

# Application of demand and control theory to measure the well-being of care worker...

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## Abstract

**Aims & Objectives:** The purpose of this study was to understand the impacts of psychosocial factors on the psychological wellbeing of care workers in a care home setting. **Design:** The study employed a quantitative descriptive research methodology. **Methods:** The validated instruments used were Cope Questionnaire, the General Self Efficacy scale, Short form Social Support Questionnaire, RoleStressQuestionnaire and the GeneralHealthQuestionnaire. **Participants:** The permanent care staffs of an organization for residential elderly care with four locations in a rural area in the Croydon participated in this study (64. 3% response rate). It took over 35 days from February 15th 2011 to March 22 nd 2011 to collect the data and was analysed using Bivariate analyses (t-tests, ANOVA, Karl Pearson's co-efficient correlation techniques). **Findings:** The results indicated that role conflict significantly negatively correlated to the participants' low psychological wellbeing. There was a significant negative correlation between the number of social support and role overload. The significant negative correlation between carer's coping and general well being supported the study hypothesis 3. The demographic variables did not point out any significant differences in findings. **Conclusions:** The study in future may require the involvement of other relevant variables such as personality factors and organizational factors and consideration of biological consequences of those factors.

## INTRODUCTION

To meet the requirements of fragile older adults, 24hours care and service has become one of the most serious subjects in Europe. The main reason that <https://assignbuster.com/application-of-demand-and-control-theory-to-measure-the-well-being-of-care-workers/>

paves a way to this controversy is the rapid progression of ageing group. According to the European Rural development project report, in the theme of “ population and Society”, by 2050, Europe will have 173 million people age 65 and above (Heilig, 2002). In England, in the next twenty years, the people over 65 will raise two times. During 2007-08, on 1. 75 million public of working age and older people used various social care services either offered by their local council or acquired on their behalf from private and third sector institutions in United Kingdom. In the similar time local establishments spent ? 16. 5 billion on social care for all adults (Department of Health; 23rd April -2009). The department of health has commissioned the centre for policy to develop national standards for nursing and residential home care services for older people.

A Care Home is a public or private institution or a distinctive part of an institution, authorised under section 19(1)(a) of the Social Security Act. It is mainly occupied in providing health care and service to individuals who are mentally or physically retarded. It also provides 24 hours care and service that can be offered to them only through institutional amenities but in turn they also focus on the point of not giving care and treatment of mental diseases alone (U. S. Department of Health and Human Services).

Stress, that had an effect on care workers, is now receiving greater attention than before (Wheeler & Riding, 1994 and Dunn et al, 1994; cited in Rout & Rout, 2002) as the social care labour force is one of the major work groups in UK at present. At the policy paper for the strategy for the Adult Social Care Workforce in England, department of health states that overall adult social

care workforce stands at about 1.5 million workers. Since 2006-07 there has been a general raise of 8% in the social care workforce. Approximate size of the adult social care work force in England in 2007-08 is 1,505,000 (100%)... Out of this total, directly employed are 1,413,000 (94%) and agency workers and those not directly employed are 93,000 (6%)” (Department of Health, 2009; Source: The state of social care in England 2007-08-Commission for Social Care Inspectorate: CSCI). A mass of care is carried by direct care workers. They attend to service users’s every day needs, with assisting in the ‘activities of daily living’ such as dressing, eating, bathing, and toileting. They are also in charge for housekeeping, service of meal, laundry, providing skin care, distributing medication, and keeping records (Handerson, 1994; cited Chou and Robert, 2008; pp: 208).

## **LITERATURE REVIEW**

Occupational stress in a care home setting (operational definitions & theories & research

Cox (1978; cited in Burnad, 1991) defined work stress as a discomfort experience of mind and body from exceed demands of environmental stimuli on person’s coping strategies. The official statistical survey report of European Foundation for the Improvement of Living and Working Conditions show that 35% of European labour force point out that their work negatively influence on their health (EFILWC, 2006). The inconsistency among individual’s perception of the sort of specific role and what is really being attained by the individual at present performing the particular role may create role stress ( Lambert & Lambert, 2001).

Kahn et al (1964) used the socio-psychological idea of role to examine work stress. They developed the methods of role ambiguity, role conflict, and role overload and demonstrate that all three were linked with psychological distress in higher levels. The Demands-Supports-Constraints model of Payne (1979; cited in Firth-Cozens & Payne, 1999) sum up the mixture of high demands, low control and poor support as the best predictor of stress.

Parasuraman & Alutto (1984) suggest that role stress comprises stressors. Those stressors have been characterized as environmental demands, control, and events that involve an individual's role accomplishment. Role stressors drop in to the psychosocial realm of stress. According to the 'person-environment fit' theory (Caplan, 1983; cited in Cooper et al, 1988) "the stress associated with lack of 'fit' between the person and the job, either in skill, ability, capacity, needs and / or values will lead to job dissatisfaction, anxiety and depression". Cohen-Mansfield (1995) has provided an exploratory model of how the factors concerned work together in the case of long-term stress of care workers in care homes. According to this model, work-related demands, individual needs and personal off-the-job stressors are considered as the sources of individual stress. The stressors and needs act together with 'intervening variables' to produce the person- job fit. These intervening variables are resources of work, an individual's personality, and off-the-job resources. The physiological and psychological stress responses come from the lack of this person- job fit.

Stressors in Care Home work environment

The negative health outcome has linked with occupational stress (Jones, 2008). Larson (1987) and Callaghan & Field (1991) report that care workers who are stressed have high rate of absenteeism, low level of job satisfaction and are more likely to voluntarily leave the organization. Interpersonal conflicts have been considered to be a significant reason of stress for care workers (Farrell, 1999). Furthermore, Foxall et al (1990) added that they also experience psychological distress of feelings of inadequacy, self doubt, and lowered self esteem, irritability, depression, somatic disturbance, sleep disorders and burnout. Undoubtedly, it will have a negative impact on the quality of care (Janssen et al, 1999). The report above says remind the Hans Selye's General Adaptation Syndrome of stress. According to Selye (cited in Cox, 1947; pp: 5)

“ Stress is the nonspecific (physiological) response of the body  
  
(the first phase is an alarm reaction; the second stage is one of  
  
resistance or adaptation, and the final stage is one of exhaustion)  
  
to any demand made upon it”.

Smith et al (2000; cited in Rout and Rout, 2002) sum up that high level of burnout were significantly related with more sick leave, and more reported absences for mental health reasons.

Cooper et al (1988; cited in Furnham & Bochner, 1986) suggest those psychosocial factors such as work place culture/relationships of poor communication, harassment, bullying and intimidation; job content of

work overload, deadlines, work difficulty, and time pressures; organizational structure of redundancy threats; and work-home interface of child care issues and housing issues may cause psychological distress. It is a well known fact that ' culture shock' as a psychological reaction to unfamiliar environments, plays a major role in any person's life when he/she enters a workplace initially. But this ' culture shock' varies from person to person, and from firm to firm, though it does not relieve anybody from its threatening claws. A person who joins a nursing home for the first time has to care for a range of service users with a mixture of problems and emotions. It can often be mainly stressful. And to work with people from different culture is also stressful as the level of individualism or collectivism in society will also influence the character and personality of persons in organizations. Work activities concerning bending, twisting, frequent heavy lifting, uncomfortable motionless posture and psychological stress are considered as fundamental factors for many physical problems (Karahan et al, 2009). Resident's physical and verbal aggression might create psychological distress and lower job satisfaction among care workers. MacPherson et al (1994) have done a study related to this subject.

Night shift work is inevitable in a 24hours care and service setting. In night workers the normal circadian rhythm of blood corticoids generally remains distorted (Selye, 1956). A large cross sectional study has been done among 5419 Finnish adult men; report that the chance of coronary heart disease is very high among the participants who slept for more than nine hours or for less than six hours per night, as contrast to with those sleeping the more common seven to eight hours(Wheatley, 1994). Job insecurity and

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incongruity in position can be created by career ceiling (Cooper & Mashall, 1978). In a care home setting lack of opportunities (blocked opportunities) for promotion of care workers appeared as a source of dissatisfaction with work.

Health-care workers are advised to wear gloves whenever there is contact to body fluids and assist service users for personal hygiene. Increased use of gloves creates latex hypersensitivity among health care workers (Zak et al, 2000). The research report 169 of Health & Safety Executive indicate that over workload, role ambiguity, absence of opportunity to use their skills (under skilled works) and conflicting work and job role demands made stressful. A longitudinal study has been done by Reeve J (2000) & Randle J (2003) along with care workers. They used unstructured and qualitative interviews for data collection which are as everyday conversations. The participants reported the experience of bullying from registered nurses in the form of exercising power and injure the dignity in front of other staffs. They complained physical and psychological symptoms of sleeplessness, anger, anxiety, stress, self hatred, powerlessness, loss of confidence, increase in sickness absence and intention to leave the profession as reaction to bullying. All branches of nursing such as adult, child, mental health and learning disability were represented in this study.

Coping theories and work related coping in care work sector

There is a key psychological model by Richard Lazarus (1966) to observe the correlation between stress and coping strategies of care workers is the cognitive-phenomenological-transactional model of stress and coping which

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contributes a theoretical support. This model demonstrates emotions as results to cognitively intervened transactions in the environment (actual, imagined or anticipated). Through the primary and secondary appraisal method, the individual organizes a sequence of coping strategies. These are intended either to problem-focused coping strategies or to emotion-focused coping strategies (Bailey & Clarke, 1989). For example, one care worker may consider the equipment such as 'hoist' as annoying; whereas another may find reassuring and encouraging that efforts are being made to assist service users. In an American study, by Yates et al. (1999; cited in Ronelle, 2005), used a representative sample population from the second phase of the longitudinal Massachusetts Elder Health Project, the results point out that the quality of relationship, support and mastery intervene the annoying outcomes of cognitive impairment, functional disability and behaviour problems of the disabled elders on care workers wellbeing. Moreover according to situational and relative variables care workers well-being is able to be improved or reduced.

While coping is supposed to mediate the consequences of burden on the well-being of the carer, from the point of view of Chappell et al. (2001) caring for a person with a life-threatening or prolonged illness like dementia and learning disability, carers efforts to actively problem solve may become more distressed as there is little that they can actually do to change service users' mental health condition. Therefore it may be more useful for the carer to implement emotional coping strategies thus protecting their own psychological and physical health. The literature regarding coping usually

specifies that females apply more emotion-focused coping than males (Lazarus & Folkman, 1984).

Stowell et al (2001) suggested that active coping was used more often than emotion coping (avoidance coping) and that active coping had more positive results on the immune system. From the point of view of Levesque et al (1999; cited in Ronelle, 2005) informal and formal social support reserved the psychological well-being of care workers.

Bailey and Clarke (1989) have opposed the cognitive psychological transactional model of stress and coping. According to them generally shared cultures and the relationship it has between care givers decisions that may have an effect on patient care. Both cognitive and behavioural strategies are coming under the subject of coping. In the case of ineffective coping, stress would prolong. Coping is subject to great individual difference. Efficient time management, team meetings, consultations, support net works and improvement in communications are considered as the primary methods of coping with stress at work place (Rout, 2000). Cultural factors play an important role in staff coping strategies, and thus influence methods of wellbeing.

#### Importance of Role Ambiguity: theories and applications

According to Beehr (1976) & Schuler (1980) role ambiguity is the lack of specificity and inevitability relating to an employee's job or role tasks and responsibilities. Cooper & Pearce (1981; cited in Beehr & Glazer, 2005) suggest that role ambiguity is an objective condition at work in which there

is inadequate, confusing, or limited flow of information relating to one's work role. French & Caplan (1970; cited in Cooper et al, 1988) suggest that stress occur from unclear goals. This ambiguity leads to job dissatisfaction, lack of self-confidence, feelings of uselessness, a lower sense of self esteem, depression, and low motivation to work, absenteeism and plan to leave the job. In the words of Baldwin et al (2003) Care workers majority of the role concentrate on direct service user care. Lack of role clarification and different views of support workers and registered nurses in the care process is being underpinned with care plan. Insufficient preparation and following supervision of care workers would create role ambiguity. These indications remind that role clarification, appropriate preparation and a continuing development process need careful concern by managers if care workers' contribution is to be fully recognized.

#### Importance of Role conflict; theories and applications

Kahn et al (1964) indicate role conflict as more than one set of contrary demands in relation to work issues. Peterson et al (1995) & Cooper et al (1988) highlight the point of incompatible burden that may be among the expectations positioned on a worker by apprehensive parties or by the involvement of two or more roles of the same person. Rizzo et al (1970) suggest that role conflict might be present when organizational requirements collide with personal ideals and obligations to others (family members and other concerned people).

Frone (2003; cited in Beehr & Glazer, 2005) identified both work-to-family conflict and family-to-work conflict as a consequence on psychological

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distress (cited in Beehr & Glazer, 2005). French & Caplan (1970; cited in Cooper et al, 1988) describes that the role conflict is associated to the psychological distress of feeling of tension and anxiety. In the 24-7 (2008, published by Coventry University) survey of work life balance centre, about 51.3% of the sample group accounted that they had suffered with work life imbalance. The respondents reported the symptoms of ill health of excessive tiredness (69.4%); sleeplessness (59.6%); irritability (54.9%); difficulty in concentrating (47.9%) and headaches/migraines (47.2%).

### Importance of Role overload; theories and applications

In the words of Sofer (1970) role overload is the outcome of too much work, time pressures and targets. Bacharach (et al, 1990) and French & Caplan (1973) found that role overload is an incongruity between work demands and time obtainable for satisfying the demands. From the point of view of Kahn (1980) role overload is generally considered as the failure to complete the expectations of organization within the available time. All these role stressors are correlated to burnout (Anderson, 1991), low level of job satisfaction (Jackson & Schuler, 1985) and high anxiety (Srivastav, Hagtvet & Sen, 1994; cited in Beehr and Glazer; 2005). Hipwell et al, (1989) found that work load is the most considerable predictor of poor mental health. A combination of poor psychosocial factors and role overload produced the highest rate ratio for work related physical problems (Johansson, 1995). Controversially under load may also have been an effect on one's psychological well being. Too little to do or boredom might make an

employee in failing to respond appropriately during emergency situations (Cooper, 1988).

### Essential theoretical frame work and research evidence of Social support

The hypothesis of social support indicates the significance of the quality and quantity of support rather than its character and source. This statement is supported by Adrian Furham and Stephen Bochner (1986) on the following way that the sum of social supports that perceived more vital than who offer it. According to Cobb (1976; cited in Rout & Rout, 2002) social support denotes the facilitation or support of members who may include spouse, family, friends, neighbours, colleagues and acquaintances. Individuals with social support regard themselves as being loved and cared for, and appreciated, and a part of a social net work that can provide guidance or services and protection during necessity.

Support from the family environment is very essential as night work/ shift work or long working hours stand for a major cause of stress. From the point of view of Larocco & Jones (1978), social support has playing a vital role to create a positive effect on stress. Davidson & Cooper (1983) suggest that the work/home interface is a major source of stress both males and females, even though differences be existing among the two sexes. In the care workers labour market, entrance of married women with young children is increasing. In UK employment of married women is considered as the major cause of higher divorcerate. Managing multiple roles is highly stressful especially in the absence of social support (Lewis & Cooper, 1995 & Emmons et al, 1990; cited in Rout & Rout, 2002). Manlove & Elizabeth (1994) have

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done a hierarchical regression analysis study among child care workers proved that in perceived emotional exhaustion and depersonalization, social support defence the negative outcome of work role conflict and work role ambiguity. Improving organizational, supervisor, and co-worker support will be vital for enhancing job satisfaction of direct care workers. Social support would be having the form of instrumental assist, counsel or guidance, paying special attentive listening, redefining problems, developing alternative lines of actions, reaffirmation of friendliness and respect, and so on. Chappell and Novak (1992) set out to explore the hypothesis that social support operate as a buffer against different work-related and managerial stressors, including the number of service users in a setting with dementia, and challenging behaviours. But social support did not show any significance as a protection from threatening situations with residents. Caregiver research reveals that social support acts a significant role in the care giving practice. Caregivers describe lesser social networks and few contact with people, and they get less support than non-caregivers (Kiecolt-Glaser et al, 1991). Also, lower support is allied with high rate of depression (Bodnar & Kiecolt-Glaser, 1994; Tompkins et al, 1988), while the ties of strong social hands and more social support acts an important role in defending the caregiver from work stress (Williamson & Schulz, 1993) and is associated to general wellbeing (Quayhagen & Quayhagen, 1988).

Positive source of Self efficacy with a theoretical back ground

According to Jones (2008) Self-efficacy is an overall evaluation of one's ability to achieve his/her essential tasks, roles, or actions and it is also

closely related to the way he successfully performs his work. On the basis of investigational report, Salanova (2004) developed a model of increased psychosocial wellbeing and performance. A personal sense of control has positive effect on human functioning. If people have a self belief that they can take active solution for a problem, they become more apt to do so and feel more dedicated to this decision. Self efficacy of care workers is an important subject as it tolerates people to cope with challenging situations, observe their surroundings, or make innovative environments. According to Albert Bandura (cited in Schwarzer, 1992) with the cognitive, affective and motivational intervening self beliefs of efficacy apply their upshots on human implementation. In this sociocognitive point of view, individuals are observed as proactive and self regulating rather than as reactive and controlled by environmental and biological forces. Also in this outlook, individuals are implicit to hold self-beliefs that allow them to employ control over their feelings, actions, and thoughts.

Burrows & McGrath (2000) suggest that the stress experience is highly individualised. It is regarded as a situation with a noticeable inconsistency between the demands placed on a worker and that worker's aptitude or perceived ability to respond. Individuals evaluate themselves incapable to fiddle with the situations due to their vulnerabilities and perceive situations as disturbed with danger. As a consequence they experience distress in cognitive functions and autonomic arousal. The fundamental implication of the theory of self efficacy in psychological wellbeing is that individual's judgements on the subject of their capacity to cope basically establish the

behavioural, cognitive, emotional and physiological reactions that characterise general wellbeing (Schwarzer 1992).

Role of socio-demographic variables – An out view from previous studies

#### Gender

Long and Porter (1984) believe that in the subject of 'stress and women', the highlight topics are role strain, dual role conflict, and role overload which supposed to affect more on married working women. Regardless of working fulltime, women are often likely to meet family commitments. Karasek et al (1987) sum up that working women reported high level of exhaustion, headaches, dizziness, depression, and respiratory problems than men. On the contrary some investigations indicate that on occupational stress and mental health outcome variables there is no gender differences (Kirkcaldy & Martin, 2000). Chesley et al (2006) have done a study to evaluate individual- and couple-level effects of care giving on changes in well-being. The researchers have followed the longitudinal survey data collection from dual-earner couples (N = 884). The authors found that care giving is related with well-being decreases for dual-earner (families with dual incomes) women and well-being increases for dual-earner men. The study proved that the women caregivers with flexible work conditions have high levels of well-being than caregivers without flexible work. But the size of this effect is small.

#### Age and marital status



In the study of stress, the demographic variable of age may take part of a moderating role. The research report of a study in job stress and satisfaction among nurses: individual differences, was done by Kirkcaldy & Martin (2000), indicate that older nurses are experiencing more stress and the younger nurses reporting better psychological health. National Centre for Health Statistics (1970) reported that separated, divorced, or widowed persons had considerably high rates of mental illness than married or single individuals (cited Rice, 1992).

### Ethnicity

From the point of view of Hofstede (1980), the critical cultural distinctions in attitude and behaviour of work set and management belonging to diverse countries are major subjects in occupational stress. These cultural differences had commenced regardless of barriers. Racial discrimination may support feeling of inadequacy, low morale, poor motivation and low self esteem which eventually will produce stress. Cole, Scott & Skelton-Robinson (2000) have done a study with respect of the effect of challenging behaviour, and staff support, on the psychological wellbeing of staff working with older adults. The result of the study reported that the Asian, African and Afro-Caribbean staff were much more often employed in care home settings. It would seem because ethnic minority groups are more liable to work in low status career such as care assistants in care home settings. Some cultures having more patients and tolerating attitudes. According to Sharma (2007), individualistic culture and collectivistic culture can build variations in workers subjective perception as regards their work environment. On the other hand

Kramer (1997) suggests that the demographic variables like gender, ethnicity, marital status, education have often failed as independent variables to affect well being.

General well being as a dependent variable.

In the previous studies, the researchers have observed the relationships between sources of stress and measures of outcome such as anxiety/depression, social dysfunction and loss of confidence (Tylor, Carrol and Cunningham, 1991). Since Fengler and Goodrich (1979) caregivers' psychological well-being has been widely considered. From that time a diversity of issues such as subjective and objective burden of care workers have been investigated (Zarit et al, 1986). In a large cross-sectional multicentre investigation, Bell et al (2001) suggest that care givers work related problems to be significantly correlated with the carers' general health and their quality of life (cited in McConaghy and Louise, 2005).

Rational of this study together with aims and objectives

Rational of this study is based on the importance of care workers psychological well being. It is a known fact that the care workers are under increased burden. Thus this will be affecting their biological and general well being. The subject is complex and multidimensional one as it is associated with subjective and objective burden of carers. At this movement economic recession is going on all over the Europe. Moreover unemployment problem is another worse thing. According to BBC One channel news (broad casted on 16-08-2009 at 15 hours) all over the Europe, 200. 000 of people lost their job

in the last economic year. In controversy employment opportunities are high in health departments as the number of fragile adults rises up. Many aspects of mental health policy and services are experiencing a revolution all over the European Region. Policy and services are motivating to attain a balance between the requirements and benefits of various mental health activities. So the demand for care workers is increasing. Even the care workers know the care giving job might have creating physical and psychological ill health and career ceiling; they might have selected this job (might be under skilled job) due to their financial strain or absence of selected carrier. InUKthe entrance of overqualified people in social care service is rise up. That might be creating lower skill utilization. In this context their psychological well being depends upon a variety of bio- psychosocial factors.

#### Aims and Objectives:

This study focus on the impacts of psychosocial factors such as coping, social support, self efficacy and role stress on the psychological well being of care workers in a care home setting. There are some realistic allegations of this study. The most prominent feature is its enhancing knowledge about ways to improve job satisfaction may help care workers to get better health and well-being. Since work is an important part of life, work satisfaction is a foremost determinant of quality andhappiness of life. Understanding determinants of psychological well being among direct care workers will shed light on how to minimise work stress, enhance management support, reduce turnover, develop coping skills and thus help improve the quality of care of service users, promoting their best possible health and well-being.

## Hypothesis:

The study was hypothesized that

- 1) Social support may be negatively correlated with role stress.
- 2) Work stress may be significantly negatively correlated with psychological well being.
- 3) Self efficacy may be significantly positively correlated with psychological well being.
- 4) Coping skills may be significantly positively correlated with psychological well being.
- 5) Age, Marital status, Work experience, Ethnicity and Gender may have effect on one's psychological well being.

## **Methodology**

### Design

The study employed a quantitative descriptive research methodology. A cross sectional survey was conducted for this study. The study was approved by the Research Ethics Committee of London spectrum college. A package of questionnaire with introductory letter, consent form, demographic details, and 57 questions used to test dependent and independent variables. They have been administered individually with participants consent. The participants taken their own time to complete the questionnaires and drop it in the box that provided in the reception of the care homes. The study was

entirely confidential and anonymous from start to finish. The individual data have been seen by the researcher and the supervisor. The questionnaires were distributed to 70 care workers, of which 45 people returned the questionnaires.

## Variables

### Independent Variables:

There are five socio-demographic variables are age, gender, work experience, marital status and ethnicity.

Coping skills with three subscales of Negative Impact Value, Positive Value Scale and Quality of Support

Role stress with three subscales of Role Ambiguity, Role Conflict and Role Overload

Social support with two subscales of Number of Support and Quality of Support

Self efficacy

### Dependent Variables:

There is only one dependent variable of General psychological wellbeing with three subscales of Anxiety & Depression, Social Dysfunction and Loss of Confidence

## Participants

The permanent staffs of an organization for residential elderly care with four locations in a rural area in the Croydon participated in this study. The agency staffs were excluded. The participants' rate was 64. 3%; 31 were female staff and 12 were male staff. Two of them have hesitated to enter their gender details. 15. 5 % (n= 8) of the participants indicated being single, 69% (n= 31) of them reported being married, 4. 4% (n= 2) divorced and 1 participant reported as lesbian. 3 of them have not mentioned their marital status. In regard to Nationality 9% (n= 4) of the participants were White and White British, 29% Black and Black British (n= 13), 53% (n= 24) Asian and Asian British. 2 reported as mixed. 2 of the participants have not reported their ethnicity.

## Materials

Role stress questionnaire (Rizzo, J., House, R. J., & Lirtzman, S. I. (1970)

Role stress questionnaire comprises 17 items that divide in to 3 subscales of role ambiguity, role conflict and role overload. The measures used in sample were the 8-item Role Conflict scale (Ex: I know exactly what is expected of me), and the 6-item Role Ambiguity scale (Ex: I have to work under vague directions or orders) developed by Rizzo, J., House, R. J., and Lirtzman, S. I. (1970). The 3-item Role Overload scale (Ex: I have to work under vague directions or orders) developed by Seashore, S. E., Lawler, E. E., Mirvis, P. & Cammann, C. (eds.) 1982. . In these three subscales responses were made alongside a 7-point Likert scale (strongly disagree= 1; strongly agree= 7). In the short scales of role conflict and role ambiguity are perplexed with negative and positive item phrasing. Around 85% of the experimental

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studies approved on role conflict and ambiguity have used Rizzo, House, & Lirtzman's (1970) Role Conflict and Ambiguity Scales (Jackson & Schuler, 1985).

Carers Coping scale (Easy care (2004), developed with the support of an education grant from Pfizer Limited)

Cares coping scale (Easy care., English version 2004) of 15 items load in to 3 subscales of negative impact scale, positive value scale and quality of support section by scoring the items responses as Always = 4, Often = 3, Sometimes = 2 and Never = 1 (Ex: Do you find care giving worthwhile?). A high score on the negative impact scale (6 items) may point out that the carer is being stressed by the care giving role (Ex: Does care giving cause difficulties in your relationships with friends?). The same, a low score on the positive value scale (5 items) may illustrate that the carer is attaining little satisfaction from the care giving role (Ex: Do you feel you cope well as a caregiver?). Other 4 remaining items (Ex: Overall, do you feel well supported in your role of care giver?) are used in order to build up a wide-ranging understanding of the carer's potential needs. . There are no threshold scores for the Negative Impact and Positive Value Scales. On the other hand although there are some norms for this scale there is some indication of cut off scores as follows, less than 15% of cares scored more than 12 on the Negative Impact scale, and less than 15% of cares scored less than 12 on the Positive Value scale. Reliability and Validity of the Cope Index has not been specified.

Short form social support questionnaire ((Sarason et al, 1983)

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Short Form Social Support Questionnaire (SSQR6) has been developed by Sarason and Colleagues (1987a) and is a 6 item edition of the original 27 - item SSQ (Sarason et al., 1983). Two scores are obtained from the questionnaire: the number of supports (Quasi - structural measure) and the level of satisfaction (Global functional measure) with these supports. For each question, the number of supports score will range from 0 (no supporting individual identified) to 9 (9 individuals identified) (Ex: Who do you know whom you can trust with information that could get you in trouble?). Thus the total score ranges from 0 to 54. This can be separated by 6 to provide a mean number of supports score. Sarason et al (1987a) explained the SSQ6 to demonstrate satisfactory psychometric properties, with high internal consistency for both the number and satisfaction subscales ( $\alpha = 0.90$  to  $0.93$ ), high test-retest reliability and a single factor accounting for the majority of the variance in each of the subscales correspondingly.

The general self efficacy scale (Jerusalem, M., & Schwarzer, R, 1993)

The general self efficacy scale (English version by Jerusalem, M., & Schwarzer, R, 1993) reflects an optimistic self-belief, as part of a more comprehensive questionnaire. The scale was formed to measure a general sense of perceived self-efficacy with the objective to foresee coping with daily hassles as well as adaptation after experiencing all types of stressful life experiences. Preferably, the 10 items are mixed at random into a larger pool of items that have the same response format. Time: it requires 4 minutes on average. Scoring: Responses are made on a 4- point scale (1=



Not at all true to 4= exactly true). (Ex: I can always manage to solve difficult problems if I try hard enough). Sum up the responses to all 10 items to yield the final composite score with a range from 10 to 40. The methods have been used worldwide with accomplishment for two decades. People under the age of 12 should not be tested. Reliability of the self efficacy scale has been proved from the sample group from 23 nations; the range of Cronbach's alpha was from . 76 to . 90, with the greater part in the high . 80s. In number of correlational studies with the scale of Self efficacy, Criterion-related validity is documented. The positive coefficients were established with positive emotions, dispositional optimism, and job satisfaction; negative coefficients were originated with depression, anxiety, stress, burnout and health complaints. The strength of the scale is its suitability as a pointer of quality of life at any point in time.

General Health questionnaire (Goldberg, D. & Williams, P. A., 1988)

In current years the 12-item General Health Questionnaire (GHQ-12) has been widely used as a short screening tool, producing results those are similar to longer versions of the GHQ 28. The validity of the GHQ-12 was evaluated with the GHQ-28 in a World Health Organization revises of psychological disorders in general health care (Goldberg, D. P. et al 1997). General Health questionnaire has (Goldberg, D. & Williams, P. A., 1988) 12 item (Ex: Have you recently been able to concentrate on what you're doing?). Each questions has 4 responses, the responses for each questions are different. GHQ-12 has been extensively used in lots of nations for identifying psychological morbidity. The 12-item GHQ consists 3 aspects,

specifically Anxiety and Depression (4 items), Social Dysfunction (6 items), and Loss of confidence (2 items). The total score is ranging from 0 to 36, with high scores representing poorer conditions.

## Procedure

The administration of the package of questionnaire has been started on 15th February 2011 and completed on 22nd March 2011. On the same day the drop boxes were provided in the reception of the care homes. Total 75 care workers have been accessed. Two of the care staffs rejected to participate in this study at the first approach of the researcher. 50% of the completed data were collected on 17th March and rest of them on 22nd March. There were three questionnaires, out of which one was blank and the others were incompleting. The researcher could not access the staffs that had been on their summer holidays and the ones who were not available during the test administration time. All data have been entered for analysis. Care's coping scale could have been analysed with its subscales of 'negative impact of care's coping, positive value and quality of support'. But its reliability has gone down as some questions have been rephrased and two questions were taken out from the scale. So the coping scale has been analysed of its overall score as reliability is very high. Concerning the questionnaire of social support participants have been confused by the second part of battery of questionnaire which has asked questions about social support i. e. the number of supporters and level of satisfaction. The questionnaire had asked the relation with the supporters in order to find out from whom they are getting more support (from the family environment, social environment

and management). But most of the participants have not mentioned the relation as they just circle the numbers.

### Statistical Analysis

Bivariate analysis (t-test, ANOVA, and correlation) are used to explain relationships among psychological well being, socio demographic variables, work stress variables, support variables, coping skills and self efficacy. Some missing values existed in many ways of variable, For example: there were missing values for some demographic variables, notably age (2 missing), marital status(3), work experience (2), ethnicity(2), number of support and level of satisfaction (4), general wellbeing (3), role conflict and role over load(1). Total number of participants was 45, mean age 36. 5 (SD 10. 5).

### Ethical considerations

The first stage of the dissertation was the submission of research proposal. The research proposal was accepted and followed by the submission of ethical approval to the ethical committee of Londonspectrum college.

Regarding the Dissertation project, at the first time I got an appointment with the General Manager of the company of the residential elderly care homes on 20/01/2011 in Bedford. On the same day I have submitted a copy of Research proposal. GM replied that they would go through and give reply.

After fifteen days i. e. on 04/02/2011, GM called me for the clarifications of some of the issues like about the question of ethical committee that “ are there any NHS funded residents in the access nursing home?” They enquired “ are the questions prepared by the students?” And they mentioned that “

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there are no hundred care workers in the company". Lastly they informed that " they are too much concerned about the confidentiality of the company name in the project work".

On the next day I sent a reply for clarifying all the above mentioned enquiries from Head Office. In the reply I mentioned that questionnaires are validated and extensively used for psychology research and ensured the confidentiality of the company name in the study and conveyed the company's rights to monitor the research procedure on ethical grounds and to refuse any future publications. On 12/02/2011 I have been asked to submit all the questionnaires for consideration. This was delayed due to busy schedule of GM. I collected the questionnaires of the Care's coping, Role stress, Social support, Maslach's Burnout Inventory scale and Physical symptoms of ill health.

On 14/02/2011 I got an appointment with the GM; in the gathering the package of questionnaire has been submitted. They went through each and every questionnaire. Necessary adjustments made based on their recommendations. Later GM informed me that they are quite interested in this study, but the company is in no way involved in this project. I discussed all the above mentioned matters with the supervisor. With the advice of the supervisor I selected the questionnaires of self efficacy and general wellbeing.

On 14/02/2011 a package of five questionnaires with introductory and consent letter which included all the required changes has been submitted to GM. On the same day I received a call from the GM stating that they have

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accepted the package of questionnaires and asked to clear some typing errors and some other amendments. GM sent an E- email on the same day stating all the above mentioned matter, they asked me to consider the same mail as permission letter for the dissertation activity. I forwarded this E-mail to the Department Chair of Ethics Committee in London Spectrum College. The committee replied that I would need to get a signed letter from the nursing home. They would be happy to contact the nursing home manager saying that I have permission to do the study from the college end and they are ready to request the GM to provide a signed letter. The committee advised me that I could write it myself and just ask them to sign it and mentioned that if I have any problems and may be able to accept the email of GM as a consent letter.

The committee advised me that ideally, around 100 participants are required for a correlation study. However, just try to get as many as I can. According to them removal of individual item from validated questionnaire is not advisable. I have again completed the ethical form and provided the supporting materials (i. e. introductory letter and questionnaire pack). On the February 15th 2011 I have received an E-mail from the committee with the information that my project now has ethical approval. They suggested me to retain all the items in the role stress questionnaire as it will invalidate it if I remove them.

## Results

Bivariate analysis (t-test, ANOVA, and correlation) is used to test the hypothesis and to explain relationships among psychological well being,

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socio demographic variables, work stress variables, support variables, coping skills and self efficacy.

(Descriptive statistics)

Table 1: Mean deviation, Standard deviation and Number of participants based on the variables investigated.

MeanStd. Deviation Number of participants

General psych wellbeingTotal Cares Coping

Role overload

Role ambiguity

Role conflict

Anxiety and depression

Social dysfunction

Loss of confidence

No: of support

Level of satisfaction

Self efficacy

Age

Gender

Marital status

Work experience

Ethnicity9. 883742. 3556

11. 5682

14. 0667

24. 6818

3. 6512

5. 0233

1. 2093

9. 0488

30. 8780

32. 9048

36. 9070

1. 7209

1. 9286

71. 6047

2. 5814

5. 831816. 07961

3. 92605

8. 53707

10. 41638

1. 99862

3. 81406

1. 10320

6. 93884

8. 20730

4. 42724

10. 53749

. 45385

. 67690

81. 73946

. 79380

4345

44



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Table 2: Reliability of the questionnaires used in the study (General Health Questionnaire (GHQ), Self-efficacy, Carer's coping, Social support and Role Stress..

GWQSelf efficacyCares CopingSocial supportRole stress

Cronbach's Alpha. 817. 814. 824. 934. 836

No: of items12 10 13617

All of the scales were high on internal consistency based on the Cronbach's Alpha ( $\alpha = .82$ ,  $\alpha = .82$ ,  $\alpha = .82$ ,  $\alpha = .82$ ,  $\alpha = .93$ ,  $\alpha = .84$  respectively).

Pearson's Product Moment correlation co-efficient test results in link to the hypothesis:

H1- Social support may be negatively correlated with role stress.

The results indicate that there is a significant moderate negative correlation between the number of social support and role overload ( $r = -0.419$ ,  $p = 0.004$ ). The correlation between the level of satisfaction and role overload is significant and negative but it is relatively weak ( $r = -0.266$ ,  $p = 0.049$ ).

H2- Work stress may be significantly negatively correlated with psychological well being.

The result shows that the Role conflict is significantly negatively correlated to social dysfunction and loss of confidence ( $r = -0.53$ ,  $p < 0.001$ ,  $r = -0.392$ ,  $p = 0.005$ ). The correlation between role conflict and total score of psychological well being indicates significant negative correlation ( $r = -0.454$ ,  $p = 0.001$ ). There is a significant negative correlation between role overload and loss of confidence ( $r = -0.290$ ,  $p = 0.031$ ).

H3- Self efficacy may be significantly positively correlated with psychological well being

This hypothesis has been refuted.

H4- Coping skills may be significantly positively correlated with psychological well being.

There is a significant moderate positive correlation between care's coping and general psychological well being ( $r = 0.420$ ,  $p = 0.003$ )

H5- Age, Marital status, Work experience, Ethnicity and Gender may all have effect on one's psychological well being.

There is no significant difference in the socio-demographic variables of age, marital status, work experience and gender.

Table 3: Significant Coefficient correlations in link to hypothesis

GWQ ROLE OVERLOAD LOSS OF CONFIDENCE SOCIAL DYSFUNCTION

LEVEL OF SATISFACTION OF SOCIAL SUPPORT -0.266\*

NUMBER OF SUPPORT -0.419\*\*

ROLE OVER LOAD 0.290\*

ROLE AMBIGUITY 0.267\*

ROLE CONFLICT 0.454\*\* 0.392\*\* 0.537\*\*

TOTAL SCORE OF CARES COPING -0.420\*\*

NB: In the psychological well being questionnaire higher score indicates poorer condition (reverse relation).

Graph 1: Graphical Representation of the differences between care's coping and ethnicity

Graph 2: Graphical representation of significant negative correlation between Role conflict and Social dysfunction.

Graph 3: Graphical representation of ANOVA Test Result

There is a strong evidence of difference of ethnicity in the loss of confidence as  $p = .056$

### Summary of the results

The numbers of correlations were found significant. The results indicated that role conflict significantly negatively correlated to the participants' low psychological wellbeing. There was a significant negative correlation between number of social support and role overload. The significant negative correlation between carer's coping and general well being supported the study hypothesis 3. The demographic variables did not point out any significant differences in findings.

### Discussion

There is a significant negative correlation between number of social support and role overload. High levels of support diminish the negative effects of role overload (Sargent & Terry, 2000). Role conflict is significantly negatively correlated to social dysfunction and loss of confidence. French & Caplan (1970; cited in Cooper et al, 1988) describes that the role conflict is associated to the psychological distress. There is a significant positive correlation between care's coping and general psychological well being. Coping styles are valuable in terms of directing to positive results such as

better health and psychological well being (Jones & Bright, 2001). There is no significant difference in the socio-demographic variables of age, marital status, work experience and gender. Hypothesis-3 (Self efficacy will be significantly positively correlated with psychological well being) has been disproved.

The psychosocial factors measured in this exploratory study have been examined in a number of population studies. The researcher attempted to address these subjects among care staffs of an organization for residential elderly care with four locations in a rural area in the Luton and Bedford. In the general well being subscales of anxiety/ depression, social dysfunction and loss of confidence the ethnic group of black or black British scored low. Lower score representing well condition. The score pointed out that Black or Black British group experienced more psychological well being than other ethnic groups. In the psychological well being there were no significant differences between black / black British and Asian/Asian British. This result was supported by previous findings of Cole, Scott & Skelton-Robinson (2000) as the Asian, African and Afro-Caribbean staffs were much more often employed in care home settings. It would seem this is because ethnic minority groups are more likely to work in low status career such as care assistants in care home settings.

The white and white British were more likely to be low psychological well being than other ethnic groups. Absence of horizontal and vertical integration is a common picture among the people from the individualistic societies (Baker, 1979). Asian and Asian British were seemed to be high

coping skills and self efficacy than other ethnic group. From the point of view of Hofstede (2001) coping with conflict is a common part of living together as collectivist family. Loyalty to the family and financial obligations make them to develop a desirable character at both work place and family environment. Asian or Asian British group seemed to be high role ambiguity than other ethnic groups. It is not significantly proved in this study but have strong evidences. Language barrier of overseas people and absence of accurate job description and person specification from the part of management might have contributed to this problem. High role conflict has been reported by the white / white British. In the individualistic society family relations and work interferences are considered undesirable. They may lead to preferential treatment and conflict of interest. There is an interesting and noticeable result that white / white British group indicated higher social support but their level of satisfaction and psychological well being is still very low. Its major reason might be pointed out to a general view that in an individualistic society the employer and employee relationship is mainly considered as a business contract, as a calculative relationship among players on a labour market. The black / black British have reported high work load even though their psychological well being is higher than others. They might be having more management support in the form of emotional, informational and instrumental way which has not been tested in this study. The result did not show any significant difference in the other socio-demographic variables of age, marital status and work experience. The demographic variables have often failed as independent variables to affect well being in others studying

as well (Kramer, 1997). So this study findings is online with that findings, but only for above variables.

The study among care workers cannot evade the other prevalent variables, which will make impact on psychological well being, such as personality, emotional intelligence, cultural variables such as collectivist/individualist, and organizational culture and so on. Due to the time limitations, the project study tried to avoid the above mentioned core factors. Individual's personality characteristics have been playing an important role in the work stress (Cohen-Mansfield, 1995). The personality characteristics arbitrate the harmful influences of hostility, loss of confidence, irritability, anxiety and aggression (Sutherland and Cooper, 2000). In theoretical aspect neuroticism could source individual to respond more negatively to potential reason of stress and to recognize distress symptoms more readily (Eysenck, 1967). Australian Industrial and Organisational Psychology Conference meeting reported (page 145) that Emotional intelligence is positively correlated to several work place performances. Emotional intelligent and emotional management are positively associated to the ability to be creative or innovative at workplace. There is a positive correlation between emotional control and the ability to work with team members for the successful completion of task and success of the organisation.

Major limitation of this study was the low rate of sample group. Sample error ( skewness) was concerned as another limitation. In the case of ethnicity there were only three people to represent white and white British. So results of this group cannot be generalised. Some of the participants have hesitated

to enter their socio demographic details. The researcher might have been misguided by the participants as the researcher was one of the participants at the same time with the intention to evade the probability of identification. Some of the questions in the questionnaire of work stress consisted about company policies and guidelines. Participants' bias towards the company should be under possibility. The study did not test the perceptions, expectations, motivations and qualifications of care workers. Perhaps these elements should need to be look in detail. The study excluded the interference of physical or biological consequence of psychosocial factors in care home setting such as lower back pain (Karahan et al, 2009), musculoskeletal symptoms and neck / shoulder symptoms among care workers (Johansson, 1995) and burnout syndrome( Martin, 1998). The study required the involvement of other relevant variables with more representative sample group.

## **Conclusions**

The study concludes with some significant findings. There is a significant negative correlation between number of social support and role overload. Role conflict is significantly negatively correlated to social dysfunction and loss of confidence. There is a significant positive correlation between care's coping and general psychological well being. There is no significant difference in the socio-demographic variables of age, marital status, work experience and gender. Future research will concern other relevant variables to find out the impact of psychosocial factors on the psychological well being of care workers in a care home setting.



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