Care workers' experience of stress and social support in caring for residents with intellectual disability at a selected residential facility in the Western Cape
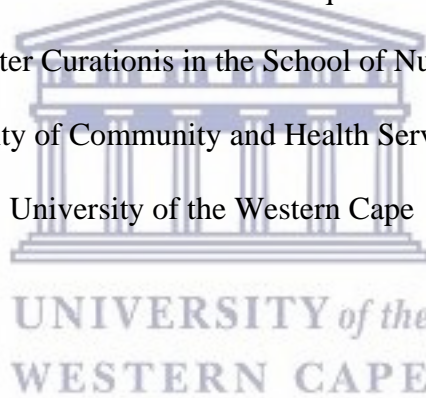
Tozama Nogemane

Student number: 2325791

A full thesis submitted in fulfilment of the requirements for the degree of

Magister Curationis in the School of Nursing,

Faculty of Community and Health Services,

University of the Western Cape

UNIVERSITY *of the*

WESTERN CAPE

Supervisor: Dr PD Martin

Date: February 2019

ABSTRACT

Caring for people with intellectual disability is stressful as they have a reduced ability to cope independently. The stress may be exacerbated by the challenging behaviours intellectually disabled people display and by the lack of social support that care workers may experience. The aim of this study is to explore and describe care workers' experience of stress and social support whilst caring for intellectually disabled residents with challenging behaviour.

A qualitative, exploratory, descriptive phenomenology study was utilised to answer the research question: "What are the experiences of stress and social support of care workers caring for intellectually disabled residents with challenging behaviour at a residential facility in the Western Cape?" A purposive sampling technique was utilised to select ten care workers working at a residential facility for intellectually disabled residents with challenging behaviour in the Western Cape. Lazarus and Folkman's transactional model of stress and coping has been used to guide the study. Data were collected by means of semi-structured interviews. Colaizzi's method of data analysis was used to analyse the data.

The four main themes that emerged are: (1) acceptance of abuse as a working condition, (2) interpersonal relationships with colleagues, residents and residents' families, (3) the self-impacted by an array of emotions and (4) social support and coping strategies used to deal with the stress experienced. The study concluded that care workers' training does not prepare them to understand and manage residents with challenging behaviour adequately. Formalised training as well as interpersonal skills building is necessary for them to cope with the stress they experience while working with intellectually disabled residents.

Ethics clearance was obtained from the Biomedical research committee of the University of

the Western Cape. Permission to access the residential facility and the care workers was obtained from the chairperson of the management committee of the facility.

iii

KEYWORDS

Care worker

Intellectual disability

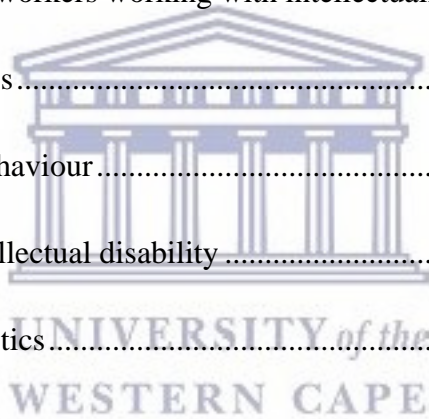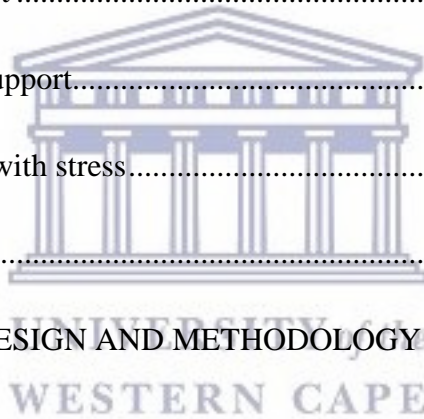Residential facility

Social support

Stress

TABLE OF CONTENTS

x

.

ABBREVIATIONS

APA   American Psychiatric Association

DoH   Department of Health

ID   Intellectual disability

WHO   World Health Organization

NPO   Non-profit organisation

UNIVERSITY *of the*
WESTERN CAPE

LIST OF APPENDICES

DECLARATION

I declare that the study, "Care workers' experience of stress and social support in caring for residents with intellectual disability at a selected residential facility in the Western Cape", is my original work, that it has not been submitted for any degree or examination at any other University. All the sources I have used or quoted have been indicated and acknowledged by complete references.

 Name: Tozama Nogemane

Date: 22 February 2019

Signed: T Nogemane

ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the guidance, support and reassurance of my supervisor, Dr P Martin, who encouraged me to keep going even when I felt I had no energy left to do so.

To my manager, Helita, thank you for being supportive and understanding when I needed to take time off and focus on my studies. I would also like to thank the Vera Grover trust for providing me with financial assistance to make this thesis possible.

To all the care workers that participated in my study despite being busy managing the ever-challenging environment, thank you for your input.

Finally, thank you to everyone in my family for your unfailing support in my journey.

xiv

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 Introduction

Care workers are as diverse as the whole world is. They come from all ages, gender, socioeconomic, and racial/ethnic groups (Williams, Rycroft-Malone, Burton, Edwards, Fisher & Hall, 2016). They share positive aspects of caregiving as well as the many struggles, and face different challenges depending on their circumstances (Perera & Standen, 2014). Care workers may need differing support depending on their care recipients' condition and needs, and their own problems, strengths, and resources (Raley & Smith, 2015).

Care workers are the foundation of the workforce in many organisations that provide care and residency for people with intellectual disability (ID) (Harries, Ng, Wilson, Kirby & Ford, 2015). Their duties involve "hands-on care, like (a) personal hygiene,(b) activities of daily living, like washing the hair, cutting the nails and cleaning of the rooms" .Life skills, socialisation and vocational training are examples duties of care workers (Vassos, Nankervis, Skerry, & Lante, 2013). According to literature, care workers who provide care to people with ID are likely to experience significantly higher stress levels than care workers in other fields (Smyth, Healy, & Lydon, 2015).

There is a general consensus in the literature that the care workers' job involves significant personal investments in relationships with the residents, and these investments can compound stress levels and necessitate resources such as workplace support and development of coping strategies (Ó Donnchadha, 2018). Stressed care workers may negatively impact on the quality of care provided to the disabled person (Smyth et al, 2015).

Stress arises when a person perceives that the demands placed on him/her exceed his/her coping

1

resources (Folkman,1984). Stress is caused by an existing stress-causing factor or "stressor" (Hickey, 2014).The stress experienced by care workers may be attributed to multiple factors, such as client characteristics (Hensel, Lunsky & Dewa, 2012),personal characteristics of care workers (Judd, Dorozenko & Breen, 2017) and organisational factors (Vassos et al., 2013), among others.

Care workers' stressors may include the pressure of expectation to succeed, an uncertain future, and social, emotional, physical and family problems (Chao, 2012).Stress may impede care workers' ability to deal effectively with the challenging behaviour (Kurz, Bethay & Ladner-Graham, 2014). Understanding work stress among care workers working with ID residents is important as it may allow for identification of strategies to improve working conditions for the care workers, with resultant benefits in the quality of care that they render (Harries et al., 2015).

Anecdotal evidence suggests that following an assault, care workers tend to be absent from their jobs, sometimes arrive late and tend to extend their tea or lunch breaks to avoid dealing with residents. For others, exposure to aggression can lead to high levels of acute stress (Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2013); Rose, Mills, Silva & Thompson, 2013).

Social support has been identified as a way of ameliorating the negative effects/consequences of stress experienced by care workers (Deveau & McGill, 2016). Work social support can help foster employee satisfaction and retention and guard against intentions to quit (Gray & Muramatsu, 2013). There is evidence that social support can attenuate the negative effects of stress on care workers (Mutkins, Brown & Thorsteinsson, 2011). Social support is associated with a list of benefits that can contribute to happiness and satisfaction with life (Judd et al.,

2017). These benefits include job satisfaction (Harries et al., 2015) and reduced intention to quit (Judd et al., 2017).

The perception of social support from others can help care workers in managing the demands at work, and it is also associated with reduced stress levels (Hastings, Allen, & Baker, 2013). Social support can be anything from tangible support to emotional support. Research has ascertained that if care workers feel supported in the workplace they are better equipped to deal with everyday stressors (Mutkins et al., 2011). Supervisor interactions like recognition of work stress were also shown to be associated with reduced signs of stress and emotional exhaustion among care workers (Gray & Muramatsu, 2013).

There is extensive research on care workers' stress and their experience of social support in ID services; however, most studies have been conducted in America and Europe. The researcher could not find a study done in South Africa, particularly in the Western Cape, hence the need for the current study. In South Africa there is a paucity of literature on care workers' experience of stress and social support in caring for people with ID and challenging behaviour in residential facilities.

Most studies that were found focused on stress, burnout and social support in caring for residents with ID and dementia (Perera & Standen, 2014), residents with ID and other psychiatric conditions (Dawson et al., 2016), or residents with physical disability in residential settings (Graham, Sinnott, Snell, Martin & Freeman, 2013)F.Given that intellectually impaired individuals with challenging behaviour are most likely to be cared for in residential facilities by care workers who have basic training, it is imperative that studies focus on the stress and social support of care workers working in these facilities.

3

This study will focus on the stress experienced by the care workers working in a residential facility for adults with ID and challenging behaviour, and on the social support received to ameliorate the negative effects of the experienced stress.

1.2 Background and rationale for the study

There are more than one billion people in the world (which represents 15% of the population) living with some form of disability (World Health Organisation, 2011). Community home-based care emerged out of a need to care for the sick in their homes or in community-type environments (Tsolekile, Puoane, Schneider, Levitt & Steyn, 2014). Research has indicated that the current pool of health workers is inadequate to handle the current demand, which can diminish the effectiveness of the care delivered. Home-based care was meant as a way of alleviating the burden from hospitals and families of caring for those who cannot take care of themselves due to a disability (Kelly, Craft Morgan, Kemp & Deichert, 2018).

In the United States of America, it is estimated that between 70 and 80% of long-term care to people with disabilities is provided by care workers, also known as home health aides or personal care aides. According to the National Centre for Health Statistics (Walsh, Dahling, Schaarschmidt, & Brach, 2016), there were 835 200 residents living in 30 200 residential facilities in the United States in 2014. The number was expected to grow in the coming years due to the aging population and an increase in diseases and disabilities (Kelly et al., 2018). Care workers therefore provide basic needs to the chronically ill in environments where resources are constrained (Kelly et al.,2018).

In South Africa, with the HIV and AIDS epidemic, the increase in non-communicable diseases and various other health problems places a great strain on health care workers that has resulted

4

in new care needs and a crisis in health and other services (National Department of Health,2001).

With rising costs of care coupled with the high cost of medical services, the health care centres found themselves unable to cope with the demand. Long-term care had to be decentralised to the community level, thereby transferring the responsibility, the cost and the burden to non-governmental organisations (NGOs), community-based organisations (CBOs),and faith-based organisations (Mackenzie, 2017).

Home-based care has since evolved to provide services to any person who needs assistance due to a health condition, physical or mental impairment or disability. The South African Government embarked on a programme of re-engineering primary health care to create a more efficient and cost-effective health system in South Africa ,and home-based care is the product of this programme (Tsolekile et al., 2014). As more people become ill, many will not be able to stay in hospitals, given the limited health care resources. Home-based care will provide back-up for people, who need extended care, not necessarily in a hospital. However, home-based care is not intended to be "second-class care" or "cheap care" for those who cannot afford hospital care (National Department of Health, 2001).

For this reason, the roles of care workers can be quite diverse, and user expectations and needs differ based on their individual circumstances and health care requirements (Mackenzie, 2017). In some countries, the government is responsible for funding most care workers; however, in South Africa the primary sources of funding may be international or national donor agencies, NGOs and faith-based organisations. Funding partnerships might also be developed between the government and non-governmental donor agencies (Qalinge, 2011).

5

1.2.2Care worker training globally

To understand the context of care workers in South Africa, it is important to provide a global overview of care workers and the training they receive.

Globally, the term "care worker" is used synonymously with others, such as personal care attendant (Macdonald, 2006). Rycroft-Malone home care worker (U.S. Bureau of Labour Statistics)and direct support professional (Aides, 2011). However, regardless of the name, similarities exist in the type of work they do. Across the globe, care worker training is offered by institutions like nursing facilities, community colleges or trade schools.

While the training modules may differ among organisations regarding the number of modules and the duration of the courses, all care workers' training focuses on basic nursing skills and the practical care of sick people in their homes (Morton, Mayekiso & Cunningham, 2018). The aim of the training of care workers is to ensure that they are skilled and knowledgeable in the care of their patients, and to empower them to upgrade and seek formal employment.

In the United States of America, care workers are classified as direct care workers (DCWs). DCWs include certified nursing assistants, psychiatric aides and home health aides. Home health aides must complete a minimum of 75 hours of training, which is required by the Centres for Medicare and Medicaid Services (CMS) for all workers providing medical care that is reimbursed through Medicare (Kelly et al., 2018). Personal and home care aides are not required to complete 75 hours of federally certified training. The decision of whether to require training for these aides is left to the states, and the states vary widely in these training requirements. The employer may, however, require training or certification of competency from a health professional before employing a health care worker (Kelly et al., 2018).

6

Care workers in the United Kingdom are not regulated; however, the coalition government is in the process of developing codes and standards as a step towards their regulation. The period of training varies from two weeks to two years (Williams et al., 2016). In Scotland and Wales there are codes of conduct for care workers and employers; these employer-led methods came into practice in 2011 (Jayaweera, 2015).

In South Africa, to be qualified or recognised as a caregiver, a person needs to undergo home-based care training at an institution accredited by the South African Qualifications Authority (SAQA) and be in possession of a certificate as a proof of training completed (Skweyiya, 2006). Care workers who work for non-profit organisations funded by the National Department of Health (DoH) must complete a SAQA-accredited Ancillary Health Care Qualification to ensure that they render quality service to the communities, and this is facilitated by the DoH. Continuous in-service training is provided by the DoH to ensure competence (U.S. Department of Health and Human Services, 2011).

According to the National Guidelines on Home-Based Care and Community-Based Care, home care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories (National Department of Health,2001).

The National Department of Health of South Africa estimates that there are 60 000 to 70 000 care workers in the country. These are mostly volunteers managed by non-profit-organisations and are paid a nominal stipend instead of a salary. These organisations are often funded by the government, but they must raise their own funds and resources as the government grant is usually not enough to sustain the day-to-day organisational expenditure (Morton et al., 2018).

7

1.3 Job description of care workers

Care workers' job descriptions are sometimes unclear, with broadly defined responsibilities and sometimes conflicting demands, and this leads to reduced role clarity and increased role conflict in the workplace (Griffith & Hastings, 2014). However, key functions of care workers working with people with ID and challenging behaviour make provision for direct and indirect care.

1.3.1 Provision of direct client care

Direct care refers to the time the care workers spend with the resident with ID and challenging behaviour. It consists of subcategories like promoting the activities of daily living, such as basic care, conversations with residents and answering calls or attending to the needs of the residents (Tsolekile et al., 2014). Basic care refers to duties such as helping the residents to bath, dress and go to the toilet. It also includes feeding or supervision of residents at mealtimes and cleaning up the dining area afterwards. Care workers' duties include direct interaction with, and training and stimulation of, people with ID (Graham et al., 2013).

Direct interaction involves supportive talks and listening and responding to the needs of residents. It also includes calming down aggressive residents and comforting those who feel unwell. Care workers are also responsible for accompanying residents to health facilities when they have an appointment; their role is to give feedback (on how the resident has been doing in terms of their overall health) on behalf of the resident to the health care provider. The duties that the care workers perform could involve high risk to themselves, both physical (e.g., high rates of on-the-job accidents and injuries) and emotional (e.g., frequent contact with clients who die, high rates of depression) compared with other health- and non-health-related

8

industries (Kelly et al., 2018).

1.3.2 Provision of indirect care

Indirect care consists of preventative care, which includes housekeeping duties (like cleaning the resident's room, keeping their surroundings clean and clutter-free and taking their dirty linen and clothes to the laundry), basic rehabilitation, health promotion, support to the resident and disease prevention (Wild, Szczepura & Nelson, 2013). Attendance of team meetings and completion of daily reports is another indirect form of care provided by care workers. This is done to monitor residents' progress. Attendance of staff meetings or handover meetings with other nursing staff categories ensures a high quality of care rendered to the residents (National Department of Health, 2001).

1.4 Problem statement

Care workers provide care to vulnerable residents who are intellectually disabled. They are exposed to several stressors in their job, which is often characterised as emotionally demanding, challenging and exhausting (Smyth et al, 2015). On a day-to-day basis, care workers may encounter challenging client behaviour, emotional family members, intense physical demands and illness (Santy-Tomlinson, 2013); Kozak, Kersten, Schillmöller & Nienhaus, 2013). In addition, they work long hours and often have few resources to help them cope (Kurz et al., 2014).

The limited training that care workers receive does not prepare them adequately to manage residents with ID and challenging behaviour (Knotter, Wissink, Moonen, Stams & Jansen,2013). This lack of adequate training and preparedness could also contribute to the stress experienced by care workers. The frustration and confusion get worse as the care workers

9

are not trained in caring for people with ID and can also miss the cues that the residents may display (Flynn, Hastings, Gillespie, McNamara & Randell, 2018).

It is crucial that care workers have non-verbal communication skills to build good relationships with the residents, especially those who do not use formal language (Jenson, Peterson-Besse, Fleming, Blumel & Day, 2015).

High-strain job demands, low support and low rewards, in addition to the challenging behaviour of residents, could be overwhelming for care workers (McConachie, McKenzie, Morris & Walley, 2014). Anecdotal evidence suggests that care workers experience negative effects from all the demands. Increased absenteeism rates due to ill health and other unexplained reasons, job dissatisfaction and high turnover rate have been observed. Literature indicates that stressed care workers are highly prone to accidents, abusive practices, increased errors because of cognitive strain and reduced motivation (Harries et al., 2015). Despite these negative effects, some care workers remain in their job. Little is known about care workers' emotional responses to stress or the social support systems they use to cope when working with intellectually disabled people with challenging behaviour; thus, there was a gap to conduct this research. The question then arises: What are the experiences of stress and social support of care workers working with intellectually disabled residents with challenging behaviour?

1.5 Aim

The aim of this study was to explore and describe care workers' experience of stress and social support whilst caring for intellectually disabled residents with challenging behaviour.

1.6 Objectives

The objectives of this study were:

10

- to explore the care workers' physiological, psychological, social and organisational emotional responses to stress whilst caring for intellectually disabled residents with challenging behaviour; and

- to explore the care workers' experience of social support to cope with caring for intellectually disabled residents with challenging behaviour.

1.7 Significance of study

Care workers experience various stressors. Accurate measurement of their perceived stress can assist in understanding their susceptibility to pathological disorders like depression and burnout. This study may:

- contribute to baseline data on the experience of stress and social support of care workers working with people with challenging behaviour in residential settings;

- assist in the development of strategies to assist in the management of stressful events;

- assist in the development of a prevention programme that will develop or enhance coping skills;

- inform the managers of the support systems that can be put in place to assist the care workers within the organisations; and

- be used in the drawing up of policies for specific organisational support needs.

1.8 Operational definitions

For the purposes of this study, the following terms are used, as defined below:

Care worker is defined as a person who is trained to provide support and contribute to the health and social well-being of a dependent or disabled individual (National Department of

11

Health, 2001).

In this study, care worker refers to an individual who has undergone home-based care training at an accredited institution and is employed in a non-professional role to support people with intellectual disabilities in a residential setting with activities of daily living.

Intellectually disability refers to problems with general mental abilities that affect functioning in two areas, namely intellectual functioning (such as learning, problem-solving and judgement) and adaptive functioning (such as activities of daily life like communication and independent living) (APA,2013).

In this study, intellectually disabled resident refers to an adult who is residing in a residential facility and requires assistance with the activities of daily living such as bathing, eating and decision-making in different areas of their everyday life.

Stress refers to physical, emotional or mental factors that cause bodily or mental tension (Fink, 2016). Lazarus and Folkman (1984) define stress as the body's reaction to anything that throws off the balance inside it, as a result of an unfavourable person–environment relationship. In this study, stress refers to the care workers' feelings and thoughts about situations in their lives that they regarded as stressful, unpredictable, overwhelming and uncontrollable while caring for residents with ID.

In this study, stress responses refer to:

- Physiological response to stress refers to a reaction that triggers a bodily or physical reaction to a stressor. Examples include increased heart rate, sweating and changes in body temperature (APA, 1994).

12

- Psychological response to stress refers to the use of coping mechanisms and emotional reactions that individuals use to adjust to the stressor.

- Sociological response to stress refers to society's influence in evoking an emotional response from the care workers.

- Organisational response to stress refers to the residential facility's influence in evoking an emotional response from the care workers.

Social support refers to the providing of assistance or comfort to people to help them cope with a variety of problems (Lakey & Orehek, 2011)

In this study, social support refers to the interpersonal needs and received support in terms of the care workers' interpersonal relationships with others.

Residential facility refers to a facility where a small number of unrelated people in need of care, support or supervision due to physical, mental or emotional disorders stay together (Carder, O'Keeffe & O'Keeffe, 2015).

In this study, residential facility refers to a community-based residential care setting that provides shelter and meals, while allowing for 24-hour protective oversight and personal care services.

1.9 Research design and methodology

A qualitative research approach using exploratory, descriptive phenomenology and semi-structured interviews was utilised to answer the research question. Research design and methodology is discussed in detail in chapter 3.

13

1.10 Data analysis

Data were analysed using Colaizzi's method of data analysis. A detailed description of data analysis is provided in chapter3of this thesis.

1.11 Outline of the study

The sequence of chapters of this thesis is as follows:

Chapter 1introduced the study and provided a background, the motivation for the study, the problem statement, aims and objectives, as well as the significance of the study. The terms used were also defined and the chapters were outlined.

Chapter 2 discusses the theoretical framework, namely Lazarus & Folkman's process model of stress and coping, which guided the study. The literature on stress and social support of care workers caring for individuals with ID is also reviewed. The chapter discusses the roles and the experiences of care workers caring for the residents with ID and challenging behaviour.

Chapter 3 introduces the methodological approach used to achieve the aim and objectives of the study. Details of the study design, sampling methods, data collection methods and data analysis are presented, as are ethical considerations and the measures taken to ensure the trustworthiness of the research.

Chapter 4 presents the research findings and discussions of the results by referring to the categories and themes that emerged from the data analysis.

Chapter 5concludes by drawing on the findings from the study. Limitations, recommendations and suggestions for further research are highlighted.

14

1.12 Summary

This chapter outlined the background as well as the aim, objectives and significance of the study. Key concepts relating to this study were described and defined. The research methodology and design of the study were briefly presented.

Chapter 2discusses the theoretical framework used to guide the study and presents the literature review on care workers' experiences of stress and social support in caring for residents with ID.

15

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter is a review of the empirical and theoretical literature on care workers' experiences of stress and social support in caring for residents of a residential facility with ID and challenging behaviour. Research has indicated that the number of individuals with ID continues to grow, and care workers play a crucial role in maintaining the health and well-being of those individuals (Institute of Medicine, 2008). Research about care workers' stress and coping in the ID field is growing and includes examination of stressors and resources; however, important gaps still exists.

The literature in this study is structured thematically. Thematic review is organised around topics rather than the progression of time (Marshall & Rossman,2011). However, progression of time remains an important factor in thematic review. The review will shift between periods of time within each section according to the point made.

This chapter will provide a detailed review of past research conducted in this field and point out the possible gaps. Literature searches were conducted for English-language, peer- reviewed journal articles published from 2008 to 2018. The following keywords were used to generate the search results: care worker, direct care worker, home-based carer, support worker, health care aid, caregiver, developmental disability, intellectual disability, learning difficulty, residential facility, group home, social support, coping, stress or distress. This was done to yield the results and findings of the most recent work done by other researchers.

Literature search was done through computerised databases (as they are typically reviewed by social science researchers) such as EBSCOhost, Google Scholar, Medline, Mendeley, Science

16

Direct, Scopus, PsycINFO, PubMed and Wiley Online Library. For inclusion in the review, studies had to meet the following predetermined criterion: participants were paid or employed caregivers, not parents or family members, of people with intellectual disabilities.

2.2 Theoretical framework

Theoretical framework is defined as the framework, based on an existing theory in a field of inquiry, that is related to or reflects the hypothesis of a study. It can also be described as a structure than can support the theory of a research study (Adom, 2018). Its role in the study is to introduce and describe the theory that explains why the problem under study exists (Grant & Osanloo, 2014). A theoretical framework deepens the essence of the study and shows the reader that the study is not based on the personal instincts of the researcher but is firmly rooted in an established theory selected through credible studies (Adom, 2018).

The process model of stress and coping developed by Lazarus & Folkman (1984) was chosen as a guide to explore the care workers 'experience of stress, coping strategies and the resources they use to deal with stressful situations while caring for residents with ID and challenging behaviour. The process model of stress and coping developed by Lazarus has been widely used in the field of stress research as it is well developed, well designed and widely accepted by researchers (Perera & Standen, 2014).This model has been chosen as it focuses on the individuals' own appraisal of the stressful event rather than the severity of the event.

The process model of stress and coping is described as a process-orientated approach to coping which is directed towards what an individual think and does within the context of a specific encounter and how these thoughts and actions change as the encounter unfolds (Lazarus & Folkman, 1984:2). The model is cognitive because it assumes that the care workers' thinking

17

processes, memory and the meaning stressful events have for them, can be used to mediate in determining stress and coping.

Care workers are in constant interaction between the intellectually disabled residents and the environment in which they work. The question then arises: How do care workers experience stress and social support in caring for intellectually disabled residents at a residential facility setting, according to Lazarus's cognitive process model of stress-appraisal-coping, to make sense of the encounters and cope in the environment? An explanation of the theoretical perspectives on emotion is necessary to contextualise the discussion.

2.2.1 Key features of the model

The Lazarus &Folkman process model of coping considers the individual's appraisal of stressful events rather than the severity of the events. An individual's process of coping mediates the effects of stress on his/her well-being. Coping is concerned with the individual's response to a demand and is related to the individual's psychological flexibility, support or the perception of support from others. Individuals differ in their appraisals of similar events and circumstances; therefore, it cannot be presumed that all the care workers working with intellectually disabled persons experience them and their challenging behaviour as stressful and difficult to cope with. If perceived demands exceed the individual's coping strategies and organisational resources, stress cannot be managed appropriately (Lazarus & Folkman, 1984).

The distinctive feature of the chosen model is the importance assigned to the care workers' appraisal of the stressor in affecting his/her adaptation to a stressful situation. The model also maintains that the psychological meaning of the event to the individual is the most influential element on the coping process. This refers to the individual selecting from active 'internal

18

situations', such as redirecting attention from a painful situation by using distraction. Distraction is important in coping with intellectually disabled residents with challenging behaviour and can change the internal focus when experiencing distressing memories of events or situations. Cognitive change occurs when care workers change how a situation is appraised to change the emotional significance of the situation. This change in appraisal of the situation/event is known as reappraisal of the event (Lazarus,1993). Perceived stress is the relationship between the care workers and the environment that is appraised as exceeding available resources, while appraisal is the care workers' perception and assessment of social support in the working environment (Lazarus & Folkman, 1984). In some instances, intellectually disabled residents may refuse to take instructions from the care workers when care workers are carrying out their daily duties like bathing them or doing other activities of daily living as per facilities' rules. The care workers may interpret this as being directed at themselves and their perceived incompetence or lack of qualification to do the job. Reappraisal or cognitive change about the situation may allow the care workers to view it as insignificant for the resident. The interpretation of the situation, whether it is correct or incorrect, may change the intensity (severity of the emotion) and quality (which emotion) of the care workers' emotional response.

The model focuses on cognitive appraisal of stressors from the perspective of the person experiencing it and how the person copes within the stressful environment to make sense of the experience. The central assumption of this theory is that any event is potentially stressful. Two processes which serve as mediators within this person-environment transaction are important: cognitive appraisal and coping. Cognitive appraisal is the care workers' evaluation of the personal significance of the event (Martin & Daniels, 2014).

19

The ability to cope with demands is given an important role by the model. Coping is the effort that the care workers apply to managing or overcoming the stressful work environment (Lazarus, 1999). Lazarus and Folkman (1984) refer to this as "problem-focused coping" as a function of coping. Problem-focused coping changes the person-environment relationship by acting on the environment itself or on oneself. The care workers' belief in their ability to solve problems influences the emotions they experience in encounters with the intellectually disabled residents with challenging behaviour in a residential facility setting.

The following diagram illustrates the process model of stress and coping.
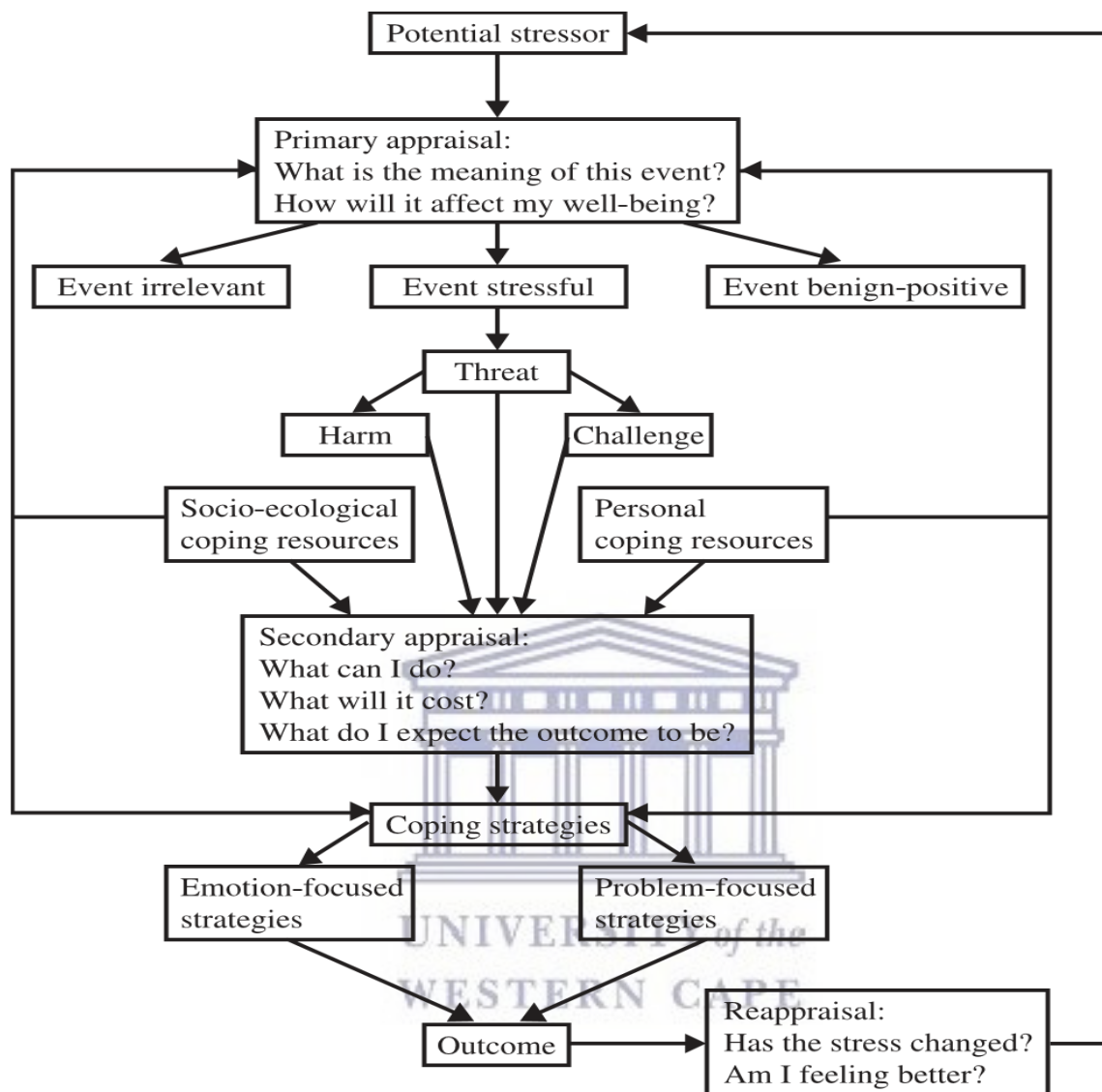
Figure 1: Lazarus and Folkman process model of stress and coping as adapted by (Kelso, French, & Fernandez, 2005)

2.3 An overview of care workers' stress in caring for residents with intellectual disability

Care workers providing care for people with ID are likely to experience significantly higher stress levels than care workers in other fields. It is estimated that the proportion of care workers in ID services experiencing stress levels indicative of mental health problems ranged from 25

21

to 32.5% (Harries et al., 2015).The stress maybe exacerbated by a range of factors, which include but are not limited to residents' challenging behaviour, limited training and lack of support (Ó Donnchadha, 2018). Stressed care workers may negatively impact on the quality of care provided to the disabled person (Smyth et al, 2015). There are high quality longitudinal research data suggesting that family care workers of adults with intellectual and developmental disabilities who display challenging behaviour are at increased risk of stress or mental health difficulties (Flynn et al., 2018).

Smyth et al (2015) conducted a study on analysis of stress, burnout and work commitment among care workers. The study was conducted in the United Kingdom in 18 residential facilities dedicated to care of adults with ranging levels of ID. The aim of the study was to explore the impact of aggressive topographies of challenging behaviour on measures of stress, burnout and work commitment among the ID care workers. Their study discovered an association between challenging behaviours experienced and participants' perceived stress and emotional exhaustion. Perceived stress and burnout were also associated with participants' commitment to their work. The results of the study indicated the need for the consideration of care workers' well-being and support. Further research in this area was also found to be necessary.

A similar study was conducted by Flynn and colleagues in the United Kingdom to determine if the exposure of care workers to challenging behaviour displayed by the intellectually disabled residents was associated with the care workers' stress or well-being. The study was conducted in different facilities for intellectually disabled residents. Differences between settings, in addition to the varying extent of individuals' challenging behaviour, may explain variability in care workers' experiences and outcomes. As well as impacting care workers'

22

psychological outcomes, challenging behaviour can be influenced by care worker variables; for example, staff behaviour can result in or exacerbate challenging behaviour for people with ID (Hastings et al., 2013). The results of the study showed no evidence that exposure to challenging behaviour has any direct association with care workers' stress or work-related well-being.

The results of this study are in contrast with those of Smyth et al (2015), whose results proved an association between challenging behaviour and care workers' stress in facilities for intellectually disabled residents. It is therefore necessary to replicate these studies in future and consider factors like duration of exposure to challenging behaviour, the severity of challenging behaviour, availability of social support and care workers' emotional intelligence (Flynn et al., 2018).

To explore the effects of mindfulness training on care workers, Ó Donnchada (2018) conducted a study on the stress of care workers of persons with ID and a systematic review of mindfulness-based interventions. The study was conducted in Ireland. The aim was to expand on previous reviews of the conceptualisation of mindfulness-based interventions. Mindfulness-based interventions are based on aiming to accept the symptoms of stress and distress instead of removing them (Ruotsalainen, Verbeek, Mariné & Consol, 2015). The results of the study had inconsistencies in terms of the reduction or increase of stress. There were some benefits of mindfulness-based interventions on care workers, such as increased mindful awareness and reduced suppression of their thoughts. The latter were indicative of reduced stress and distress in care workers of residents with ID. The results of this study acknowledge that some form of training is beneficial for care workers' well-being and helps guard against the negative effects of stress.

Studies in Africa focusing on paid care workers' experience of stress and social support in residential facilities for intellectually disabled residents are rare. The researcher could not locate any study specific studies on care workers' experience of stress and social support.

2.4 Causes of stress in care workers working with intellectually disabled residents

There are many factors which contribute towards the stress experienced by care workers working in residential facilities for intellectually disabled persons with challenging behaviour. These include client characteristics (Hensel et al., 2012), personal characteristics of care workers (Devereux, Hastings, Noon, Firth & Totsika, 2009), and organisational characteristics (Thompson & Rose, 2011; Vassos & Nankervis, 2012). Despite the mentioned factors, the care workers may still appraise the stressful situations differently, as implied by the Lazarus and Folkman process model.

2.4.1 Client characteristics

Client characteristics include challenging behaviour, the severity of the ID, the nature of the ID and the gender or age of the intellectually disabled resident.

2.4.1.1 Challenging behaviour

Challenging behaviours are those that are socially inappropriate, such as threat of aggression or actual aggression, inappropriate sexual or self-harm conduct, or property damage (Emerson & Einfeld, 2011). Studies indicate that challenging behaviour occurs in 10 to 20% of adults with ID (Lundqvist, 2013). Literature has identified aggression as one of the most common risk markers of challenging behaviour (Rose et al., 2013). Aggression is defined as any verbal, non-verbal or physical behaviour displayed by the resident that is threatening or causes harm to self, others or property (Hensel et al, 2012). The unpredictable nature of challenging behaviour is

24

an important source of stress for care workers as it creates a sense of unease and hypervigilance (Zijlmans, Embregts, Gerits, Bosman & Derksen, 2014).

Research has identified biological and psycho-social factors as vulnerabilities or risk factors for challenging behaviour (Hastings et al., 2013). These factors are a part of the context in which challenging behaviours emerge. Biological factors are further divided into physical and genetic factors (Cudre-Mauroux, 2010). Challenging behaviour maybe be related to an underlying physical problem like pain. It is therefore important that a physical assessment be done when dealing with challenging behaviour to exclude any underlying sickness (Hastings et al., 2013). Care workers maybe frustrated with residents' attitudes only to find that the resident is unable to communicate how they are feeling. It is therefore important to rule out physical ailments when dealing with challenging behaviour (Hastings et al., 2013). It has been noted that some genetic syndromes in ID, such as autism spectrum disorder, are associated with a high risk of challenging behaviour (Lundqvist, 2013).

Psycho-social vulnerabilities are divided into poor communication skills, impoverished social networks, lack of meaningful activity, and psychiatric or general mood problems (Hastings et al., 2013). Research has suggested that exposure to negative life events increases the risk of challenging behaviour in residents with ID (Hastings, 2008). These behaviours are typically associated with the workers' experience of stress (Judd et al., 2017).

Some residents with ID have diminished ability to communicate feelings clearly or may do so through challenging behaviours (Collins, Gratton, Heneage & Dagnan, 2017). Challenging behaviour may cause a range of negative emotional reactions in care workers, such as fear, anger, and disgust (Kurz et al., 2014). It is therefore important for care workers to interpret

25

their needs and respond accordingly to prevent the escalation of challenging behaviour (Collins et al., 2017). Anecdotal evidence suggests that following an assault, care workers tend to be absent from their jobs, sometimes arrive at work late and tend to extend their breaks to avoid dealing with residents. The effect of ongoing stress on care workers can lead to negative physical and psychological effects such as low frustration tolerance, anxiety and hypertension (Griffith & Hastings, 2014).

2.4.1.2 Severity of intellectual disability

Intellectual disability is defined as neuro-developmental disorders that begin in childhood and are characterised by intellectual difficulties in conceptual, social and practical areas of living (APA, 2013). According to the DSM-5, the degree of impairment is diagnosed based on the (a) mental abilities, such as reasoning, academic learning and abstract thinking and (b) the deficits in adaptive functioning, like social skills, communication and personal independence and the type needed. ID is classified into four categories: mild, moderate, severe and profound ID (Lee, 2017).

Working with individuals with severe disabilities is often viewed as tedious, monotonous work, and care workers may find themselves frustrated by their clients' slow progress. Care workers in such positions may come to experience feelings of inadequacy and hopelessness (Juhmani, 2016). Residents with severe or profound ID vary widely in their cognitive, communicative, social and emotional capabilities and functionality, and the expression of their challenging behaviour may vary accordingly (Quilliam, Bigby & Douglas, 2018).

It is notable that residents with severe ID experience the lowest levels of contact with care workers, while those with mild ID experience the highest levels of contact. Residents with mild

26

ID are better able to engage in verbal conversation with care workers and have a broader communicative repertoire, which might explain the higher levels of contact (Zijlmans et al., 2014).

Another risk marker identified was gender; males are at greater risk of developing challenging behaviour, especially aggressive behaviour (Bowring, Totsika, Hastings, Toogood & Griffith, 2017).

2.4.2 Personal characteristics

Personal characteristics of care workers comprise personality traits, cultural beliefs (R. Hastings et al., 2013)locus of control, age and gender, and interpersonal relationships with colleagues (Zijlmans, Embregts & Bosman, 2013).

2.4.2.1 Personality traits

Personality traits refer to a person's characteristics in terms of thoughts, feelings and behaviours. It is important to look at care workers' personality traits because in experiencing stress, people respond to work settings in their own unique, individual ways (Wilderjans, Lambrechts, Maes & Ceulemans, 2014). Research has shown that care workers experiencing negative emotions may act in a hostile and controlling manner (Zijlmans, Embregts, Bosman & Willems, 2012). In sum, negative emotions may negatively impact well-being and behaviour of care workers towards residents with ID and challenging behaviour (Zijlmans et al., 2013).

According to Rose et al. (2013), care workers' own interpretation of challenging behaviour, rather than the behaviour itself, is the main contributor to care workers' experience of stress. Care workers' beliefs about the causes and functions of challenging behaviour impact their responses to the behaviour. Care workers who believe that challenging behaviour is the result

27

of uncontrollable factors, such as a medical condition, are more willing to help clients than those who consider the resident displays the challenging behaviour on purpose (Zijlmans et al., 2014). Research has even shown that a training programme focused on emotional intelligence, related to the treatment skills of care workers, is effective in improving emotional intelligence (Zijlmans et al., 2014).

2.4.2.2 Cultural beliefs

Care worker's beliefs and emotional life also need to be considered as they play a role in how the care workers respond to the residents' challenging behaviour or stressful situations (Hastings et al., 2013).Care workers' cultures are also likely to be important factors in this regard. It is therefore important that care workers' beliefs be taken into consideration when determining their stressors. Care workers' cultural beliefs are likely to play a role in how they perceive the stressful situations they encounter, which might influence their willingness to seek or accept external help and advice (Emam & Al-Bahrani, 2016). Care workers may believe in certain accepted ways of doing things, certain individuals who are leaders and whose advice is followed, and the competing demands of the context (e.g. the need to ensure a safe and clean physical environment) (Hastings et al., 2013).

2.4.2.3 Age and gender of care workers

Most literature on ID care workers has focused on depression and stress among mothers or the families of young children with ID; research on paid care workers in residential facilities is still a neglected area (Chou, Pu, Fu & Kröger, 2010). However, it has been found in literature that female care workers are likely to have higher stress levels than males, since females are likely to focus not only on their job but also on family. Thus, women are likely to have higher job

28

burnout rates than men (Lin , 2013).

2.4.2.4 Locus of control of care workers

Locus of control is the degree to which people believe that they have control over the outcome of the events in their lives, as opposed to external forces beyond their control (Gray & Muramatsu, 2013). Care workers with an internal locus of control believe that their own ability determines what happens, while those with an external locus of control believe that fate, luck or outside forces are responsible for what happens (Rose et al., 2013). Care workers with an internal locus of control demonstrate greater mastery and control within their work environment.

Gray & Muramatsu (2013) conducted a study in the United States of America on care workers' intentions to quit their jobs caring for intellectually disabled residents. The aim of the study was to examine how work stress, work social support, and locus of control were associated with intentions to quit among the care workers in the disability services. The study concluded that care workers with an internal locus of control were unlikely to quit their job, while those with an external locus of control were likely to quit (Gray & Muramatsu, 2013). It can be concluded that locus of control determines how a care worker responds or deals with challenging or stressful situations.

2.4.3 Organisational characteristics

Organisational characteristics are aspects of the organisation that can be identified in relation to performance (Rose et al., 2013). Characteristics of organisations that contribute significantly to staff stress include high job demands, role conflict and role ambiguity, and lower levels of job support, training and work experience of care workers (Knotter, Wissink, Moonen, Stams

29

& Jansen, 2013).

2.4.3.1 High job demands

High job demands placed on care workers, including work over-load and working long hours, can lead to negative consequences like reduced quality of care and decreased job morale (Roy, Gujar, Ali, & Borah, 2018). Demands placed on care workers and the negative consequences of stress seriously affect not only the care workers but also the quality of care that they provide to the intellectually disabled residents (Rose et al., 2013). While all work stressors are problematic, being overwhelmed with lots of work tasks and other stressors can cause coping to be challenging for care workers (Gray & Muramatsu, 2013).

The interpersonal demands of the helping role are seen as a major source of stress, and when these demands exceed available resources, care workers may experience stress and burnout (Judd et al., 2017). Equipping the care workers with stress management and coping resources could improve the quality of care they provide to the residents and increase their job morale (Vassos et al., 2013). It is therefore important for the management of the residential facilities to examine the workloads of care workers and how they cope with them.

2.4.3.2 Role conflict and role ambiguity

Role ambiguity and role conflict are job characteristics that are studied worldwide. The concepts were originally introduced by Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964), as cited in Schmidt, Roesler, Kusserow and Rau (2014). Role conflicts arise when there is inadequate information about job performance, or conflicting demands at the job (Kozak et al, 2013). Care workers are then confronted with two or more conflicting or opposing roles and expectations. Supervisors and colleagues may also have unclear expectations and this leads to

30

stress for care workers (Schmidt et al., 2014). Long-term role conflict and role ambiguity can lead to stress and inability to perform the work duties (Judd et al., 2017).

2.4.3.3 Lower job support

In studies by Hatton & Lobban, (2007) and Kurz et al., (2014) it was asserted that the training care workers receive in ID and challenging behaviour does not prepare them adequately to deal with and manage residents with challenging behaviour. Lack of management insight into the high expectations for care and constant pressures due to staff shortages and challenging client behaviour could increase the risk of care workers experiencing stress (Rose et al.,2013; Gray & Muramatsu, 2013; Kozak et al., 2013; Vassos et al., 2013).

Most care workers in South Africa work in organisations that have their own funding challenges, which leaves the care workers with little job security and a lack of professional development opportunities (NACOSA, 2013). Low wages and low few to no fringe benefits also contribute to stress in care workers working in ID services (American Health Care Association,2008).
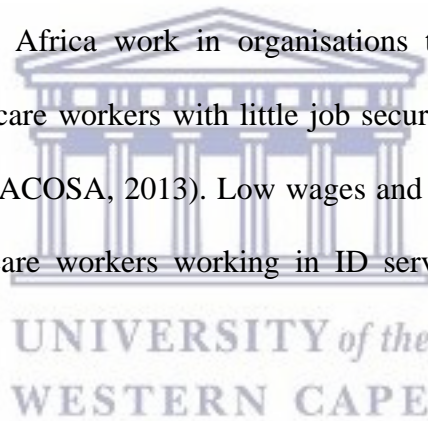
2.4.3.4 Training and experience of care workers

According to Rose et al. (2013), training of care workers in the ID services regarding challenging behaviour can change the way they perceive challenging behaviour and improve their emotional responses. Adequate care worker training appears to be essential in promoting quality and safe practice (Ravoux, Baker & Brown, 2012). Care workers may have reduced fear of being assaulted, less emotional exhaustion and less stress (Rose,2013; Harries et al., 2015).

Zoder-Martell et al. (2014) conducted a study on training care workers to increase positive

31

interactions with individuals with intellectual disabilities. The study was conducted in the United States of America in a residential facility for people with intellectual disabilities. The aim of the study was to test the effect of direct training on care workers to initiate positive interactions with residents who reside at a residential facility. The study further aimed to evaluate the link between increased positive interactions with care workers and a decrease in the residents' challenging behaviour.

The results showed that following the training with the care workers, the rate of interaction between them and the residents increased, and the rate of challenging behaviour decreased. The results also showed improved treatment outcomes for residents when regular positive interactions are incorporated into active treatment. However, it was difficult to evaluate the lasting impact of training and feedback procedures. It is therefore necessary that continuous training be provided using in situ prompts (Zoder-Martell et al., 2014). The results of the study were consistent with those of a previous study conducted by Zoder-Martell et al, (2014). It can therefore be concluded that training for care workers could play a big role in improving the way they manage residents with ID and challenging behaviour. Training may also help care workers to develop more internalised control beliefs and ways to approach stressful work situations more proactively, though such beliefs do take time to change (Gray & Muramatsu, 2013).

2.5 The effects of stress on care workers

The effects of stress on care workers for the intellectually disabled could be physiological, psychological or social (Flynn et al., 2018). It is reported that stressed care workers may experience emotional exhaustion, have reduced job satisfaction and may develop negative attitudes towards those that they care for (Vassos et al., 2013). Care workers' stress can lead to

32

poorer quality interactions between clients and staff (Schuengel, Kef, Damen, & Worm, 2010), which might lead to increased challenging behaviour and further elevated stress levels among staff.

2.5.1 Physiological effects of stress

Caring for intellectually disabled people requires physical labour, which may also lead to stress in care workers when they are unable to fulfil this function due to their own physical ill health (Hatton & Lobban, 2007). Exposure to stress over a long period has been found to lead to adverse physical health outcomes like cardiovascular disease, fatigue, headaches, lowered immunity and risk of developing musculoskeletal disorders. The physiological effects may include physical exertion which produces muscle strain, skeletal injury, aggravation of chronic illness such as arthritis, or other sources of physical discomfort and pain (Lin & Lin, 2013). The number of hours involved in caregiving and constant assistance with activities of daily living (bathing, toileting and meal preparation)can lead to trauma of the body causing muscle strain or skeletal injury (Wilderjans et al., 2014).

2.5.2 Psychological effects of stress

Various studies have reported on care workers' psychological responses to the stress experienced when caring for residents with ID (McConachie et al., 2014). Care workers experiencing higher levels of stress also tend to experience more anxiety, feel significantly more demands are put upon them and are significantly less likely to interact with the individual they support (Ingham, Riley, Nevin, Evans & Gair, 2013).Studies have suggested that staff stress could be understood in terms of the transactional model, which purports that "stress is neither in the environment nor in the person but a product of their interplay" (Lazarus &

33

Folkman, 1984: 354). The model suggests that the relationship between a person's coping resources and their appraisal of their environment determines the stress they experience, with imbalances between coping resources and the perceived external pressures predicting levels of stress (Lazarus & Folkman, 1984). Stressed care workers have described having trouble performing to their full potential when stressed. Sometimes the effects were minor, such as feeling withdrawn or lacking the motivation to socialise with residents (Judd et al., 2017).

Prolonged effects of stress include mental health outcomes like sleep disturbances, anxiety and depression (Judd et al., 2017). Stressed care workers inevitably impact on the wider organisation in terms of higher absenteeism rates and high turnover rate (Thompson & Rose, 2011).This can lead to low staff morale and poor quality and continuity of care (McConachie et al., 2014).Anecdotal evidence suggests that following the incidents, dedicated care workers are absent from work, they become impatient and avoid the residents to cope with the situation.

2.5.3 Social effects of stress

Care workers are part of the communities or societies that they live in. The stress that they experience at work affects not only their work but their social life as well. Due to the long hours that they spend at work, family time becomes limited, and they experience increased social isolation and disruption of leisure time (Lucchetti et al., 2014).

2.6 Different kinds of social support available for care workers

Social support is defined as the emotional and practical assistance an individual believes is available during a time of need (Mattson & Hall, 2011). When defining social support, it is important to take note of the actual support as well as perceived support. Actual support refers to the support that an individual receives in terms of what is said, what is given, and what is

34

done for that individual, while perceived support refers to an individual's belief that social support is available and provides what s/he considers to be needed (Mattson & Hall, 2011).

There are factors that may influence the care workers' likelihood to seek social support, such as the stigma attached to needing support. Social support is categorised into four types: emotional, instrumental, informal and appraisal. Two of these, emotional and instrumental, are of importance in the support work setting.

2.6.1 Emotional support

Emotional support refers to the provision of reassurance, acceptance and encouragement during stressful times (Poulsen, Overgaard, Vestergaard, Christensen, & Hartvigsen, 2016). Supervisory or work support is classified under emotional support. Supervisory support refers to guidance, acknowledgement of care workers' skills and worth (Poulsen et al., 2016), rewarding them for good performance and care about their well-being while working with residents with ID (Astvik & Melin,2013). Support from supervisors can help care workers to feel closer and affiliated to the organisation (Schmidt et al., 2014).

Supervisors' response to care workers' concerns and on-the-job problems, and their managing of conflicts among staff, maybe viewed by care workers as instrumental in setting clear and realistic job responsibilities (Vassos & Nankervis, 2012). Supervisor interactions like recognition of work stress were also shown to be associated with lower levels of stress, while a perceived lack of social support is associated with higher levels of stress (Poulsen et al., 2016). Getting the care workers involved in decision-making can boost staff morale and ultimately boost organisational loyalty (Gountas & Gountas, 2015).

While studies have been conducted on stress experienced by care workers working with

intellectually disabled people displaying challenging behaviour and the buffering effects of social support, the researcher could find no studies conducted in private residential facilities which accommodate adults with ID who present with a range of negative behaviours and the social support care workers use to cope with the behaviours they experience, hence the need to conduct this study.

2.6.2 Instrumental support

Instrumental support is defined as the act of offering tangible assistance, such as materials and resources necessary for performing the job, guidance or knowledge needed to complete the task, or actual physical aid. It includes the provision of real and perceived support, both instrumental and expressive, from the community, social networks and close friends. (Hombrados-Mendieta, Dominguez-Fuentes, Garcia-Leiva & Castro-Travé, 2012). There have been suggestions in literature that when caring staff feel supported in the workplace they are better equipped to deal with everyday stressors (Mutkins et al., 2011). Social resources like work social support may help care workers perceive work overload and other work stressors as less threatening and galvanise them to cope more effectively to prevent more stress which can lead to mental and physical health issues (Chancey et al., 2018).

Training is also perceived as a form of support as it equips care workers with necessary skills for dealing with challenging behaviour, reducing their risk of stressful encounters (Chancey et al., 2018).

2.6.3 Benefits of social support

Social support has been investigated extensively in connection to stress (Kozak et al., 2013). It has been found to buffer the effects of stress experienced by care workers in the ID services

36

(Mutkins et al., 2011). The perception of support from others is a resource that is used to manage demands at work and is associated with reduced stress levels (Gray-Stanley & Maramatsu,2011). Support from colleagues and social networks is valuable in managing stress and preventing burnout (Gray-Stanley & Muramatsu, 2011; Mutkins et al., 2011; Rose et al., 2013).

This is supported by a study conducted by Mutkins et al., (2011) on care workers in an Australian facility for residents with ID. The aim of the study was to examine direct and indirect associations between work stress, staff emotional response to clients' behaviour, and social and organisational support resources. The sample consisted of 80 care workers in a residential facility for intellectually disabled residents. The findings alluded to low organisational support being associated with depression and signs of burnout. They also suggested that personal support from friends and family boosted the direct care workers' sense of personal accomplishment. Social support was also found to be a buffer against the potential for stress and emotional exhaustion. The results indicated that care workers do acknowledge that they need support, in the form of either training or emotional support, to cope with caring for intellectually disabled residents. When staff members feel supported in the workplace, they are better equipped to deal with everyday stressors (Gray & Muramatsu, 2013).Teaching care workers to manage the challenge behaviour and providing them with better tools for stress management can reduce their stress levels (McConachie et al., 2014; Van Oorsouw et al., 2014).

2.7 Strategies used to cope with stress

Coping is defined as "cognitive and behavioural efforts a person makes to manage demands that tax or exceed his or her personal resources" (Lazarus, 1995: 6). Lazarus describes two

main types of coping: problem-focused coping, where information is sought and used to change either the person's behaviour or the environment to eliminate or reduce the psychological threat; and emotion-focused coping, which involves seeking information to manage the emotional distress (Cudre-Mauroux, 2010).

Care workers have several coping strategies at their disposal, including but not limited to: wishful thinking, humour, distancing themselves from stressful situations, releasing frustrations in safe environments, good relationships with co-workers, and switching off or separating work stress from home stress (Zijlmans, Embregts, Bosman & Willems, 2012). These strategies include task-orientated coping and avoidance-orientated coping (Lazarus,1999). Task-orientated coping focuses on solving the problem, while avoidance-orientated coping focuses on escaping the problem or the events that led to stressful situations (Zijlmnas et al., 2014).

Judd et al. (2017) conducted a study on workplace stress, burnout and coping in care workers for intellectual disabled residents. The study was conducted in Australia on 12 participants. Its aim was to explore care workers' perceptions of enjoyable and challenging aspects of disability support work, sources of stress and burnout, and the strategies they use to cope when these issues arise. The results showed that participants described several negative aspects of their work, including a lack of decision-making power, earning a low income, lack of management insight into the high expectations for care, and constant pressures due to staff shortages and challenging client behaviour. These results were in line with previous research done by Rose 2010: Rose et al. 2013; Dilworth, Phillips & Rose, 2011; Gray-Stanley & Muramatsu, 2011; Mutkins et al., 2011; Hensel et al., 2012; Gray & Muramatsu, 2013; Kozak et al., 2013 and Vassos et al. (2013).

Despite the above negative aspects, some participants noted positive aspects like putting a smile on a resident's face or assisting them in achieving their goals. The participants described stress occurring when the negatives outweigh the positives. On coping, the participants said they often had to seek support actively rather than waiting on the employer. They tended to rely on their own strategies to manage stress and burnout. The participants agreed that support from their colleagues and management helped them to cope when they were feeling stressed or burnt out. This finding corresponds with current literature, which recognises that support from colleagues and social networks is valuable in managing stress and preventing burnout (Gray-Stanley & Muramatsu, 2011; Mutkins et al., 2011; Rose et al., 2013).

2.8 Summary

While there is a substantial body of literature regarding health care workers' stress and the availability of social support in caring for people with ID in hospital or home environments, there is a paucity of literature that discusses the care workers' experience of stress and social support in caring for residents with ID in a residential facility setting. There is a need to construct approaches to support the development of more appropriate coping strategies among care staff to help shift their appraisals of working with challenging behaviour and reduce their negative emotional reactions, to potentially reduce stress and improve well-being.

39

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter provides an account of the research design and methodology used to understand the care workers' experiences of stress and social support in caring for residents with intellectual disability. A qualitative exploratory descriptive research approach, utilising a phenomenological design, was conducted. Using a qualitative research methodology, the researcher can explore a problem or issue pertaining to a group or population, of which the variables cannot be easily measured (Ben Salah, 2015).

3.2 Research design

Research design is defined as the methods and procedures used in collecting and analysing measures of the variables in a logical and coherent way, ensuring that the research problem is effectively addressed (Creswell & Creswell, 2017). A qualitative research approach has been chosen for this study because it values individuality, culture and social justice, providing content- and context-rich information (Tracy, 2013).

3.2.1 Qualitative research approach

According to Creswell (2013), a qualitative study is defined as an enquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. Researchers choose a qualitative approach to emphasise the researcher's role as an active learner who tells the story from the participants' viewpoint, rather than as an 'expert' who passes judgement on participants. Qualitative research can further be defined as a form of research in which the researcher collects and interprets data, making the researcher as much a

40

part of the research process as the participants and the data they provide (Corbin, & Strauss, 1990)

The researcher used a qualitative approach to unearth the insider views of the participants, which, in this study, involved their lived experiences of stress and social support in caring for intellectually disabled residents at this selected residential facility.

3.3 Phenomenology

Phenomenology is defined as the exploration of the phenomena under investigation within a group of individuals who have experienced the same or similar phenomena (Creswell, 2013). Phenomenological studies consider induction and bracketing to be very important. Induction means that the researcher allows the data to be self-explanatory does not influence the data with any preconceived ideas and assumptions, while bracketing involves putting aside what the researcher already knows about the experience being investigated and approaching the data with no preconceptions about the phenomenon (Tufford & Newman, 2012).

The researcher achieved bracketing, as suggested in (Tufford & Newman, 2012), by delaying the literature review until after the data collection and data analysis processes. This was done so that the researcher could refrain from phrasing questions or analysing data with a preconceived aim, for example, seeking themes that are evident in the literature. Each participant's lived experience of stress and social support while caring for residents with ID at the selected residential facility was valued as unique and relevant.

3.3.1 Exploratory research

Exploratory research is defined as an attempt to identify new knowledge, insight and meaning (De Vos, Strydom, Fouché, & Delport, 2011). In this study, semi-formal interviews were

41

conducted, and the care workers described their experiences while caring for residents with ID. The literature did not reveal any studies conducted in the Western Cape that described the care workers' experience of stress and social support while caring for residents with ID and challenging behaviour. Exploratory research was therefore deemed an appropriate fit for this study.

3.3.2 Descriptive research

Descriptive research refers to research in which every day conscious experiences are described, while preconceived opinions are set aside or bracketed (Tufford & Newman, 2012). According to (Christensen, Johnson, & Turner, 2011), the primary objective of a phenomenological study is to explicate the meaning, structure and essence of the lived experiences of a person, or group of people, around a specific phenomenon.

Descriptive phenomenology was chosen as the researcher wanted to describe the phenomena under study from the participants' point of view only, while putting aside, or bracketing, her own biases about the phenomena. The researcher wanted to explore and describe the care workers' experiences of stress and social support in caring for residents with ID at the selected residential facility in the Western Cape from the participants' insider point of view.

3.4 Research setting

Research setting refers to the physical, social and cultural site in which the researcher conducts the study (Given,2008). All the interviews were conducted at the selected residential facility. The facility is a 30-bed residential centre situated in Maitland, a suburb in Cape Town, Western Cape, South Africa. Maitland is about 6 km from Cape Town's central business district. The suburb is situated along several transport networks which connect it to the rest of the city, the

42

most important of these being the railway line that runs through the middle of the suburb and the N1 road that is situated on its northern boundary. Maitland lies to the north of Pinelands, south of Brooklyn, east of Salt River and to the west of Kensington (See attached map, figure 2). According to the 2011 census, the recorded population consisted of 9 782 people.

Registered as an NPO in 2013, some parents gathered together to lobby government to provide a residential facility that would accommodate residents with challenging behaviour who had previously been excluded from other group homes that could not cope with them. A joint decision was taken by the Western Cape departments of Health and Social Development to renovate an old nurses' home on the grounds of a psychiatric hospital. The residential facility was officially opened on 6 May 2015.

For residents to be admitted into the facility, they must be 18 years or older. The facility serves adults with various intellectual disabilities, e.g., mild, moderate or severe ID, Down syndrome, autism spectrum disorder and foetal alcohol spectrum disorder. Care workers were responsible for assisting with tasks of daily living. Residents must: exhibit challenging behaviour when psychiatrically stable; be physically fit, mobile and able to climb stairs; have been previously excluded from other residential facilities owing to long-standing challenging behaviour; be referred by a mental health care worker or facility; and reside in the Western Cape. Residents should not have a history of criminal behaviour.

The facility has 30 residents: 14 females and 16 males. Professional staff includes the manager, an occupational therapist and a registered nurse who work normal office hours, from 07:00to 16:00. There are four enrolled nurses and 18 care workers who work 12-hourshifts, either07:00 to 19:00ornight shifts from 19:00 to 07:00. For each shift the enrolled nurse on duty acts a shift

leader and reports to the registered nurse. The care workers all have an ancillary certificate in basic training in caring for sick people in general medicine. This centre was chosen as it is the only non-governmental facility in the Western Cape that caters for adult intellectually disabled residents with challenging behaviour. The facility is funded by the departments of Health and Social Development. However, their funding is not enough to cover all the expenses of running the facility. The facility management committee must do their own fundraising to supplement the organisation's income. Figure 2 is a map of Cape Town, Western Cape, that shows the geographic location of the facility under study.

Figure 2: Map of Cape Town

3.5 Research methodology

Methodology is described as the procedures by which researchers go about their work of describing, explaining and predicting phenomena (Almalki, 2016). Research methodology focuses on the research process, as well as the types of tools and procedures to be used in the study (Mouton, 2001). Additionally, it focuses on the individual steps in the research process and the most unbiased procedures to be employed. In this section, the population, sampling method, data collection instrument and methodology, and data analysis process will be discussed. The research method chosen for this study, was phenomenology. This method was chosen as its focus is on describing the lived experiences of care workers (Vosloo, 2014). The researcher aimed to identify the true essence or meaning of the phenomenon and present it as it truly appears to the participants, and this method was considered the best fit to meet the aim of the study.
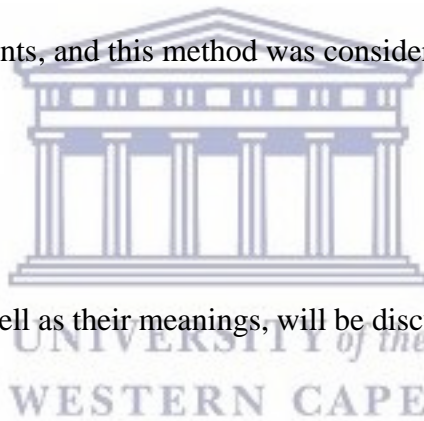
3.6 Population and sampling

Population and sampling, as well as their meanings, will be discussed in the following section.

3.6.1 Population

Population is defined as the entire set of individuals, objects, events or elements that meet the sampling criteria for inclusion in a study (Gray, Grove & Sutherland,2016). The population in this study were the care workers who were permanently employed at the selected facility at the time of the study. They had to be working for the facility for more than one year. The population was selected because they were likely to be knowledgeable on the study topic due to their first-hand experience working with residents with ID and challenging behaviour. They were likely to yield the relevant information as they are currently working with the residents with ID and

46

may have experienced some form of stress while caring for the residents.

3.6.2 Sampling

Sampling is a process of selecting samples from a group or population to become the foundation for estimating and predicting the outcome of the population and to detect an unknown piece of information (Perumal, 2014).Purposive sampling was used in this study. Purposive sampling means that the inquirer selects individuals and sites for the study because they can purposefully inform an understanding of the research problem and central phenomenon in the study (Creswell, 2013). Participants were also judged to be knowledgeable about the issues under study (Polit & Beck, 2012). In this study, the individuals who provided information to the researcher about their experiences are called participants (Frazer, Sullivan, Weatherspoon, & Hussey, 2017). The researcher selected several appropriate participants who were able to give rich and convenient information about their experiences (Perumal, 2014). The participants, who were purposefully selected by the researcher to participate in this study, were care workers who met the inclusion criteria.

Inclusion criteria: Participants need to be care workers employed on a permanent basis for more than one year at the selected residential facility. These staff members were chosen as they were likely to produce reliable results as they have been working long enough with the residents.

Exclusion criteria: All nursing staff and any other support staff working at the selected residential facility; all care workers that are not permanently employed at the residential facility during the study. The reason for their exclusion is that they were not working close enough with the residents to provide the researcher with information rich data.

47

3.6.3 Sample size

Sample size refers to the number of participants that were chosen from whom data were gathered (Perumal, 2014). In qualitative studies, the number of participants depends on what information is required, the purpose of the study, what is useful and credible, as well as the availability of time and resources (Almalki, 2016). One general consideration for sample size in qualitative research is to study a few individuals and collect extensive detail about everyone studied until data saturation is reached. Data saturation is the point in the study when the researcher begins to hear the same information repeatedly (Creswell, 2013). There were 18 care workers working at the selected residential facility, and ten were purposively selected to participate in this study; however, data collection only continued until participant number seven, at which point data saturation was reached. The researcher observed that no new information or themes were emerging, hence decided to stop the interviews at participant seven.

3.7 Data collection

Data collection refers to the process of gathering and measuring information on targeted variables in an established systematic fashion which enables one to answer relevant questions and evaluate outcomes (Creswell, 2014: 4).

3.7.1 Data collection instrument

Data collection instrument refers to the device used to collect data, such as questionnaires, interviews or focus groups (Creswell, 2014). Data were collected by means of semi-structured interviews. A semi-structured interview consists of several key questions that help to define the areas that are to be explored. Its structure allows the interviewer and the interviewee to diverge, to pursue a response in more detail (Vosloo, 2014)

48

An interview guide (Appendix 6) consisting of five open-ended questions was used to collect data about the stress experienced and the social support used to cope by the participants. Semi-structured questions were used to facilitate discussion. The questions were drafted to reflect the constructs of the Folkman and Lazarus process model of stress and coping. The questions pertained to (a) what events had been experienced as stressful when working with residents with ID; (b) what resources were accessed to help manage events perceived as stressful; (c) what coping strategies were employed; and (d) whether these were helpful in alleviating the stress.

Probes such as "please elaborate," "like what?" and "please give an example" were used to encourage the interviewees to talk about the issues that did not come up spontaneously. The use of the probes gave the care workers the opportunity to talk more about their experiences of stress and social support while caring for residents with ID.

3.7.2 Data collection process

Data collection process refers to the process of gathering and measuring information on targeted variables in a systematic way, which enables the researcher to answer relevant questions and evaluate outcomes (Vosloo, 2014).After obtaining ethics clearance (Appendix 1) from the research committee at the University of the Western Cape and written permission from the manager of the selected residential facility, the researcher arranged to address the care workers and inform them about the study, its aim and its objectives at the monthly meeting.

The researcher then distributed information sheets pertaining to the study, with her contact details so that the care workers could contact her if they wished to participate in the study. Appointments were made with the care workers who volunteered to participate. The semi-

49

structured interviews were conducted at a date, time and venue agreed upon with the participants. Each interview lasted between 25 and 40 minutes. All the participants regarded the venue, which was situated at the facility under study, as convenient.

All the care workers who agreed to participate signed the consent form before the interviews. Prior to commencement of the interviews, the researcher thanked the participants for offering up their time. Permission to use an audio recorder to capture the interview was sought from each participant. The interviews did not last more than 40 minutes. The interview schedule (Appendix 6) was used to guide the interview. During the interview, the researcher made use of probes to elicit information about the stress experienced and social support used. Data collection took place from March to May 2017. Interviews took place in quiet room far from the residents' socialising places. This was done to minimise any interruptions, like noise and unauthorised entry into the room. Despite all the preparations to avoid interruptions, background noise could still be heard and there were a couple of knocks on the door by the residents who were curious to find out what was happening. Participants did not seem to mind the interruptions, verbalising that they were used to it.

The researcher collected the data personally, allowing her to gain first-hand knowledge of the experiences shared by the participants regarding the studied phenomena. The researcher was aware of the potential influences on the study as she works in the facility as the care workers' manager. The researcher engaged in self-reflection during all the stages of the research process (Berger, 2015). During the interviews, it was explained to the participants that the researcher was there as a student, not as their supervisor, and that therefore they should feel comfortable answering the questions asked. No information obtained from the interviews would be used against the participants.

Conducting the semi-structured interviews personally also allowed the researcher to gain an insider perspective into the life and world experienced by each participant. She took the opportunity to observe the participants during the interview process for non-verbal communication. Saturation of data was reached at interview number seven. This approach allowed for a thorough examination of the participants' experiences, feelings and opinions, making it relevant to the aim of the study, which is to understand the care workers' experiences of stress and social support in caring for residents with ID in a residential facility. This in turn provided the researcher with more meaningful data.

3.8 Data analysis

Data analysis refers to the process of bringing order, structure and meaning to the mass of collected data (Vosloo, 2014).The transactional model of stress and coping was used to inform the analysis. The process of data analysis in qualitative research, according to Creswell (2013), involves organising the data, conducting a preliminary read-through of the database, coding and organising themes, representing the data, and forming an interpretation of them. All recorded data was transcribed verbatim, dated and labelled. The data were analysed by means of Colaizzi's (1978) process of descriptive phenomenology analysis, as follows:

1) Each transcript was read and re-read to get a general sense of the whole content. During this stage, the researcher added some thoughts, ideas and feelings that she had based on prior experience of working with care workers who experience stress or social support, to her reflective diary.

2) For each transcript, significant phrases and statements pertaining to the phenomena were extracted

51

3) Meanings were formulated from these significant statements. Each underlying meaning was coded as one category that reflected an exhaustive description. An independent coder, the researcher and the research supervisor reviewed the statements and their meanings.

4) After reaching an agreement regarding all formulated meanings, the codes were grouped into categories that reflect a unique structure of themes. Each cluster of themes was coded to include all formulated meanings related to it. This group of clusters of themes that reflected issues was combined to form a distinctive theme.

5) Emergent themes were then defined into an exhaustive description. The researcher, research supervisor and an independent researcher reviewed the description to confirm that it reflected the experiences of stress and social support of care workers working with intellectually disabled residents with challenging behaviour.

6) A reduction of findings was conducted, in which misused, redundant or overestimated descriptions were removed from the overall description. A literature control was also conducted in which the findings were placed in empirical research findings.
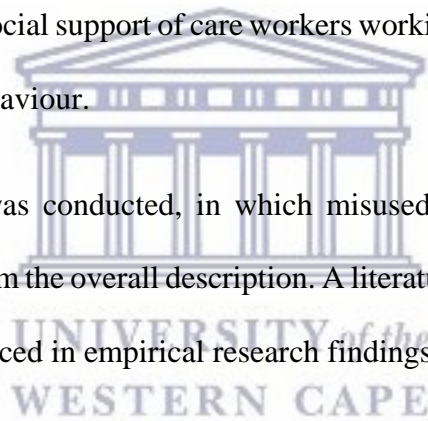
3.8.1 Bracketing

Bracketing refers to the act of suspending judgement about the natural world and focusing on the analysis of the lived experiences (Tufford & Newman, 2012). The researcher was at the time employed at the facility under study, was also the interviewer for this study, and was also a manager of the participants. However, the researcher held all preconceptions in abeyance in order to reach experiences before they were made sense of and ordered into concepts that related to previous knowledge and experiences. The researcher made use of a reflective diary at the commencement of interviews. The diary was helpful in enabling the researcher to bring

these issues to mind, plan personal bracketing strategies, and document these in a logical manner. The diary was mainly for the researchers' personal use, it was not part of the data collection or analysis. The researcher documented any issues that came to mind and bracketed them to ensure that they would not interfere with what the participants might say. The researcher practised neutral and non-verbal behaviour before the interviews took place and made use of active rather than passive listening skills to facilitate the transfer of original meaning from the participants. The use of bracketing made it possible for the phenomena under study to emerge clearly.

3.8.2 Reflexivity

It is important for qualitative researchers to realise the importance of positioning themselves in their writings. This is the concept of reflexivity, in which the researcher is conscious of the biases, values and experiences that s/he brings to a qualitative research study Creswell, 2013). At the time of this study, the researcher was still employed at the facility, and was familiar with all the care workers, and in the light of this, had to be aware of the need to consistently pursue interpretations in different ways, in conjunction with a process of constant and tentative analysis (Almalki, 2016). The researcher also took into consideration that all the participants were known to her and therefore maintained a professional relationship with them, focusing on the research objective and aim.

The researcher made use of clarifying questions when the participants mentioned information, they assumed the researcher should know; for example, when the participants mentioned their duties that they do daily or one of the difficult residents, the researcher would ask them to elaborate on these duties and explain exactly what they meant by daily duties. This was done to emphasise the researcher's role as an active learner, rather than an expert. Self-awareness is

53

an important aspect for the researcher to understand his/her history and situation. The researcher kept a journal of reflection during the data analysis process to minimise personal biases.

The researcher stopped the recording device after the interview, at which point the participants engaged in further dialogue and appeared to be more relaxed. All interviews were transcribed by the researcher, each transcribed interview was sent to the researcher's supervisor to ensure that they were transcribed correctly and accurately.

3.8.3 Trustworthiness

According to Lincoln and Guba (1985), in Babbie & Mouton, 2014), the key criterion, or principle, of good qualitative research is found in the notion of trustworthiness: neutrality of its findings and decisions. Quantitative studies cannot be considered valid unless they are reliable; similarly, qualitative studies cannot be called transferable, or deemed credible unless they are dependable (Babbie & Mouton, 2014). Trustworthiness in this study involved credibility, transferability, dependability and conformability.

3.8.4 Credibility

When checking for credibility, the researcher asks the following: Is there compatibility between the constructed realities that exist in the minds of the participants and those that are attributed to them (Babbie & Mouton, 2014). The researcher engaged in the exploration of the care workers' experience of stress and social support in caring for intellectually disabled residents at the selected residential facility, is aware of and has experienced similar experiences to those of the care workers, as she was at the time employed at the facility under study.

The credibility was enhanced by 'member checking' of the interview transcripts by the care

54

workers to ensure accurate translation of their views. The research findings were returned to the participants and discussed with them as a way of 'member checking'. Applicability was ensured by the presentation of a dense description of the participants, research context and setting. Neutrality was ensured by using actual quotes from the participants and using an audit trail. To further enhance trustworthiness, the researcher kept a self-reflective journal to facilitate reflexivity and bracketing of her own opinions.

3.8.5 Transferability

Transferability refers to the extent to which the findings could be applied in other contexts or with other respondents (Babbie& Mouton, 2014). The researcher established transferability by providing the reader with a thick description of the research study and what it entailed. A detailed description of the study was given to ensure that the reader is familiar with the context of the study.
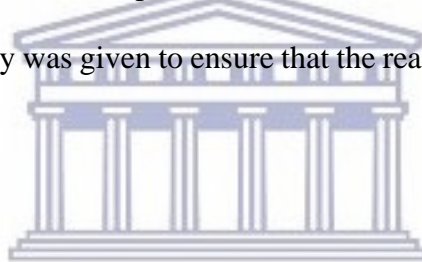
3.8.6 Dependability

For a study to be accurate, Lincoln and Guba (1985) suggest that an audit trail be kept. An inquiry must also provide its audience with evidence that if it were to be repeated with the same or similar participants (subjects), in the same (or a similar) context, its findings would be similar (Babbie & Mouton, 2014).

In this study, the co-coding was done by an independent coder to minimise bias during the data analysis process. The researcher made use of field notes during the interview process and specifically recorded entries, based on the interviews, in a reflective journal, as soon as possible after the conducting of each interview.
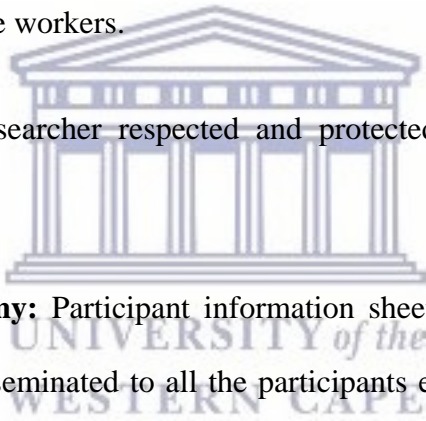
3.8.7 Confirmability

Confirmability was established through triangulation. Triangulation refers to the application and combination of several methods in the study of the same phenomenon (Almalki, 2016). The researcher combined empirical materials and theories to overcome the biases that come from single observer studies. An audit trail was kept throughout the data collection process, and reflexivity was observed.

3.9 Ethics

Ethics clearance to conduct the study was obtained from the Research Ethics Committee at the University of the Western Cape. Written permission from the residential facility manager was also obtained to access the care workers.

Throughout the study the researcher respected and protected the participants' rights by adhering to the following:

Confidentiality and autonomy: Participant information sheets (Appendix 4) and consent letters (Appendix 5) were disseminated to all the participants explaining the purpose, ethics and guidelines for participation and obtaining individual consent. Participation was voluntary and participants' confidentiality was maintained throughout the research. Their names will not be used in the results of this study.

Autonomy: The participants were clearly informed by the researcher of their right to withdraw at any time from participating in the study, without prejudice.

Justice: The participants all met the criteria for inclusion in this study.

Privacy: The researcher advised the participants that they could determine when and where

56

the data should be collected. Codes were used to identify the participants.

Risk: In this study, there were potential risks for the participants, although the risks were minimal. Since the research explored personal experiences during the semi-structured interview sessions, some experiences might have affected the participants emotionally. The researcher therefore informed the participants that, should they experience the need for counselling as a result of the in-depth interviews, they should inform the researcher, and a counsellor would be made available. There was also the risk that the participants might experience fear, which could affect them emotionally, due to factors such as being victimised at the facility, as a result of information revealed during the interview sessions. The researcher assured the participants that the value of confidentiality and anonymity was a personal matter. No reward was offered or paid to the participants for participation in this study.

The participants were made aware that the questions asked during the interviews may evoke feelings of distress, and the researcher was open to referring the participants to an experienced counsellor, which she had pre-arranged should it be necessary. The researcher respected the participants' right to privacy by ensuring that the participants decide to what extent the information may be shared with the manager of the residential facility.

3.10 Summary

In this chapter, the research methodology was described. A qualitative approach, with exploratory descriptive phenomenological research type was employed to investigate the lived experiences of the participants, using semi-structured interviews to give each participant an opportunity to share his/her experiences. At the end of the interview s, the researcher did not observe any psychological distress from the participants. Therefore, no emotional support

57

referrals were made. The results obtained from the research will be discussed in chapter 4.

CHAPTER 4: RESULTS AND DISCUSSION OF FINDINGS

4.1 Introduction

The aim of using descriptive phenomenology research design was to explore and describe care workers 'experiences of stress and social support while caring for intellectually disabled individuals who present with challenging behaviours at a residential facility in the Western Cape. To achieve this aim, data were collected by means of semi-structured interviews. Questions were drafted to reflect the constructs of the Folkman and Lazarus process model of stress and coping. The questions pertained to (a) what events had been experienced as stressful when caring for residents with ID and challenging behaviour; (b) what resources were accessed to help manage events perceived as stressful; and (c) what coping strategies were employed.

Data were collected from information-rich participants over a period of two months. Prior to the data collection, written consent was obtained from the participants. A total of 18 care workers volunteered to participate in the semi-structured interviews. These interviews were held until data saturation was reached, which was after seven interviews.

4.2 Demographic profile of the study participants

A total of seven care workers participated in the semi-structured interviews. Three were females and four were males, and their ages ranged from 25 to 38. Six of the participants had previously been employed in residential homes for people with ID, while one did not have prior experience with ID. The residential facilities they had previously worked at were run by NGOs and were for intellectually disabled residents who did not present with challenging behaviour. All the participants were in possession of a basic care worker certificate in basic nursing care.

59

4.3 Central story

The central story that guided this research is one of care workers who, in the face of adversity in their daily work of managing residents who display a wide range of negative behaviours, display a lack of cohesiveness as a team which results in them shifting responsibility to each other to cope with the residents' behaviour. This may be because they are not trained to manage people with ID who present with challenging behaviour and thus use defence mechanisms to cope in this volatile environment. The participants lacked knowledge on dealing with challenging behaviour, which was exacerbated by a perceived lack of teamwork among colleagues. Participants dealt with the challenges using adaptive and maladaptive coping strategies. Based on prior experience addressing colleagues who did not work as a team, fear of confrontational reactions prevented them from managing their colleagues' behaviour. However, some care workers had built relationships with some of their colleagues and felt supported by them in the workplace.

4.4 Results

The results are presented as themes and categories that emerged during data analysis. Four main themes emerged with various overarching categories that were identified from the transcribed interviews. An overview of the emergent themes and categories is presented below in Table 4.1

Table 4.1: Themes and categories

Stress and coping model	Theme	Category
Organisational and social responses	1. Acceptance of abuse as a working condition	1.1 The perception of deliberate acts of verbal and physical abuse from residents created a sense of helplessness in care workers.
		1.2 Witnessing acts of violence was compounded by manipulative behaviours displayed by residents.
		1.3 Participants experiences intrusion into their personal, physical and emotional space.
		1.4 Different approaches were used to manage residents' behaviour in an environment which was perceived as normal.
		1.5 Effects of dealing with colleagues and residents' behaviour spilled over into personal life.
	2. Interpersonal relationships with colleagues, residents and residents' families	2.1 Colleagues were perceived as not doing their work.
		2.2 Poor interpersonal relationships between staff resulted in lack of teamwork, which increased the experience of stress.
		2.3 Demands from residents' families and manipulation by residents exacerbated the experience of stress.
		2.4 Participants expressed feelings of sadness about colleagues not doing their work.
Psychological and	3. The self-impacted by	3.1 Participants felt a sense of powerlessness as a result of inconsistencies among

61

physiological responses	an array of mixed emotions	staff regarding behaviour modification in managing the challenging behaviour of residents.
		3.2 Participants reported residents' behaviour making them feel disregarded, humiliated and inferior.
		3.3 The fear of being assaulted was coupled with shock at witnessing residents' unpredictable behaviour.
		3.4 Hope was displayed when participants felt that they were making a difference in the lives of residents.
		3.5 A sense of helplessness and frustration was experienced as residents' negative behaviour was perceived as having no consequences.
		3.6 Participants experienced a potential for growth and job fulfilment.
		3.7 Participants displayed surface acting to cope with the effects of abuse.
		3.8 The repetitive nature of the work resulted in exhaustion of participants.
Adaptive and maladaptive coping	4.Social support and coping strategies used to deal with stress experienced	4.1 Types of social support available for care workers
		4.2 Resources available for care workers
		4.3 Pastoral care assisted participants to cope in the unpredictable environment.
		4.4 Reframing of residents as children who were not a threat helped participants to cope.
		4.5 Participants used physical activity and relaxation techniques to assist them to cope.

62

		4.6 Organisational support in terms of training and feedback from supervisor
		4.7 Peer support, family support, other sources of gratification
		4.8 Participants reported having the ability to separate work and personal stressors.
		4.9 Participants displayed various defence mechanisms such as distraction, humour, wishful thinking and avoidance to cope.

UNIVERSITY *of the*

WESTERN CAPE

Organisational and social responses to stress

Organisational and social responses were combined, emanating as two themes describing the experiences of participants working with residents with ID displaying challenging behaviour.

4.4.1 Theme1: Acceptance of abuse as a working condition

Participants described their experiences related to the constant exposure to the violence displayed by residents during their daily work. This display was then internalised as being part of the working conditions related to working with intellectually disabled residents with challenging behaviour. The abuse entailed physical acts of violence and verbal abuse by the residents and participants being sworn at as they carried out the various caring activities. A participant alluded to violence being expected in the working environment. Participants perceived the abnormal working environment as normal as it is part of their daily work. Another participant mentioned a sense of helplessness as there are no consequences for resident's negative behaviour:

"lately I don't know what I feel anymore because it doesn't matter how I feel, It's like you feel like your hands is cut off." P03

Boundaries were overstepped by residents who invaded participants' personal space:

"For an example, the office, the lounge, our lounge, are not allowed to go there when we are having our lunch there or anytime, but they will go there." P06

"Residents are swearing at us, they are insulting us, and then secondly they are beating us, and then there's nothing I can do because it's my job." P04

64

"You just don't think it's necessary for you to go and tell someone that, that thing, that incident stress me like this and this and this, because sometimes you feel like it's part of your job to be stressed so why do you have to make something big out of it?" P02

"I have been taught that even if you feel like you are scared of that situation, and the pressure is high, you must remain calm." P02

"If the resident hits you I have to act like it didn't happen it's going to pass, whereas deep down inside itis hurting me." P04

"When you started this job, you knew what you, were, you're putting yourself into." P02

One participant spoke about residents' manipulative behaviour, such as accusations related to missing items and sexual abuse, and how that affected the staff's morale:

"...that time when she starts to cry you can't do anything with her..."

"...lying about the staff and say the staff did say something..." P05

Some participants had a perception that the residents' challenging behaviour was deliberate, and that they were quite aware of their actions. The participant verbalised being frustrated and helpless about this kind of behaviour. This might be due to the lack of knowledge about the nature of ID and challenging behaviour:

"...maybe these residents are acting like they are sick; they are not sick..." P04

"These residents know, they know that hitting and fighting and swearing is not allowed and its wrong, but they will still continue doing it." P04

65

"She knows that she's wrong, but don't want to admit that she's wrong; instead she shows it at your face." P02

"You can explain to him 20times, he knows this thing its wrong, I don't understand why he can't put his mind like the other things that he's doing right." P04

"They know that it's not right, and some others they fight with the others they know that it's not right, they swear and they also manipulative..." P07

4.4.2 Theme 2: Interpersonal relationships with colleagues, residents and residents' families

This is one of the more dominant categories that emerged during the interviews. The care workers spoke in detail about the volatile relationships they had with their colleagues. Some participants mentioned a lack of teamwork and colleagues not doing their work and blaming the next shift for their mistakes. However, some participants perceived themselves to be supported and verbalised the positive aspects of colleagues' behaviour towards them. Participants also mentioned feeling disregarded by both colleagues and residents, and that this also contributed to their feeling of helplessness. The following quotes reflect the care workers' experiences of interactions with their co-workers:

"Some people would just tell themselves, okay, you know what, I'm not going to do." P01

"Most things we see it as normal, like I think especially when it becomes normal you don't see it anymore." P03

66

"The most thing that stresses me it's when the residents are fighting." P02

"You get residents who just don't want to listen, like residents who want to do things their own way." P06

Participants reported feeling uncomfortable talking with their colleagues as the responses are often confrontational:

"... it's that because once maybe you've told that person, 'no man, you're not supposed to do this, you're supposed to do this,' he will respond in a way that you won't like. Maybe he will tell you, 'you're not my boss.'" P04

"And then the person will be asking, 'are you my supervisor now?' or, 'are you my superior?'" P01

- Psychological and physiological responses to stress

Psychological and physiological responses were combined to describe the care workers' experiences of stress and social support. Participants reported being stressed and exhausted by several physical intrusions to their bodies, such as being physically assaulted by residents. Emotional intrusion, such as being physically and verbally abused by the residents, was also mentioned by some participants. Shock and fear were also experienced by participants in reaction to residents' unpredictable behaviour.

One participant recalled how a resident attacked her:

"I was sitting there in the ladies' lounge, he just come ran out and just grabbed me…" P03

67

High risk of physical injuries while on duty was also mentioned by some participants:

"We are getting injured, but we don't realise at that time" P04

"We need to do lots of physical work because we restrain people who are aggressive, of course, so you have to use like lot of energy, you see?" P06

"For me personally it's…since I was attacked by one of our residents, I get this fear…" P03

"At first, at first, I sort of felt small and, like, I ask myself, okay, is this how it's going to happen for all the time that I'm going to work here?" P01

Participants verbalised being emotionally abused by the residents that they take care of and how the incidents left them stressed:

"She's going to shout you and swear, but then she's closing the door inside her room and then she's going to shout at you." P07

"She's shouting at you, she is provoking you, definitely, you would feel angry, you won't feel sympathy, but angry at that time." P02

"You don't know what to expect, today they are calm and tomorrow they are fighting and making noise." P02

"They are full of surprises, they will say somethings that you do not expect, that he or she will say, or he will do something that you were not expecting that he will do." P03

4.4.3 Theme 3: The self-impacted by an array of mixed emotions

The severity of injuries sustained on duty was deemed to be insignificant by the participants. They verbalised feelings of numbness due to their experiences with the challenging behaviour displayed by the residents:

"Lately I don't know what I feel anymore because it doesn't matter how I feel because it's like nothing will be done." P03

"...she's screaming, and then she's swearing and then she's biting, so you feel like all these things is bringing confusion in your mind – stress and everything." P02

Incongruence resulted as male and female participants experienced teamwork differently. The following quotes are from male participants:

"What's really stressful to me as a care worker, it's like when we have no teamwork at all." P05

"Some people would say, 'I'm not going to that because I did that maybe yesterday, so today it's not my turn to do that.'" P01

"When they are not doing the job the way they supposed to do it, and then when you come to work, Yoh, there is a lot of work for you." P04

"You must be called that your resident is doing such and such and such knowingly, that we are doing a teamwork, that we…working together." P05

"At the end of the day, shift ended up like blaming each other because things are not done properly, that's the thing." P06

69

The female participants have a different perspective regarding teamwork:

"I have the colleague, if I see I can't handle, I must go and talk to the other one…" P07

While participants acknowledged that their working environment was stressful, some were hopeful and felt that they were making a difference in the lives of the residents. Some participants were hopeful and could see the potential for growth regardless of the residents' behaviour:

"We are growing together, and for me it's now we are growing so much together." P03

4.4.4 Theme 4: Social support and coping strategies used to deal with stress experienced

Participants mentioned some social support resources they utilised to cope with residents with ID and challenging behaviour. The following quotes are indicative of how they perceive and utilise the available social support resources. Religious, familial and other types of support were mentioned as ways of coping with the stress and challenges experienced when caring for residents with ID. The following quotes emerged:

"I get the support here at work, because we do get the training here…" P04

"Our employer decided to employ the services of a wellness nurse, whereby if ever you've got a problem, like any problems, you can talk to her and then she will be able to guide you to the right direction if need be." P06

"When you go on tea, we talk, we would talk about the last, or the past day, or that morning." P01

"My mom and aunt, I can talk openly to them, so if I can say emotional support? All

70

kinds of support I get from them.” P02

“I go to church a lot.” P03

When participants were asked how they cope with the stressful situations they experience while caring for residents with ID and challenging behaviour, they mentioned using adaptive and maladaptive coping resources. Some mentioned the use of the following adaptive coping strategies, like asking their colleagues for assistance when struggling:

“If I work with that one that is difficult just to calm him or her down, and then when I’m feeling like it’s too much now, then I leave him alone and tell my other colleague to come and help me.” P04

“You don’t have to lift all this heavy duty alone, there’s someone else. While you’re busy stopping this one, there’s someone else whose helping with the other side, so that makes it easy.” P02
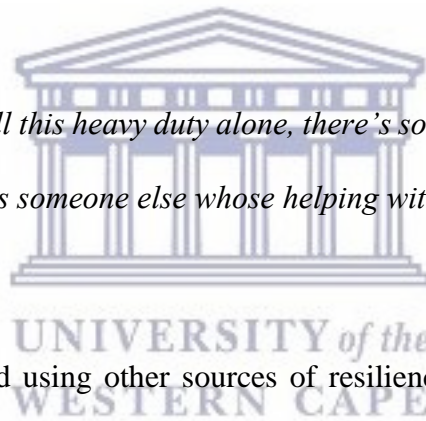
Another participant mentioned using other sources of resilience, such religion, as a coping strategy:

“If I’m dealing with a stress, for me to release the stress, I just pray, maybe I play music that is soft, and I feel calm and then I feel like yes, I can go back and work.” P02

“I’ve joined a support group which is also helpful to stress relieving.” P01

“My personal source of support is mostly, I go a lot to church, and I praying a lot.” P03

Physical activity was also mentioned as a way of coping with the stress:

71

"This short distance from the gate to here sometimes does you so good. Even though you can go with stress from here to there, you can rethink all these things, but once you go out or in then you decide how you going to deal with it." P03

Some participants mentioned detaching or separating work stress from their personal lives as a way of coping:

"When I'm off work, I'm not going to say I forget about work, but then I sort of switch my brain." P01

The love of their job and seeing the improvements in residents' behaviours also emerged as a way of coping for some participants:

"I fell in love with them because I know they need help, and to help someone like in a more professional way, it's something that is fulfilling to me." P06

"We worked really hard to know and understand them, and then there were some changes to them." P05
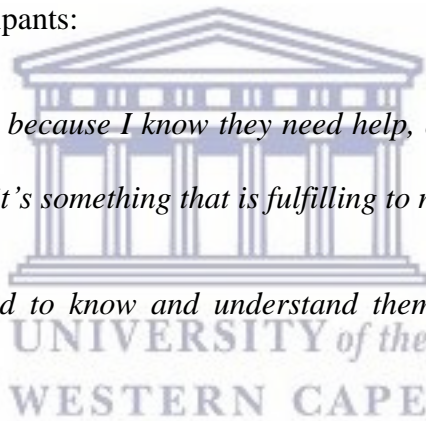
Some participants made use of maladaptive coping resources, such as avoiding dealing with residents who presents with negative behaviour:

"She was really cross for whatever, she was really aggressive, so, and for me, I did avoid her for I think two to three months." P03

Another participant used humour as a coping mechanism when dealing with stressful situations:

72

"We just make a joke and talk, and then we end up laughing." P04

Some participants mentioned optimism or wishful thinking as a coping strategy:

"There are those moments whereby you feel tired, but then I know that the next day I will be okay." P06

"I just face the challenges and deal with them in my own way." P04

4.5 Discussion of findings

The aim of the researcher was to explore and describe the care workers' experience of stress and social support in caring for people with ID in a residential facility. The present research contributes to an understanding of the experiences of care workers in several ways. Firstly, the study provides insight into common experiences of stress that care workers encounter when caring for residents with ID and challenging behaviour.

The findings are based on the care workers' accounts and their appraisal of stressful situations they deal with, and how they cope with those situations while working with residents with ID.

The findings demonstrated that care workers believed that their work was making a difference in the lives of the residents, despite the stresses associated with it.

Although this study focused on a particular group of care workers of intellectually disabled residents, the outcomes correspond with the previous literature in terms of descriptions of factors, symptoms and strategies of coping with stress while working with residents with ID (Bowring et al., 2017; Hastings et al., 2013; Van Oorsouw et al., 2014; Quilliam, 2018).

73

4.5.1 Acceptance of abuse as a working condition

Care workers appeared to experience elevated stress due to the residents' unpredictable and uncontrollable behaviour (Nevill, 2018).The unpredictability of residents' behaviour was perceived to be stressful in the absence of participants' ability to deescalate volatile situations. This unpredictable behaviour may lead to care workers being more vigilant for any aversive experiences or show uncharacteristically little patience in dealing with challenging behaviour(R. Hastings et al., 2013).

An aggression encounter with residents may evoke a range of emotions and avoidance behaviours in the care workers (Zijlmans, Embregts, Gerits, Bosman & Derksen, 2014). Some participants verbalised experiencing shock and fear in reaction to residents' unpredictable behaviour. Although the care worker may be providing the resident with his/her basic needs, previous experience of aggressive behaviour may result in limited interactions and the care worker being hyper-vigilant (Chancey et al., 2018).These avoidant behaviours may cause an increase in the resident's challenging behaviour as s/he may act out, seeking attention.

Aggressive behaviours can be frightening, and when care workers are the subject of aggressive behaviours it is natural to feel angry (Rose et al., 2013). Most participants related how some of the residents' challenging behaviour impacted on their stress levels and their physical health. The participants acknowledged physical exhaustion and feelings of confusion and despair; however, they felt that it was what they signed up for, that physical and verbal abuse is part of their job (Flynn et al., 2018).

Lack of knowledge on the nature of ID led to some the care workers believing that the residents' challenging behaviour might be deliberate or that they were pretending to be sick. This lack of

74

knowledge led care workers to have less empathy for the residents and behave in manners that would increase the challenging behaviour (Collins et al., 2017).

Care workers were unable to understand or make sense of how adults with ID and higher functioning would display behaviours that are not consistent with their functionality. Participants lacked an understanding that residents with intellectual behaviour are complex human beings (Griffith & Hastings, 2014). Despite the challenging behaviour displayed by the residents, some participants acknowledged feeling hopeful when they saw that they were having a positive impact on the residents' lives.

There was some ambivalence with respect to residents' functioning. Participants perceived residents as being like children because their behaviour emulates children's behaviour. It is evident that there is a need for intensive and specific training to improve care workers' understanding of the nature of ID and challenging behaviour. Studies also allude to the need to improve the skills and training approaches currently used to develop care workers. There is evidence to suggest that support workers are not used as effectively as possible and are often undervalued (Williams et al., 2016).

According to the literature, care workers can benefit from emotional intelligence or mindfulness-based training. The feelings that care workers may experience are more cognitive and reflective than emotional; therefore, regulating feelings might be more effective than trying to regulate immediate emotions. Training care workers to regulate their feelings regarding the challenging behaviour of residents may lead to care workers behaving more appropriately and improve their well-being (Zijlmans et al., 2013).

Following training in emotional intelligence, the care workers might reflect more neutrally on

incidents with residents. It is important to bear in mind the care workers' differences when training them in emotional intelligence, as these differences serve as a broad and useful construct that could provide a significant contribution to the research field focusing on care workers working with residents with intellectual disabilities and challenging behaviour.

There is also a need for the staff to be trained in understanding and being aware of their stress symptoms, appraisal processes and coping strategies regarding stressful situations (Lazarus & Folkman, 1984). These findings corroborate those of Van Oorsouw et al. (2014).

4.5.2 Interpersonal relationships with colleagues, residents and residents' families

Interpersonal relationship is defined as a strong, deep association between two or more people. These relationships are a basis of society as whole. In the context of this study, these relationships are between care workers, their colleagues, residents and residents' families. The issue of poor communication among colleagues came out strongly during the interviews. While some participants acknowledged conflicts between staff, most emphasised how their collective approach to their work allowed them to work towards a common focus – the residents (Quilliam et al., 2018).

Male and female participants experienced teamwork differently; males felt that there was no teamwork while the females felt differently. One male participant verbalised that he felt powerless when it came to deal with an unproductive colleague. All four male participants that were interviewed felt their male colleagues would give them responses that they were not prepared to hear. There was a sense of fear of confrontational responses they might get from their colleagues. The nature of shift work was also mentioned by participants as another source of stress. Participants verbalised that there was a lack of responsibility and that shifts ended up

76

blaming each other for incomplete jobs (Kozak et al., 2013).

This lack of assertiveness among colleagues was mentioned as another source of stress for some participants. The effects of work stress, dealing with residents and staff's behaviour, spilled over into some participants' personal lives. A sense of powerlessness in managing colleagues' lack of teamwork, a sense of disregard and residents' challenging behaviour proved to be stressors for some participants (Mackenzie, 2017). Good interpersonal skills would enable care workers to interact positively and work effectively with their colleagues. Interpersonal skills involve listening, communication and delegation of tasks. Training care workers to obtain such skills could be constructive and enable them to handle disputes and conflicts with their colleagues, residents, and residents' families (Zoder-Martell et al., 2014).

4.5.3 The self-impacted by an array of mixed emotions

Participants' experience of residents' challenging behaviour had an impact on how they expressed their emotions; however, they experienced the impact differently. Participants felt powerless in their role because they felt disregarded by their colleagues and experienced intrusions into their physical and emotional space and personal time by the residents (Quilliam et al., 2018). These factors led some participants to act against their chosen values. Values are defined as freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity (Castro, Rehfeldt & Root, 2016).

Caring is perceived as a female-dominated profession. Male and female participants displayed different emotional responses to the residents' challenging behaviour. One female participant felt that certain residents are aware of their actions and display challenging behaviours on

purpose. That perception caused the participant not to feel anger rather than empathy for the resident. Alack of empathy may have a negative impact on the residents' level of care (Collins et al., 2017).

A female participant verbalised feeling numb and that the residents' behaviour had desensitised her over a long period of being a victim of verbal and physical abuse. There are expectations that males should be strong and not complain when it comes to physical labour and displaying emotions. The effects of dealing with residents' challenging behaviour and staff's behaviour spilled over to some participants' personal lives.

4.5.4 Social support and coping strategies used to deal with the stress experienced

The use of qualitative methods provided a rich data set on both the range of resources accessed, and the strategies employed by care workers in the coping process. The care workers were able to generate a list of coping resources. Social supports appeared to be the biggest resources available to them. These ranged from colleagues, close family members and friends, to support groups, church or pastoral care and employee wellness support offered by the workplace. Participants' experience in managing residents with ID influenced their responses and approaches in dealing with challenging behaviour. Some verbalised that the challenging behaviour was not stressful for them as they were used to it.

All three female participants interviewed acknowledged that support from work and colleagues played an important role in their coping with difficult working conditions, while there was some ambiguity among the male participants when it came to their responses about their male colleagues. For some, colleagues or co-workers were their source of support, while others verbalised being stressed by their colleagues who were not doing their work as they should.

Coping, as defined by Lazarus and Folkman (1984: 283), is "the process of managing demands that are appraised as taxing or exceeding the resources of the person". Participants mentioned several strategies that they used to cope with stress. Without their awareness, participants utilised both adaptive and maladaptive coping strategies to cope with caring for residents with ID and challenging behaviour.

Adaptive coping strategies include the use of religion as a coping strategy. For care workers, religion played a positive role in the coping with caring for the intellectually disabled residents. Studies indicate that care workers who utilise religious beliefs to cope experience less strain and have more positive emotions than those who do not (Lucchetti et al., 2014). Due to the stress-buffering role of religious involvement, research suggests that religious care workers might experience a lower incidence of stress, depression and a better relationship with residents (Lucchetti et al., 2014).

Maladaptive coping strategies used by care workers included surface acting as a defence mechanism to deal with stress. Surface acting refers to the portrayal of emotions that are not currently felt (Andrews, Kacmar & Valle, 2016). The care workers engaged in this type of emotional labour as a way of masking their immediate dislike of the residents' behaviour. Participants verbalised that during their training, they were taught to remain calm even when faced with difficult situations. This requires some degree of surface acting. Cultural influence may have played a role in how participants perceived stress and their ability to seek help. Male participants had a different appraisal of the same stressful environment as compared to their female colleagues. Caring is interpreted as a female-dominated profession; therefore, male care workers could be expected to cope with emotional as well as physical stressors experienced at

79

work and these expectations might compound the emotional stressors than men experience.

Surface acting could be physically and emotionally draining for the care workers as it requires a lot of effort because of its insincerity (Nguyen, Groth, & Johnson, 2016). However, there is a positive aspect of surface acting: care workers remain positive and their morale remains high. Employers can help identify care workers with emotional issues and provide them with training to help them manage their emotional and personal struggles.

Wishful thinking is an emotion-focused coping strategy characterised by attempting to avoid or alter one's emotional reactions to a stressful situation, rather than attempting to alter the situation (Kurz et al., 2014).Coping characterised by wishful thinking mediated the relation between perceived workplace demands and psychological distress for care workers such that greater endorsement of wishful thinking increased the damaging effects of perceived workplace demands (Smyth et al., 2015).

4.6 Summary

This chapter discussed the research findings, regarding the care workers' experiences of stress and social support in caring for residents with ID at a residential facility in the Western Cape. The findings were discussed under their main themes and subsequent categories, as outlined in Table 4.1 The findings revealed that most participants had not received any kind of training in the management of residents with ID. The training they received before commencing work as care workers is not adequate to equip them with the knowledge and skills to manage residents with ID and challenging behaviour. The use of adaptive and maladaptive coping and the availability of social support made coping with the stressful environment possible for the participants.

Chapter 5will conclude the study, providing a summary of the findings, limitations as well as recommendations for further research and practice.

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This study illustrated the value of using a theoretical approach and qualitative methods to describe and specify the nature of stress and coping in care workers of residents with ID and challenging behaviour. This study provides a snapshot of the common stressors encountered by the care workers and indicates that the consideration of individual experiences of stress is essential. The study also illustrated that despite the challenging environment that the care workers are exposed to, some can utilise the coping resources available to them and manage in the challenging environment.

5.2 Limitations

This study was conducted at a residential facility for people with ID. The population comprised of all care workers currently employed there, and the sample size was purposefully selected. The findings, therefore, cannot be generalised and are only applicable to this study.

The researcher, currently employed as the nursing manager at the facility under study, was also the interviewer for the study and a manager of the participants in the study. This may have influenced the participants' responses, as they might have revealed what they thought the researcher wanted to hear. Therefore, despite the researcher's attempt at bracketing, it must be acknowledged that, however minimal, her presence might have influenced the results.

Despite the researcher's assurances that all relevant ethical considerations had been adhered to, the participants might have been reluctant to share more explicitly, for fear of being victimised or discriminated against, which might also have influenced this study.

82

5.3 Recommendations

Significant factors were identified in this study, and the recommendations below are based on the findings.

Clinical practice

- Standard work operational procedures must be put in place to manage residents' behaviour.

- Stress management programmes targeting care workers' emotional reactions to challenging behaviour must be implemented.

- Newly appointed care workers must undergo orientation to teach them about the nature of ID and challenging behaviour and alleviate any discrepancy between their job expectations and the actual workload.

Education

- Care workers should receive formalised training on the nature of ID and challenging behaviour and management of people with ID.

- Care workers should receive training in development of their interpersonal skills.

Research

- Further studies are recommended on other residential facilities for adults with ID, with a multi-disciplinary team on site to compare the findings, as the care workers might perceive the environment as less stressful in the presence of health care professionals.

- Further research is needed to fully understand the relationship between ID and

83
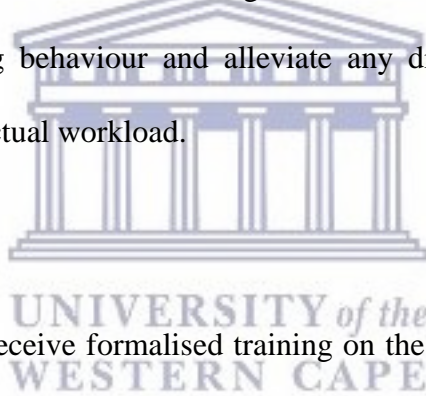
challenging behaviour and care workers' level of stress.

- Future research should include a comparison group of ID care workers who are not exposed to aggressive challenging behaviour to ascertain whether staff who are exposed to some aggressive challenging behaviour are at a greater risk of stress than staff who are not exposed to any aggressive challenging behaviour within their work environment.

5.4 Conclusion

The focus of this research was on care workers for residents with ID and challenging behaviour. The aim of this research was to explore and describe the care workers' experiences of stress and social support in caring for residents with ID at a selected residential facility in the Western Cape. In addition, the researcher aimed to determine care workers' physiological, psychological, social and organisational emotional responses to stress while caring for intellectually disabled residents with challenging behaviour and to determine care workers' experience of social support to cope with caring for intellectually disabled residents with challenging behaviour. During the semi-structured interviews, the researcher used open-ended questions and elicited more information from the participants by making use of probing.

Data were analysed using Collaizi's data analysis method. The analysis was done by the researcher and the researcher's supervisor.

Based on the findings, the care workers are generally satisfied with their jobs and value the helping role that they fulfil. The care workers perceived themselves as valuable contributors, and yet, felt powerless in their role. They are unhappy with certain aspects, such as the poor teamwork and the challenging behaviour displayed by residents. They acknowledged feeling

84

stressed and tired at times; however, knowing that they make a difference in the lives of those they care for gives them the drive to continue doing their work.

This study concluded that the care workers were using their social support and the coping resources available to them, be they adaptive or maladaptive, to cope with whatever stress they experienced as they care for the residents with ID. The researcher ultimately trusts that the recommendations made will be carried out appropriately, as this will possibly provide the care workers with tools to help them deal with stress and manage difficult team members.

85

REFERENCES

Adom, D. (2018). A.--agyem Joe, "Theoretical and conceptual framework: Mandatory ingredients Engineering,". *International Journal of Science Research*, *8*(2), 8-16.

Aides, H. H. (2011). Facts 3. *New York*, (February).

Almalki, S. (2016). Integrating Quantitative and Qualitative Data in Mixed Methods Research—Challenges and Benefits. *Journal of Education and Learning*, *5*(3), 288. https://doi.org/10.5539/jel.v5n3p288

American Health Care Association (2008)

Andrews, M. C., Kacmar, K. M., & Valle, M. (2016). Surface acting as a mediator between personality and attitudes. *Journal of Managerial Psychology*, *31*(8), 1265–1279. https://doi.org/10.1108/JMP-11-2015-0414

Astvik, W., & Melin, M. (2013). Coping with the imbalance between job demands and resources: A study of different coping patterns and implications for health and quality in human service work. *Journal of Social Work*, *13*(4), 337-360.

Babbie, E., & Mouton, J. (2012). *The practice of social research*. Cape Town. Oxford University Press

Ben Salah, H. (2015). In Creswell, JW (2013). *Qualitative inquiry and research design. Choosing among five approaches* (3ed.). *Approches inductives*. London: Sage.

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bowring, D. L., Totsika, V., Hastings, R. P., Toogood, S., & Griffith, G. M. (2017).

86

Challenging behaviours in adults with an intellectual disability: A total population study and exploration of risk indices. *British Journal of Clinical Psychology*, *56*(1), 16–32. https://doi.org/10.1111/bjc.12118

Castro, M., Rehfeldt, R. A., & Root, W. B. (2016). On the role of values clarification and committed actions in enhancing the engagement of direct care workers with clients with severe developmental disorders. *Journal of Contextual Behavioral Science*, *5*(4), 201–207. https://doi.org/10.1016/j.jcbs.2016.09.003

Chancey, C., Weihl, C., Root, W. B., Rehfeldt, R. A., McCauley, D., Takeguchi, K., & Pritchard, J. (2018). The impact of mindfulness skills on interactions between direct care staff and adults with developmental disabilities. *Journal of Contextual Behavioral Science*, 1–10. https://doi.org/10.1016/j.jcbs.2018.07.004

Chao, R. C. L. (2012). Managing perceived stress among college students: The roles of social support and dysfunctional coping. *Journal of College Counseling*, *15*(1), 5-21.

Chou, Y. C., Pu, C. Y., Fu, L. Y., & Kröger, T. (2010). Depressive symptoms in older female carers of adults with intellectual disabilities. *Journal of Intellectual Disability Research*, *54*(12), 1031-1044.

Christensen, L. B., Johnson, B., & Turner, L. A. (2011). *Research Methods, Design, and Analysis*. Pearson. Retrieved from https://books.google.co.za/books?id=-J_4QwAACAAJ

Collins, K., Gratton, C., Heneage, C., & Dagnan, D. (2017). Employed Carers' Empathy Towards People with Intellectual Disabilities: The Development of a New Measure and Some Initial Theory. *Journal of Applied Research in Intellectual Disabilities*, *30*(1), 133–146. https://doi.org/10.1111/jar.12226

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, *13*(1), 3-21.

87

Creswell, J. W. (2013). Qualitative inquiry and research design. Choosing among five approaches (3ed.). London: Sage

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches*. (4th ed.). Thousand Oaks, Sage.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Fifth edition. Thousand Oaks, Sage.

Cudre-Mauroux, A. (2010). Staff attributions about challenging behaviours of people with intellectual disabilities and transactional stress process: A qualitative study. *Journal of Intellectual Disability Research*. https://doi.org/10.1111/j.1365-2788.2009.01221.x

Dawson, F., Shanahan, S., Fitzsimons, E., O'Malley, G., Mac Giollabhui, N., & Bramham, J. (2016). The impact of caring for an adult with intellectual disability and psychiatric comorbidity on carer stress and psychological distress. *Journal of Intellectual Disability Research*. https://doi.org/10.1111/jir.12269

De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2011). *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Van Schaik Publishers.

Department of Health, U., & Services, H. (2011). Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs, (March).

Deveau, R., & McGill, P. (2016). Impact of practice leadership management style on staff experience in services for people with intellectual disability and challenging behaviour: A further examination and partial replication. *Research in Developmental Disabilities*, *56*, 160–164. https://doi.org/10.1016/j.ridd.2016.05.020

Emam, M., & Al-Bahrani, M. (2016). Religious coping, meaning-making and stress:

Perspective of support staff of children with disabilities in residential disability centres in Oman. *Journal of Research in Special Educational Needs*, *16*(2), 102–112. https://doi.org/10.1111/1471-3802.12063

Fink, G. (2016). Stress, Definitions, Mechanisms, and Effects Outlined: Lessons from Anxiety. In: Fink G, ed. *Stress: Concepts, Cognition, Emotion, and Behavior,* Volume 1 of the Handbook of Stress Series. San Diego: Elsevier Inc., 2016: 3-11.

Flynn, S., Hastings, R. P., Gillespie, D., McNamara, R., & Randell, E. (2018). Is the amount of exposure to aggressive challenging behaviour related to staff work-related well-being in intellectual disability services? Evidence from a clustered research design. *Research in Developmental Disabilities*, *81*(October 2017), 155–161. https://doi.org/10.1016/j.ridd.2018.04.006

Frazer, C., Sullivan, D. H., Weatherspoon, D., & Hussey, L. (2017). Faculty Perceptions of Online Teaching Effectiveness and Indicators of Quality, *2017*.

Gountas, S., & Gountas, J. (2015). How the ' warped ' relationships between nurses ' emotions, attitudes , social support and perceived organizational conditions impact customer orientation. https://doi.org/10.1111/jan.12833

Graham, F., Sinnott, K. A., Snell, D. L., Martin, R., & Freeman, C. (2013). A more "normal" life: residents', family, staff, and managers' experience of active support at a residential facility for people with physical and intellectual impairments. *Journal of Intellectual & Developmental Disability*, *38*(3), 256–264. https://doi.org/10.3109/13668250.2013.805738

Grant C, Osanloo A. (2014) Understanding, selecting, and integrating a theoretical framework in dissertation research: creating the blueprint for your "House". *Admin Issues Journal*. https://doi.org/10.5929/2014.4.2.9.

Gray, J.A., & Muramatsu, N. (2013). When the job has lost its appeal: Intentions to quit among

direct care workers. *Journal of Intellectual and Developmental Disability*, *38*(2), 124–133. https://doi.org/10.3109/13668250.2012.760728

Gray, J. R., Grove, S. K., & Sutherland, S. (2016). *Burns and Grove's The Practice of Nursing Research-E-Book: Appraisal, Synthesis, and Generation of Evidence*. Elsevier Health Sciences.

Gray-Stanley, J. A., & Muramatsu, N. (2011). Work stress, burnout, and social and personal resources among direct care workers. *Research in developmental disabilities*, *32*(3), 1065-1074.

Griffith, G. M., & Hastings, R. P. (2014). "He's hard work, but he's worth it". The experience of caregivers of individuals with intellectual disabilities and challenging behaviour: A meta-synthesis of qualitative research. *Journal of Applied Research in Intellectual Disabilities*, *27*(5), 401–419. https://doi.org/10.1111/jar.12073

Harries, J., Ng, K. Y. Y., Wilson, L., Kirby, N., & Ford, J. (2015). Evaluation of the Work Safety and Psychosocial Wellbeing of Disability Support Workers. *Australasian Journal of Organisational Psychology*. https://doi.org/10.1017/orp.2015.9

Hastings, R., Allen, D., & Baker, P. (2013). A conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities. *International Journal of Positive Behavioural Support*, *3*(2), 5–13. Retrieved from http://www.ingentaconnect.com/content/bild/ijpbs/2013/00000003/00000002/art00002

Hastings, R. P. (2008). Life events as a risk factor for psychological problems in individuals with intellectual disabilities : a critical review, *52*(november), 883–895. https://doi.org/10.1111/j.1365-2788.2008.01110.x

Hatton, C., & Lobban, F. (2007). Staff supporting people with intellectual disabilities and mental health problems. *Psychiatric and Behavioural Disorders in Intellectual and*

90

Developmental Disabilities, 388–399. https://doi.org/10.1017/CBO9780511543616.025

Hensel, J. M., Lunsky, Y., & Dewa, C. S. (2012). Exposure to aggressive behaviour and burnout in direct support providers: The role of positive work factors. *Research in Developmental Disabilities*. https://doi.org/10.1016/j.ridd.2014.10.033

Hickey, R. (2014). Prosocial motivation, stress and burnout among direct support workers. *Journal of Applied Research in Intellectual Disabilities*, *27*(2), 134–144.

Hombrados-Mendieta, M. I., Dominguez-Fuentes, J. M., Garcia-Leiva, P., & Castro-Trave, M. (2012). Types of social support provided by parents, teachers, and classmates during adolescence, *40*(6), 645–664.

Ingham, B., Riley, J., Nevin, H., Evans, G., & Gair, E. (2013). An initial evaluation of direct care staff resilience workshops in intellectual disabilities services. *Journal of Intellectual Disabilities*, *17*(3), 214–222. https://doi.org/10.1177/1744629513494642

Jayaweera, T. (2015). Impact of Work Environmental Factors on Job Performance , Mediating Role of Work Motivation : A Study of Hotel Sector in, *10*(3), 271–278. https://doi.org/10.5539/ijbm.v10n3p271

Jenson, R. J., Peterson-Besse, J., Fleming, L., Blumel, A., & Day, A. (2015). Accessibility and responsiveness review tool: Community agency capacity to respond to survivors with disabilities. *Family and Community Health*, *38*(3), 206–215.

Judd, M. J., Dorozenko, K. P., & Breen, L. J. (2017). Workplace stress, burnout and coping: a qualitative study of the experiences of Australian disability support workers. *Health and Social Care in the Community*, *25*(3), 1109–1117. https://doi.org/10.1111/hsc.12409

Juhmani, O. (2016). Ownership Structure and Corporate Voluntary Disclosure : Evidence from Bahrain, (July 2013). https://doi.org/10.5296/ijafr.v3i2.4088

91

Kelly, C., Craft Morgan, J., Kemp, C. L., & Deichert, J. (2018). A Profile of the Assisted Living Direct Care Workforce in the United States. *J Appl Gerontol*, 733464818757000. https://doi.org/10.1177/0733464818757000

Kelso, T., French, D., & Fernandez, M. (2005). Stress and coping in primary caregivers of children with a disability: a qualitative study using the Lazarus and Folkman Process Model of Coping. *Journal of Research in Special Educational Needs*, *5*(1), 3–10. https://doi.org/10.1111/j.1471-3802.2005.00033.x

Knotter, M. H., Wissink, I. B., Moonen, X. M. H., Stams, G. J. J. M., & Jansen, G. J. (2013). Staff's attitudes and reactions towards aggressive behaviour of clients with intellectual disabilities: A multi-level study. *Research in Developmental Disabilities*, *34*(5), 1397–1407. https://doi.org/10.1016/j.ridd.2013.01.032

Kowalenko, T., Gates, D., Gillespie, G., Succop, P., & Mentzel, T. (2013). Prospective study of violence against ED workers. *The American Journal of Emergency Medicine*, *31*, 197–205. https://doi.org/10.1016/j.ajem.2012.07.010

Kozak, A., Kersten, M., Schillmöller, Z., & Nienhaus, A. (2013). Psychosocial work-related predictors and consequences of personal burnout among staff working with people with intellectual disabilities. *Research in Developmental Disabilities*. https://doi.org/10.1016/j.ridd.2012.07.021

Kurz, A. S., Bethay, J. S., & Ladner-Graham, J. M. (2014). Mediating the relation between workplace stressors and distress in ID support staff: Comparison between the roles of psychological inflexibility and coping styles. *Research in Developmental Disabilities*, *35*(10), 2359–2370. https://doi.org/10.1016/j.ridd.2014.06.003

Lakey, B., & Orehek, E. (2011). Relational regulation theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review*. Lakey,

Brian: Psychology Department, Grand Valley State University, One Campus Drive, Allendale, MI, US, 49401, lakeyb@gvsu.edu: American Psychological Association. https://doi.org/10.1037/a0023477

Lazarus, R. S. (1995). Psychological stress in the workplace. *Occupational stress: A handbook*, *1*, 3-14.

Lazarus, R. S. (1999). The cognition-emotion debate: A bit of history. *Handbook of cognition and emotion*, *5*(6), 3-19.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer publishing company.

Lee, K. (2017). Defining intellectual disability : Finally we all agree ... almost defining and determining intellectual disability . Retrieved from http://www.apa.org/pi/disability/resources/publications/newsletter/2016/09/intellectual-disability.aspx

Lin, L.-P., & Lin, J.-D. (2013). Job burnout amongst the institutional caregivers working with individuals with intellectual and developmental disabilities: Utilization of the Chinese version of the Copenhagen Burnout Inventory survey. *Research in Autism Spectrum Disorders*, *7*(6), 777–784. https://doi.org/10.1016/j.rasd.2013.03.004

Lucchetti, G., Lucchetti, A. L. G., Oliveira, G. R., Crispim, D., Pires, S. L., Gorzoni, M. L., … Koenig, H. G. (2014). Nursing home care: exploring the role of religiousness in the mental health, quality of life and stress of formal caregivers. *Journal of Psychiatric and Mental Health Nursing*, *21*(5), 403–413. https://doi.org/10.1111/jpm.12092

Lundqvist, L. O. (2013). Prevalence and risk markers of behavior problems among adults with intellectual disabilities: A total population study in örebro County, Sweden. *Research in Developmental Disabilities*, *34*(4), 1346–1356. https://doi.org/10.1016/j.ridd.2013.01.010

93

Macdonald, J. (2006). Commentary on McKenna HP, Keeney S and Hasson F (2005) Views on the ground: Teaching and clinical assessors' views on vocational training for healthcare assistants in Ireland. Journal of Clinical Nursing 14, 426-434. *Journal of Clinical Nursing*, *15*, 246–247. https://doi.org/10.1111/j.1365-2702.2006.01183.x

Mackenzie, V. (2017). Home- and community-based care services : identifying consumers and needs in a rural Western Cape Province setting, (March). Unpublished thesis

Martin, P. ., & Daniels, F. M. (2014). Application of Lazarus's cognitive transactional model of stress-appraisal-coping in an undergraduate mental health nursing programme in the Western Cape, South Africa.

Mattson, M., & Hall, J. G. (2011). Linking health communication with social support. *Junker Shutter Stock*, *23*(4), 22-45.

McConachie, D. A. J., McKenzie, K., Morris, P. G., & Walley, R. M. (2014). Acceptance and mindfulness-based stress management for support staff caring for individuals with intellectual disabilities. *Research in Developmental Disabilities*, *35*(6), 1216–1227. https://doi.org/10.1016/j.ridd.2014.03.005

Morton, D., Mayekiso, T., & Cunningham, P. (2018). Structural barriers to South African volunteer home-based caregivers providing quality care: the need for a policy for caregivers not affiliated to primary healthcare clinics. *African Journal of AIDS Research*, *17*(1), 47–53. https://doi.org/10.2989/16085906.2017.1397719

Mouton, J. (2001). *How to Succeed in Your Master's and Doctoral Studies: A South African Guide and Resource Book*. Van Schaik. Retrieved from https://books.google.co.za/books?id=uX4lAQAAIAAJ

Mutkins, E., Brown, R. F., & Thorsteinsson, E. B. (2011). Stress, depression, workplace and social supports and burnout in intellectual disability support staff. *Journal of Intellectual*

Disability Research, *55*(5), 500–510. https://doi.org/10.1111/j.1365-2788.2011.01406.x

National Department of Health. (2001). National guidelines on home-base care / community-based care: Defining Home-bases Care (HC) and Community-Based Care(CC), (Cc), 1–14. Retrieved from http://www.westerncape.gov.za/Text/2003/define_homebased.pdf

Nevill, R. E. A. (2018). Retention, resilience, and burnout of staff caregivers for aggressive adults with DD. *ProQuest Dissertations and Theses*. Retrieved from https://login.dist.lib.usu.edu/login?url=https://search.proquest.com/docview/1994580423?accountid=14761%0Ahttp://xz6kg9rb2j.search.serialssolutions.com?ctx_ver=Z39.88-2004&ctx_enc=info:ofi/enc:UTF8&rfr_id=info:sid/ProQuest+Dissertations+%26+Theses+Global

Nguyen, H., Groth, M., & Johnson, A. (2016). When the Going Gets Tough, the Tough Keep Working: Impact of Emotional Labor on Absenteeism. *Journal of Management*, *42*(3), 615–643. https://doi.org/10.1177/0149206313490026

Ó Donnchadha, S. (2018). Stress in caregivers of individuals with intellectual or developmental disabilities: A systematic review of mindfulness-based interventions. *Journal of Applied Research in Intellectual Disabilities*, *31*(2), 181–192. https://doi.org/10.1111/jar.12398

Perera, B. D., & Standen, P. J. (2014). Exploring coping strategies of carers looking after people with intellectual disabilities and dementia. *Advances in Mental Health and Intellectual Disabilities*, *8*(5), 292–301. https://doi.org/10.1108/AMHID-05-2013-0034

Perumal, T. (2014). Research Methodology. https://doi.org/http://dx.doi.org/10.5210/fm.v8i1.1023

Polit, D. F., & Beck, C. T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Wolters Kluwer Health/Lippincott Williams & Wilkins. Retrieved from https://books.google.co.za/books?id=aiSGSQAACAAJ

95

Poulsen, E., Overgaard, S., Vestergaard, J. T., Christensen, H. W., & Hartvigsen, J. (2016). Pain distribution in primary care patients with hip osteoarthritis. *Family Practice*, *33*(6), 601–606. https://doi.org/10.1093/fampra/cmw071

Qalinge, L. (2011). Community home-based care programme: A marginalised key community resource. *Social Work*, *47*(1), 51–58.

Quilliam, C., Bigby, C., & Douglas, J. (2018). Being a valuable contributor on the frontline: The self-perception of staff in group homes for people with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, *31*(3), 395–404. https://doi.org/10.1111/jar.12418

Raley, W., & Smith, E. (2015). Caregiving in the US 2015. *Caregiving in the U.S.*, (June), 1–87. https://doi.org/10.1016/j.renene.2008.04.030

Ravoux, P., Baker, P., & Brown, H. (2012). Thinking on Your Feet: Understanding the Immediate Responses of Staff to Adults Who Challenge Intellectual Disability Services. *Journal of Applied Research in Intellectual Disabilities*, *25*(3), 189–202. https://doi.org/10.1111/j.1468-3148.2011.00653.x

Rose, J., Mills, S., Silva, D., & Thompson, L. (2013). Client characteristics, organizational variables and burnout in care staff: The mediating role of fear of assault. *Research in Developmental Disabilities*. https://doi.org/10.1016/j.ridd.2012.11.014

Roy, A. K., Gujar, N. M., Ali, A., & Borah, U. (2018). Anxiety Depression and Burden among the Caregivers of Persons with Neurological Illness. *Indian Journal of Psychiatric Social Work*, *9*(2), 63-67.

Ruotsalainen, J. H., Verbeek, J. H., Mariné, A., & Consol, S. (2015). Preventing occupational stress in healthcare workers (Review) summary of findings for the main comparison.

96

Cochrane Database of Systematic Reviews Preventing, (4).
https://doi.org/10.1002/14651858.CD002892.pub5.www.cochranelibrary.com

Santy-Tomlinson, J. (2013). Nursing Older Adults, J. Reed, C. Clarke, A. MacFarlane (Eds.), Open University Press, McGraw Hill Education, Maidenhead (2012), £28.99, ISBN-10: 0335240844, ISBN-13: 978-0335240845.

Schmidt, S., Roesler, U., Kusserow, T., & Rau, R. (2014). Uncertainty in the workplace: Examining role ambiguity and role conflict, and their link to depression-a meta-analysis. *European Journal of Work and Organizational Psychology*, *23*(1), 91–106. https://doi.org/10.1080/1359432X.2012.711523

Schuengel, C., Kef, S., Damen, S., & Worm, M. (2010). "People who need people": Attachment and professional caregiving. *Journal of Intellectual Disability Research : JIDR*, *54 Suppl 1*, 38–47. https://doi.org/10.1111/j.1365-2788.2009.01236.x

Skweyiya, Z. (2006). Guidelines for ECD Services, 3–88.

Smyth, E., Healy, O., & Lydon, S. (2015). An analysis of stress, burnout, and work commitment among disability support staff in the UK. *Research in Developmental Disabilities*, *47*, 297–305. https://doi.org/10.1016/j.ridd.2015.09.023

Tsolekile, L. P., Puoane, T., Schneider, H., Levitt, N. S., & Steyn, K. (2014). The roles of community health workers in management of non-communicable diseases in an urban township. *African Journal of Primary Health Care and Family Medicine*, *6*(1), 1–8. https://doi.org/10.4102/phcfm.v6i1.693

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*(1), 80–96. https://doi.org/10.1177/1473325010368316

van Oorsouw, W. M., Embregts, P. J., Bosman, A. M., & Jahoda, A. (2014). Writing About

Stress: The Impact of a Stress-Management Programme on Staff Accounts of Dealing with Stress. *Journal of Applied Research in Intellectual Disabilities*, 27(3), 236-246.

Vassos, M., Nankervis, K., Skerry, T., & Lante, K. (2013). Research in Developmental Disabilities Work engagement and job burnout within the disability support worker population. *Research in Developmental Disabilities*, *34*(11), 3884–3895. https://doi.org/10.1016/j.ridd.2013.08.005

Vosloo, J. J. (2014). Chapter 6: Data Analysis and Interpretation. *Data Analysis and Interpretation*, *449*(53), 316–324. Retrieved from http://dspace.nwu.ac.za/bitstream/handle/10394/12269/Vosloo_JJ_Chapter_6.pdf?sequence= 7

Walsh, G., Dahling, J., Schaarschmidt, M., & Brach, S. (2016). Surface-acting outcomes among service employees with two jobs: Investigating moderation and mediation effects. *Journal of Service Management*, *27*. https://doi.org/10.1108/JOSM-05-2015-0169

Wild, D., Szczepura, A., & Nelson, S. (2013). How social care staff working in residential homes perceive their professional status. *Nursing Older People*, *23*(7), 29–36.

Wilderjans, T. F., Lambrechts, G., Maes, B., & Ceulemans, E. (2014). Revealing interdyad differences in naturally occurring staff reactions to challenging behaviour of clients with severe or profound intellectual disabilities by means of Clusterwise Hierarchical Classes Analysis (HICLAS). *Journal of Intellectual Disability Research*, *58*(11), 1045-1059.

Williams, L., Rycroft-Malone, J., Burton, C. R., Edwards, S., Fisher, D., Hall, B., … Williams, R. (2016). Improving skills and care standards in the support workforce for older people: a realist synthesis of workforce development interventions. *BMJ Open*, *6*(8), e011964. https://doi.org/10.1136/bmjopen-2016-011964

Zijlmans, L., Embregts, P., Gerits, L., Bosman, A., & Derksen, J. (2014). Engagement and avoidance in support staff working with people with intellectual disability and challenging behaviour: A multiple-case study. *Journal of Intellectual and Developmental Disability*, *39*(3), 233–242. https://doi.org/10.3109/13668250.2014.918592

Zijlmans, L.J.M., Embregts, P. J. C.M., Bosman, A.M.T., & Willems, A.P.A.M. (2012). The relationship among attributions, emotions, and interpersonal styles of staff working with clients with intellectual disabilities and challenging behavior. *Research in Developmental Disabilities*, *33*(5), 1484–1494. https://doi.org/10.1016/j.ridd.2012.03.022

Zijlmans, Linda J.M., Embregts, P.J.C.M., & Bosman, A.M.T. (2013). Emotional intelligence, emotions, and feelings of support staff working with clients with intellectual disabilities and challenging behavior: An exploratory study. *Research in Developmental Disabilities*. https://doi.org/10.1016/j.ridd.2013.08.027

Zoder-Martell, K. A., Dufrene, B. A., Tingstrom, D. H., Olmi, D. J., Jordan, S. S., Biskie, E. M., & Sherman, J. C. (2014). Training direct care staff to increase positive interactions with individuals with developmental disabilities. *Research in Developmental Disabilities*. https://doi.org/10.1016/j.ridd.2014.05.016
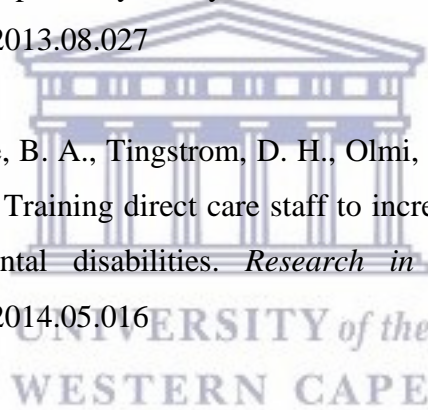
APPENDICES
APPENDIX 1: ETHICS APPROVAL LETTER

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

UNIVERSITY *of the*
WESTERN CAPE

16 January 2017

Ms T Nogemane
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: BM16/5/38

Project Title: Care workers' experience of stress and social support in caring for residents with intellectual disability at a selected residential facility in the Western Cape.

Approval Period: 24 November 2016 – 24 November 2017

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

100

APPENDIX 2: LETTER REQUESTING PERMISSION TO CONDUCT THE STUDY

To: The management committee of the Open Circle

Date: 20 January 2017

Subject: request to conduct a study

Good morning

My name is Tozama Nogemane. I am a Registered Nurse doing my masters at the University of the Western Cape. Currently I am working at Open Circle group home on the grounds of Alexandra Hospital. I will be conducting my research on stress experienced by care workers working with intellectually disabled adults as well as the role of social support. I will need the assistance of the care workers to participate in semi-structured interviews that will not take much of their time.

I will be conducting semi-structured interviews which will take less than 45 minutes. The whole study results as well as answers to the questionnaires will be kept anonymous and the name of the facility will not be mentioned in my thesis. I would like to have an appointment with the manager just to ask a few questions about the facility and the staffing and if they have had the challenges of staff being absent from duty or if they offer staff any kind of support to their staff. I will really appreciate your assistance. I have attached a guide of the consent and the questions that may arise.

My contact number is 021 510 1259 or 0722991578. I have copied my alternate email address

Kind regards

Tozama Nogemane

101

APPENDIX 3: FACILITY'S APPROVAL LETTER

THE OPEN CIRCLE
120-942-NPO

24th January 2017

Ms Tozama Nogemane
University of the Western Cape

Dear Ms Nogemane:

RE: Application to do research at The Open Circle
Ethics Reference Number: BM16/5/38

This note serves to confirm that the Management Committee of The Open Circle has approved a request by Ms Nogemane to conduct research for her thesis at this facility.

Please let me know if there is any further information you require.

Sincerely

Cheryl Barratt
Chairperson.

Physical Address: Grounds of Alexandra Hospital, Corner of Alexandra & Annex Roads,
Maitland, 7405 **Postal Address:** P.O Box 140 Maitland 7404
Tel: (021)510 1259
Reg no: 120-942-NPO **PBO** 930049194 **Tax ref no.** 9133926197
Website: www.opencircle.org.za

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: 0722991578
E-mail:2325791@myuwc.ac.za

INFORMATION SHEET

Project Title: Perceived stress among care workers and the role of social support in coping with intellectually disabled residents at selected residential facilities in the Western Cape

What is this study about?

This is a research project being conducted by Tozama Nogemane at the University of the Western Cape. We are inviting you to participate in this research project because you are a care worker that works at a residential facility for adults with intellectual disability and challenging behaviour. The working environment has been identified as stressful at times and can be difficult to cope with caring for the intellectually disabled residents. The purpose of this research project is to determine the care worker's perception of stress perceived while caring for intellectually disabled residents. To determine the role that is played by social support in coping with the stress experienced while caring for the intellectually disabled residents. This information is sought to give some insight to the employers about the employee's psychological well-being. The results of the study can contribute to the literature about the stress and coping of care workers in the intellectual disability services. There could be an initiation of training programs and also support services made available to the care workers to help in managing the challenges and stress that they encounter while taking care of the intellectually disabled residents.

You will be asked to complete short questionnaires that will give you options to tick or circle. The research will be conducted at your place of work as arrangements will be made with the manager. There will only be one session and the session should not take more than 45 minutes to complete and will not interfere with your breaks. The researcher will be present to answer

103

any questions that you might have.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, you will not be required to put your name on the questionnaires. The researcher will use codes to identify the data collected and no one else will know those codes To ensure your confidentiality, all the surveys collected will be kept in a lockable cupboard that only the researcher will have access. The data will be captured into the computer that will be protected by a password that is only known to the researcher.

If we write a report or article about this research project, your identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authority's information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. The risks may include discomfort and psychological distress as there will be questions related to stress and coping tools. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

This research is not designed to help you personally, but the results may help the investigator learn more about stress perceptions, stress experienced and coping needs and if there is a need for the provision of social support to the care workers. We hope that, in the future, other people might benefit from this study through improved understanding of perceived stress and the role that social support plays in coping with intellectual disabled adults.

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If

104

you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Tozama Nogemane at the University of the Western Cape. If you have any questions about the research study itself, please contact Tozama Nogemane at: Open Circle, Corner Annex and Alexandra Road, Maitland. 0215101259, 2325791@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr Sathasivan Arunachallam

Acting Director: School of Nursing

University of the Western Cape

Private Bag X17

Bellville 7535

sarunachallam@uwc.ac.za

Prof José Frantz

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za

APPENDIX 5: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: 0722991578
E-mail:2325791@myuwc.ac.za

CONSENT FORM

Title of Research Project: **Perceived stress among care workers and the role of social support in coping with intellectually disabled residents at selected residential facilities in the Western Cape**

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name…………………….

Participant's signature…………………

Date………………………

106

APPENDIX 6: INTERVIEW GUIDE

Specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.

Questions	Probes
1.Would you please describe situations which you regarded as stressful whilst caring for intellectually disabled residents with challenging behaviour.	1.physiological, psychological, Social, organizational emotional responses
2. How did the experience/situation make you feel?	Tell me more about that?
3. What thoughts came to mind during your experience?	Can you explain what you mean?
4. How do you cope with the stress experienced?	
5. Who supports you during this time? How do they support you?	

107

APPENDIX 7: SAMPLE INTERVIEW TRANSCRIPT

Interview OC02

Date: 10/04/2014

Length: 25 min 41 seconds

Venue: OC. Maitland

I: Okay, good morning, ah, thank you for agreeing to take part in my study. Like I said, I'm coming as a student, student researcher, not as your manager, so whatever we agreed on today will not be used against you and I will not use it in any way, um, that is related to OC. Just to remind you about the topic of my research, um, it says (TITLE) AT this specific facility. Um, in front of you is a consent, it just explains what is the study about, if you have any questions, your participation is completely voluntarily and that it your choice to take part, no identity will be disclosed to anyone, and you also have a choice to withdraw at any time during the study without any fear of negative consequences. Um, is that clear?

OC02: Yes.

I: Okay, I will need you to just sign and date it, that means you agree to all what I just told you now, and the interview consists of few questions, I just need you to answer as honest as you can, uh, shall we continue?

OC02: Yes.

I: Okay, uh, the first question that I have for you, uh, I just need you to tell me about yourself, how old are you? Are you married? Have you got any kids?

OC02: I'm not married, I have one child, I'm 30 years this year.

I: Mm, how long have you been working in the ID FIELD?

OC02: It's been two years now.

I: Okay, so was OC… (giggles) your first facility?

OC02: Yes, OC was my first facility.

I: Okay, um, so tell me, since you've worked here, would you just describe for me what situations which you regarded as stressful while working here with intellectual disability residents and CB residents?

OC02: Repeat the question.

I: Can you think of any situations that you regard as stressful, like what stresses you while working here for the past two years?

108

OC02: The most thing that stresses me it's when the residents are fighting, and when they are shouting at each other. You trying to stop them but you can't get it right because this one is shouting, this one is shouting, and one thinks this one is the wrong one and I'm the right one. It's very stressful.

I: Okay, uh, the residents are shouting, amongst each other or…?

OC02: Yes, amongst each other.

I: Okay, what exactly stresses you there?

OC02: Eh, it's when you don't know what to do. You're trying to do your best, but it's like nothing is working, they are shouting, making noise, fighting all those kind of things, so they can be very stressful.

I: Okay, do you maybe sometimes feel like you are in danger or…?

OC02: Ja, lot of times you do feel like you are in danger, because you don't know what to expect, when they are angry, anything is possible, so I do feel in danger sometimes (facial expression changes to sad).

I: Okay, so, eh, when you do feel like that, what do you normally do?

OC02: Uh, when I feel like I'm in danger?

I: Yes

OC02: Because, what I have been taught is that even if you feel like you are scared of that situation, and the pressure is high, you must just remain calm. You don't want to show them that you are scared of what they are doing. Just remain calm until everyone is calm.

I: Okay, so in the past two years ,is there maybe a situation whereby there was a fight in front of you or someone was assaulted in front of you by a resident?

OC02: Ja, there was (looks down). There's been few fight that happened in front of me.

I: Mh…

OC02: Few fights (shifts from the seat, looks uncomfortable).

I: Okay, and how did you feel as a person when those things are happening in front of you?

OC02: (inaudible mumbles, face covered with both hands)

I: You can talk in your language

OC02: Okay, *Xa besilwa* (when they fight), nhe, *njengoba senditshilo* (as I said), you become shocked, scared, and then *amaphaphu aba phezulu yonke lonto* (there's an adrenaline rush and all that), but at the same time, you know *uba* (that) you are here. At the beginning, when you

109

started this job, you knew what you, you were, you're putting yourself into, so you just have to *uba* (to be).

I: Okay, so you must just be strong?

OC02: Ja, you must be strong.

I: Okay, um, and then, uh, I think you sort of touched to that, coz I want to ask you, how did the whole situations make you feel, like after a fight, how do feel? Do you still feel like being here, or do you feel like running away and…?

OC02: Ja, after let's say maybe few minutes after the incident or whatever that was happening, then you do feel like, yoh! My God, what have I put myself into? But when then times go then you feel, and you've calmed down, then you realise this is not just a job, it's a calling, because for…it's not for anyone to work in this field, it's for the chosen ones. So at that time then you realise that I need to be here because I'm making the difference.

I: Okay, so you do feel like there is some difference that you guys are making that are working here?

OC02: Ja, there is a difference that we're making here, because some of the residents, when they came to OC, they were just, like, they used to do things the way they like. Then we teach them things, we teach them to be responsible, we teach them to respect, we teach them to follow the rules. It's not easy, but we do see the progress, so ja, the change is there.

I: Okay, there is some rewards being here?

OC02: Ja, there is rewards.

I: And, um, just to go back a little bit, like, when the whole situation is stressful for you, what are the, what the first thoughts that come to your mind? Like, you feel like maybe calling for extra help or do you get the help, or do you feel like you're getting the help that you need?

OC02: Ja, because we always, you always, cannot be alone, mos. You always have your colleagues around you, so you don't have to really seek for help, because immediately, while you are busy, maybe you are in between those who are fighting, one of you will come in and then help you, so we make the work easy, so you don't have to feel that all the work is for you alone. There's always help, teamwork.

I: Okay, so, um, teamwork is great so far?

OC02: Yes, teamwork is great so far.

I: Okay…

OC02: Because I'm thinking now, if we didn't have this teamwork, what could have happened in these incidents, in those situations when you just feel like, "I don't know what to do," but at least if there's someone else next to you, you feel like you don't have to lift all this heavy duty alone, there's someone else, while you're busy stopping this one, there's someone else who's helping with the other side, so it makes it easy.

I: Okay, so, uh, your colleagues are supportive?

OC02: Yes.

I: Okay, uh, besides the residents, like, when it comes to stressing, is there other things that you maybe feel like are stressful?

OC02: YHOOO! For now, for this two years, I can't say, there's nothing I can say is the stress to me than the residents, coz for them is like every day is a challenge, you don't know what to expect. Today they are calm, the other day they are all fighting and angry and making noise and all these things, fighting, so it's only the residents that you don't know what to expect, but the staff and other things is okay.

I: Okay…

OC02: (mumbling)

I: Okay, um, so, um, tell me, how do you cope with the stresses, like can you think of a specific incident and say maybe, after this happened, this is how I coped, or…?

OC02: Mmh, for me, because I'm a spiritual person, if I deal with those things… Yes, at work they did offer us this… a shoulder for us to go, if you want to debrief for what you can go and talk to someone. But some of us, we are not like, open, so for me, I just, if I'm dealing with a stress, for me to release the stress I just pray, maybe I play music that is soft and I feel calm and then I feel like yes, I can go back and work.

I: Okay, um, when you say you are not open, what do you mean?

OC02: I mean, it's not easy for me to just go and talk about, talk about what happened, unless if maybe someone ask, what happened? How did you feel about this thing? But for me it's like sometimes you just don't think it's necessary for you to go and tell someone that, that thing, that incident stress me, like this and this and this, because sometimes you feel like it's part of your job to be stressed so why do you have to make something big out of it? Because, obviously when you come to work, OC, you know what type of residents you're dealing with, so stress will always come every day.

111

I: Okay, it sounds like you have just accepted that stress should be there? Is it so?

OC02: No (giggles). No, didn't accept like that, it's just the way I feel, not because I accepted the stress, no one accepts the stress, no one wants to be stressed, but for me it's the way I, I like. Because you asked me how do I deal with the stress and I just told you that for me I deal with the way I say, not because I accept the stress, no.

I: But do you think maybe being more open and talking, do you think that helped, or would it help you?

OC02? Ja, I think it helps to talk about things.

I: So if you were to talk, who can you talk to?

OC02: Here at OC?

I: Here and outside, who do you think would be your great support when it comes to being frustrated and stressed and…?

OC02: Here at OC (work), I never spoke with anyone. But outside, as you mentioned, I do talk to my pastor at the church. For guide, I do go to him for counselling, ja, for now I think he's the only person I talk to about my things.

I: Mh. Okay, uh, sorry to interrupt…

OC02: Yes?

I: When it comes to work, um, why do you feel like you can't talk to anyone here?

OC02: Ja, at work they did say there is a lady who comes for counselling, and everything, but maybe when the lady comes I would be, I won't see it necessary at that moment, maybe when she comes there's no stress and so I wouldn't go if I feel there's no need for me to go at that time. I wouldn't go to talk to someone, only when I feel like what I'm stressing about now need, I need to talk about it. Maybe when that lady comes I don't have stress at that moment, so I don't see a reason for me to talk to her.

I: Okay, um, let's talk a little bit about work in general, like, uh, do you think whatever is expected of you is too much, or can you handle everything without feeling overburdened?

OC02: No, the work is fine, I don't feel any burden. I feel like anything that is expected of me is what I should do, so I don't feel like I have been given too much work here at OC.

I: Mmhmm.

OC02: Yes, I can handle the work.

I: So, um, physical work is fine…?

112

OC02: Yes, physical work is fine, I can't complain.

I: Okay, um, so you told me the person who supports you mostly is your pastor. Is there any family or friends in your circle that you feel they are your source of support?

OC02: Yes, my aunt and my mother.

I: Okay…

OC02: Yes.

I: So, um, what kind of support do they offer to you?

OC02: Um, I talk mos to them, at least, I feel they are one of the, some of the people that I feel open, I can talk openly to them, so if I can say emotional support? All kinds of support I get from them.

I: From your mom and aunt?

OC02: From my mom and aunt, yes.

I: Okay, um, when it comes to residents now being challenging and all that, is there maybe specific ones that are sort of, really, constantly on your mind? You can mention the names, you can say the alphabets, but I…

OC02: (laughing) But you said it's confidential.

I: It is, I will still edit the tape mos.

OC02: *Ay yayazi ke uMi*… Uh, *hay hay*! (You know Mi… no, no), that child is too much, too much. Who else can I think of?

I: So, what is it about her that is too much?

OC02: That child, that resident, you can't reprimand her, that's the thing. You can't say NO to her. Everything is about her (facial expression changes to frowning).

I: Mh…

OC02: She's doing something wrong, and you are there trying to tell her, "what you doing is wrong," and she's going "aaahw" instead of seeing the point. She will just swear at you, making you feel like you are stupid or what. So that one is working…is number one in OC to give me stress.

I: Okay, so besides stressing you, what are, like, feelings that surface when she's doing all that? Do you maybe feel, like, angry, or maybe sympathy towards her? Like, what…

OC02: NO! I feel angry.

I: Mhmm.

OC02: I feel angry a lot, because, you know, when you're talking to someone, you try to show them that… She knows that she's wrong, but don't want to admit that she's wrong. Instead, she's just throwing everything at your face, and then…because even at the moment she's doing that something wrong, you become like, how can you do this? And then you already, you already angry for her to do that thing, so instead of her to see that she's wrong and feeling sorry, she's throwing it at your face, she's shouting at you, she provoking you. Definitely, you would feel angry, you won't feel sympathy, but angry at that time.

I: Mh. So what do you do with all that anger?

OC02: I just walk away, because there's nothing I will do. I just walk away from her. And then she's the resident, always there, and then it's like every day she's gonna make you angry, every day, so just walk away from her and ignore her, that's all you do.

I: Mhmm, okay, so how long does the ignorance go on? Until you f….

OC02: As far… until you… but for me, it's like I no longer put it, like, at the beginning, when she just arrived, it used to… you know, you like this, "how can this resident be like this?" Like, now, as you get used to her, you just know, aggh, she's being Mi… so you just brush it off and you forget about it.

I: Mhmm, okay, and then, is there someone else?

OCO2: Um…

I: Or something else?

OC02: Um, no, nothing else about her, its only that thing, because the other things she's fine. If you wanna bath her, she's gonna bath. If she was bathed last night or someone bathed her, she won't bath. So it's only this part of don't want to listen to anyone that is not right about her.

I: Mhmm…

OCO2: And then another resident that can make you… your day a little bit not nice, is…(laughing) you said alphabet? Its Ma…

I: (laughing) Okay, so one M and then another M.

OC02: Ja, one M (laughing). When she starts this thing of… like that child is… I don't wanna say she's spoilt, maybe that can be very… not nice word, way to describe her, but it's like for her, she wants to get things the way she wants. She always want to get things so if she says she wants this thing and then you say, "no, you can't have it because of this and this and this," she

114

don't have time to listen to your reasons why you're saying she can't get it. She just wants this thing and then she wants to get it now, immediately. So if you don't want to give to her and then she starts to scream, undress, biting the breasts and everything, so and now at the same time you, you are trying to, to, to… Because other residents will come and look at her when she's undressing (facial expression changes to sadness).

I: Mmh.

OC02: Then you try to cover her because these all these things must be private, but she throwing all the things, all the clothes and the blankets and everything, so you just feel so stressed, for her. It's like you don't become angry, but you become so stressed because… and the visitors are coming in and out, and then the resident is sitting there naked and then she's screaming, and then she's swearing and then she's biting her "titty", so you feel like all these thing is bringing confusion in your mind, stress and everything, so…

I: So is…

OC02: So, she's one of the residents that can stress you.

I: Okay, with her, it's the different story, you don't feel the anger, you feel…?

OC02: You don't feel the anger, but confused and stressed, because you don't know now what to do, because you can't pull her to the room. She's gonna come out, you can't cover her while she sitting there making noise because she's gonna tear the clothes and the blankets.

I: Mmh.

OC02: So… and then, now, you're thinking people are watching her and you don't want people to watch her at the same time. She's making noise, the people are watching, you want to cover her, you want her to keep quiet, nothing is happening, you keep failing all those things.

I: Okay, um, you sort of worried about her… what, can I say, dignity?

OC02: Yes, her dignity. And she's also injuring herself at the same time, so I'm feeling all those things.

I: Hmm…

OC02: She's injuring herself, her dignity also, you are also worried about it.

I: Mmh, okay, so I've got two people that are giving you different emotions…

OC02: Mmhmm.

I: Is there another one or another situation?

OC02: No, no, that's those two that mos… (inaudible)

115

I: Okay, when it…

OC02: The stressful ones for me…

I: Okay, when it comes to programme, like the daily routine, the weekly routine, and all that, how do you feel about those things?

OC02: Like the activities?

I: Ja.

OC02: Activities are fine, you know. The whole purpose, it's like you always think outside of the box. You might think you know this, but when the OT (occupational therapist), the lady whose doing, whose helping us with the OT, comes with new ideas, then she's kind of opening your mind and then you feel like it's easy to do this activity, so for me, it's the daily routine and stuff, it's still working okay.

I: Okay, so you would say after a difficult morning with whoever, uh, OT is something you can look forward to?

OC02: Yes, you can look forward to.

I: Okay, um, do you have a question so far?

OC02: No, I don't have any question

I: Okay, um, I just want to explain something, um, like I said earlier on, this is for my study, and then once we finish with this recording, I will send it to my supervisor, who's at University, and then she gonna listen to the recording and see if we have missed out any important points. And if she feels so, um she's gonna ask me to do a follow up interview with you.

OC02: Okay.

I: Will that be fine if we have a second interview?

OC02: No, its fine, I don't have a problem.

I: Okay, um, I think we are done for now, and thank you for taking part in my research and, um, we will see each other next time.

End of interview number 02.

APPENDIX 8: CERTIFICATION OF EDITING

117

Nathan T Lowe
9 Lamborghini Avenue
Wierda Park
Centurion
0157
Tel: 076 362 7852
Email: nathanthomaslowe@gmail.com

To whom it may concern

I hereby certify that I, Nathan Thomas Lowe, edited the thesis of Tozama Nogemane, entitled 'Care workers' experience of stress and social support in caring for residents with intellectual disability at a selected residential facility in the Western Cape', for grammar, clarity and consistency.

Regards

Nathan T Lowe

Editor for the University of Pretoria's Language Unit

118