01 \]
A measure of strength of the association (Phi) suggests the association is approaching large (0.3 classed as medium and 0.5 as large)

\[ \text{Phi} = 0.49, p<0.01 \]

Table A8.6: Frequency Chart for Factor 1

<table>
<thead>
<tr>
<th>Interview Score</th>
<th>Factor 1 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Adequate</td>
<td>8</td>
</tr>
<tr>
<td>High</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

No association was found between the interview rating and Factor 1

Table A8.7: Frequency Chart for Factor 2

<table>
<thead>
<tr>
<th>Interview Score</th>
<th>Factor 2 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Adequate</td>
<td>11</td>
</tr>
<tr>
<td>High</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

A significant association was found between the interview ratings and the full emotional support scale

\[ x^2 (1) = 7.48, p<0.01 \]

A measure of strength of the association (Phi) suggests the association is approaching large (0.3 classed as medium and 0.5 as large)

\[ \text{Phi} = 0.46, p<0.01 \]

Both Emotional Support and Factor 2 show a significant association with the interview ratings. The strength of this association is approaching large (0.3 classed as medium and 0.5 as large). As shown in the frequency tables, fewer than expected high scoring participants were rated as adequate on the interview and a greater number high scoring participants were rated as good. Fewer than expected medium and low scoring participants were rated as good on the interviews and more were rated as adequate. Therefore, the association between the scales and the interview rating was in the
direction that would be expected for the interviews to validate the scale. The association was good although there were still unexpected findings with some participants scoring low on the scales and high on the interviews and vice versa. In particular, 7 care assistants were rated as ‘good’ on the questionnaire, but scored ‘low’ on the emotional support scale or factor 2 (knowledge of residents). This could reflect the method that has been used, in that the scores on the scales have been divided into two equal groups. It is possible that some of these care staff scored just below the ‘high’ cut-off. It could also reflect that care staff were more likely to present positive image of themselves in face to face interviews than when completing relatively impersonal questionnaires. This could reflect a bias in the interview ratings. This is possible as most of the care staff were rated as good, and none as poor.

However, overall, these findings strongly suggest that the emotional support scale and Factor 2 do generally relate to more detailed responses given in the interviews. Interestingly, Factor 2 was also the factor with a much higher proportion of negatively worded items. Although it would be better to reduce the number of negatively worded items in a future scale, it would appear from these results that this did not necessarily impact on the overall understanding of the items for the majority of participants.

As previously stated, Factor 1 did not show any association with the interview ratings. Factor 1 related to prioritising emotional support in general terms, whereas Factor 2 related to knowing the residents and building a relationship with them. In retrospect, the interview schedule gave far more opportunity for care assistants to highlight how well they knew particular residents and meaningful relationships they had with residents. While some care staff did talk about prioritising emotional support, many did not and it was not specifically referred to in the interview schedule. Particularly, those who had cared for a dependent relative often spoke about how important particular aspects of emotional support were. As this was often spoken about in general terms with no examples given this was not rated in the interviews. While many care staff did appear to prioritise emotional support as part of their understanding of their care role, it was also likely that some care staff spoke about
those things they had looked at in training, such as dignity, choice and respect, but the
general knowledge did not necessarily translate into how they cared for the residents.
The interview data would also suggest that organisational factors play a greater role in
prioritizing emotional support than getting to know residents. These findings highlight
some difficulties with Factor 1. It is a skewed scale, with most people scoring high (as
discussed in chapter 9), but it is also particularly difficult to validate.

These findings are promising, as there is some association between the emotional
support scale and the interviews. However, it is not yet clear how useful the inclusion
of Factor 1 as a separate scale is in determining variation between care assistants or
homes. This confirms that the full emotional support scale as well as the 2 factors
should be analysed separately in future analysis.

Discussion

This chapter has described the method of assessing the reliability of the empathy,
emotional labour and emotional support scales, and the process of decision making
arising from the findings. As expected, there have been some difficulties in reliability
for all staff specifically for those staff who speak English as an acquired language.
This has highlighted many of the wider issues relating to the use of quantitative
psychometric scales with particular groups.

The Empathy and Emotional Support scales, have both previously been tested for
reliability and split into subscales. Overall, these scales were found to be reliable for
use with care staff. However, the empathy scale did not split into 2 factors relating to
the Perspective Taking and Empathic Concern subscales (Davis, 1983b), and the
emotional labour scale (Brotheridge & Lee, 2003) split into 3 subscale, not 5, although
these consisted of grouping of the original 5. Only one of the emotional labour
subscale (deep acting and frequency) was found to be unreliable for EAL staff. This
analysis has highlighted the need to carefully analyse and prepare data before further
statistical analysis, as, while useable, these scale and subscales can not reliably be used in their original form and using the original subscales.

More complex, has been the analysis of the newly designed emotional support scale. While the language on the scale was more simple compared with the other scales, the language effected the formation of subscales, with negatively coding item loading on one factor (Factor 2). Despite this, however, the two scales do appear to fall into two theoretical categories: Prioritising emotional support and knowledge of and relationship with residents. While the second factor relied more heavily on verbal communication and so was less reliable for EAL staff, it was also the factor that was found to be significantly associated with the detailed interview responses. Therefore there is a contradiction with the factors partly relating to the language of the items, but also being shown to be differently associated with the interviews. It could be that those that tended to score lower on the Factor 2 scale due to language problems, would also have scored lower on the interviews for the same reason. The problem arises as to whether this scale is therefore invalid and unreliable for overseas staff, or if they reflect actual differences in linguistic skill which do in fact influence emotional support.

In contrast, Factor 1 was not found to be associated with the interview responses, a disappointing finding although it was acknowledged that in hindsight, there was less scope for care staff to provide specific evidence of 'prioritising emotional support' compared to showing their knowledge of the residents. Factor 1 was more reliable though. Overall then, some caution must be taken with factor 2 with EAL staff due to reliability problems. While factor 1 and 2 are clearly indicating different aspects of care work, it is not clear how valid factor 1 is. Given the nature of Factor 1 (prioritizing emotional support), it is likely another method of validation would be more appropriate than the current interview data. More research involving a larger care assistant sample would be necessary to fully assess and understand this scale and the two factors. However, for the current research the scale is both reliable and shows some indication of validity for it to be of use in further analysis.
APPENDIX 9

Examples of Interview Ratings

Good Care

R.L: Would you be able to talk me through getting that particular person up and exactly what you did?

Wendy: Um. One particular resident, well she has to be hoisted out of bed. And sometimes can be slightly confused. Um, I walked into the room, I always walk in sort of, not silent, but gently, not sort of like barging in and just flinging open the curtains. I normally go up to her and say ‘good morning’ by her name, and she’ll respond. And I’ll just stroke her hand, ask how she is how she’s feeling today. I say would she like to get up washed and dressed or would she like a little bit longer? So she goes ‘yes I want a bit longer’ or vice versa. But than I have to press staff call for assistance for the hoist. And we were waiting 15 minutes (sighs) which it happens, but you know. So we just generally talked about her artwork. She’s got paintings on her room walls which she’s done herself because she lived abroad in the Seychelles and, she’d done some lovely paintings. So we discussed that. And um, would she like to later go down for lunch and sort of things in general like that, just keeping everything calm. And then, she said she was a bit frightened of falling so we said, you know, I explained that we did have the cot sides attached to the bed so there’s no chance of her falling, she’s nice and safe. It’s just reassurance. And, the carer came, got her up and then I left the other carer to wash and dress and then, while I went off and saw to another resident and do the medication, cos one of us that’s on a wing has to do the meds. Then came back. So, you know, that’s my morning with my one particular resident which I’m a keyworker to and quite fond of really.

Adequate Care

R.L: Um, can you think of a shift that you found particularly stressful and explain why, why you were stressed?

Emma: Um.. About 2 weeks ago it was a particularly stressful shift. Not because it was any more stressful than any other one but just because of my ability to be able to cope with it. John, I went into his room after supper. You have after 6.30 when suppers are finished, you’ve got 2 and a half hours to get everybody in bed and drinks and everything done. In 2 and a half hours, you’ve only got one float in the evening for 4 wings as well. And I went into him and he said ‘thank you for my supper and blah de blah, and by the way I think I’m dirty’. And I said right well I’ll go and get you on the toilet then. So I got rid of his supper things and came back to him. And he’d just been incontinent of faeces in his pad and he must have been sat in it for about half an hour an hour. And he says he doesn’t like to, you know, I said, why didn’t you
buzz? He said cos I don’t like to disturb you. And I said but John you buzz for a cup of tea you need to be buzzing for this sort of thing, this is what you need to be buzzing for. ‘Oh, but I didn’t know I’d gone, I couldn’t feel it, I never knew that I’d even been’. And I was like, right. So it took us an hour to get him done with him constantly telling us that we’re doing it wrong, that we’re being spiteful, ‘oh I think I must have done something to offend you at some time, and this is your way of getting back at me’. I’m like John I’m being nice here, I’m cleaning you up and, you know. And then another lady came in and we’d been into him for an hour. Half past seven and we go off shift at 9. Half past 7 and he says ‘you people just don’t have the time for me’ at which point both of us just went ‘oh John!’. It’s just like, oh, I just don’t know what we could do anymore. And then after that I was just so tired that everything was just, you know, it justs takes it out of you. If they’re having a laugh and a giggle with you, it’s enjoyable. When they’re like that you come out and it’s just like ughh.

Poor Care

R.L: Is there anything that sticks out in your memory or anything like that?

Olga: Yeah, I was helping one gentleman. He’s, he likes when you shave him, every day. Because he used to be a soldier or something and he likes to be shaved every morning. And some of them, just sometimes we haven’t got time, or just sometimes there’s lots of, you know it’s just up to the day. Like Monday it’s pretty alright we’re not really busy, but sometimes you know, when you can’t cope, you’re just sort of telling him like, we’ll shave you later, if you don’t mind to have the shave tomorrow, because we’re like so, a bit busy and stuff. So he was quite upset that day, since morning, you know and we were really busy and stuff. And I was upstairs but there was 2 people downstairs but they couldn’t shave him cos they were so busy. So I was, I was so, I went downstairs to like see how they getting on and stuff. And I saw him and he’s not very happy and stuff, you know and I was told hat he’s not shaved and he’s off to breakfast. So I said, would you like to have a shave, and he’s like, yeah lovely. And he was like so pleased that I actually shaved him that day. So yeah he’s very happy when he’s having a shave.

Note: In this example time constraints mean this resident is not always shaved which is an example of poor care. Olga’s action in this case can be regarded as adequate care and so this example includes aspects of each.
### APPENDIX 10

**Descriptive Statistics for Non-significant Variables**

*Table A10.1:* Frequency table for Part-time and Full-time staff

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part-time</td>
<td>19</td>
<td>28.4</td>
</tr>
<tr>
<td>Full-time</td>
<td>48</td>
<td>71.6</td>
</tr>
</tbody>
</table>

*Table A10.2:* Frequency table for How long staff have worked as a CA

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 months</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Under 1 year</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1-2 years</td>
<td>8</td>
<td>11.9</td>
</tr>
<tr>
<td>2-4 years</td>
<td>9</td>
<td>13.4</td>
</tr>
<tr>
<td>4-6 years</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>6-8 years</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>8-10 years</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>10-15 years</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>15</td>
<td>22.4</td>
</tr>
</tbody>
</table>

The median group is 4-6 years. If the first 3 groups are collapsed, 16 care assistants, 23.9% have been care assistants for under 2 years.

*Table A10.3:* Frequency table for ‘how long staff have worked at that home’

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 months</td>
<td>12</td>
<td>17.6</td>
</tr>
<tr>
<td>Under 1 year</td>
<td>6</td>
<td>8.8</td>
</tr>
<tr>
<td>1-2 years</td>
<td>11</td>
<td>16.2</td>
</tr>
<tr>
<td>2-4 years</td>
<td>21</td>
<td>30.9</td>
</tr>
<tr>
<td>4-6 years</td>
<td>8</td>
<td>11.8</td>
</tr>
<tr>
<td>6-8 years</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>8-10 years</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>10-15 years</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>4</td>
<td>5.9</td>
</tr>
</tbody>
</table>

The median group is 2-4 years. 18 staff had been working at the home for less than a year, representing 26.4%, which suggests an average staff turnover of around 25% per year.
**Table A10.4:** Frequency table for number of other homes currently worked in

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table A10.5:** Frequency table for have another job other than as a care assistant

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>9</td>
</tr>
<tr>
<td>no</td>
<td>58</td>
</tr>
</tbody>
</table>

**Table A10.5:** Frequency table for highest level of education

<table>
<thead>
<tr>
<th>Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>14</td>
<td>20.9</td>
</tr>
<tr>
<td>GCSE</td>
<td>22</td>
<td>32.8</td>
</tr>
<tr>
<td>A-level</td>
<td>9</td>
<td>13.4</td>
</tr>
<tr>
<td>Degree</td>
<td>7</td>
<td>10.4</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>22.4</td>
</tr>
</tbody>
</table>

**Table A10.6:** Frequency table for currently working towards a care home training qualification

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>42</td>
</tr>
<tr>
<td>NVQ2</td>
<td>17</td>
</tr>
<tr>
<td>NVQ3</td>
<td>9</td>
</tr>
</tbody>
</table>

**Table A10.7:** Frequency table for ‘have children’

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>44</td>
</tr>
<tr>
<td>no</td>
<td>23</td>
</tr>
</tbody>
</table>

**Table A10.7:** Frequency table for ‘known friend or relative enter residential care

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>24</td>
</tr>
<tr>
<td>no</td>
<td>40</td>
</tr>
</tbody>
</table>
**APPENDIX 11**

Crosstabulations for the Variables 'Age' and 'English as 1st Language'

### Crosstabulations for the variable 'Age'

**Table A11.1: Crosstabs for 'Age' and 'Still in education'**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>7</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>40-49</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>50-59</td>
<td>3</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

**Table A11.2: Crosstabs for 'Age' and 'Completed manual handling'**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>30-39</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>50-59</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

**Table A11.3: Crosstabs for 'Age' and 'Completed NVQ2'**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>6</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>30-39</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>50-59</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>

**Table A11.4: Crosstabs for 'Age' and 'Cared for a dependent relative'**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>8</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>30-39</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>40-49</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>50-59</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

**Table A11.5: Crosstabs for 'Age' and 'Relative entered residential care'**

<table>
<thead>
<tr>
<th>Age</th>
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<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>6</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>30-39</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>40-49</td>
<td>2</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>50-59</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>
Table A11.6: Crosstabs for 'Age' and 'English as a 1st language'

<table>
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<tr>
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<th>No</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>18-29</td>
<td>15</td>
<td>8</td>
<td>23</td>
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<tr>
<td>30-39</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>40-49</td>
<td>10</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>50-59</td>
<td>14</td>
<td>2</td>
<td>16</td>
</tr>
</tbody>
</table>

Table A11.7: Crosstabs for 'Age' and 'Care home'

<table>
<thead>
<tr>
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<th>6</th>
<th>7</th>
<th>8</th>
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</thead>
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<td>2</td>
<td>0</td>
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<tr>
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<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>50-59</td>
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<td>1</td>
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<td>1</td>
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</tbody>
</table>

Crosstabulations for the Variable 'English as a 1st language'

Table A11.8: Crosstabs for 'English as a 1st language' and 'Still in education'

<table>
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<tr>
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</tr>
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<tbody>
<tr>
<td>English 1st Lang</td>
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<tr>
<td>English Acquired Lang</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
</tbody>
</table>

Table A11.9: Crosstabs for 'English as a 1st language' and 'Completed NVQ2'

<table>
<thead>
<tr>
<th></th>
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<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>49</td>
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<tr>
<td>English Acquired Lang</td>
<td>15</td>
<td>2</td>
<td>17</td>
</tr>
</tbody>
</table>

Table A11.10: Crosstabs for 'English as a 1st language' and 'Cared for dependent relative'

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>English 1st Lang</td>
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<td>48</td>
</tr>
<tr>
<td>English Acquired Lang</td>
<td>9</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

Table A11.11: Crosstabs for 'English as a 1st language' and 'Known relative enter residential care'

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>English 1st Lang</td>
<td>23</td>
<td>25</td>
<td>48</td>
</tr>
<tr>
<td>English Acquired Lang</td>
<td>1</td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>

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