

**The Shared Experience of Care:
A Social Identity Approach to Understanding the Motivation of
People who Work in Social Care.**



Submitted by Kirstien Bjerregaard to the University of Exeter
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Abstract

Widely viewed as under-valued and under-paid, yet sentimentalized as working more for love than money, the social care workforce is a fundamental economic and social resource; the importance of which is growing in line with the rapidly aging, global and national population (Care Quality Commission, 2012; DoH 2009; International Helptheaged, 2013). Classic motivation theories, which focus on economic and individualistic work motives, fail to fully account for the high rates of satisfaction and commitment among care workers, (Skills for Care 2007, 2013; Stevens et al 2010). Yet a growing body of empirical research demonstrates that health and social care workers' motivation is related to patient/client satisfaction and wellbeing (Maben et al., 2012). Moreover the quality of the relationship between the carer and client contributes to the motivation and the wellbeing of both (Wilson, 2009; Wilson et al., 2009). Therefore this thesis seeks to better understand the collective and relational aspects of care workers' motivation. It does this by detailing a program of research which examines care workers motivations through a social identity lens that asks 'what's in it for us' as well as 'what's in it for me' (Haslam 2004). A social identity perspective on motivation focuses on how workers experience themselves and their work at a personal, relational and organizational level (Ashforth et al 2008; Ellemers et al., 2004). In doing so it offers a multi-dimensional, theoretical framework through which to understand the dynamics of care workers' motivations. Moreover, this framework offers an empirically proven psychological framework for explaining why adopting a relationship-centered approach to care is pivotal for organizations to achieve a compassionate care culture.

The first study explored care workers' experience of work and inquired about what they did and why it mattered to them. Semi-structured interviews were conducted with 19

care workers who worked in residential and domiciliary care settings. A thematic analysis of the transcripts identified four overarching themes that contributed to care workers' motivation, those of fulfillment', 'belonging', 'valuing' and 'pride'. These motives were found to be actualized in their shared experience of caring, particularly with clients and also with co-workers and as an organizational member. The findings of the study shed light on the content of care workers' personal, relational and social identities and the interactions between them. Care workers primarily emphasized the meaningfulness of their work in terms of its caring nature. They expressed this in terms of their personal attributes, their relational role with clients and their perceptions of how the organisation treated them. This led us to hypothesize that their identification with the organisation is likely to increase to the extent they feel the organisation 'cares'. Indeed to build on and harness care workers' identities at work, the findings suggest that organisations need to place care workers' relationships with clients at the heart of what they do.

The second study was a longitudinal quantitative analysis of care workers' motivations which consolidated and extended the findings of the first study. It had two parts, the first part was an examination of how care workers' motivations are shaped by their sense of identity, and the second part tested how a professionalization intervention affected their motivation. To achieve this we administered an organisational survey at two time points, one year apart (T1 $n = 643$, T2 $n = 1274$, T1 & T2 $n = 204$). Analysis of the survey responses assessed what it was that incentivized care workers (love and/or money), the relationship of this to work outcomes (i.e. job satisfaction, pride, stress, turnover intentions and positivity about professionalisation) and the extent to which it was affected by patterns of identification. We also examined variation in responses over time as a function of whether or not people had undertaken professional qualifications in the intervening period (so that, in effect, undertaking a qualification constituted an

experimental treatment). This meant that the study had a quasi-experimental design in which we could examine the putative impact of exposure to a professionalisation intervention on organizational identification and motivation (for a similar logic see Lim & Putnam, 2010).

In line with the five main hypotheses that were generated from the findings of Study 1 and from predominant findings in organisational and social identity research; the results showed first (H1), that care workers' collective identification with different groups at work, was positively related to their motivation (Ellemers et al., 2004). More specifically, their work motivation was predicted by their identification with (a) the people they care for (client identification), and (b) the care organization they work for (organisational identification). Furthermore, although care workers indicated strongest identification with clients, it was their identification with the organisation that was the most proximal indicator of increased motivation. Second (H2 & H3), although care workers were most incentivized by their relationships with clients and the least incentivized by the pay; the extent to which either led to improved work outcomes was mediated by client and organisational identification. Where being incentivized by relationships with clients led to improved work outcomes, client identification predicted organisational identification, whereas client identification played a lesser role in mediating the likelihood of being incentivized by pay leading to improved work outcomes. In addition (H4), care workers' identity varied as a function of the work context. More specifically, whether they worked in residential / nursing home care or in domiciliary care affected the nature and extent of their relational identification with their clients and the congruence between client identification and organizational identification (Ashforth et al 2008, Haslam et al 2003). Finally (H5), care workers' motivations were enhanced by the professionalization intervention of undertaking a qualification, to the extent that it built on and maintained meaningful work-related

identities. In particular, the results showed that, care workers' motivation increased as a result of undertaking a qualification to the extent that the training increased identification with the organisation and other groups at work (Pidd 2004).

Study 3 further investigated the effects of identification on motivation, learning and performance by examining the likelihood of professionalisation training being transferred to the workplace. A 2×2 longitudinal study evaluated the effects of a new generic professionalisation (NGP) training program, that tapped into distal work identities, and a standard localized professionalisation (SLP) training program, which spoke more to localised identities, on participants' identification and motivation at work. Overall the findings indicated that compared to the NGP, the SLP (H1) maintained and strengthened participants' work identification. Furthermore compared to the SLP, the NGP was associated with (H2) a reduction in trainees' perception of the relevance and usefulness of the training, (H3) a reduction in motivation to enact the training, and (H4) a reduction in trainees' immersion in the program. Moreover the findings demonstrated that (H5) the reduction in motivation to transfer learning associated with the NGP relative to the SLP, was explained by the reduction in identification it engendered, which in turn reduced participants' sense of relatedness within the training context. These findings imply that learning is more likely to be applied when it (a) has relevance to identities which are more meaningful to participants, in this case local identities, (b) is delivered by people with whom care workers identify, (c) is validated by others in the workplace environment with whom the participants' identify.

Taken together, this program of research demonstrates that care workers' motivations can be understood through a social identity perspective that incorporates the collective, relational and personal dimensions of providing care. It concludes by

considering how organisations can tap into, harness, strengthen and develop care workers' identification at work as a means of enhancing their motivation and retaining professional care staff. Through bridging theoretical and applied concerns, this research has wide-reaching implications for developing and maintaining compassionate work cultures within care organisations and other helping professions.

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The ongoing support and encouragement of many wonderful people has enabled me to complete this PhD journey, made it meaningful, and at times even made it enjoyable.

Foremost, I would like to thank my three vibrant children, Leon, Kai and Frida, because it was through having them that I considered making the time to study for a PhD. They have tirelessly kept my perspective and priorities in check.

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A big thank you goes to Thomas Morton for supervising the final stages of this PhD, in particular for his statistical wizardry and thoughtful clarity, not to mention his kindness. I also feel very fortunate to have had invaluable support and guidance from Avril Mewse.

At Exeter University I enjoyed the company of some great fellow researchers including Adrian Bruegger and Craig Knight, and especially, Sonya Saroyan, whose insightfulness, wit and generous spirit kept me sane.

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I am delighted to have opportunities to transfer some of my research findings into practice and infinitely grateful to Mo, Simon and Mike at Interbe for supporting my transition back into vocational work and a world of possibility.

The practical and emotional support I have received from my family throughout my life and during this PhD has been a vital resource. I am especially grateful to my dad for teaching me to always question ‘the right way’ and to my mum for encouraging me to do it graciously. The love I receive from them, my sister Sarah — an absolute gem, my brothers, Martin and Peter and my stage sister, Alex is phenomenal.

Finally, I struggle to find the words to express my infinite, immense gratitude to my husband, Mox, for his belief in me, his unmeasurable support and the continual source of inspiration he is in my life. I would not be without him.

Dedication

During the period in which I undertook this PhD, two of my grandparents died. Both they and my surviving granny relied on care workers to support them towards the end of their lives. The quality of care they received greatly influenced the quality of their lives. It is to them, William and Muriel Webb, and Peter and Jean Brook, that I dedicate this thesis. They passionately cared about others, inspired great caring from others and deserved the best care.

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Statement of the candidate's contribution to co-authored papers

The three studies included in this thesis were written up in three papers for publication. As detailed below, the substantial contribution to the co-authored papers presented in this thesis was made by the candidate. However, while the candidate is fully responsible for the work presented in this thesis, where the first person is used it is in the plural (i.e., 'we' rather than 'I') as in the original peer-reviewed articles to reflect the collaborative efforts guiding the research process. All chapters that have been written up are presented in the format requested by the respective journal; since each manuscript is meant to stand alone, some information may be repeated.

Paper 1: Study 1 – Chapter 5

Bjerregaard, K., Haslam, S.A., Mewse, A., & Morton, T. A. (2014). *The Shared Experience of Caring: A Study of Care workers' motivation and identification*. Manuscript submitted to the Journal of Ageing and Society.

The qualitative research presented in study was designed by the candidate in collaboration with Professor Alex Haslam and Dr Avril Mewse. The data was collected and analyzed by the candidate. The interpretation of the results together with the framing of the arguments was carried by the candidate with supervisory support from Professor Alex Haslam. Dr Thomas Morton also provided supervisory support.

Paper 2: Study 2 - Chapter 6

Bjerregaard, K., Haslam, S.A., Morton, T.A., & Ryan, M. (2014). *The motivation of care workers. Clarifying the importance of collective and relational identification*. Manuscript submitted to the Journal of Occupational and Organizational Psychology.

The longitudinal study was designed by the candidate in collaboration with Professor Alex Haslam, and reviewed by Professor Michelle Ryan. The data was collected and analyzed by the candidate. The interpretation of the results together with the framing of the arguments was carried by the candidate with supervisory support from Professor Alex Haslam and Dr Thomas Morton.

Paper 3: Study 3 - Chapter 7

Bjerregaard, K., Haslam, S.A., & Morton, T.A. (2014). *How identification facilitates effective learning: The evaluation of generic versus localized professionalisation training*.

Manuscript submitted to the Journal of Organizational Behavior.

The candidate designed the longitudinal training program evaluation in collaboration with Professor Alex Haslam. The candidate collected and analyzed the data, and wrote the paper with supervisory support from Professor Alex Haslam and Dr. Thomas Morton.

Statement of the Supervisor's Contribution to Co-authored Papers

As outlined in the candidate's statement above, the substantial contribution to the co-authored papers presented in this thesis was made by the candidate. This includes the review of the literature presented in each paper, study design, statistical analyses, and interpretation of the data, together with the write-up for publication. The supervisors contributed to the papers by advising on statistical analyses and interpretational issues, relevant literature, and writing style. Moreover, the theoretical framing of the empirical work in this thesis and the arrangement of the papers is a product of a concerted discussion of the thesis content between the candidate and her supervisors.

Dr Thomas Morton (first supervisor)

Chapter 1

The adult social care workforce:

An essential yet undervalued social and economic resource

The adult social care workforce is a vital economic and social resource, the importance of which continues to grow in step with the rapidly ageing population (Care Quality Commission, 2012; Center of Workforce Intelligence, 2011; ICF GHK, 2013, Skills for Care 2011). Yet care workers are widely acknowledged to be undervalued and underpaid, at the same time as being sentimentalized as working for love rather than money (Himmelweit, 2007; Lepong, 2007; Nelson & Gordon, 2006). Categorized as undertaking ‘dirty work’ (Kreiner, Ashforth & Sluss, 2006; Stacey, 2005; Strauss, 1985; Sluss & Ashforth Twigg, 2011), care workers provide intimate, personal care to those who are vulnerable and unable to look after themselves. The nature of care work is physically, emotionally and socially demanding, yet the skills and aptitudes required to do this work well are only just starting to be acknowledged and accredited, partly through the professionalization of the sector (DoH, 2009; DoH, 2012). Even though there is unquestionable demand for a high quality compassionate workforce, the complexity of fully understanding and harnessing care workers’ motivation is reflected in the relatively low pay they receive, the often precarious conditions they work under, and the inconsistency between the high moral and low material values attached to such work (Atkinson & Lucas, 2013; Folbre, 2012; Lepore, 2008). Nonetheless, it remains that “one of the most pressing contexts in which examination of the motivations at stake is a priority is the case of social welfare for older people” (Kendall, 2001; p. 360).

The aim of this introductory chapter is to look more closely into the context of care work, to gain an understanding of the factors that might affect care workers' work experience and motivation. I start by briefly discussing the current care crisis, and the social and economic climate in which this is taking place. Then I provide a historical overview of care work, which takes us up to the present-day context of professionalization and the drive to create and sustain a compassionate health and social care culture. Next, I look at the nature of the work itself and the makeup of the workforce. I then go on to outline the findings from research undertaken with care workers to date that relates to their motivation and professionalization. Finally, I summarise the key issues that appear to affect care workers' motivation.

Implications of the growing demand for care

Globally, many countries are seeing a significant population change with a rise in the number of elderly and an increase in life expectancy. One in nine people in the world are aged 60 years or over and this is set to rise to one in five by 2050 (HelpAge International / UNFPA 2012). According to the Global Agewatch Index, “such is the pace of change that, by 2050, the older generation will outnumber those under 50” (HelpAge International, 2013). In the UK, as in many developed countries, there are more people over 65 than there are children under 16 years old. Today, 23% of the population in the UK is over 60, this compares to 22.8% in the Netherlands, 26.7% in Germany, in Portugal, 24.4% in Portugal, 19% in the USA, 31.6% in Japan and 19.6% in Australia (HelpAge International, 2013)¹. Over the next twenty years, the number of over-65 year olds living in England is predicted to increase by nearly 50%, and the number of over-85 year olds will double (DoH, 2009).

¹ For further breakdown of global ageing population and wellbeing statics see HelpAge International Global Age Watch at www.helpage.org/global-agewatch.

According to the government, only a third of men over 65, and 15% of women, will *never* need social care (White Paper on Caring for Our Future, HM Government, 2012). Moreover, an increase in demand for care is projected, due to the rising life expectancy in combination with medical advances which mean that more people are living longer with a disability or long-term condition. This includes a dramatic rise in dementia (CQC 2012), along with an increase in cancer survivors and survivors from other long-term chronic illnesses. This unprecedented increase in demand for care services is accompanied by uncertainty surrounding how to finance care provision. Costs of care are rising without a clear plan of how this is going to be funded (AgeUK, 2012). The drivers of this ‘care crisis’ — that is the combination of increasing demand for care and reduced ability to provide and pay for this — are also evident in other developed countries (Palmer & Eveline, 2012).

These demographic and health changes are affecting the adult social care workforce in a number of ways. First, and as already noted, there is a greater demand for their services. Second, expectations of care services are also changing. The post-World War II generation of baby boomers are used to having greater control of their lives, and accordingly expect to have more say in the ways they are supported through care (Philips, 2007). Third, there is recognition that more skills and knowledge are required to be able to understand and respond to the key needs of people with increasingly complex age-related conditions. Finally, fourth, as a larger proportion of the population are likely to need social care support, the profile and value attached to care work is rising (Platt 2007). Nevertheless, given the rising costs of care combined with uncertainty about how to fund it, there are no imminent signs that adult care work will ever be well-paid work.

The size and continuing growth of the care sector also makes it an economic resource. The direct economic value of the adult social care sector in the UK is estimated to be worth more than £20 billion per year. The sector employs 1.63 million people (Skills for Care,

2011) — which is more than the construction industry, public administration or defence sectors (ICF GHK, 2013). Moreover, this sector is predicted to grow to between 2.1 and 3.1 million employees by 2025 (Centre for Workforce Intelligence, 2011). It is interesting to note that in spite of the growing size of the formal care sector, the majority of care in the UK is provided by informal carers (families, friends and relatives). The 2011 Census figures show that there are nearly 5.5 million informal carers in England, 6.5 million in the UK, and the care provided by them is “worth an estimated £119bn per year, considerably more than the total spending on the NHS” (Carers Report 2012).

In spite of the increasing size, economic and social value of the adult social care workforce, relatively little is known about it — particularly with regard to the long-term care workforce — that is, residential (care home) and domiciliary (home care) care workers. In response to a recent observation that the adult social care sector was a “data desert” (DoH, 2009; Skills for Care, 2007), studies on the care workforce have gradually started to increase (Atkinsonson & Lucas, 2013; Hussein, 2009; Hussein, Stevens, Moriarty & Manthorpe, 2010; Lepore, 2008; Lucas & Atkinson 2009, Sczepura, Nelson & Wild, 2007). Mechanisms have also been put in place to ensure the regular, systematic collection of data, as seen, for example, with the National Minimum Data Set for Social Care (NMDS-SC) launched in 2007. Nevertheless, there still “has been little investigation or theory development that specifically addresses the motivation to care” (Moody & Pesut, 2006: p. 16).

In the main, research undertaken on care work tends to provide a snapshot of care workers’ situation alongside a general analysis of recruitment and retention in the sector (Atkinson & Lucas, 2013; Hussein, 2009; Lucas et al., 2008, 2009). This falls short of providing a detailed exploration of care workers’ experience and motivation, and lacks robust theoretical analysis of what activates and sustains motivations to work in a

professional and compassionate manner (Adamson et al., 2012; Lucas, Atkinson & Goddard, 2009; Nelson & Folbre, 2006). This dearth of theoretical research on the care workforce is seen as indicative of the low value attached to skills and capabilities required to undertake care work (Himmelweit, 2007). Given the relative shortage of research undertaken on the adult social care workforce, this thesis also draws on the plethora of work undertaken on the recently professionalised nursing workforce (including Adams & Nelson, 2009; Bond 1992; Ousey & Johnson 2007; Rytterstrom et al., 2009; Woodward 1996). Although the specific demands in each of these domains can differ, there is also a clear overlap between the pressures being faced by these workforces and the motivations that might underlie work in these sectors.

Background and nature of care work

An overview of the background of care work illustrates how prevailing historical, social and economic contexts have shaped, and continue to shape, discourses about care work and caring practices. As outlined below, this has entailed the marketization of the provision of care services, with an accompanying emphasis on the efficiency and effectiveness of care services being best delivered through increasing the bureaucratisation and medicalization of care. The shortfalls of this approach have been cited as resulting in care environments that are susceptible to exploitation and abuse. This, in turn, led to increased emphasis being placed on professionalization of the care sector through regulation and training, as well as the promotion of individualistic person-centred care. Most recently, in 2013, the agenda is to provide compassionate care, in an affordable manner, and this is accompanied by the recognition of the value of relationship-centred care.

Up until after World War II, adult social care work in the UK was almost entirely undertaken on an informal basis by family members and friends, or exceptionally by private arrangements. Indeed, and as noted above, even today the majority of care in the UK is

provided by informal carers (Carers Report, 2012). The arrival of the welfare state, initiated by the Bevan report in 1942 — in particular, the establishment of the National Health Service (NHS, 1948) and the National Assistance Act (1948) — required local authorities to provide residential accommodation, and later in 1962, care in the home for older and disabled people in need. This, along with the geographical splitting of families, resulted in an increased dependence on a formal public care workforce (Bell, Nash & Thomas, 2010).

From the 1980s onwards, however, the increasing costs of care have resulted in governments reducing state support for care provision to those people who were assessed to have critical or substantial needs. Alongside this, governments have progressively reduced the direct provision of care and instead have looked more towards the independent sector (private and voluntary organisations) to provide residential and community care and have taken on more of an external regulatory role. The marketization of care services, and the accompanying commoditisation of care provision (Bell, Nash & Thomas, 2010; Fotaku, 2010), marked the beginning of a shift in emphasis in care practice towards a focus on the efficiency of care provision; which included the generation of care schedules, the regulation of tasks, and marketed time slots, along with the implementation of specific protections (safeguarding of clients/ patients and staff; Philips, 2007). This emphasis on medical, physical and bureaucratic activities, an emphasis that has dominated the last thirty years, has been criticised for neglecting the social and emotional aspects of providing care, which were either assumed as a given or viewed as potential threats to the provision of efficient and effective care (Folbre, 2012; Help the Aged 2008, Hesselink, Kuis, Pijenburg & Wollersheim, 2013; Philips, 2007).

By the end of the 1990s, there were increasing concerns that older people, as well as other vulnerable adults, were not receiving the quality of care they required (HAS, 1998). In response to these concerns, a National Service Framework (NSF) for older people was

developed in 2001. This set the first national standards for the care of older people in the UK (DoH 2001). One of the key principles underpinning this framework was the promotion of ‘person-centred care’ — that is, the idea that the provision of care should respect service users as individuals and be organised around their needs (DoH 2001). This was structurally supported by the introduction of ‘Direct Payments’ in 2000, a mechanism whereby the service user pays the provider directly (Help the Aged, 2008). Thus, after transitioning from being direct providers of care, the government’s commissioning of care services has extended from organisations and now to individuals themselves. The current emphases on individuality and person-centred care have become major care policy drivers by focussing discussions on the importance of promoting the independence and autonomy of older people, and encouraging greater user involvement in personal care planning, as well as policy development (Hanford et al., 1999; Nolan et al., 2003). For instance, the UK government’s white paper on reforming care and support sets out legislative aims to “prevent, postpone and minimise people’s need for formal care and support” and intends to enable people to be “in control of their own care and support, with personal budgets” (HM Government, 2012, p.3).

Following in the footsteps of the neighbouring domains of nursing and social work, since the turn of the 21st century a process of professionalization in the social care workforce has started to take place, albeit at a slower pace. This has entailed the setting of standards for workforce training and qualifications, the regulation of care practices and the accountability of the sector to a professional body. A number of government funded organisations were established to deliver and monitor this, key bodies including the Care Quality Commission, CQC; the General Social Care Council, which subsequently (in 2012) became part of the Health and Care Professions Council, HCPC; and the Social Care Institute for Excellence and Skills for Care.

A key part of the professionalization of the care workforce was the introduction of statutory training, and the strong emphasis on care workers acquiring career-related qualifications and specialist training in issues such as dementia and palliative care. The issue of improving the effectiveness and efficiency of training remains particularly challenging in the professionalization of the care workforce. Typically characterised by low investment (related to low financial return, and the low value attached to caring skills) there is, nevertheless, an on-going emphasis on improving the quality of workforce training in order to meet the escalating demand for better quality of care (CQC, 2012; DoH 2009; Wild 2010).

While workforce training is viewed as playing a pivotal role in the drive to professionalise the sector, it also suffers from the paucity of research undertaken on the care sector, in particular that which assesses the impact of this training on the quality of care (Meyer 2008; Wild et al., 2010). As Meyer notes, “the literature on education and training in care homes is sparse, fragmented and made up of small-scale studies, largely qualitative in nature” (2007, p.133). More recently too, questions have been raised about the quality and effectiveness of social care training and whether it is fit for purpose. Social care organisations are accused of offering “training as a panacea to all the ills of health and social care work,” without clear evidence that it actually changes the way care workers do their job (Kinessa, 2012).

The increased drive to improve the quality and regulation of care provision and to professionalise the workforce at the beginning of the 21st century was fuelled by a growing awareness of the exploitation and mistreatment taking place in care provision. This was exposed in a number of high-profile, serious investigations into incidents of abuse and

neglect in hospitals and care and nursing homes,² and was followed by a series of reports that aimed to highlight what was wrong in the care of older people and what care should look like.³ These reports concluded that failures in health and social care were overwhelmingly the result of too much focus being given to efficiency rather than quality of care. For instance, Robert Francis QC, chairperson of the Mid-Staffordshire review, one of the most prominent inquiries, stated that:

“Patients were routinely neglected by a Trust (organization) that was preoccupied with cost cutting, targets and processes, and which lost sight of its fundamental responsibility to provide safe care” (www.midstaffinquiry.com).

The key recommendations of the above-mentioned reports centred around providing patient-centred care, up-skilling the workforce to provide high quality professional training that included emphasis on installing compassionate values and practices, and developing strong leadership and management to support the development and maintenance of a caring workforce. In this way, the emphasis on professionalization has developed alongside the evolving discourse of person-centred care.

Part of the response from government bodies and other organisations to these extensive concerns about poor practice was the promotion of a compassionate working culture. Compassionate care became explicitly linked to an overall agenda in nursing care from 2007 (Adamson et al., 2012) with the publication of a briefing from the NHS

² The most well-known included the Francis inquiry into the Mid Staffordshire NHS Foundation Trust, 2005 — 2009; the inquiry into the Winterbourne View Hospital, 2012; The Health service ombudsman report on 10 investigations into NHS care of older people, 2011; and, The Equality and Human Rights Commission’s inquiry into older people and human rights in home care, 2011.

³ Among the most influential included: *Defending Dignity: At the heart of everything we do*, a Royal College of Nursing campaign in 2008; the Nursing & Midwifery Council’s *Guidance for the Care of Older People* (2009); *Patients Not Numbers, People Not Statistics* by the Patients Association (2009); *Counting the Cost: Caring for people with dementia on hospital wards* from the Alzheimer’s Society (2009); Age UK’s *Hungry to Be Heard* campaigns 2006–10; *Delivering dignity* report by the Commission for Dignity in Care, 2012.

Confederation (2008) which asked: "Has compassion in healthcare become the missing dimension of health care reforms: Is compassionate care fundamentally at odds with modern healthcare?" At the end of 2012, the DoH launched a three-year strategy — 'Compassion in Practice' — which sought to address some of the failures of care outlined in the above mentioned inquiries and to put into practice the various recommendations that arose from these reports. This strategy was developed in consultation with over 9000 nurses, midwives, care staff and patients and centred around six fundamental values (the 6Cs) and six areas of action to support professionals. The 6Cs include care, compassion, competence, communication, courage and commitment. The six areas of action involve: helping people to stay independent; working with people to provide a positive experience of care; delivering high quality care and measuring impact; building and strengthening leadership; ensuring we have the right staff, with the right skills in the right place; and, supporting staff experience (DoH, 2012, p.28).

While there is generally support for the ideal of creating a compassionate culture in health and care organisations, among the organisations themselves and the public alike, there are also some doubts about the capability of an increasingly privatised health and social care sector to be compatible with prioritising a compassionate caring culture ((Flynn & Mercer, 2013).⁴ Questions have also been raised about whether compassion has become the latest buzzword, which hides the complexity of achieving a much-needed change in working approaches (Nolan, 2012). However, in spite of the growing calls for compassionate care, "to date there is a lack of empirical studies which point to interventions and approaches which will enhance delivery" (Adamson, 2012).

⁴ For a full review of organisational and market-driven factors which compromise dignity and compassionate practices in the workplace see the body of work by Baille and collaborators (Baille & Gallagher, 2011; Baille, 2009; Baille et al., 2009).

Although best practice guidance has predominantly promoted person-centred care, it has recently started to incorporate a more *relationship-centred focus*. This reflects an appreciation that care provision, far from taking place autonomously, takes place within a rich matrix of interdependent relationships between the carer and client, as well as with the client's relatives and friends, and the carers' colleagues (Clarke 2002; McCormack 2001; Nolan et al., 2003). More than anything else, personal relationships in care homes influence perceptions of the quality of care, from the point of view of clients, their family members and care staff (Bowers, Fibich & Jacobson, 2001; Grau, Chandler & Saunders, 1995; Sandberg, Nolan & Lundh, 2002; Wilson, Davies & Nolan, 2009). In addition, relationships between staff, clients and their families and other care staff have also been shown to be key in determining staff job satisfaction (Moyle et al., 2003, Wilson, Davies & Nolan, 2009).

Supporting this conclusion, research conducted by Wilson and Davies (2009; Wilson, Davies & Nolan, 2009) in residential care homes, looked at the nature of relationships between staff, residents and their family members, the effects these had on the quality of care, and the contribution staff made to the development of these relationships. By differentiating three types of care-routine delivery, the researchers found that care staff's delivery of the care routine influenced the type of relationships that developed, and that this was also affected by input from clients and their families (Wilson & Davies, 2009). The individualised task-centred approach to care routines was to focus on the practicalities of 'getting the job done', sometimes at the expense of supporting staff motivation to develop personal relationships with residents. The resident-centred approach focused on finding out what matters to the resident and adapting the routine accordingly, and "supported the development of personal and responsive relationships" (Wilson & Davies, 2009, p.13). However, it lacked opportunities for residents to make active, reciprocal contributions to their home environment. The relationship-centred approach, in comparison,

focused on enabling residents, their families members and care staff to share in “the planning and organisation of care routines to take into account the needs of all” (p.14). Specifically, it entailed “developing shared understanding of how we all fit into the community, often entailing reciprocal relationship” (p.9). According to the researchers, the reciprocity involved in a relationship-centred approach to care “promotes mutual exchange in social relationships which creates a sense of belonging and recognises the contribution older people make to the social life of their community or residential setting” (Wilson, Davies & Nolan, p. 3). Moreover, this sense of reciprocity and belonging to a group contributes to care worker job satisfaction and motivation.

The relationship-centred approach to care, RCC, was initially developed in the USA by Tresolini and the Pew Fetzner Task Force (1994) in response to strong concerns that the healthcare system was failing to meet the needs of increasing numbers of patients because of its medical and individualistic approach. The approach was developed in order to reflect and harness the “importance of interactions amongst people as the foundations for any therapeutic or healing activity” (Tresoline et al., 1994, p.22). More specifically:

“RCC is founded upon 4 principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable. In RCC, relationships between patients and clinicians remain central, although the relationships of clinicians with themselves, with each other and with community are also emphasized” (Beach & Inui, 2006, p.42).

The principles of RCC underpin recent approaches adopted by the NHS and other independent health and social care settings to generate compassionate practice — for example, Schwartz Centre Rounds, the purpose of which is to facilitate a regularly scheduled time when healthcare providers at all levels are able to share and discuss social

and emotional issues that arise in caring for patients.⁵ The success of these Rounds is believed to be attributable to the way in which they enable and support practitioners to stay in touch with their feelings and emotions, which in turn transfers to positive, authentic caring relationships with patients, and their colleagues (Goodrich, 2012; Lowe, 2010). The emphasis on valuing people and their relationships was also evident in the title of the government's recent strategy for adult social care workforce in England, (2009) — 'Putting people first' — a declaration that was seen by the Minister of State for Care Services to "tap into the very essence of why so many dedicated, committed and talented people work in adult social care in the first place" (Hope 2009, p.4).

This historical overview of the context of care work illustrates a trend in social care provision that has shifted from focusing (almost entirely) on the efficiency of care provision to valuing the quality of care provided. This has been aligned with a change in the emphasis of care approaches from task-centred, to person-centred and, most recently, relationship-centred care. Care workers' experience of working in the changing context of care is, in turn, likely to be affected by the evolving social and professional discourses that surround care work. The next section looks at these discourses in more detail and at the way these reflect the values and meaning attached to care work.

The Social Context of Care

The social and professional discourses surrounding care work both reflect and generate trends in social care provision and influence peoples' experience of working in care (Gordon & Nelson, 2006; Himmelweit, 2007; Weicht, 2010). According to some, "care is a feeling, an identity, a commodity and a way of thinking" (Philips 2007; p.1): it is rooted in the heart of our being in relationships, as family, friends and communities. As

⁵ Schwartz Center Rounds were first adopted in the US, and recently spread out across the UK following a successful piloting of the scheme (www.schwarzcenter.org).

such it reflects strong social and cultural values, which in turn affect norms and behaviours. The experiences of everyone involved in care, whether they are the care-givers or receivers of care, feeds into and are fed by societal discourses on morality, ethics, ageing and disability (Wiecht, 2010). Socio-cultural and economic values attached to caring work are deeply entrenched in a highly gendered caring discourse (for detailed analysis, see Nelson & Gordon 2006; Nelson, 2012). This is exemplified in the observation that: “The paid work that women go into, is often an ill-paid version of the unpaid caring work they do at home” (Held, 2002; p.21). Socio-cultural discourses surrounding care are strewn with dichotomies that reflect inconsistencies between moral and material values and practices —as is evident, for example, in the distinctions between informal (unpaid) care and formal (paid for) care; but also distinctions between working out of love, for virtuous reward or for money, and between providing personalised or commoditised care (Bond 1992; Folbre & Nelson 2000; Himmelweit 1999; Nelson & Gordon 2006).

As with nursing, the discourse surrounding social care is viewed as being restricted by a ‘virtue script’ (Gordon & Nelson, 2006 p.1), which emphasises the altruistic motives and attributes of care workers and trivialises the skills entailed in performing their work (Adams & Nelson, 2009; Nelson & Gordon, 2006; Weicht, 2010). This pervasive ‘virtue script’ associated with nursing and care work is argued (a) to potentially “sentimentalise and “decomplexify” the skill and knowledge involved in nurses' (carers') interpersonal or relational work with patients (clients)” (Nelson & Gordon 2006, p.11), and; b) to juxtapose money with altruistic reward (Heyes, 2005; Nelson & Folbre 2006), which is seen to result in wages being inflicted with a ‘care penalty’ (England, Budig & Folbre, 2002). Indeed, England and colleagues examined the relative pay of occupations involving care and found that they receive “on average, lower hourly pay than we would predict them to have based on other characteristics of the jobs, their skills demands, and the qualification of those

holding the jobs” (England, Budig & Folbre, 2002, p 455). Reciprocally, “doing it for the money” is seen to be incompatible with the values of care. This socio-cultural dichotomy between receiving the virtuous reward of ‘love’ rather than the materialistic reward of ‘money’ pervades debates about care workers’ motivation. Indeed, this discourse has been accused of stalling the development of more holistic and accurate understandings of care workers’ motivation (Folbre, 2012; Palmer & Eveline, 2012; Nelson & Folbre, 2006).

The social discourse surrounding care itself affects the discourse surrounding the professionalization of this occupation. Studies carried out with nurses and care workers have found that both struggle to articulate the knowledge and skills entailed in their work, especially with regards to the important role of their relationship with their patients or clients to their professional practice (Adams & Nelson 2009; Atkinson & Lucas, 2012; Rytterstrom, Cedersund & Arman 2009; Ousey & Johnson, 2007; Woodward 1999; Weinberg 2006). For example, in her study of nurses during a hospital merger, Weinberg (2006) found that, in general, nurses were unable to describe their relationships with patients beyond a personal, virtuous rhetoric, which failed to account for the knowledge gathering and therapeutic role of these relationships. Likewise, from their interviews with 76 care workers in 18 different care establishments, Atkinson and Lucas (2012) found that the emphasis care workers placed on developing a relationship with clients was based “not on a series of instrumental tasks but on their role about knowing and understanding their clients and making a difference to their lives” (p. 11). This deficit of a professional language through which to describe the skills entailed in caring practices reflects a caring discourse, which emphasises the familial, intuitive nature of caring rather than the skills entailed in it (Himmelwait, 2007).

Through the process of professionalization and instilling best practice, efforts are being made to create a technical- (skills- and knowledge-) based language around caring

practices. For instance, seemingly mundane and simple activities entailed in personal care such as washing and dressing a person, or helping them to the bathroom, are starting to be recognised as offering important opportunities for gathering intimate ‘body knowledge’ (Adams & Nelson, 2009). Moreover, the effort and skill entailed in demonstrating and maintaining compassion in a working context is being increasingly acknowledged as ‘emotional labour’ (Hochschild, 1983). Nevertheless, as with nursing it seems that, as things stand, this technical language of relational, caring practices has still to be embedded within the day-to-day working discourse of adult social care workers (Atkinson & Lucas, 2012; Weinberg, 2006).

The Working Context of Care

Having looked at how the broader economic, social and professional contexts might affect care workers’ work experience, I now turn to focus on the specific contexts in which they work and on how this structures their behaviour and thinking. This is because the specific domains of care work further influence the values and attitudes attached this work, as well as the nature of the work and what motivates people to undertake it. Care work is unique among economic activities in that so much of it is performed by unpaid labour in domestic settings. This has strong implications for the value ascribed to it in social and economic discourse (Held, 2002; Himmelwait, 2007, p. 582). Although this thesis focuses on formal paid care work, it is useful to consider the nature of informal care because this shapes the discourse surrounding formal care.

Informal Care. Informal, unpaid and unregulated care is predominately carried out by women in private homes, where care is understood to be performed as part of a “natural disposition” linked to mothering and familial logic (Daly & Lewis, 2000; Held, 2002; Moss et al., 2006). The skills entailed in such care go (arguably, until very recently) unrecognized and unrewarded (Atkinson & Lucas, 2012; Bolton 2005; Himmelweit 2007; Nelson &

Gordon 2006). Caring is perceived as an intuitive, natural response, grounded in relationships, and viewed as an attribute rather than a skill. Moreover, people are seen to be motivated by a sense of duty and compassion (Atkinson & Lucas, 2012; Bolton, 2005; Palmer & Eveline, 2010). Within this domain, discourse suggests that any one — or at least any woman — can care.

Formal Care. Formal care, on the other hand, is paid and regulated. It takes place within occupational and organisational settings and those who deliver it, again primarily women, are understood to be motivated by money as well as compassion. It has traditionally demarcated personal and relational behaviour from professional and detached behaviour. Formal care is distinguished by its commodification of care into visiting slots and institutional schedules, and the regulation of care in health and safety procedures and best practice tasks and standards (Cunningham & James, 2009; General Social Care Council, 2010). In this formalised context, ‘good’ care has primarily been measured by the delivery of a tightly prescribed series of tasks (Atkinson & Lucas, 2012). Yet the skills, attributes and motives called upon in informal care are also practiced in formal care, and recently in the context of creating a compassionate workforce care workers have been explicitly requested to treat clients as if they were members of their own family (DoH, 2012, Dignity report, 2011).

Residential and domiciliary care Formal adult social care work is provided in three ways: in institutional settings such as residential and nursing homes; directly in people’s homes through domiciliary care service, and via personal care assistants employed on direct payment arrangements. This thesis focuses on the former two types of care work — residential and domiciliary care. In both domains, care work takes place in a familial working context that is reinforced through the working environment, the intimacy of the personal care, the typically long-term nature of the care, and the relationships that develop

through it. There are, however, key differences between the two domains. In residential care, care workers and clients alike are operating in a collective setting, with close-knit staff teams and groups of residents. In domiciliary work, care workers primarily work independently and are visitors in clients' homes. This difference in working environment affects the style and nature of the work, but also potentially has implications for the motivations of care workers. In particular, this is because it seems likely that different care workers are attracted to different working domains and that this tends to reflect their preferred working behaviour (being part of a close-knit team or working more independently), and their preference for working with people in their private homes versus being in more collective, institutional settings.

The care workforce, their clients and their work

The care workforce is primarily made up of women (82%), and is spread across all age groups. In the UK, British nationals make up the majority of this workforce (82%) but this varies significantly. For example, in large cities the proportion of Black and Minority Ethnic groups working in care is higher (Skills for Care, 2012). Of the 1.63 million people estimated to be employed in the social care workforce in 2012, 36% were residential care workers, 43% domiciliary care workers, 14% community workers, and 5% in day care work (State of the Social Care Sector Report, Skills for Care 2012, pp. 7-8). In the main, care workers are low skilled and poorly qualified (Boddy et al., 2006). Nevertheless, 7 in 10 care workers have completed statutory induction training and almost half of care workers are qualified to at least NVQ (National Vocational Qualification) Level 2 (Skills for Care, 2012, p.8).

Care involves considerable physical work, including the frequent lifting and moving of people. The adult social care workforce primarily provides care for the elderly and

people with physical and learning disabilities⁶ — work that involves supporting clients who are often physically and/ or mentally impaired or otherwise vulnerable. In many cases of home visits, care workers provide the only social interaction a client will receive all day. Delivering help in such circumstances could require feeding clients, dealing with soiled diapers and cleaning up when they are ill. Irrespective of the circumstances, carers need to calmly and reassuringly interact with their clients and to respond to them appropriately and in a caring manner whatever their mental state or mood, which could range anywhere from happiness to boredom to anxiety and anger.

On average, care workers' pay starts at, or just above the national minimum wage, and rises slowly with promotional status. A study undertaken by the Resolution Foundation think tank (2013) found that across the UK a large number of domiciliary care workers (estimated between 160,000 and 220,000 care workers) are not being paid the national hourly minimum wage. This is because they are not paid for their travel time between visiting clients, which is exacerbated by the fact that visiting time can be as little as 15 minute slots, before having to travel (most often drive) some distance to the next client, at a care worker's own time and expense (Pennycook, 2013). In addition, the much-maligned 15-minute care slots are rarely sufficient to provide adequate or even humane care, and care workers frequently report working longer than they are paid (UNISON, 2013; Leonard Disability, 2013). Care work is frequently made even more precarious by zero-hour contracts (i.e. no assurance of work), with over half (56%) of all domiciliary care workers

⁶ The terminology used to describe those cared for has varied over time and the appropriateness of specific terms is routinely debated (for further discussion about this see McLaughlin, 2009). Typically, those cared for are referred to as “residents”, “clients” or “service users”. Within the context of this Phd, the terminology used was guided by the language of the care workers we interviewed. In keeping with this, we predominately refer to those they cared for as “clients” but this used interchangeably with "service users", "residents" or, in health settings, "patients".

working between 2011-2012 found to be on zero-hour contracts (Bessa, Forde, Moore & Stuart, 2013).

Overview of the research undertaken on care workers' motivation

To date, the majority of research undertaken on care workers' motivation has looked at this from a human resources perspective and in terms of the factors that affect turnover and retention. What theoretical underpinning there is to this research tends to be in terms of the extent to which the work is seen to meet care workers' needs, and how the intrinsic qualities associated with care might compensate for the poor extrinsic incentives attached to it (i.e. pay and security). As already described, care work is physically, socially and emotionally demanding, and yet, as professed by the majority of care workers in research studies undertaken to date, it is largely perceived as rewarding and satisfying (Atkinson et al., 2009; Cameron & Moss, 2007; Lepore, 2008; Lucas & Atkinson, 2013; Skills for Care, 2007; Skills for Care, 2013). Speaking to this point, Skills for Care commissioned interviews with 502 care workers across the UK who were working in residential and domiciliary settings and found that 88% reported their work made them feel happy, while 83% stated that they would recommend the job to a friend because they found the work enjoyable — in particular because they enjoyed working with clients (Skills for Care, 2007, p.6).

These findings are consistent with findings from studies on the retention and turnover of staff in the UK (Lucas et al., 2009; Skills for Care, 2013) and the US (Bishop et al., 2008; Brannon & Berry, 2006; Pilomer & Meador, 2006). For instance, care staff interviewed by Lucas and colleagues (2009) reported “professional pride” and “making a difference” as the top reasons for doing their job (p.4), as indicated in the following statement by a Domiciliary care worker:

I think it's probably the only job I've ever done where I go home at the end of the day and I feel like I've really done something... You know the smallest thing that you might do for somebody and you know it totally makes their day. (cited in Lucas et al., 2009, p.5).

As noted previously, relationships with clients, other care staff, supervisors and managers have also been found to be important contributors to job satisfaction and wellbeing (Moyle et al, 2003; Parsons, 2003, Wilson, Davies & Nolan, 2009). In all previous studies, pay was not found to be a main factor that contributed to retention, nevertheless it was acknowledged to be an essential requirement for working. Typically pay was criticised for being low, after which care workers' discussions about their motivation typically turned to other factors (Lucas & Atkinson, 2009). However, the importance of pay should not be overlooked, as suggested by the following comment of a residential care provider in the private sector:

Pay is important as it's about professionalising care work. There are some homes who think you can pay people peanuts because they just like doing the job and they get a lot out of it. But your gas bill doesn't get paid just because you like doing a job so you have to pay people well. Also care work isn't easy and so people need to be recognised." (Skills for Care, 2013, p.25)

In a study undertaken by Skills for Care (2013), which compared human resource practices between high-retention organisations (HROs) to low-retention organisations (LROs), employers from HROs were slightly more likely to offer enhancements to basic pay than LROs. These enhancements included additional pay for working unsociable hours and bank holidays, and travel costs in the case of domiciliary care (Skills for Care, 2013 p.4). Other factors that related to improving working conditions of care workers, such as providing full or fixed term contracts, paid sickness leave, and pension contributions have also been found to be key to improving recruitment and retention (Lepore, 2008; Lucas & Atkinson, 2009). Furthermore practices that have been found to enhance retention, and thereby contribute to care workers' motivation, include open communication, staff

participation in decision making, good supervision and organisational support, opportunities for training and development, and the ring-marking of non-care-related contact time between care workers and service users (Care Sector Alliance Cumbria, 2007; Lucas et al., 2009; Lepore, 2008; Rubery et al., 2011; Skills for Care, 2013). These practices are related to whether an organization is seen both to value employees' contribution and to provide appropriate support to build and sustain their competence and motivation.

Other non-material or moral aspects of the work, such as working arrangements, have also been shown to affect care workers' motivation. For example, some have argued that "lone working and isolation [is] a real issue for (domiciliary) care workers and this is intensified by the reduction in supervisory staff, which also undermines the development of worker voice and representation" (Bessa et al., 2013, p.9). Indeed, the Skills for Care (2013) study concluded that:

Whilst there are some differences (e.g. low retainers appear slightly less likely to offer financial enhancements in addition to basic pay), it is much more about how practices are implemented and the relative importance of different aspects of leadership. The greater importance that high-retention managers attach to communication with and from their staff is of particular note (p.8).

Overall, researchers looking at the social care workforce have linked care workers' high levels of satisfaction and pride to the fulfilment of their moral values and feelings of worthiness (Cameron & Moss, 2007; Hall & Wreford, 2007; Hussein et al., 2010; Lepore, 2008). These virtuous rewards ostensibly compensate for the lack of material rewards, like pay and status. Yet it is also recognised that such a simplistic dichotomisation of care workers' motivations' — as being for money versus love — fails to capture or explain the reality of care workers' motivation; which is that they "take employment expecting it to be

consistent with their moral values *and* to satisfy their economic needs” (Lepore, 2008; p.165; Lucas & Atkinson, 2009).

The dichotomy between the virtuous reward of ‘love’ and materialistic reward of ‘money’ also magnifies the inconsistency between the social and economic values attached to care work. Portraying care workers as primarily motivated by “love” rather than “money” justifies and rationalises the low financial remuneration they receive, and the reluctance to recognise the professional and skilled nature of care work (Folbre, 2012; Lepore, 2008; Heyes, 2005; Himmelweit, 2007; Nelson & Gordon, 2006). Care workers’ explanations of their motivation also refer to this moral and material dichotomy. For example, in his studies looking at motivations surrounding long-term care work, Lepore (2008) found that care workers’ “employment motivations illustrate a process of reconciling material and moral values” (p.165). When interviewing care workers, he found numerous examples of care workers subordinating material motives for undertaking care work to moral connotations.

Finally, this dichotomy also falls far short of explaining the complexities of care workers’ motivation and therefore offers a limited and arguably unhelpful conceptual framework through which to develop and harness care workers’ motivation (Folbre, 2012; Hussein, 2010; Nelson & Gordon, 2006).

Summary

The rapidly ageing population means there is an unprecedented demand for quality adult care workers. Whilst at a macro level this demand has resulted in the care workforce being recognised as an important economic and social resource, this importance has yet to translate into the adult care workforce being professionally, economically and socially valued. This neglect is evident in (a) care workers’ low pay and precarious working conditions; the prioritisation of care efficiency over care quality, (b) the lack of professional

recognition of the skills and aptitudes required to provide quality care, and (c) the minimal research carried out on the care workforce. Nevertheless, recent investigations, and resultant concerns about the quality of care, have raised the profile of care and necessitated a change in policy to emphasise the need for a professional, compassionate, caring work-based culture. However, to date, there are only limited examples of this focus being put into systematic practice. The combination of low pay, low status, and taxing physical and emotional labour makes care workers' motivations to perform this role "very enigmatic" (Lepore, 2008; p.164). Furthermore, the research undertaken to date on the adult care workforce in general only offers a static snapshot of care workers' motivation, which, in the main, refers to the extent to which care work meets care workers' needs, and tends to defer to the simplistic dichotomy of being motivated out of love and/ or money. Nevertheless, increasing attention is being given to the role of relationship-centred care in simultaneously benefiting the quality of care provided to clients as well as the quality of care workers' work experience, and their capacity to be compassionate.

Given the complexities surrounding care workers' motivation, the meaningfulness attributed to their work, and its importance in terms of looking after an increasing proportion of the population, there is substantial impetus for research to take a holistic, dynamic approach to examining employees' motivation in this domain. A key factor that is likely to improve retention of care workers who provide a good quality of care, is a comprehensive understanding of their motivation — what makes them do it and why does it matter to them? In other words, a theoretically structured exploration is needed in order to better understand what factors energise people to work in care, what directs them to undertake certain behaviours associated with providing good quality care (for instance, being compassionate, hard-working and responsible), and what sustains them to keep providing good quality of care.

The purpose and structure of this thesis

In line with the foregoing discussion, and in an attempt to address the lacunae we have identified in the extant literature, the purpose of this thesis is to conduct an in-depth examination of care workers' motivation in order to provide a comprehensive understanding of what energises, directs and sustains their working behaviour and attitudes. The intention is that the development of such an understanding of care workers' motivation can be drawn upon to improve the retention of a caring, professional workforce.

Following on from this first chapter, which has provided an overview of the contemporary context of adult social care, Chapter 2 provides a review of the mainstream theories of work motivation and helping behaviour, and their applicability — or lack thereof — to care work. This chapter will specifically contrast mainstream individualistic/economic models of (care) worker motivation with more socially-informed models that see individual motivations as flowing from the socially-defined self. Specifically, we advance a perspective on carer motivation informed by the social identity approach (SIA; Haslam, 2004). This approach is outlined in more detail in Chapter 3, which looks at how collective social and cultural contexts are integrated into an individual's motivation. After this, the chapter reviews previous research that has applied the SIA to understand a wide variety of work-based behaviours, such as motivation, commitment, helping behaviour, communication, learning and professionalization.

Chapter 4 introduces the three empirical studies conducted as part of this thesis and explains how these in combination develop an empirical picture of care workers' motivation, and how these motivations and professional behaviour are shaped by work-based identities. Moving on to this empirical work, Chapter 5 presents the findings from Study 1, a qualitative study that investigates the contents and nature of care workers'

identities. This study establishes that care workers' experience of caring is primarily a shared one grounded in specific social identities. Chapter 6 presents the findings from Study 2, a longitudinal quantitative study that examines the relationship between what incentivises care workers (i.e., love versus money) and their wellbeing and job attachment. This study also considers the relationship between undertaking qualifications and increased motivation. Structural equation modelling shows that the extent to which incentives or training lead to increased motivation is mediated by social and relational identification. Chapter 7 presents the findings from Study 3, a quasi-experimental study that demonstrates how work-related learning and performance are facilitated by meaningful work-based identification.

Following the presentation of the empirical work, Chapter 8 recapitulates the main findings from the studies and discusses the practical and theoretical implications of the work. It also outlines a conceptual model through which organisations might gain an overview of the dynamics of care workers' identification. Chapter 9 concludes the thesis by looking at how research might be developed further and its potential contribution to the generation of a sustainable, motivated, caring workforce.

Chapter 2

Motivational theories: what motivates people to work (in care)?

Theories about work motivation seek to explain what makes people act or behave in particular ways at work. The majority of these theories originate from research with industrial and commercial organisations, and focus primarily on individualistic and economic motives. The impact of these theories is evident in the motivational approaches and practices commonly adopted by contemporary organisations, such as financial bonuses, personalised incentives and goal-setting. That research which has been done on the motivations of people who work in the not-for-profit, public service and helping professions, largely focuses on innate personality characteristics such as “public service motivation” (PSM; Perry, Hongeghem & Wise 2010). Moreover, this research has largely emphasised the role of intrinsic (internally driven) versus extrinsic (externally driven) motivators in explaining why people are motivated to do work for little or no pay (Deci & Ryan, 1999).

These various motivation theories generally assert that a person’s work motivations are (a) based on their calculation of the likely personal benefits or costs incurred or anticipated from the work activity and behaviour (economic and social exchange theories); (b) determined by innate, individualistic characteristics and attributes (individual difference approaches); (c) derived from an individual’s assessment of the extent to which work behaviours meet their personal needs (needs-based theories); and (d) shaped by the intrinsic or extrinsic quality of motivation (self-determination theory). Taken together, the underlying premise of these theories is that people are driven by self-interest, be it for

either money or love. In proposing this, such perspectives frequently overlook the complexities of how people's motivation is shaped by the dynamic interaction between the individual and the socio-cultural work context in which they operate. This is particularly pertinent for understanding the complexities of people's motivation to work in occupations that are paradoxically poorly paid and undervalued yet also constitute a vital economic and social resource. Undertaking work that is physically and emotionally demanding, yet nonetheless experienced as rewarding, exemplifies work in the care sector. This conundrum is further complicated by the fact that the central act entailed in such work — the act of caring — is one of the, if not the, most important social behaviours, and as such has powerful social and cultural connotations. In an attempt to gain a clearer picture of the relevance of motivational theories and practices to care work, this chapter reviews mainstream theories about work motivation along with a brief overview of the motivation literature, that surrounds two crucial elements of care workers' work experience: helping behaviour and the motivation to learn. Additionally this chapter critically considers the extent to which these perspectives contribute to an understanding of care workers' motivation.

Mainstream approaches to motivation

Motivation Theories Based on Economic and Social Exchange

Economic theories typically reduce work motivation to financial and material exchange. These are rooted in Frederick Taylor's principles of scientific management, also known as Taylorism. Taylor developed these principles with the aim of increasing productivity in the manufacturing industries by improving the efficiency of workers. His production efficiency methodology rejected workers as craftsmen and took away the autonomy associated with their work. Instead, Taylor proposed that workers should only perform one part in a production line in which the craft had been broken down into a series of unskilled,

simplified jobs. He believed that workers were motivated entirely by self-interest, and without incentives would engage in ‘soldiering’ behaviour and purposefully operate below their capacity (Kanigel, 1997). According to this logic, the implementation of a pay system that rewarded or penalised the individual against their measured outputs, should result in the highest levels of productivity. Taylor paid little attention to the contribution work could make to meeting workers’ other needs for growth and wellbeing, and famously asserted that “in the past the man has been first, in the future the system must be first” (Taylor, 1911, p.2). He also placed little value on the contribution of the group to productivity and motivation, asserting that “personal ambition always has been and will remain a more powerful incentive to exertion than a desire for the general welfare” (Taylor, 1911; p.95).

In spite of Taylor’s views being widely criticised as too mechanical, restrictive and cold (see, Dewey, 1996; Kanigel, 1997; Tompkins, 2005), “the principles of scientific management (are seen to) have been absorbed into the living tissue of American life” (Kanigan, 1997; p. 6), as well as elsewhere in the western world. Elements of this approach are clearly apparent in modern management systems — for example, in goal setting and financial bonus schemes (Bain, Watson, Mulvey et al., 2002). These practices are also equally evident in the care sector, for example, in the controversial, yet still widespread, commissioning by local authorities across the UK of 15-minute care slots for care workers to provide personal care in people’s homes (Leonard Cheshire Disability, 2013; Pennycook 2013). It is also apparent in the prioritisation of a rational and process-orientated view of health and social care improvement rather than one that encompasses the improvement of the relational aspects of care (Hessellink et al., 2013). Indeed this prevailing mindset was the target of the recent assertion by the Chief Executive of the UK’s Commission for the Quality of Care, David Behan, that in order to rise to the challenge of responding to the complex conditions created by an ageing population; health and care services would need to

deliver “care that is based on the person’s needs, not care that suits the way organisations work” (Launch of the State of the Care Workforce Report, 2012).

Economic perspectives on motivation have also been strongly influenced by social exchange theory, which views people’s behaviour to be an outcome of their subjective cost-benefit analysis of the particular social and economic situation and its comparison to reasonable alternatives (for a detailed review, see Cooke & Rice, 2003). Heralded as a macro-theoretical framework (Emerson, 1976), social exchange theory underpins many of the assumptions found in rational choice theory. It conceives individuals’ motivation in terms of their ‘utility function’ — a mathematical expression, typically employed by economists, that characterises what people care about (Akerloff & Kranton, 2010, p.9). The key principle inherent in social exchange theory is that workers are motivated tacticians who base decisions about how to act on "an appraisal of the personal meaning and implications of the rewards (and costs) associated with any behavioural strategy” (Haslam, 2004; p.65). This is also a principle from which many cognitive and behavioural psychological theories of motivation are based (Fiske & Taylor, 1991?).

Vroom’s expectancy theory (1964; further developed and tested by among others Lawler 1973; Naylor, Pritchard & Illgen, 1980; Porter & Lawler, 1968) was particularly influential in organisational research that sought to understand the process of how people are motivated. This approach asserts that the strength of people’s work motivation (motivational force) is directly related to their *expectancy* that their efforts will result in desired performance and outcome(s); their perception of the *instrumentality* of the outcome to result in increased rewards, and the perceived attractiveness, or *valence* of the outcome. Consistent with the basic economic perspective, people are seen to behave with a view to maximising their personal desired outcomes. More particularly, a person’s motivation is said to be guided by their calculation of the likelihood of an outcome occurring along with

the value they attribute to be attached this particular outcome, versus other comparable outcomes. For instance, people's motivation to undertake long-term care work has in part been explained by the lack of alternative opportunities available to poorly educated, frequently marginalised people, (i.e. the high proportion of women and immigrants in the long term care workforce). The virtuous nature of the work is also seen to make it preferable to other similarly accessible work, such as that to be found in a factory or shop (Lepore, 2008).

Equity theory is another influential theory developed within the social exchange paradigm that extended understanding of the social aspects of workers' motivation. Initially propounded by Adams in 1963, and further developed by, among others, Thibaut and Walker (1975) and Tyler (1989), equity theory proposes that people's motivation is affected by the extent to which they perceive the rewards and costs associated with effort to be equitable between individuals. Hence, people's motivation is affected by their desire to be seen as fair and to be treated fairly. Thus, instead of always maximising their own monetary reward, research has shown that employees tend to choose outcomes that look fair (Mowday, 1978). Motivational theories that prioritise a notion of people acting primarily in terms of their self-interest have been criticised for not fully incorporating the role of the social environment and cultural context in shaping workers' norms about fairness, and determining the values attached to their calculations of effort and reward (e.g., Akerlof & Kranton, 2010; Haslam, 2004). Moreover, social and economic exchange theories pay little attention to the effect of an individual's characteristics on their motivation.

Individual difference perspectives on motivation

In addition to focusing on the process and mechanics of people's motivation at work, organisational scholars and psychologists have focused on the nature of people's motivation and have viewed motivation to be determined by differences in individuals' attributes and

characteristics. These individual difference approaches to understanding work behaviour have strongly influenced organisational recruitment and retention practices. They view motivation as largely a product of people's personality: the extent to which they are likely to work hard, and what is likely to motivate them to do so, is seen as an innate characteristic of the person — something that can be measured, quantified and applied in recruitment decisions (Haslam, 2004; Pfeffer, 1998).

This particular theoretical approach to workplace motivation was instigated by Hugo Munsterberg, a keen proponent of Taylorism. Munsterberg (also considered the founder of industrial psychology; Hothersall, 1984), advocated a scientific approach to finding the “best possible man” to do the best possible work. To achieve this, he developed psychological tools that aided the selection of the most suitable personnel who had the best skills and aptitude to do the specific job in question. Influenced by Galton's (1869) psychometric system for measuring people's mental faculties, he is seen as responsible for initiating the various psychometric tests of employees' characteristics and suitability that continues to pervade modern recruitment and management practices (Clouser, 2007).

To this day, the influence of individual differences approach is witnessed in the widespread organisational use of psychometric tests in recruitment, and in feedback to employees and managers about individual effectiveness (e.g., as in the well-known Myers Briggs personality type indicator; Myers & Myers 1980, 1995; Maylett & Ribold, 2007) as well as “team player” characteristics (as in the Belbin model; Aritzeta, Swailes & Senior, 2007; Belbin, 1981; www.belbin.com). Yet, the theory that most influenced these various tests and models was McClelland's (1985, 1987) acquired needs model of motivation. This approach applies an individual differences perspective to more basic needs-based theories (outlined in more detail below), arguing that although everyone shares lower-level physical and security needs, work motivation operates at higher level of need, in particular the need

for achievement (nAch). Further, it is argued that this only develops in a sub-section of the population. Accordingly, by assessing people's characteristics, McClelland's motivational model ascertains the ways in which people are likely to be motivated: by achievement (nAch), by the need for power and authority (nPow), or/and the need for affiliation (nAff). The degree to which each characteristic is present in a person is thus seen to affect their behavioural style and motivation as workers, team players and managers.⁷

Although “profiling, or psychometric testing, is a well-established practice in most sectors, it remains virtually unheard of in social care — particularly for front line workers” (Mumford, 2013). Nevertheless, as part of the drive to increase the quality of care provision, there have recently been high-profile calls in the UK for health and social care workforce employers to undergo aptitude tests to assess their aptitude for caring and compassion (Francis QC, 2013). The core element of the individual differences approaches is that it perceives people's work motivation to be derived from their individual disposition to be suited to do a particular job. One example that is pertinent to the care sector is seen in attempts to understand people's work motivation as a reflection of their being more or less intuitively able to provide care (Adams & Nelson, 2009; Nelson & Gordon, 2006) and/ or being more or less pro-social.

Related to this, a body of work has examined public sector motivation (PSM; Perry, Hugreghemt & Wise 2010; Perry & Wise, 1991). PSM is seen as an innate characteristic that predisposes people to “act in the public domain for the purpose of doing good for others and society” (Le Grand, 2003; p.687) and to serve the interests of the community and human-kind as a whole (Perry et al., 2010). Researchers have found that people who are high in PSM are more likely (a) to work in public sector organisations than profit-making companies (Francois, 2000), (b) to move from jobs in the profit-making sector to the public

⁷ For more in-depth detail see McClelland et al., 1982; for a summary of its application see www.netmba.com/mgmt/ob/motivation/mcclelland/.

and voluntary sector (Georgellis, Isossa & Tabvuna, 2008) (c) to act in ways which are more associated with altruism and other-orientated motivation (Perry & Wise, 1999), and (c) to exert effort when working in organisations which serve the public and community (Francois, 2000). Furthermore researchers have drawn on PSM to explain motivation in terms of the person-environment fit model; that is, how congruent an individual is within a job or social unit (Bright, 2008).

Interestingly, however, findings from research undertaken with people who work in the public sector versus the private sector on the importance attached to pay and other extrinsic rewards are mixed. Public sector employees tend to attach similar levels of importance to pay and promotion opportunities as private sector employees do (Frank & Lewis, 2004; Vandenabeele et al., 2002). Nevertheless, intrinsic rewards are generally found to be more important to public sector employees than to private sector employees (Crewson, 1997; Wright, 2007), and are seen to “compensate for the limited availability of performance- related extrinsic rewards” (Wright, 2007; p. 60). It therefore appears that the effect of the reward is related to the meaning attached to it. This suggests that an understanding of what meaning and importance workers attach to their work (i.e. the content of their motivation) is vital to appreciating the possible influence of incentives — a point that we return to below in discussing in needs-based theories of motivation.

The individual differences approach in general, and psychometric testing in particular, has been criticized for specifying a fixed picture of the nature of people’s motivation based on a dubious construct on validity and measurement reliability. For instance, following a review of the data from 20 research studies using the Myers-Briggs Type Indicator test, the US National Academy of Sciences committee (1991) concluded that the test did not demonstrate adequate construct validity or reliability (a lack of consistency in measurements between times). Moreover, as Spillane (2007) argues “the

technical deficiencies of most personality tests have been known for many years. Yet they are conveniently ignored by those with vested interests in their continued use,” (p.13).

Other criticisms levelled at individual differences approaches more generally, are that it does not adequately explain what sustains or regulates people’s motivation, and does not account for the interaction of the situational context on the individual’s disposition (Furnham & Procter, 1989).

Needs-based perspectives on motivation

The reductionist approach to work motivation that was endorsed by Taylor’s principles of scientific management and Munsterberg’s individual differences paradigm was challenged by needs-based theorists, who asserted that people’s behaviour is instead motivated by the desire to satisfy multiple needs. In his seminal paper on a Theory of Human Motivation (1943) Maslow introduced his archetypal model of the ‘hierarchy of needs’ that presents needs as being ordered into levels, which range from basic animal needs for food, security and shelter, to social needs associated with love and belonging, and then to higher human needs related to self-esteem and self-actualisation. According to Maslow (1943), the most important motivator of people’s behaviour in any context is their lowest level of unsatisfied need. It is therefore unsatisfied rather than satisfied needs which motivate behaviour. Moreover, what is considered a satisfied need will vary from person to person. Accordingly, while financial needs should not be trivialized, in general once people are in receipt of a sufficient, regular income, the importance of pay is likely to be “as an indirect consequence of its capacity to satisfy other needs, like a need for respect and self-esteem” (Haslam, 2004; p.61). This contrasts with the expectancy and utility theories, outlined previously in this chapter, which characterise humans as motivated tacticians who are primarily driven by the desire to maximise reward and pleasure. Needs-based theorists adopt a more organismic theoretical approach to understanding motivation which espouses

a human's natural disposition towards growth and being an integral part of a greater whole (society, organisation etc.: Sheldon et al., 2003)

Several other influential needs-based motivation theories have evolved from Maslow's work and have (a) further differentiated categories of need; (b) shown the effects of meeting different categories of needs on the quality of motivation and (c) advocated enabling and supportive management practices in contrast to the restrictive, controlling management practices promoted by Taylor. Herzberg (1968), for example, contributed to a needs-based analysis of motivation by ascertaining when particular needs were more prevalent, and therefore more influential. His motivator-hygiene theory distinguished between the different factors that motivate people. He observed that when workers are dissatisfied, they perceive this to relate to the absence of hygiene factors (i.e. the meeting of their basic needs — work conditions, security and work relationships), but when they are satisfied they link this to motivator factors (personal satisfaction and achievement). Following this, he recommended that incentives to motivate workers should not be ones related to hygiene alone (e.g. pay), but also to job enrichment (Haslam 2004). Alderfer (1969, 1972) further differentiated between three categories of needs, existence, relatedness and growth (ERG) that were hierarchically ordered from existence at the lowest level, to growth at the highest level. His research showed that when higher-levels needs were not met, people would double their will in lower-order needs. This means that where growth needs are not being met people would invest more in relatedness, and/or where the need for relatedness are not being met people will invest more in financial and personal security.

McGregor's *XY theory of management* (1960; 1966) also challenged the prevailing Taylorist wisdom that workers were intrinsically unmotivated and needed to be coerced into working. Referring to the pessimistic view of workers as Theory X, McGregor argued that although this theory might hold true in a limited set of circumstances, workers'

motivation was in fact much better understood in terms of Theory Y, which held the exact opposite view. In keeping with Maslow's positive psychology, Theory Y held that expenditure of effort (i.e. motivation) is a natural behaviour and people are self-motivated to meet higher order needs associated with self-esteem and self-actualisation (McGregor, 1960; 1966). The two theoretical perspectives lend themselves to very different management approaches. Theory X supports an authoritarian management style, which relies on close supervision and systems of control, whereas managers who act in accordance with Theory Y should adopt a participatory management style and assume that their staff are self-motivated and self-directed, and work to support them to achieve their ambitions (Heil, Bennis & Stephens, 2000).

McGregor proposed — and a body of organisational evidence has since demonstrated — that managers acting in greater accordance with Theory Y receive greater commitment and motivation from their workers as well as generating a climate or culture of trust and innovation (Heil et al., 2000; Kopelman, Prottas & Falk, 2010). The value of the Theory Y management style is also promoted by self-determination theorists (outlined in more detail below) as facilitating peoples' basic psychological needs for growth and wellbeing. The popular transformational leadership approach that is increasingly adopted by public and private sector organisations can also be seen to have its roots in the Theory Y management approach advocated by McGregor. The success of transformational leadership is defined by the impact it has on organisational or group followers, in particular how leaders garner trust, respect, and admiration from their followers because they (a) encourage followers' creativity and competence; consider followers' needs, (b) act as a coach or mentor, (c) provide inspirational motivation through being visionary, and (d) deliver idealised influence through their embodiment of ideals and values (for more information see Bass & Avolio, 1994; Bass, 1998). Although often drawn on to provide

broad explanations of motivation (Hackman & Oldham 1976), needs accounts of motivation are criticised for being too vague, and not accounting for the cultural and social context (Hofstede 1984; Markus & Kitayama, 2003), nor addressing the complexities of the process by which particular needs come into play (Chell 1993; Haslam, 2004; Landy 1989).

Self determination theory (SDT) offers a more nuanced explanation of motivation which goes some way to considering the impact of the environment on peoples' motivation (Deci & Ryan, 2000). At its most basic level, SDT proposes a distinction between intrinsically motivated behaviour and extrinsically motivated behavior (Deci & Ryan 2000; 2002; 2008; Ryan & Deci 2000; Ryan, 2012). Building on findings from research into needs-based motivation, intrinsic motivation relates to higher-order needs for self-actualisation and growth, and “refers to doing something because it is inherently interesting or enjoyable”. Extrinsic motivation instead “refers to doing something because it leads to a separable outcome” (Ryan & Deci, 2000, p.57) and relates to meeting lower-order needs for security, belonging and self-esteem.

A large body of research conducted in the 1970s compared individual outcomes associated with intrinsically versus extrinsically motivated behaviour. Overall this research found that intrinsically motivated behaviour results in higher quality learning, performance and creativity, compared to that which results from extrinsically motivated behaviour (Deci, 1971). Furthermore, a key finding to emerge from this perspective is that extrinsic incentives can undermine intrinsically motivated behaviour and have a detrimental effect on learning, performance, and other behavioural and experiential outcomes (Deci 1971; Deci, Koestner, Ryan, 1999; Lepper & Greene, 1978; Lepper, Greene & Nisbett 1973). For example, Titmuss (1970) demonstrated that people were less inclined to donate blood when they were offered a monetary incentive for doing so (see also, Rapport & Maggs, 2002, Titmuss, Oakley & Ashton, 1997). Indeed, in their meta-analytic review of 128 experiments

examining the effects of extrinsic rewards on intrinsic motivation (1999), Deci and colleagues found that tangible rewards undermine intrinsic motivation. However, there were also circumstances in which extrinsic rewards had less detrimental effects, for example when rewards were unexpected, task non-contingent, and when they were administered with an informational rather than controlling style (Deci et al., 1999).

Building on this basic distinction, Deci and Ryan have developed a more general theory of individual motivation. In line with Maslow's thinking about people's innate predisposition towards self-actualisation, SDT argues that humans' natural disposition for psychological growth, integrity and wellbeing (i.e., intrinsically motivated behaviour) is dependent on the satisfaction of three basic psychological needs, for autonomy, competence and relatedness (Deci & Ryan, 2000). Specifically, Deci and Ryan (2000) summarise that:

“Social contexts and individual differences that support satisfaction of the basic needs facilitate natural growth processes including intrinsically motivated behaviour and integration of extrinsic motivations, whereas those that forestall autonomy, competence or relatedness are associated with poorer motivation, performance and wellbeing”. (p.227).

Self-determination theory proposes that the effects of extrinsic motivation on wellbeing and growth are related to the extent to which they are integrated into a person's sense of self. Behaviours that are internalised into the self are perceived and experienced as autonomous and self-determined, compared to those that are not, which are instead experienced as controlled and external to self. As Sheldon and colleagues (2003) point out, according to SDT “autonomy is conceptualised as the freedom to behave in accordance with one's sense of self” (p.366).

A central tenet underpinning SDT is the idea of the perceived locus of causality (PLOC), which explains how the varying effects of extrinsic motivation are dependent on the degree to which they are internalised (Gagne & Deci, 2005). Essentially, PLOC offers a

measurement of “the reason for one’s actions, and ranges along a continuum from internally motivated to externally motivated behaviour.” The greater the internality of PLOC, the more likely a person is “to exert greater effort and experience greater satisfaction in performing the behaviour than when they have a more external, E-PLOC” (Turban et al., 2007, p.2376). Thus SDT outlines a continuum of self-determination which ranges from amotivation, which is entirely controlled and wholly lacking in self-determination, to intrinsic motivation, which is entirely autonomous and self-determined. Along this continuum are four types of extrinsic motivation: two relate to controlled motivation, which take the form of externally regulated and introjection; and another two relate to autonomous motivation, which manifests itself through identification and integration. The prototypical example of extrinsic motivation is externally regulated behaviour, which involves acting with the intention of achieving a reward or avoiding a penalty. Introjection refers to behavioural regulation “which has been taken in by the person but not accepted as their own...such as contingent self-esteem” (Gagne & Deci, p. 334: “I work because it makes me feel like a worthy person”). In the case of ‘identification’, behaviour becomes autonomously extrinsically motivated and people identify with the value of behaviour for their personal goals and identities, where the cause of their behaviour reflects an aspect of themselves. Integrated motivation represents the fullest type of internalisation, with “integrated regulation, people have a full sense of that the behaviour is an integral part of who they are, and it emanates from their sense of self and is thus self-determined” (p.335).

Using this framework, Gagne and Deci (2005) illustrate how a nurse whose work behaviour is motivated by autonomous identified regulation is likely to “strongly value their patients' comfort and health and understand the importance of doing their share of unpleasant tasks for the patients' wellbeing”, whereas a nurse whose work behaviour is

motivated by integrated regulation would not only “identify with the importance of the activities for maintaining their patients’ comfort and health, but the regulation of the activities would be integrated with other aspects of their jobs and lives. Thus the profession of nurse would be more central to their identity” (p.335) and they could come to appreciate the importance of doing such unpleasant activities.

Work behaviour is likely to become more integrated to the extent the social or working context supports a person’s basic need growth. As such, SDT theorists posit that a work climate that promotes the fulfilment of individuals’ three basic psychological needs — for competence, autonomy and relatedness — is likely to enhance the quality of workers’ motivation and yield important work outcomes, including sustained behaviour change, effective performance, job satisfaction, positive work-related attitudes, organisational citizenship behaviours and psychological adjustment and wellbeing (Gagne & Deci, 2005; Sheldon et al., 2003). Nevertheless, it should be noted that the authors acknowledge this to be a supposition “based largely on laboratory experiments and field research in other domains” (Gagne & Deci, 2005 p. 337), rather than in specific organisational settings (Sheldon et al., 2003; Turban et al., 2007).

In addition to the effects of the social and work context in supporting (or thwarting) the satisfaction of people's need for autonomy, relatedness and competence; individual differences are also viewed to affect intrinsically motivated behaviour and the integration of extrinsic motivations (Deci & Ryan, 2000). Individual differences are seen as innate and viewed in terms of a person being more or less intrinsically or extrinsically value-orientated. For example, intrinsically held work value orientations of self-actualisation and self-expression are “associated with higher well-being because their pursuit facilitate the satisfaction of the basic psychological needs for autonomy, competence and relatedness” (Vansteenkiste et al., 2007; p. 253), whereas extrinsic work value orientations focus on

security and material acquisition, such as financial success, power and status. In these terms, adopting a greater extrinsic, or ‘having’, orientation is likely to diminish psychological health because it thwarts the satisfaction of basic psychological needs.

Likewise, SDT acknowledges that the effect of extrinsic incentives on intrinsic motivation depends on the extent to which the particular incentive has been internalised. The more internalised the incentive (i.e., the more a person perceives it to support their autonomy, relatedness and competence) the more likely it is to be intrinsically motivating. Thus Sheldon et al. (2003) argue that the ways in which money is valued and pursued will shape the specific effect it has on workers’ motivation. The process whereby an external incentive becomes more internalised is argued to depend on “intrapersonal factors, such as the person’s causality orientation, and contextual factors such as supervisor autonomy support” (Sheldon et al., 2003, p.364). Nevertheless there is little explanation as to how intrapersonal factors interplay with the external environmental factors.

SDT is popularly upheld as empirically disproving the conventional economic wisdom that financial incentives will result in better performance, a concept grounded in Taylorism yet still very active and pertinent in organisations today (particularly with reference to organisations that created the global financial crisis, 2008/9 (Ariely et al., 2009; Deci, 1972; Deci et al., 1999; Ryan 2012; Vansteenkiste, Neyrinck, Niemiec, et al., 2007). However, to better understand the role and impact of incentives, some economic theorists have drawn on psychological theories surrounding intrinsic motivation, including some of the propositions from SDT. The idea that monetary incentives crowd out intrinsic motivation to undertake an activity was considered a major anomaly by economists, who typically subscribe to the basic behavioural belief that higher incentives lead to more effort and higher performance (Gneezy, Meier & Rey-Biel, 2011). Yet a substantial body of research in economics as well as social psychology has corroborated the crowding-out

effect (Fehr & Gächter, 2002; Frey & Jegen, 2001) and has sought to identify the conditions whereby external incentives are beneficial rather than detrimental (for a detailed breakdown, see Gneezy et al., 2011). Partly, the explanation of this resides in social norms — that is, on how the individual frames the social nature of the situation (Akerlof & Kranton, 2010; Gneezy et al., 2011).

Self-determination theory offers a detailed explanation of the quality of people's motivation — that is, the extent to which it meets their needs for autonomy, competence and relatedness — and how this can be encouraged and developed or thwarted by external environmental factors. However, although it acknowledges the importance of these factors, it pays less theoretical attention to the *processes* through which features of the work environment and broader social context support (or thwart) people to meet these growth needs. “In summary although SDT provides some promising places to start, we believe that organisation researchers need to extend the theory by examining other factors that influence the extent to which workers develop internalised motivation” (Sheldon et al., 2003, p.385).

Furthermore SDT can be argued to fall short of fully accounting for the interplay between social, cultural and environmental factors in shaping the motivation of people who have different personal orientations towards intrinsic or extrinsic behaviour. Indeed SDT researchers have pointed to the need for future work to look at “how different aspects of the person–environment fit may play an important role in need satisfaction” (Greguras & Diefendorff, 2009; Kovjanic et al., 2012). As with other needs-based theories, SDT is criticised for underplaying the complexities of the cultural and social context in shaping the quality and content of peoples' motivation. A point that is particularly relevant to the limited research applying this perspective in different cultural as well as organisational settings. In common with the other motivation theories, outlined above, which are founded on a meta-theory of individualism (Ellemers & Haslam, 2004; Haslam, 2004; Pfeffer,

1997), SDT can also be seen to “downplay the contribution of groups to individual psychology” and as such runs the risk of being “...ill equipped for examination of the psychological processes that are at work in the broad class of organisational contexts where group membership is the primary determinant of individual behaviour (Haslam, 2004, p.224).

Collective perspectives on motivation

The motivational theories presented thus far are all premised on an individualistic perspective on motivation, in which the individual is seen as a distinct entity whose behaviour takes place within a separately defined working and social context. As Pfeffer (1988) notes: “Social psychology’s increasing emphasis on individual cognition on the one hand and personality on the other, with a de-emphasis on groups and social influence...has left a growing gulf between psychological research and organisational issues and problems (p.735). *Human relations theory* (Mayo, 1949) and cross-cultural perspectives on motivation (Markus & Kitayama, 1991; Geertz, 1973) offer interpretations of motivation that incorporate its collective nature. In contrast to Taylor and Munsterberg’s findings that improvement in performance were primarily linked to controlling individual worker’s efforts, human relations theory (HRT) understood the efforts of individuals to be related to their involvement in groups. Elton Mayo, the founder of the theory, conducted extensive studies, many of which were undertaken at the Hawthorne Works of the Electric Company in Chicago from 1927 — 1932, which showed the importance of groups in shaping the behaviour of individuals at work (Haslam, 2004). He asserted that worker’s performance was actually determined by their feeling a sense of relatedness and belonging to a social group. This, he argued, was more important than monetary incentives and good working conditions. Specifically, he outlined a tension between workers’ “logic of sentiment” and managers’ “logic of cost and efficiency”, a tension that could lead to organisational conflict

(Mayo, 1949). He further argued that managers must be aware of and support workers' 'social needs' to ensure that employees collaborated with the organisation rather than work against it (Wood, 2004). In this way, human relations theory was aligned with the work of interactionist and group dynamic theorists such as Lewin (1945, 1947), who (along with being a pioneer of Gestalt psychology that defined the group 'to be more than the sum of its individual parts'), famously equated behaviour as the function of a person in their environment (Sansone, Morf & Panter, 2003).

The influence of the human relations theory is evident in increasingly popular organisational practices of participatory decision-making and employee involvement in organisational leadership (Carson, Tesluk & Marrone, 2007; Heller, Pusic, Straus & Wilpert, 1998; Wegge et al., 2010); as well as in the recognition of the importance of cooperation and teamwork for innovation (West & Hirst, 2005). HRT is also particularly relevant to care work (a) because the working context is frequently considered to be similar to being part of a family group (residential care) or can entail feelings of working in isolation or independence (domiciliary care); and (b) due to the high value care workers attach to their relationships with clients and other carers. Indeed HRT also underlies the relationship-centred approach to care (outlined in the previous chapter) advocated under the current compassionate care agenda (Nolan et al., 2006).

However, while there is an increased focus in organisational psychology on the importance of relatedness and belonging to a person's motivation and wellbeing, in the main relatedness and belonging are viewed as being outcomes of the interaction between separate individuals (e.g. by the needs-based theories including SDT, and economic social exchange theories outlined above) rather than as the result of members working in a group or collective. Haslam (2004) credits HRT for "pointing to the capacity of group life to *transform* the behaviour and psychology of the individuals..." (p.13) and reasons that the

lack of attention given to it, is in part explained by the challenge it places to the dominant (western) ideology of individualism.

Given that the psychological approaches to motivation that we have discussed so far have been developed by researchers working in Western cultural settings, it is perhaps unsurprising that they are infused with an individualistic perspective on the nature of self and a person's self-concept (Hiebert, 2008; Markus & Kitayama 2003). For example, and as outlined above, these approaches typically explain motivation as being driven and sustained by meeting universal, individually-rooted needs and interests. Yet cross-cultural analysis of motivation has shed light on alternative interpretations of the self-concept as well as motivation, and illuminated some of the limitations of adopting an entirely individualistic perspective.

In their influential paper on 'Culture and the Self' Markus and Kitayama (1991) joined attempts by social anthropologists (among them, Geertz, 1981) to draw attention to the way in which people's motivation (along with other psychological processes) depends on the nature of the self, and that this self-concept is culturally and socially defined, embodied and acted on. Drawing on comparisons between American and Japanese cultures, Markus and Kitayama (1991) describe two broad (but not exhaustive) modes of being — an independent self-construal and an interdependent self-construal. An independent self-construal "requires construing oneself as an individual whose behaviour is organised and made meaningful by reference to one's own internal repertoire of thoughts, feelings and actions". Conversely an interdependent self-construal entails understanding oneself "as part of an encompassing social relationship and recognising that one's behaviour is determined, contingent on, and, to a large extent organised by what the actor perceives to be the thoughts, feelings and actions of others in the relationship" (Markus & Kitayama 1991, pp. 226-227). On the basis of this distinction they argue that the "motivational processes that

implicate the self, depend on the nature of the self-system” (p. 240). Gaining a context-specific understanding of the nature of self is also deemed important (yet recognized as under-researched) in self-determination theory (Chirkov, Ryan, Kim & Kaplan, 2003) where a central component of motivation, autonomy, is conceptualised as behaving in accordance with one’s sense of self (Sheldon et al., 2003).

The collective perspectives of motivation taken by HRT and cross-cultural analysis illustrate that a person’s sense of self is defined by the collective as well as individualistic contexts in which people operate, however they do not provide a psychological explanation as to how people’s self concepts are shaped in interaction with the social and relational environments. This we return to in the next chapter when we examine in detail the social and relational components of people’s motivation.

Motivation literature on key elements of care work: helping and training

Helping Behaviour

A central aspect of care work is that it involves activities and behaviour that are akin to helping behaviour. The desire to help people is frequently referred to by care workers to be a key motivator. In the main, social psychological research has focused on helping behaviour that occurs in interpersonal contexts (when people perceive and react to one another as individuals rather than members of groups; e.g., as care workers and clients). To this end helping behaviour research has focused primarily on individual dispositions, such as being more or less altruistic and demonstrating pro-social value orientation (e.g., public sector motivation, PSM; Perry & Wise, 1990), and individual decision-making processes. Primarily understood in terms of social exchange principles, helping behaviour is often viewed as the product of a cost–benefit analysis, for instance through reward seeking and punishment avoidance as well as desire to reduce aversive arousal (Eisenberg & Fabes,

1990; Hoffman, 1981). In this way, psychological theories typically assert that people's motivation to help is egoistic: people undertake helping behaviour to fulfil some direct or indirect personal benefit; be it in the form of an extrinsic reward such as material and social gains through reciprocation, or an intrinsic reward (e.g., personal gratification); or alternatively as punishment avoidance (e.g., the avoidance of guilt or the desire to reduce others distress in order to reduce personal unpleasant feelings). Thus the helper's ultimate goal is seen to be to improve (restore or preserve) their own welfare, and improving the other's welfare serves as an instrumental means to do so (Batson & Shaw, 1991).

In contrast to this individualistic, self-serving model of helping motivation, Batson and Shaw (1991) proposed the empathy-altruistic hypothesis, which considers the role of other-orientated emotional reactions in increasing the likelihood of altruistic behaviour. This perspective allows for the possibility that people often help others genuinely out of the goodness of their hearts rather than out of self-interest (Aronson et al., 2005). Specifically, "feeling empathy for [a] person in need evokes motivation to help [that person] in which these benefits to self are not the ultimate goal of helping; they are unintended consequences" (Batson & Shaw 1991, p. 114). Consistent with this idea, experiencing empathy in the context of helping someone with whom the individual has a special relationship, such as with friendship or family or even with a group (e.g., in terms of identification), has been shown to amplify altruistic motivations (Batson & Shaw, 1991; Dandio et al., 2006; Sturmer & Snyder, 2010). This is an important finding because motivation which is altruistic in nature — that is, directed towards the ultimate goal of relieving the others' need and not some self-benefit — has been found to provide a better quality of helping and to lead to improved helping outcomes (Sibicky, Schroeder & Dovidio, 1995; Sturmer & Snyder, 2010).

Although research on the motivation to undertake helping behaviour is largely undertaken in contexts in which people offer help to strangers, it does offer an insight into what might facilitate, motivate and sustain compassionate behaviour, in particular the role of empathy in self-other closeness. Given the working context of care workers' motivation, their drive to carry out helping activities can be interpreted as entirely egoistically motivated (i.e. for material compensation, a salary), the professional reward of doing the job well, and/ or to alleviate negative arousal (from soiled, wet beds, loneliness). Nevertheless, the above research around empathy-induced altruistic motivations suggests that feeling personal closeness (i.e. a sense of self-other relatedness), will affect the quality of help provided and the nature in which it is given (Sturmer & Snyder, 2010). This then also supports some of the reasoning that argues for the value of relationship-centred care (Nolan et al., 2003).

Motivation to Learn and Transfer Learning

The professionalization of the care work force depends to a large extent on the effectiveness of training. Motivations to learn and transfer training are seen as key factors that determine performance outcomes (Axtell et al., 1997; Colquitt, 2000; Noe, 1986). In keeping with the dominant motivational theories discussed above, research on the motivation to transfer has, in the main, drawn on individualistic, innate notions of motivation, such as those proposed within individual differences theories and social exchange theories (Aguinis & Kraigher, 2009; Gegenfurtner et al., 2009, Simosi, 2012). More recent research has shown that both individual-level characteristics (e.g., locus of control, cognitive ability, self-efficacy) and situational characteristics (organisational culture and context) play a powerful role in determining whether training is transferred to the workplace (Egan et al., 2004; Grant, 2000; Holton et al., 2003). In particular, increased attention has been given to the work-based training transfer climate (Pike, 2012) and the

key features within it (such as the opportunity to perform, feedback and support), which have been found to facilitate the implementation of learning on the job (Ford et al., 1992; Kontoghiorghes, 2003).

There are, however, widespread calls amongst training researchers for a theoretical framework which accounts for the inter-relationships between individual trainees and the environmental, situational characteristics of the organisation which together promote the transfer of training onto the job (Aguinuis & Kraiger, 2009; Korte, 2007; Pidd, 2004; Simosi, 2012). Thus, it appears that when it comes to explaining the process by which individuals and the environmental context affect motivation there is a theoretical gap in research on training motivation as well as in the broader construal of motivation.

The Applicability of Motivational Theories to Care Workers' Motivation

As discussed in Chapter 1, the poor pay and low status of care work confound traditional economic theories that premise workers' motivation on self-interest — that is, on the desire to make money or gain personal prestige. In accordance with social exchange theories, the virtuous rewards associated with working in care are ostensibly viewed to make up for deficits in material gain (Lepore, 2007). Drawing on theories of intrinsic and extrinsic motivation, such rewards are linked to intrinsic motivation, and the associated benefits of this for wellbeing are cited as explaining care workers' high levels of work satisfaction. Moreover, evidence of extrinsic rewards undermining intrinsic behaviour serves to justify keeping pay low. What is more, popular conceptions of care workers' motivation for performing care — that is, for intrinsic 'love' or extrinsic 'money' — are readily linked with the quality of care provided. The deeply embedded socio-cultural discourse surrounding care workers' motivation is that high-quality care workers are driven by the virtuous satisfaction they receive from their work, whereas doing it for the money is

indicative of providing poor quality of care (England, 2005; Folbre, 2012; Folbre & Nelson, 2000; Heyes, 2005; Himmelweit, 2007; Knijn & Verhagen, 2007; Weicht 2010). Indeed “(t)he question of whether pay threatens the quality of care underpins the now well traversed ‘for love or money’ debate” (Palmer & Eveline, 2012, p.258).

In his controversial article on “The Economics of Vocation or ‘Why is a badly paid nurse a good nurse?’” economist Heyes draws on a compensatory wage differential analysis and the value attached to intrinsic motivation to argue that: “Other things being equal, a lowly paid nurse is more likely to have a vocation, and so over-perform in his role, than a highly paid one”. He goes on to suggest that this is in keeping with general social intuition that “a higher wage may attract the ‘wrong sort’ of person” (Heyes, 2005, p.568). Despite being strongly rebuffed, in particular by feminist economists (Adams & Nelson, 2009; Himmelweit, 2007; Nelson & Folbre, 2006; Palmer & Eveline, 2012), the article reflects a deeply entrenched socio-cultural belief that the selflessness engendered in caring is incompatible with materialistic gain. Palmer and Eveline (2012) argue that a socio-cultural valuation is upheld and perpetuated by aged care employers (in Australia) to justify keeping wages low (as it is compensated by emotional reward) and legitimise the high quality of the care (which must be intrinsically motivated). In this way, such theory sustains the ideology that low monetary reward ensures high quality care.

This virtuous versus materialistic notion of care workers’ motivation can be seen to have created a cul-de-sac, which prevents a more accurate, and hence useful, understanding of care workers’ motivation. Rather than regard the cultural and social context of care as an additional factor that affects workers’ motivation, as premised in individualistic theories of motivation reviewed above, an alternative approach would be to start by understanding the socially and culturally embedded nature and content of the self-concept that is tied up with being a care worker. This would then allow for an analysis of care workers’ behaviour

which takes into account the multi-faceted nature of care work—including the moral, material, profession, environmental and social components that affect their motivation (Atkinson & Lucas, 2012; Lepore, 2008; Lucas, Atkinson & Godden 2009; Nelson & Folbre, 2006). For instance, as Lepore (2008) argues, care workers' motivation is bound up in a sense of self that is grounded in socio-cultural values of morality and materialism. Indeed, recognising the inconsistency of these values (doing a worthy thing helping people and yet being unworthy of receiving material reward and recognition), helps to explain the challenges associated with recruiting and retaining a high-quality caring workforce.

Summary

In general, “theory and research in work motivation have focused mainly on the individual needs people may have, their own independent goals and expectations, or the personal outcomes they find rewarding.” (Ellemers et al., 2004, p.459). Human relations theory and the social and cultural approach argue that this individualistic slant on understanding motivation is insufficient when it comes to understanding the motivation of people with dynamic and collective as well as personal and stable self-concepts. Arguably too, research on the motivation and retention of care workers has been restrained by these individualistic perspectives that primarily view motivation to be driven by self-interest, be it in the form of meeting basic needs for security and relatedness or higher needs for self validation and worth. The omission of a social and relational theoretical perspective of motivation is starkly apparent given the prominence of the social and relational context of care work. The importance of belonging and the psychological implications of this are probably nowhere more apparent and meaningful than in the context of caring and the motivation to undertake care work. Not only does belonging affect the wellbeing of service users, through the quality of care provided, it also affects the wellbeing of care workers and the sense-making—that is, the meaning and value—attributed to care work. A holistic

explanation of the motivation of care workers (and arguably other workers) therefore needs to take account of the collective, relational and personal contexts in which they operate and of the way in which these relate to a person's psychology and self-concept. Speaking to this, the next chapter therefore presents a theoretical perspective which accounts for the socially-structured nature of motivation.

Chapter 3

The collective and relational aspects of care workers' motivation

“Care is fundamental to our individual identity as this is played out in our social interactions and relationships”. (Philips 2007, p.1)

As discussed in the previous chapter, the vast swathe of mainstream motivation theories prioritises a notion of the individual as a separate, stable entity who is primarily self-serving. However, as expressed in the above quote, the act of caring is an integral element of ourselves as social and relational beings. The enactment of caring, with its associated affects and behaviours, is deemed an essential yet neglected component of providing a quality care service. As will be recalled from Chapter 1, the quality of care provision is viewed — by clients, carers, scholars and policy makers alike — to depend on the quality of relationships in care contexts. Therefore, in order to fully understand the motivation of people who provide care it makes sense to consider motivation in terms of how it is generated and maintained by the collective and relational self as well as by the personal self.

In line with broader psychological theories, motivational theories have primarily viewed groups as settings within which individual behaviour takes place, and little attention is paid to the ways in which groups actively shape and determine the cognitive processes of individuals (Haslam, 2004; Reicher & Hopkins 2011). Yet it is evident that individuals are defined and changed by the groups to which they belong, be they groups at a broad collective level of cultural and societal categories (nation, religion, class, tribe; Markus & Kitayama, 1991) or a more localised level, such as work-based groups (i.e. organisations, occupations and teams; Ashforth & Mael, 1989; Mayo 1949) or community groups and

families (Lewin, 1947; Sherif, 1954). As Brewer & Gardner (1996) assert, “individuals seek to define themselves in terms of their relationships with others and with larger collectives and derive much of their self-evaluation from such social identities” (p.83). The predominant body of research into how people's self concepts are shaped by the collective contexts in which they operate has developed out of social identity theory (Tajfel et al., 1978) and self-categorisation theory (Turner et al., 1987).

The seminal minimal group studies undertaken by Tajfel and colleagues in the early 1970s (Tajfel 1970; Tajfel, Billig, Bundy & Flament, 1971) demonstrated that the mere act of being arbitrarily categorised as a group member was sufficient to produce behaviour that favoured the in-group (and discriminated against the perceived out-group; Brewer, 1979; Tajfel 1978; Turner et al., 1987). These studies paved the way to the development of *social identity theory* (SIT: Tajfel 1978, 1979; Tajfel & Turner, 1979) and *self-categorisation theory* (SCT: Turner 1985, 1985; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), which sought to define and explain how people's individual self-concept is socially constructed in dynamic interaction with any given situation. Incorporating both SIT and SCT, the *social identity approach* (SIA) looks at the processes that surround “the interdependence of individual cognition and a social context with structural, comparative and normative dimensions” (Haslam, 2004, p.38). The SIA understands the self-concept to be an organic entity integrated within the socio-cultural environment in which it operates, rather than universally determined or fixed (Hopkins & Reicher, 2011; Markus & Kitayama, 1991). In understanding the self-concept to be collectively structured as well as personal, the SIA argues that socio-cultural and psychological elements are structured by each other, asserting that “social groups exist in, as and across organisations and... [explaining how] ... such groups fundamentally transform the psychology of the individual” (Haslam, 2004, p.224),

In their article on motivating individuals and groups at work, Ellemers and colleagues (2004) focus attention on how people are motivated to act at a collective level and apply the SIA to understanding this question. Rather than perceiving workplace motivation as the result of an exchange relationship between the individual and the group, or reflecting the interdependence of individuals, they see this to be a function of the collective identities that individuals integrate within their self-concept. Specifically, they argue that “self-conception in collective terms *energises* people to exert themselves on behalf of the group, facilitates the *direction* of effort toward collective (instead of individual) outcomes and helps workers *sustain* their loyalty to the team or organisation through times when this is not individually rewarding” (Ellemers et al., 2004, p.461).

In this chapter I draw on this broad analysis, to outline how the social identity approach (Haslam, 2004) in conjunction with organisational identity research (Ashforth et al., 2008; Riketta, 2005; Sluss & Ashforth, 2007) and a narrative approach to identity formation (Brown, 2006; Ibarra, 1999; Pratt, 2006) can offer a dynamic, multi-dimensional theoretical framework through which to understand and harness care workers' motivation. I do this, first, by explaining the integration of social, relational and personal identities in a person's self-concept, and; second, by examining the self-categorisation process. Third, I focus on identification in the workplace, in particular the effects of organisational identification on work outcomes, and the generalisation between different foci of identification (i.e., work groups and role relationships). Thereafter I look at the process of identity construction, and introduce Ashforth et al.'s (2008) model, which outlines an interplay of top-down and bottom-up processes which give sense to, and make sense of, a new or adapted identity. I then go on to present the ASPIRe model (Haslam, 2003), as an example of an organisational mechanism for actualising social and personal identity

resources. Finally, I look at the relevance of the SIA to understanding care workers' motivation and the value it adds as an alternative approach to conceptualising motivation.

The self-concept as defined by social, relational and personal identities

In keeping with Maslow's philosophy of humans' need for self-actualisation, the social identity approach (SIA), argues that (a) motivation in the workplace derives from employees' desire to enhance the self, *but* that (b) the self can be defined in different ways and at different levels of abstraction (Turner, 1985). Underpinning the SIA and identity theory is the notion that an individual's self-concept derives from a collective sense of self (social identity) as well as a personal sense of self (personal identity; McGuire & McGuire, 1988; Ontario & Turner, 2004). Personal identity refers to 'me' versus 'not me' distinctions and consists of the individual's knowledge of their own unique attributes and characteristics. In contrast, social identity refers to 'us' versus 'them' comparisons and consists of the shared attributes and characteristics that are associated with belonging to any given psychological group, along with "value and emotional significance attached to that membership" (Tajfel, 1978, p.63). In other words, social identity gives meaning to people's sense of who they are *socially*, and shapes how they perceive the world about them, be it as father, British, care worker, football supporter" (Turner, 1982).

Advocates of the SIA propose that "shared social identification can be seen as the basis for all forms of social interaction between people" (Haslam et al., 2012, p.206).

Indeed, Tajfel (1978) argued that:

"It is impossible to imagine a social encounter between two people which will not be affected, at least to some minimal degree, by their assignments of one another to a variety of social categories about which some general expectations concerning their characteristics and behaviour exist in the mind of the interactants. ...This will

... be even more true of professional 'role' encounters, as between patient and doctor, student and teacher, car owner and mechanic, however familiar those people may have become and however close their personal relationships may happen to be". (p.41)

Once a person categorises (or identifies) themselves in terms of a psychological group membership, as 'we' rather than 'I', they perceive a sense of "oneness with or belongingness to some human aggregate" (Ashforth & Mael, 1989, p.21). Consequently they will (a) "seek to achieve positive self-esteem by positively differentiating their in-group from a comparison out-group on some valued dimension" (Haslam, 2004, p.21) and, (b) will behave in a way which is representative of, and advances the group (Ashforth & Mael, 1989; Oakes & Turner, 1980; Spears, Doosje & Ellemers, 1997; Turner et al., 1987). This can equally be seen to occur at a personal and relational level (Ashforth et al., 2008; Brewer & Gardner, 1997; Sluss & Ashforth, 2007). That is, when these alternative bases of identity are salient, people are equally motivated to achieve positive distinctiveness and to behave in ways that are consistent with and advance their understanding of who they are, however the target of these comparisons, self-validations, and self-actualisations are made at a different level of abstraction (i.e., in comparison to other individuals or other social relationships).

To illustrate more fully: a care worker who identifies with his or her work organisation will seek to perceive their organisation as comparatively better than other organisations (e.g., because it cares more, pays more, or offers more training) and will be motivated to behave in a way which is aligned with and supportive of the values and norms of the organisation. Equally a care worker who identifies with their relationship with their supervisor will seek to compare this relational self favourably to other relationships (be it as more authentic, empowering, or supportive, etc.), will be motivated to sustain and enhance

the positivity of this relationship, and will behave in ways that are aligned with the norms and values acted out in the relationship. Finally, a care worker whose personal identity is salient will seek to perceive themselves as comparatively better than other individuals (be this in terms of intelligence, wealth, happiness, status, etc.) and will behave in a way that enhances the positivity of the individualistic self. Thus, the extent to which something is responded to as motivating (i.e., as an incentive or a disincentive) will depend on the norms, values and behaviours associated with a person's prevailing sense of self and identity (Ellemers et al., 2004; Morton et al., 2012).

The social identity approach acknowledges that a person simultaneously has multiple identities that are defined at different levels of abstraction. According to self-categorisation theory, higher levels of self-categorisation are more inclusive of other people — for example, seeing the self (and others) in terms of the super-ordinate *human* category or in terms of broad *social* categories (like, women vs. men; academics vs. practitioners, nurses vs. care workers). Conversely, lower-level self-categorisations are more exclusive of other people — for example, viewing the self at the *relational* level (e.g. trainer vs. trainee; supervisor vs. supervisee) or the *personal* level (as a unique individual, e.g., Berty, Saori...). Lower-level self-categorisations “can be subsumed within higher ones and are defined in relation to comparisons made at that higher level” (Haslam 2004, p.30). For example, when attending a multi-disciplinary care meeting, Saori might define herself in terms of a variety of self-categorisations ranging from the more to less abstract: as a representative of her organisation, a senior care worker, a friend of the client, and as Saori. The more inclusive categories, or distal identities, provide the backdrop from which others understand who Saori is, be it woman, care professional, organisational employee. In comparison, more exclusive categories, or localised identities (e.g., as a team member, family, colleague or friend), tend to have greater meaningfulness to the individual and

greater influence on their behaviour (Haslam et al., 1996; Oakes et al., 1991; Sluss et al., 2012).

Self-categorisation theory further elaborates the cognitive process whereby “the relative degree to which [a person] sees each of their different identities as self-descriptive in a particular situation or at a given point in time...determine[s] the extent to which these identities affect a [person’s] motivational behaviour in that context” (Ellemers et al., 2004, p.463). SCT predicts that an identity is likely to be more or less salient to the extent that (a) the identity or category ‘fits’ the situation because it is comparatively and normatively appropriate, and (b) the identity is accessible, because it is habitually triggered or because the individual routinely engages it to make sense of their self or their social world (Haslam et al., 1999; Turner, 1985; Turner et al., 1987). For example, Harry’s identification as a care worker is likely to be stronger when he is with people working along side other occupations rather than when he is at a football match (comparative fit), and when he perceives working in care to be aligned with his expectations (normative fit). Moreover, he is likely to experience a stronger sense of care worker identity if he frequently uses this occupation to provide meaning to his life (accessibility).

The accessibility of an identity is defined by the extent to which a person experiences a “relatively enduring identification with a group or organisation (that is, their pre-existing readiness to use a social category to define themselves” (Haslam, 2004, p.272). Researchers have examined the short and long term nature of collective identification and the implications it has on people’s self-concept. Traditional SIT/SCT research has been criticised for focusing on situational, temporary identification (Mayhew, 2007). Ashforth and colleagues (2008) propose that it is important to differentiate between situated versus deep-rooted identification, because the latter “more fully implicates the self in the experience of organisational life” (p.332). For instance, the extent to which identity cues

(such as uniforms, logos, national flags) prime situational identity and the degree to which they invoke more 'deep-rooted' identification is likely to effect a person's behaviour and self-esteem. The more deeply-entrenched or easily accessed the identity, the greater the influence of it on behavioural sense-making and motivation. This is further substantiated by Sani and colleagues (2007) work on the importance of perceived collective continuity (PCC) in predicting a person's social wellbeing (Sani, Bowe, Herrera et al., 2007). In a series of studies (Sani et al., 2007, 2008) the researchers found that PCC consists of two dimensions, the perception that core beliefs, values, mentalities and traditions are transgenerationally transmitted within the group and events in group history are coherently linked together in a collective narrative. This is evident in Millward's research on the change in content of nurses professional identities, Millward identified two patterns of identity orientation, the more common and traditional 'patient-centred' orientation and more modern 'professional distinctiveness' orientation that was more frequently indicated by higher status and newer nurses. However, both orientations centred their identity around core values, beliefs and mentalities about caring for others that have endured over time and drew on historical collective narratives to validate their collective continuity (Millward, 1995). Although the SIA explicates the dynamic and multi-dimensional nature of peoples' self-concept, it can be viewed to incorporate the influence of deep rooted and enduring collective identification in a person's readiness to define their self in terms of a particular personal, relational or social identity (Haslam, 2004; Meyer et al., 2006; Van Dick, 2001).

This brief explanation of the social identity approach (for further detail see Haslam, 2004; Tajfel, 1982; Turner et al., 1994; Van Knippenburg, 2000) sketches out the way in which it provides an interpretation of motivation that incorporates the individual's experience, needs and interests with that of the groups or relationships in which it operates. It indicates how a person's self-concept (as well as self-esteem, self-actualisation etc.) is

shaped not only by their personal, individual-level identity but also by their collective and relational identities. Moreover, it provides an explanation (through self-categorisation) of the process whereby particular identities are made more or less salient in any given context and thereby become more or less influential. The implications of identification for work motivation and behaviour are discussed in more detail below, along with an account of how social and relational identification develop in organisational and work settings.

Work-based social and relational identification

Since Ashforth & Mael's (1989) seminal article introducing the social identity concept to the organisational literature, organizational identification has become increasingly recognized across a wide range of disciplines as critically underpinning organizational and occupational life, not only within psychology, but also in economics (Akerlof & Kranton, 2011), and management (Cornellissen, Haslam & Balmer, 2007). Consistent with the broader theory, the social identity analysis of organisational and work life has focused on (a) the extent to which workers' identification with the organization as a whole is related to positive work outcomes (Ashforth & Mael, 1989; Mattieu & Zajac, 1990; Morrow, 1993; Ricketta, 2005), (b) the effects of identification with groups that are situated *within* the organizational or occupational structure, (e.g., the team, location, organization and occupation: Barbuto & Story 2011), and (c) the degree to which identification with different groups and role relationships at work predicts organizational identification (Brewer 1995, Ellemers et al., 2004; Reade, 2001; van Knippenberg et al. 2003; Sluss & Ashforth, 2007; Sluss et al., 2012).

A broad body of research has shown that the more a person identifies with the organisation and other work-based groups the more inclined they will be to enact and support the norms and values of the organisation and more localised subgroups, even if this

is detrimental to personal wellbeing (e.g., because it leads to stress and burnout: Haslam, Ryan, Postmes et al., 2006). By focusing attention on the influence of the collective self, in addition to the personal self, the social identity approach has provided novel insights into a range of topics that are central to organisational life (Ashforth & Mael 1989; Haslam 2004). These include motivation and performance (Ellemers et al., 2004; Hewapathirana 2012; Riketta & Nienaber, 2007; Van Knippenberg, 2000), communication (Bartel et al., 2007, Morton et al., 2012; Tanis & Beukeboom, 2011), learning and knowledge transfer (Child & Rodrigues 1996; Haslam et al., 2009; Kane, 2010; Korte, 2007; Pidd, 2004; Wright et al., 2011), leadership (Haslam et al., 2011) and newcomer socialisation (Ashforth, Sluss & Saks, 2007; Korte, 2009; Smith et al., 2012; Sluss et al., 2012). Research has also shown that organisational identification is related to a broad range of work-related attitudes and behaviours such as job satisfaction, job motivation, job performance, turnover intentions, or absenteeism (Ellemers, De Gilder & Haslam, 2004; Haslam, 2004; Haslam, Ryan, Postmes et al., 2006; Riketta & Van Dick, 2004; Tyler & Blader, 2000; Van Knippenburg, 2000). Additionally, and of particular relevance to care work, social identity research on helping behaviour has demonstrated that the nature and quality of help that is provided (and experienced) in a given context is contingent of there being a perceived sense of shared social identity between the helper and person helped (Leeuwen & Tauber, 2010; Levine et al., 2002, 2005; Sturmer & Snyder, 2010).

However research undertaken by, among others, Riketta and colleagues, has drawn attention to some of the complexities of organisational identity. For example, their work has highlighted how relations between organisation identification and work outcomes, although significant, are “also often disappointingly low” (Riketta & Van Dick, 2004, p.492; Riketta, 2002). To address this, the authors compared employee identification and commitment to a more localised target, the team, and conducted, a meta-analytical comparison of the

strength and correlates of workgroup versus organisational identification and commitment. Overall they found that employees indicate greater identification with their workgroup than with the organisation as a whole; and “that workgroups (1) are the more salient social unit, (2) serve employees' needs for optimal distinctiveness, and (3) are the more important instances for socialization and control” (Riketta & Van Dick, 2004, p.504). They went on to argue that “the focus of attachment merits a central role in attempts to explain difference in work-related attitudes and behaviours” (Riketta & Van Dick, 2004, p.505).

In line with this point, overall it has been found that employees identify simultaneously with different foci at work, for example, with customers or service users, supervisors, occupations, work groups and the organisation (Ashforth & Johnson, 2001; Becker, 1992; Ellemers, 2001; Haslam, Eggin & Reynolds, 2003; Johnson & Ashforth, 2008; Riketta & Nienaber, 2007). Moreover, the effects of this multiple identification on job satisfaction, motivation, performance, turnover intentions and wellbeing have been found to be related to the extent to which these identities are aligned and experienced as congruent (Ahearne, Haumann, Krauss & Wieske, 2013; Riketta & Nienaber 2007; Sluss, Ployhart, Cobb & Ashforth, 2012).

This discovery has led to a recent upsurge in research that examines the extent to which individual, relational and group identities converge or are nested within broader organization identity (Ashforth, Kulik, & Tomiuk 2008; Haslam, Eggin et al. 2003; Riketta & Nienaber 2007; Sluss & Ashforth 2008; Sluss et al., 2012). In particular, work of this kind has more explicitly acknowledged and explored the role of relational identification (i.e., in terms of people's work roles) and the connections this has to other forms of identification. For example, Ashforth and colleagues (2008; Sluss & Ashforth 2007, 2008) drew on structural identity theory to look in more detail at the role of relational identities in shaping a person's self-concept at work. They proposed that relational identity involves all

three levels of identification: social, relational and personal (Sluss & Ashforth, 2008). For instance, a worker's relational identity with their supervisor combines the broader social identity within which these roles are nested, and the shared higher-level collective identification this entails (such as with the organisation, department or team), as well as implicating the personal level of identity through the unique enactment of their role. In addition, relational identity can be seen to be actualised through the juxtaposition of the roles enacted by the two individuals. Thus, in line with these broader perspectives on identity in the workplace, a person's self-concept and the accompanying motivation to enhance this self-concept, is seen to be shaped as much by their relational self as it is by a person's personal and collective self (Brewer & Gardner, 1996; Sluss & Ashforth, 2007; 2008).

Much of this recent research has been conducted on newcomer socialisation (Ashforth, Sluss & Saks, 2007; Korte 2009; Smith, Amiot, Smith et al., 2012; Sluss et al., 2012) — that is, the process where by a newcomer “becomes’ an adjusted, integrated, and accepted member of a new organisation” (Sluss et al., 2012, p.966). Typically socialisation research has primarily considered the effects of work-based identification at the broad level of organisational identification. Following on from which, scholars have investigated and recommended top-down interventions and strategies to develop organisational identification; such as collective and formative orientation programs (Ashforth & Saks, 1996; Ashforth, Sluss and Saks, 2007), and efforts to increase perceptions of organisational attractiveness and prestige (Riketta, 2005). Although relationships have been shown (across a wide body of occupational and organisational research, and especially in the helping professions) to be key determinants of employee satisfaction, wellbeing, performance and turnover intentions (in particular, relations with supervisors and co-workers, as well as with

clients in the case of care workers), the influence of the relational context has largely been overlooked (Kammayer-Mueller, Wanberg, Rubenstein & Song, 2013; Sluss et al., 2012).

Nevertheless, the above mentioned, recent socialisation research highlights the pivotal role that relational identification (particularly that between the supervisee and supervisor) plays in facilitating new comer adaptation and integration, and how this is related to the generalisation of relational identity to organisational identity. For example, Sluss and colleagues (2012) found that “relational identification does converge with organisational identification through affective, cognitive and behavioural mechanisms — yet only when a newcomer perceives the relational other as proto-typical of the organisation” (p.969). Furthermore, a study by Smith et al. (2012) found that relational identification affected a newcomers' experience of social validation of their new role, and acts as an essential mechanism through which new or altered identities are made sense (Smith, et al., 2012).

As illustrated above, the effects of relational identification at work has primarily been demonstrated in relation to role relationships that are nested within organisational or occupational structures. Nevertheless there is also some acknowledgement that the specific influences of role relational identification are structured within the broader working context and extend to relational identification with clients, customers and service users (Ashforth, Kulik & Tomiuk, 2008). This focus on relational identification is particularly relevant to an analysis of care workers' motivation given the importance of developing quality relationships not only with clients but also with the families of clients and other care staff (as noted in more detail in Chapter 1). Having covered the implications of work based identity on motivation, I turn to the question of how identification is constructed and how organisations might engage with this process.

Constructing and harnessing work-based identities

The social identity approach has primarily focused on the questions of when and why identification occurs. “To date the literature has provided little empirically grounded guidance for organisations trying to develop organisational identification amongst their employees” (Peters et al., 2013, p.129). In order to gain insight into how organisations and groups might develop identity resource, I first consider the ways in which identities are constructed (i.e. the process of identification), and I then briefly present the ASPIRe model for Actualising Social and *Personal Identity Resources* as a possible theoretical tool for understanding and intervening in the process of identity construction.

People actualise their self-concept through conversations and interactions with others, and express this through their identity narratives (Brown, 2006; Ibarra & Barbulescu, 2010; Pratt et al., 2006). As structural identity theorists point out, the “story we tell of ourselves in interaction with others...is the essence of identification (Scott, Corman & Cheney, 1998, p.305). Pratt et al., (2006) observed that “the centrality of identity in how individuals makes sense of and ‘enact’ their environments ... [makes] addressing issues of professional identity construction is timely” (p.235). Examination of people’s identity narratives in the field can illuminate the content (norms and values) associated with, and enacted by, work-based identities as well as the construction of identities — that is, the process of identifying oneself as an professional or organisational member (Ibarra, 1999; Pratt & Ashforth, 2003; Sveningsson & Alvesson, 2003). Focusing on a person’s individualist agency and their active construction of identity in the social context, Pratt et al. (2006) further argued that “achieving alignment between identity and work is a fundamental motivator in identity construction” (p. 255). Specifically, professional identification is seen to develop through a process of personal identity customisation and adaptation. This professional identification process is affected by the extent to which the

work context supports or violates a person's work-identity integrity assessments (the alignment between what a worker does and who they perceive they are), and provides social validation of role through feedback and role models. (Smith et al., 2013).

Recent research on professionalization and socialisation offers some insight into the process through which people become identified with an organisation, work-based group or role (Ashforth, Sluss & Saks, 2007; Ibarra, 1999; Korte, 2007, 2010; Pratt, 2006; Smith et al., 2013). Furthermore, in their examination of identification in organisations, Ashforth and colleagues (2008) draw on the work outlined above, as well as work associated with the SIA more generally, to propose a process model of identification. The model outlined in Figure 1 provides “a sketch of the general dynamics undergirding the process”, which they hope will “provide a point of theoretical convergence and thereby facilitate future research” (p. 340). This model incorporates the bottom up processes individuals use to construct work-based identity narratives, such as sense-making activities of interpreting and enacting identities; as well as the top down sense-breaking and sense-giving processes organisations might use to engender identification.

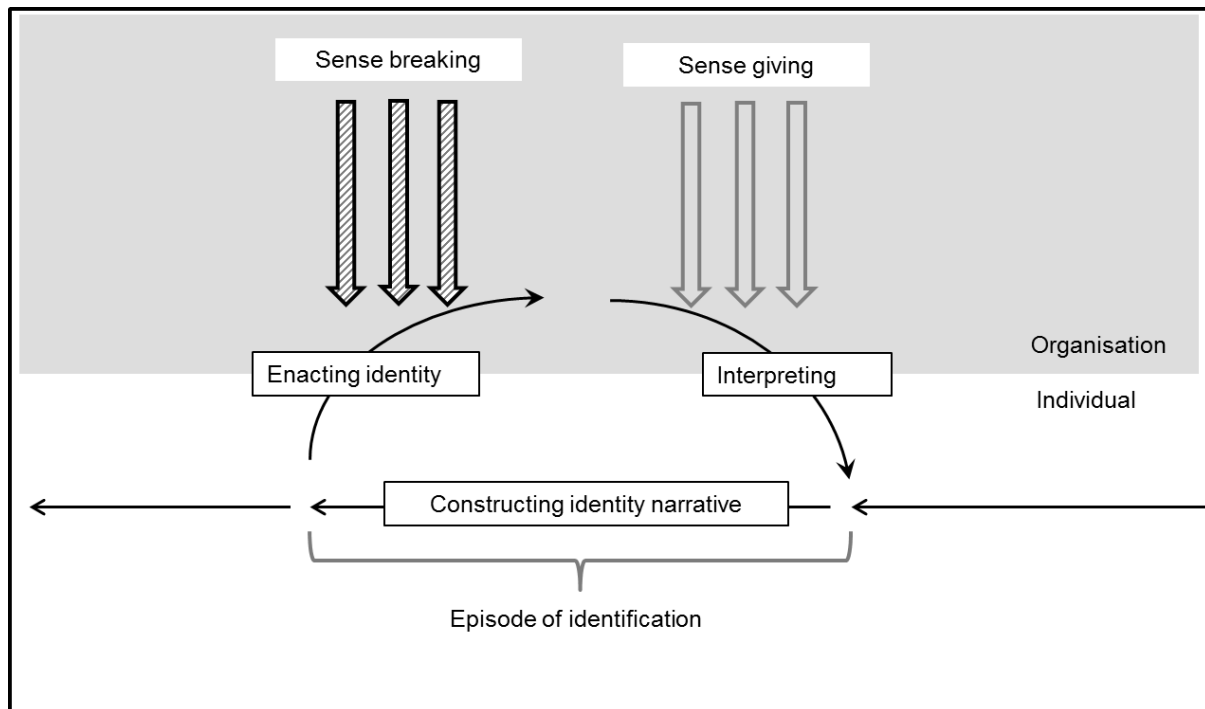


Figure 1: A Process Model of Identification (Ashforth et al., 2008, p.341)

In this model of identity construction or adaptation, *sense-breaking* “involves a fundamental questioning of who one is, when ones’ sense of self is challenged... [creating] a meaning void which must be filled” (Pratt, 2000, p.464). The search for meaning to fill the void motivates further identity exploration, and increases the likelihood of a person responding favourably to organisational *sense-giving* through its communication about working life. Sense-giving also acts as a mechanism of social validation, which is deemed necessary for new identification to develop (Ashforth 2001; Ibarra 1999; Korte, 2007; Smith et al. 2013). *Sense-making* is the individual’s construction of an identity narrative which draws on past experience and identities to interpret organisational sense-giving and their present experience of enacting the identity. Thus the process of identification is viewed “as a cycle that iterates between organisational sense-breaking and sense-giving and individual identity enactment, sense-making, and identity narrative construction” (Ashforth et al., 2008, p.359). Although intended as a rudimentary model through which to generate

further research, I suggest that with further refinement in relation to the particular working context, this theoretical framework could provide organisations with an overview of the dynamic development of work identities which could be drawn on to design, plan and monitor activities to motivate and retain employees. This could be particularly helpful during the first three to six months of employment when turnover is typically at its highest, especially in the care industry (Atkinson et al., 2009).

Another approach to capitalising on identity resources in an organisational context is outlined by Haslam et al. (2003) who developed their ASPIRe model in response to concerns that there was “little consideration...given to the way in which [social] capital can be *developed, utilised* and *sustained* through organisational practice” (p.86). This approach emphasises that (a) identities need to be recognised and internalized by individuals and not simply imposed on them (e.g. on the basis of demography); (b) that because subgroup (e.g., workteam) identities make an important contribution to employees' self-concept, organisations should enable these identities to be expressed and be involved in high-level decision making, and (c) that positive organisational outcomes are likely to be contingent on an ability to develop shared goals and strategy (Haslam et al., 2003; Peters et al., 2013). Peters et al. (2013) empirically tested the validity of the model with military medics, and found that the sequence of structured activities to define, harness, and mobilise identity resources, as outlined in the model, did increase indeed organisational identification and commitment to organisational strategy. They concluded that although broader tests of the model were needed, as a means “to translate theoretical understandings into practical interventions, this would appear to be a very important and promising first step” (Peters et al., 2013, p.141). Both the ASPIRe model and the model of identity construction offer mechanisms through which employees identities can be built, harnessed and developed in

practice. I will return to these models, and the question of how they relate to the context of care work, in the final chapter of this thesis.

The relevance, and value adding of SIA to understand and capitalise on care workers' motivation

By explaining how a person's existence as a member of a multitude of groups or social categories is internalised into their self-concept, the SIA shows how care workers' behaviour and motivation is enacted and shaped by their collective, relational and personal identities. In its simplest terms, the SIA offers an alternative perspective to social / economic exchange theories, and needs-based theories (including SDT), which principally view group and inter-personal behaviour to be a calculative and instrumental process structured by to an individual's personal self-interests and needs. Instead of prioritising individual self-interest, the SIA proposes that motivation is often structured by the needs and interests of a number of social, relational as well as personal identities, as defined by the situational context and the individual's history of self-definition (Ellemers et al., 2004). This perspective can be seen as particularly pertinent to care work, where the fundamental act of caring entails thinking beyond personal self-interests and needs. In particular, the quality of care benefits from the creation of a mutually experienced sense of belonging and being valued, both in terms of the client's wellbeing and the care worker's job satisfaction, work motivation and wellbeing (Adamson et al., 2012; Onyette, 2012; Wilson et al., 2009).

Furthermore, by focusing on the process of motivation rather than its content, the SIA does not seek to determine what motivates people in some universal sense. Instead it views the objects of motivation to be determined by the social and cultural context and the norms and values of the groups in which people psychologically operate (Hopkins & Reicher, 2011). In this way, the SIA is able to transcend the 'love' versus 'money' dichotomy, which currently dominates perceptions of care workers' experience and

motivation. For instead it views these to be reflective of socio-cultural norms and values, and to be more or less meaningful, and thus influential, to the extent they are integral to a person's salient identity.

From this perspective, whether or not something is perceived to be intrinsic (internal to self) or extrinsic (external to self) should be guided by the individual's salient identity. In accordance with self-categorisation principles, Haslam (2004) specifically predicts that "a motivator which is perceived to be extrinsic when a person's personal identity is salient, can be redefined as intrinsic when they define themselves in terms of a more inclusive identity" (p.72). Thus, the social identity approach can be seen to offer an explanation of the internalisation process which, as will be recalled from the previous chapter, is integral to self-determination theory but as yet not clearly defined. The stronger a person's identification with their organisation and other work groups, the more likely they are to internalise, enact and represent the values, norms and language of the organisation or group. Thus, a care worker who identifies strongly with a care home is likely to experience cooperative behaviour as intrinsically motivating to the extent that the care home values and endorses cooperative behaviour. Conversely, a care worker who identifies strongly with a care home that supports cooperative behaviour more in rhetoric than in reality is likely to perceive cooperative behaviour as extrinsically rather than intrinsically motivating.

Summary

Relative to the theories that have come to dominate psychologists understanding of workplace motivation, the social identity approach offers an alternative way of thinking which suggests that people's experience of working in care and their working behaviour is energised, directed and sustained by their social and relational identities as much as it is by their personal identity. In viewing motivation as multi-dimensional and dynamic rather than innate and fixed, the SIA presents a novel rationale (and suggests novel opportunities) for

organisations to engage in recognising, supporting and capitalising on employees' need for growth via considering the development of the collective and relational entities to which they belong.

Notwithstanding the increasingly influential body of research undertaken on the effects of organisational and work-based identity, organisational theorists highlight the need for further examination of (a) the perceived compatibility of work-based identities (at a personal, relational and collective level), (b) the implication of the compatibility (or lack of it) on work outcomes related to employee motivation, wellbeing and performance (Ashforth et al., 2008; Riketta & Neinaber, 2007; Sluss et al., 2012), as well as (c) how work-based identification (along with its attached positive work outcomes and psychological contract) can be harnessed, developed and sustained (Haslam et al., 2003; Peters et al., 2012). This, in turn, necessitates a richer understanding of the processes through which identities are formed and come meaningful (i.e., the construction of identity: Ashforth et al., 2008). In applying the social identity approach to the practical issue of careworker motivation, I hope to address some of these issues, while also addressing some of the key practical concerns that confront the field —specifically those that relate to the retention of careworkers and to strategies of supporting them to deliver high-quality care.

Chapter 4

Overview of Empirical Work

To examine care workers' motivation, and look at the effects of incentivisation, professionalization and training we conducted three studies. These studies, detailed across the next three chapters, have been written up as stand-alone manuscripts and submitted to academic journals. This means that there is some unavoidable repetition — particularly relating to the presentation of the social identity approach that informs this work and the state of the care sector that provides its backdrop. This chapter provides some additional information about these studies and is intended to provide a sense of how the studies are linked together within the overall program of research.

As a starting point for this identity-based investigation of care work, the first study aimed to find out which work-based groups and roles are most self-defining and self-relevant for care workers, and to look at the content of those roles and group memberships (i.e., the identity-based norms and values). Moreover, the first study aimed to gain some insight into the process of care workers' identification with their work, especially those processes that shaped their becoming more (or less) identified as compassionate professional care workers. To achieve these aims, this study adopted a qualitative approach, which generated a rich and nuanced understanding of care workers' motivation as well as an awareness of the categories by which they identified themselves at work. This understanding, in turn, ensured that our subsequent quantitative research — which measured and analysed motivation — realistically reflected care workers' self-categorisations as articulated by care-workers themselves.

The purpose of the second study was to consolidate and build on the findings from Study 1 via a longitudinal organisational survey. In accordance with other research on social and organisational identity (summarised in Chapter 3), we expected that the

more care workers identified with their organisation and the other work-based identities this contained, the more likely they were to be motivated at work. Second, we anticipated that those identities that are most meaningful to carers (in particular client, care professional and organisational identities), would mediate any relationships between organisational incentives, increased wellbeing, turnover intentions and positivity about professionalisation, regardless of whether those incentives involved the caring relationship (love) or pay (money). Stated differently, incentives were expected to be motivating to the extent that they spoke to meaningful identities. Third, we examined how these work-based identities (in particular relational and collective identification) might converge, and thereby reinforce each other. This was accomplished by conducting regression analysis which was then reinforced by structural equation modelling (SEM).

Based on the findings from research on the social care workforce (Atkinson et al., 2009; Hussein & Manthorpe, 2011; Skills for Care, 2007; 2013) and on the generalisation of relational identification to organisational identification (Sluss et al., 2012), we expected that (lower-order) client identification would predict (higher-order) organisational identification. Stated differently, the satisfaction of more local, and more immediately meaningful, bases of self-definition should pave the way to more abstract forms of self-definition. As evidenced by a wide body of organisational research, these identity synergies that should, in turn, feed into numerous positive work outcomes (including motivation), and are likely to be predicted by higher levels of organisational identification (for thorough reviews see Mael & Ashforth 1989; Haslam 2004; van Knippenburg, 2000). Finally this study also examined how professionalization (undertaking a qualification) affected motivation, and indeed whether this relationship was itself mediated through patterns of organisational identification.

This second study enabled us to test the utility of the social identity approach as a means of better understanding care workers' motivations on a very large data sample and over a period of time. Surprisingly perhaps, there was little significant change in participants' perceptions of their work experiences and work outcomes over time other than an increase in positivity about professionalization, a decrease in turnover intentions, and a decline in care professional identification. Therefore, on the back of this, we conducted further analysis on the large sample of cross-sectional data at Time 2, which included responses from participants in a wide spectrum of roles and from the two different working domains. Moreover, we focused our analysis of the longitudinal data on the impact of professionalization, by considering undertaking a qualification to constitute a quasi-experimental intervention.

One of the limitations of Study 2 is that its findings are based on an analysis of correlational patterns and pathways, and this limits our ability to make causal inferences. Accordingly, our third study had a quasi-experimental design that tested the effects of work-based identification on increasing care workers' motivation. This third study, which evaluated the impact of professionalization training on individual workplace motivations, sought to consolidate and extend findings from Study 2 by examining more closely the ways in which workgroup identification facilitated any learning and performance outcomes derived from training. This aim was realised by examining the impact of two different types of professionalization training programs on trainees' motivation to learn and their motivation to transfer their learning to the workplace. More specifically, this study tested the hypothesis that generic professionalization training, which emphasises and speaks to distal workgroup identities, would result in reduced motivation to transfer training relative to localised professionalization training, which taps into more meaningful localised workgroup identities. We also predicted that this difference would be explained largely by

differences in trainees' patterns of workgroup identification. Specifically, the more the training supported their identification with the organisation and as care professionals the more likely they would be to transfer the learning into work place practice. More broadly, the study aimed to demonstrate how the social identity approach might speak to increasing demands from training researchers (Aguinuis & Krainer, 2009; Grossman & Salas, 2011; Korte 2007; Pidd 2004; Simosi 2012) for a comprehensive, multi-dimensional, theoretical framework through which to understand the interplay of trainee and contextual factors which contribute to effective learning and performance in the workplace.

Together, these three studies offer a mixed-methods approach to the examination of care workers' motivations, and to validate the SIA as a theoretical framework that might usefully be applied to harness, develop and sustain workplace motivation, and thus improve retention. The extent to which these aims were realised in each of the studies is detailed in the following empirical chapters, and will be further synthesised in the final two concluding chapters. Supportive documentation not included in the manuscripts is attached in the appendices. A copy of the questions from the semi-structured interviews, along with the longitudinal survey questionnaires and the training evaluation questionnaires can be found in Appendices 1, 2 and 3, respectively. A detailed breakdown of the descriptive statistics from each organisational survey can be found in the reports submitted to the organisation in Appendices 4 and 5.

Chapter 5

Study 1

The shared experience of caring: A study of care workers' motivations and identification at work.

The consequences of a rapidly aging and healthier population in the UK and other industrialised countries are well documented (Centre for Workforce Intelligence, 2011; Care Quality Commission 2012; Department of Health (DoH), 2007, 2009; Helpaged International 2012). Most importantly, perhaps, this is increasing the size, as well as the economic and social importance, of the adult social care workforce (ASCW). In response to this, over the past decade there has been an increasing emphasis on the professionalization of the ASCW with the aim of ensuring a consistently high quality of care. Moreover, following on from the high number of investigations and reports into incidents of abuse and neglect in hospitals and residential care and nursing homes (European Human Rights Commission, 2011; HM 2011; Mid-Staff NHS Foundation Trust, 2013; Winterbourne View Hospital, 2012), emphasis is being placed on the challenges of creating and maintaining a compassionate care culture (DoH, 2012; Hesselink, Kuis, Pijenburg et al., 2013). With this in mind, understanding what it is that motivates care workers to do their work would seem critical to the process of helping organisations adopt and sustain professional and compassionate working practices.

Although there has been an increase in research undertaken with people who work in social care (Atkinson & Lucas, 2013; Hussein et al., 2010; Lepore, 2008; Lucas, Atkinson & Godden, 2008; Skills for Care, 2007) this research is still in its infancy, and falls short of providing a detailed exploration of care-workers' experience and motivation.

In contrast, there has been a plethora of research undertaken on nursing, which has both contributed to and resulted from the recent professionalisation of this occupation (Adams & Nelson, 2009; Bond 1992; Ousey & Johnson 2007; Rytterstrom et al., 2009; Woodward 1996). Although much of this work can be drawn on as a basis for understanding workers' experiences in social care and the current professionalisation of this sector, this does not obviate the need for a more focused understanding of social care work itself. Moreover, research on nursing is also seen to lack a robust theoretical analysis of what activates and sustains nurses' motivation to work in a professional and compassionate manner (Folbre, 2012).

To address this widely acknowledged 'data desert', the National Survey of Care Workers (SKfC, 2007) aimed to find out more about members of this workforce, including their motivations for working in care. The overall findings (which reveal, among other things, high levels of satisfaction), suggest that economic motives tend to be secondary for workers in this sector. This accords with other research into care-worker attitudes and responses to HR practices (Atkinson & Lucas, 2013), which has found that, overall, care-workers have clearly defined altruistic values, but ambivalent feelings about pay. This is in line with other research on the impact of rewards and incentives on recruitment and retention in the ASCW (Lucas et al., 2008; 2009) which has found that "pay is rarely the major influencing factor in taking up and remaining in care jobs" (Lucas, 2009, p.4). What is more, over three-quarters of staff planned to stay in their current organisation as a result of their liking the nature of the job, their relationship with clients, the team atmosphere, and opportunities for training and development (Lucas et al., 2009). Relationships at work, in particular with clients, as well as with other care staff and supervisors or managers have consistently been found to be key contributors to job satisfaction and wellbeing (Moyle et al., 2003; Wilson, Davies & Nolan, 2009).

These findings are widely recognised to conflict with traditional economic theories of work motivation, that are predicated on financial incentives and (personal) self-interest and which struggle to account for the more altruistic and ‘selfless’ behaviours which care work demands (Lucas & Atkinson, 2009). However, where more contemporary models of work motivation — that emphasise intrinsic versus extrinsic motivation such as self-determination theory, SDT, (Deci & Ryan 2008, Gagne & Deci, 2005) — have been applied to social care and nursing, they have resulted in controversial interpretations of motivation, which have been damaging to, and misrepresentative of, the workforce (Himmelwait, 2007; Lepore, 2008; Nelson & Folbre 2005). For example, some economists have sought to justify giving care-workers and nurses poor pay in light of the gratification they receive from caring and healing (Heyes, 2004). Moreover, the intrinsic versus extrinsic perspective of motivation exemplifies the dominant social discourse surrounding care work that dichotomises material and moral rewards and values — discourse that is seen to inhibit a more holistic and thorough understanding of care-workers and nurses’ motivations (Folbre, 2012; Lepore, 2008; Nelson & Folbre, 2005; Palmer & Eveline, 2012).

In line with other popular models of motivation, such as those based on personality and individual differences, these mainstream motivation theories emphasise the individualistic nature of motivation and pay limited attention to the interactions between personal and social dynamics (Ellemers, De Gilder & Haslam, 2004; Haslam 2001). Nevertheless, the pivotal importance of relationships and group identification in determining wellbeing and quality of aged care is increasingly being recognised by researchers, policy makers, and practitioners (Jetten, Haslam & Haslam, 2012; Moyle et al., 2003; Nolan et al., 2003, 2006; Wilson & Davies, 2009; Wilson et al., 2009). Indeed, a relationship-centred approach to care underpins the national agenda in the UK (and elsewhere, e.g. USA, Australia) to instil compassionate working cultures in health and

social care (DoH, 2012; www.myhomelife.org.uk). In light of the above, a holistic understanding of the motivations of care-workers needs to take into account the collective, relational, and personal contexts in which they operate and the way in which these relate to a person's psychology and self-concept.

Identification, motivation and helping behaviour

In trying to address some of the shortcomings that are evident in individualistic models of motivation, our analysis is guided by a social identity approach (SIA), to motivation (Ellemers et al., 2004; Haslam 2004). This approach, combines the principles of social identity theory (SIT; Tajfel & Turner, 1979) and self-categorisation theory (SCT; Turner 1985; Turner, Hogg, Oakes, Reicher & Wetherell 1987) and argues (a) that motivation in the workplace derives from employees' desire to enhance the self, but (b) that the self can be defined in different ways and at different levels of abstraction (Turner 1985). According to the social identity perspective, a person's self-concept is fluid, dynamic, and context-dependent and it incorporates identities which are defined at both a personal and collective level (for more detail, see Haslam 2004; Turner et al., 1985). In this way, the central tenets of the social identity framework provide an alternative to dominant personality-based theories of the self-concept (e.g., self-schema theory), which construe identity primarily in terms of stable personal self-representations (Onorato & Turner 2004). Moreover, the SIA provides a theoretical framework which attends to the collective, personal and (more recently) relational contexts in which individuals operate and which seeks to understand how these inform their self-concept.

Extensive research (originating in the minimal group studies, Tajfel et al., 1971; Tajfel, 1974) has shown that to the extent that a person identifies with a group in a given context, their behaviour will be aligned with group norms and values and be oriented to the advancement of the group (Haslam, 2004). In a working context, this means that the more

someone identifies with their organisation and/or a particular workgroup within the organisation the more likely they are to act on behalf of the organisation and/or the workgroup, and to seek to embody and enact the values and norms associated with them (Ellemers et al., 2004; Haslam, Postmes & Ellemers, 2003; Hogg & Terry, 2000; Van Knippenberg & Ellemers, 2003). Along these lines, a large body of research has found that the stronger an employee's organisational identification (i.e. their sense of oneness with the organisation, Ashforth & Mael, 1989) the greater their motivation to work on behalf of and in accordance with the organisation's aims, values and objectives, and the more positive they feel about this work (Ellemers & Haslam, 2004; Haslam, 2004; Ashforth & Mael, 1989; Van Knippenberg, 2000). Hence, in a range of organizational contexts, individual motivation is understood to be driven as much (if not more) by the need to enhance a collective sense of self ('us') as it is to enhance their personal sense of self ('I'; Ellemers et al., 2004; Ontario & Turner 2004; Haslam, 2004, Hogg & Terry, 2000). In line with this point, previous work has applied the social identity approach to the analysis of helping and pro-social behaviour and shown that where there is perceived sense of shared social identity between a helper and a person needing help this serves not only to increase the likelihood of helping (Levine, Prosser, Evans & Reicher, 2005), but also to increase the (perceived) quality of the help that is provided (Leeuwen & Tauber, 2010; Sturmer & Snyder, 2009).

Drawing on structural identity theory, Ashforth and colleagues (2008) also focus on the role of relational identities in shaping a person's self-concept. Defined as "the goals, values, norms, and so on, of the respective roles as well as the more or less unique ways in which the individuals enact the roles" (Ashforth & Sluss 2006, p.9), relational identity involves all three levels of identity. As such, a worker's relational self with their supervisor or client can be understood to be (a) nested within a shared collective identity (be it within a team, organisation or service sector; i.e. as users and providers), as well as (b) implicated

by their personal identity through the individual style and enactment of the role, and then (c) actualised at the relational level through the juxtaposition of the two roles enacted by two individuals (Sluss & Ashforth, 2008).

The pivotal importance of role relationships is acknowledged in organisational studies and social psychology (Korte 2010; Kram 1985; Sluss & Ashforth, 2007, 2008) not only in terms of their influence on performance (in defining task-related needs) but also in terms of satisfying “various social-psychological needs, including a sense of belonging, of meaning and of identity” (Sluss & Ashforth, 2008, p. 3). It therefore makes sense that people’s motivation will also be driven by a need to enhance their self-esteem at a relational level (Brewer & Gardner, 1996). That is, a care worker’s motivation could be stimulated and shaped as much (if not more) by their wanting to enhance their relational identity with a particular client, supervisor or co-worker, as it could wanting to enhance their personal or group-based identity.

Identification at a relational level is likely to adhere to the general predictions of self-categorization theory, which propose that the extent to which behaviour and motivation is guided by attachment to particular personal, social (and relational), self-categories, is determined by the interaction between peoples’ present context and their prior experience. According to self-categorisation theory, people are likely to define themselves in terms of a particular self-category (e.g., as a care worker) to the extent (a) this ‘fits’ a particular situation (i.e., is comparatively and normatively appropriate), and (b) that it is accessible to the individual, either because it is situationally salient or because the person routinely employs the category to define themselves or their social world (e.g., because it has proven meaning for them in the past; Hogg & Turner 1987, Haslam et al., 1999, Turner 1982). Similarly, how a person experiences and expresses a salient identity is explained by the meanings that they have attached to it through prior engagement and expectations.

Ashforth and colleagues (2008) differentiate between situated and deep-rooted identification (see also Haslam, 2004, p.272). The former (frequently manipulated in laboratory experiments), fosters more temporary and transient identification based on situational cues, such as membership in a group. On the other hand deep-rooted identification (also activated by situated cues) invokes a more visceral connection between self and the collective, one which contributes to an enduring sense of self, in which a person experiences a greater “congruence between self-at-work and [their] broader self-concept” (Rousseau 1998, p.218). It is primarily through exploring the deep-rooted identification of care-workers in the field that this study aims to arrive at a nuanced, multi-dimensional picture of their motivation and wellbeing at work.

Drawing on the above review of the social identity approach incorporating the role of relational identification, we suggest that it is likely that care-workers’ explanations of (or narratives about) their work motivation will (a) be tied into their enduring, identity narrative, that connects the contents of relevant personal, relational and social identities; (b) be influenced by the context in which they are interviewed (specifically, the extent to which this makes salient particular personal, relational, and social identities) and (c) be reflective and constructive of the collective narrative as a whole.

Aims of the present study

The aim of this qualitative study was to gain an in-depth, holistic and dynamic understanding of care-workers’ motivations that takes into account the social context in which they work. To achieve this, we apply a social identity approach to examining care workers’ narratives about their work experience and seek to better understand the following research questions: (1) *What is it about care-workers’ work experience that motivates them?* (2) *Why does care work matter to them?*

Method

A key premise of the social identity approach is that the psychological impact of groups derives not from demographic features (e.g., a person's sex, age, social class) but rather from the extent to which particular group memberships are psychologically meaningful and form a basis of shared self-definition (a sense of 'we-ness'; Turner, 1987). Therefore it was important to use a qualitative research approach that enabled an open inquiry into how care workers' identities were "self-relevant and self-defining" (Haslam et al., 2003, p.88), and which did not impose (directly or indirectly) particular identity definitions upon respondents. Accordingly, we were careful not to foist pre-conceived identities on participants, and to avoid closed questions about a given identity as well as quantitative measure of identities that might have been reactive in this respect. Instead we utilised a thematic analysis approach (Braun & Clarke, 2006; see also Haslam & McGarty, in press) to ascertain the themes and sub-themes underlying participants' narratives about their work-related selves. This starts by examining the content of care-workers' identities (as revealed in their narratives about work behaviour and the associated norms and values), and then goes on to looking at the abstraction of identities, which were more or less meaningful in the context of engaging in care work.

Participants

Participants were care staff drawn from a large care organisation responsible for delivering care services across the south of England. A care organisation that had recently been formed by an amalgamation of four different care organisations and a training organisation, and so incorporated a variety of working cultures. To reflect the range of working contexts (location, size, type of care), participants were recruited to the study from three different community care bases and from three different care and nursing homes. A stratified random sampling approach involved the principal researcher selecting participants

from staff pay lists on the basis of job role and availability to attend the interviews. The number of interviews conducted was determined by the collection of a saturated sample from each setting, which captured the range of views of care staff working in different care roles (Pidgeon & Henwood, 1997). Of the 19 included in the final sample, 9 worked in domiciliary care and 10 in care and nursing homes. A breakdown of participants' details is provided in Table 1.

Table 1: A breakdown of participants' characteristics

Participants*	Age	Work place	Job	Years in care	Previous work	Quals
DCW1	40	Dom care	Supervisor	2.5yrs	Military	NVQ2
DCW2	22	Dom care	Care worker	18mths	Student	GNVQ
DCW3	28	Dom care	Care worker	11mths	Holidaycamp	NVQ2
DCW4	52	Dom care	Snr Care worker	8 yrs	Child care	NVQ2
DCW5	30	Dom care	Snr Care worker	10 yrs	Student	NVQ3
DCW6	58	Dom care	Snr Care worker	5 yrs	Pub	NVQ3
DCW7	28	Dom care	Care worker	2 yrs	Chef	NVQ2
DCW8	30	Dom care	Care worker	5 yrs	Learning disabilities	NVQ3
DCW9	38	Dom care	Care worker	8 mths	shop work	None
RCW1	35	Res care	Snr Care worker	6yrs	care work	NVQ2
RCW2	20	Res care	Snr Care worker	2 yrs	Factory	NVQ2
RCW3	38	Res care	Snr Care worker	8 yrs	Factory	NVQ3
RCW4	20	Res care	Snr Care worker	2 yrs	Office admin	NVQ2
RCW5	53	Res care	Snr Care worker	8 yrs	shop work	NVQ3
RCW6	46	Res care	Snr Care worker	8 yrs	shop work	NVQ3
RCW7	19	Res care	Assistant CW	1 yr	none	
RCW8	38	Res care	Assistant CW	7 yrs	mother	NVQ2
RCW9	63	Res care	Assistant CW	19 yrs	carer	NVQ1
RCW10	38	Res care	Supervisor	8 yrs	carer	NVQ 3

Note: * DCW = Domiciliary Care Worker; RCW = Residential Care Worker

Interviews

Semi-structured, tape-recorded interviews were conducted with 15 care and senior care staff. The interviews were typically conducted in a quiet place (office, or rest room) at the care home and community base. They took around forty minutes to conduct. In the care and nursing homes interviews took place during participants' work shifts. At the community bases, participants came into the base, before or after their shift, and were paid by the care organisation for their time.

The interview script was piloted on three care-workers, and phrases and words were reviewed to ensure a shared understanding. Following a phenomenological approach (Smith & Osborn, 2003), the interviews were guided by, but not restricted to, this script. Where appropriate, the interviewer asked exploratory questions in response to issues brought up by the participants, and thus tried to allow the participants to shape the dialogue as much as possible. Further to an opening question, in which interviewees were asked to introduce themselves and describe their job, the interview included open-ended questions such as: "If you have had a good/bad day what has made it a good/bad day?" "What made you decide to work in care?" "Who do you feel you relate to most at work?"

Ethical approval for this research was granted by the relevant University ethics committee, and participants were given the opportunity to withdrawal from the research at any stage in the process. The second stage of analysis was undertaken using the qualitative analysis software, Atlas/ti.

Data analysis

The analysis of the data followed a thematic analysis approach as outlined by Braun and Clarke (2006). This provides a "recipe for people to undertake thematic analysis in a way which is theoretically and methodologically sound" (Braun & Clarke, p.78). Thematic analysis was considered the best approach for this research as it accommodates the

interplay between a ‘top down’ theoretical perspective and the ‘bottom up’ knowledge and experience of participants. It is acknowledged to be “compatible with an inductive, data-driven approach whilst, at the same time, allowing for integration of prior theory and research” (Allen, Bromley, Kuyken & Sonnenberg, 2009, p.417; Haslam & McGarty, in press).

The research process was led by the first author and she played an active role in identifying and interpreting the themes (Taylor & Ussher, 2001). She was sensitive to how the interaction inherent in the interviews between the researcher and participant played an active role in constructing an account of participant’s experiences (Nightingale & Cromby 1999), and kept reflective notes. This interaction is likely to have been affected by both (a) the environmental context of the interviews, in the working environment (care homes) and in the organisational base (domiciliary care)⁸, and (b) the nature of the interviews, as conducted by an external researcher from a university and involving care workers who had varying experiences of research. It is worth noting that in accordance with self-categorisation principles, the relationship between the participant and interviewer was predominantly experienced as not entailing shared social identity. This was evident in the way participants primarily talked about their work and occupation in the third person. In keeping with Braun and Clarke’s (2006) guidelines for conducting thematic analysis, the analysis identified key questions on which it sought to shed light. The primary question was “What is it about care-workers’ work experiences that motivates them?” Two further questions were driven by the interview data: “Why care?” and “What is important about care work?” The analysis generated is therefore very much the result of “a constant interplay between data and the researcher’s developing conceptualisations” (Pidgeon & Henwood, 1997, p. 252). The interview recordings were listened to in full and then

⁸ The pressure of limited time and a need to return to the shift was particularly present in interviews that took place in care homes. Interviews took place in organisational time and territory.

transcribed. The resulting transcripts were re-read several times. Specific thoughts, feelings and observations were identified in the verbatim data and coded according to them representing “some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p.82). These meanings were then generated in to themes, which were compared and, where warranted, differentiated further to capture different nuances of meaning or grouped according to their commonalities. This differentiation and merging of themes “allowed for the development of an analytic hierarchy in which abstract, overarching themes were composed of sub-themes that, in turn, were descriptively close to the verbatim data” (Allen et al., 2009, p.417). The inter-relatedness and juxtaposition of different themes were explored and refined through spider diagram models. The credibility and coherence of the coding and themes was then reviewed by two independent parties (both experienced qualitative researchers). Any discrepancies were discussed and agreement was reached before the coding was amended accordingly.

Results

Three core themes were identified from the data as reflecting what it is that motivates care workers about their work. These themes of ‘fulfilment’, ‘valuing’ and ‘belonging’ contributed to the fourth theme, of ‘pride’, which was identified as reflecting why it mattered to them. As Figure 2 illustrates, the overarching theme of ‘shared experience’ was also identified as being integral to how interviewees made sense of and understood their work behaviour and motivation.

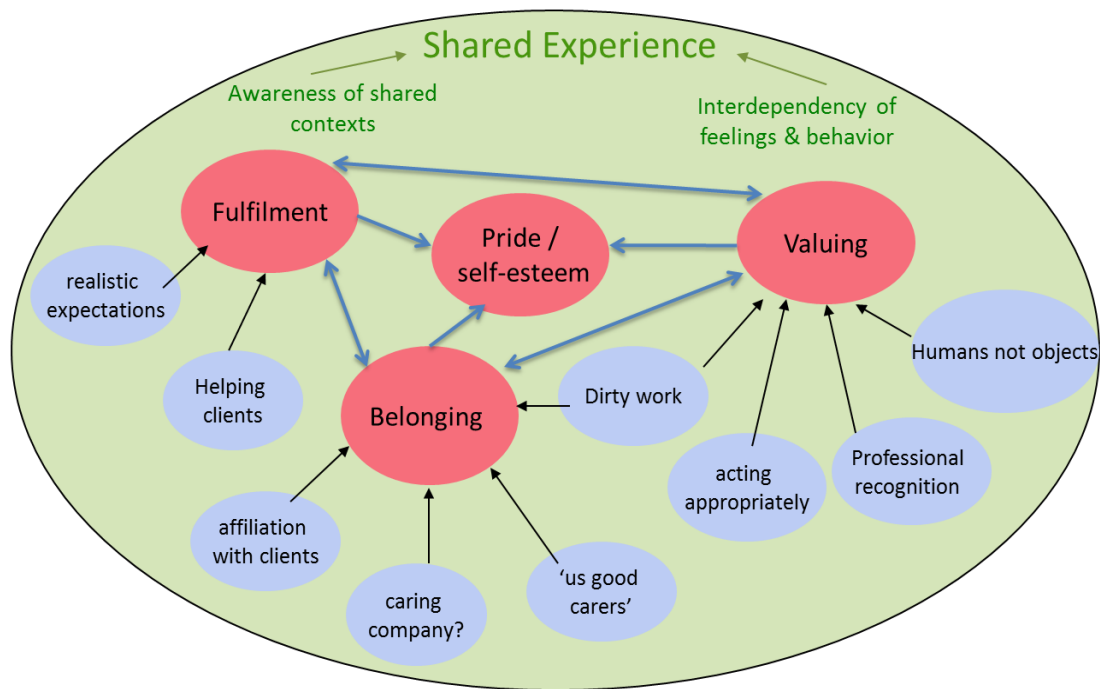


Figure 2: A schematic representation of the key themes identified as contributing to care workers' motivation

A number of themes and sub-themes that captured norms and values were identified in participants' narratives as contributing to these core themes, which reflected their thoughts and feelings about working in ASC. These are outlined in Table 2, and discussed in more detail below.

Table 2: A Summary of Themes from Participant Interviews

Overarching themes	<i>Themes: and *sub-themes</i>
Fulfilment	<p><i>Helping clients:</i> supporting them to live as a fulfilled life as possible and feeling <i>*rewarded</i> and <i>*satisfied</i> by doing so. <i>*Clients appreciation</i> contributed to feeling fulfilled.</p> <p><i>Realistic expectations:</i> of the nature of the work, and the emotional and physical demands it places on you.</p>
Belonging	<p><i>Affiliation with clients:</i> empathy for clients' situations and the connection of it to their own experiences. The <i>*family</i> at work.</p> <p><i>'Us good care-workers'</i> desirable attributes and values of care-workers often contrasted with workers in other sectors.</p> <p><i>Peer support and shared expectations:</i> how they materialised and what were the implications on care-workers' work</p> <p><i>Caring company?</i> relationship with organisation referred to in terms of the extent to which it cared enough about carers and clients</p>
Valuing	<p><i>Humans not robots:</i> treating clients and care-workers as 'humans not numbers' concerns about the <i>*commodification</i> of work.</p> <p><i>Acting appropriately:</i> behaving sensitively 'regardless of what you feel'. Caring beyond the call of duty.</p> <p><i>Dirty work:</i> social and cultural stigma attached to care work.</p> <p><i>Professional recognition?</i> Evident in pay & status, the knowledge and skills required to do the job of 'just helping'.</p>
Pride	<p>In the nature of the work, the <i>*unique</i>, 'special' type of person it takes to do it. A person who also puts are to do it <i>*Love before money</i>.</p>
Shared experience	<p>Related to <i>*interdependency of feelings and behaviours</i>, and <i>*awareness of shared contexts</i></p>

In an attempt to mirror the bottom-up approach through which we analysed the data, we first report on the data as it related to our analytical exploratory questions, in terms of

the sub-themes and broader themes, before moving on to discuss the way in which ‘shared experience’ appears to actualise and embed participants’ motivations and wellbeing.

Fulfilment: Why care?

Fulfilment was identified as a key underlying theme that reflected and explained what interviewees sought from their work. This was identified from participants’ narratives in the themes and sub-themes outlined below.

Helping clients. All participants talked in some detail about the satisfaction of helping clients. They referred to helping them in a number of ways: by providing physical care; supporting independence; socialising with them; identifying illnesses; ‘being there’, and providing domestic support. In her explanation about why she works in care, DCW9 summarises a “feel-good factor” which was evident in many participants’ accounts:

I think it’s just because the people are so nice, you’re just popping in, giving them a chat, and obviously the aspects of the fact that you feel you’re doing a worthy thing, you’re giving something to somebody and they are appreciative of it. So I think that’s the biggest thing with the job, you just feel you’re helping people. Whatever small little thing you’re doing, you’re helping them. [p.2]

There was also strong conviction about the work being “rewarding” and “worthy” [DCW5, p.9]. As DCW4, [p.1] put it “I don’t know what questions you want to ask me but it’s a good job, it’s a very, very rewarding job”. Several participants contrasted their positive experience of care work with negative public perceptions: “People think it’s a horrible, horrible job but it’s not its really enjoyable and you really get something rewarding out of doing it” [RCW2, p.5]. All of the participants emphasised feeling *satisfaction* in relation to helping clients live as a fulfilling life as possible, whether it be to support their independence at home “not to get shipped off as my nan puts it” [DCW2, p.8] or making them “feel like this is their home” [RCW3 p.3]. Notably there was an association between what carers valued about the working conditions, ‘being your own boss’ [DCW1,

p.3], and what they felt they were contributing to peoples' lives, 'keeping them independent' [DCW1, p.9].

The feedback participants received from clients, *clients' appreciation*, also contributed to whether they had a good or bad day and whether they found their work enjoyable. "That's the only thing when you've done your best and they still turn around and say you don't do nothing for us" [RCW5 p.5]. Appreciation of their work, or lack of it, was a prevalent issue not only in relation to clients but also in relation to the organisation and the general public. Indeed, this can be seen to validate interviewees' sense of the worthiness of a care-worker role and identity.

Realistic expectations. 'Realistic expectations' was a factor that was seen to determine whether or not carers experienced the work as fulfilling. As DCW2 observed, "I think sometimes people come into this job very blind. And when they do start they're thinking god what have I let myself in for?" [p.2]. Recruitment strategies that involved "rose-tinted advertising" were one of the explanations given for people having unrealistic expectations. Others were inadequate inductions, as well as the public perception that anyone can care.

Belonging: What is special about us?

'Belonging' is another core theme that was identified as representing and explaining why participants were motivated to care. The themes and sub-themes that contribute to this sense of belonging are detailed below.

Affiliation with clients. It was noticeable that all respondents experienced a sense of '*affiliation with clients*'. This relates to an aspect of the way in which care workers identify with their clients, as a result of empathising and relating their circumstances to their own contexts and situations. "When I work here it's like how would I like to be treated when I am older, I want to be treated with respect and nice and that's what I try and do" [RCW2,

p.6]. RCW3 explained how she felt about the residents, “It is, my grandparents...I think of them being in here and what they would need” [p.6]. This sense of affinity was also referred to as what distinguished care-workers from others who didn’t value it, “you’re going to get old someday. You want to make sure someone’s out there to help you” [DCW2, p.5]. Personal connections with clients also contributed to this sense of affiliation and participants regarded bonding, at least with some clients, as an inevitable part of their work. “I met a chap the other day who served as a chaplain and he actually served as a chaplain in my regiment” [DCW1, p.8].

‘Family’ and family relations were referred to in terms of their influence on care-workers’ decision to work in care. As well as being spoken about in terms of their mutual belonging in a group at work, this also involved seeing oneself as being part of a family (in care homes) or being a friend of the family (in domiciliary care):

I don’t know what’s keeping me here, ‘cause I felt I am in a family...a family...people say “well that’s not very professional, you shouldn’t think it’s a family”, but if you go into a home, a residential home, you have people like families. [RCW5, p. 20]

Us good care workers. References to belonging to an occupational group of care-workers or a profession were largely implicit rather than explicit. They were generally apparent in references to what “we do” in contrast to “others who don’t”. Participants made reference to their in-group of carers “those who can” in contrast to “those who can’t”. This included personality traits and attributes as well as values, such as doing it for “more than the money”, [DCW7, p.18] having “a strong head, strong stomach”, (RCW4, p.18) not being “a grumpy, a bagpuss”, (RCW3, p.13). For example, DCW4 contrasted the motivation of good and bad care-workers in these terms as “there are some people that just do this job for money but there are other people that do it because they are professional people and they enjoy doing everything correctly” [p.23]. Notably, participants felt themselves to be part of a group that displayed a unique aptitude for the work. “And I think

if you speak to anybody it's the same with anyone. They either can't do it or they love it" [DCW9, p.1]

Participants talked about their colleagues in relation to the support they received from them and expectations surrounding collaborative working, '*peer support and expectations*'. The different working environments of domiciliary care and residential care were reflected in participants' discussion of their experiences of collaborative working in pairs as double ups or in teams (shifts). "I would say we work together very closely as a team" [RCW6, p.4]. They discussed the support they received from the colleagues and their expectations of support. "I think you've got to have that communication. There's got to be a lot more respect for each other" [DCW2, p.59].

Caring company. Participants primarily talked about belonging to the organisation in terms of how much it cared about the clients and the staff; that is, was it a "*caring company*"? For example, DCW1 explained that "they (the organisation) are taking more care in the people they pick as carers" [p.18]. Moreover, there were mixed opinions about whether the organisation cared enough. "We are a caring company and as the years go on I suppose ... because the company is good ... it just needs a few changes to make us a caring company not just a money company" [DCW4, p.12]. Overall, participants spoke more inclusively (and often implicitly through references to shared experience), about their relationship with clients. Participants' references to the organisation differed as to whether they were inclusive 'we' or more abstract 'they' and an authoritative 'other'. Care-workers' sense of loyalty was also sometimes split between clients and the organisation:

"I work for [name of organisation], so you do what you got to do with them, your loyalties are with them in a certain respect but I suppose your client comes first because you have a bigger bond with them". [DCW9, p.7]

Valuing: Validation of their role and work

Valuing people, be they the clients or the carers, valuing living, and valuing the provision of quality of care to ensure quality of life, was an integral theme in participants' discussions about the importance of their work. The themes and sub-themes which reflected the different aspects of valuing are outlined below.

Humans not robots. Participants spoke about their dissatisfaction at not having enough time to spend with clients and the negative consequences this had on the provision of care and their health. The pressure placed on care-workers' time was frequently mentioned: "it can be frustrating [being] pushed pillar to post" [DCW1, p.15], "it can feel like you're chasing your tail" [RCW6, p.6]; and interviewees were critical of the priority being placed on completing the task rather than looking after people. As RCW5 explained, "you can't do it in 10 minutes...you can do the washing and the dressing but you can't do the caring" [p.21]. A range of references were made to clients being treated "more like in a factory", and the "domino effects" [DCW5, p.11] caused by visiting slots being too short.

Acting appropriately. Part of the unique set of skills and attributes that care-workers perceived themselves to have were related to the need to 'act appropriately' even when this was hard work. This construct could also be understood in terms of the exertion of 'emotional labour' (James, 1989; 1992; In this regard, there were explicit expectations "to put on a face regardless of what you feel" [RCW6, p.14] to express kindness and warmth "because you have to talk to this person and not treat them like a machine" [DCW3, p.16]. As RCW4 made clear "You don't turn around and go 'Oh my god look at that big toe!' Even if you want to" [p.20]. Although highlighted by participants, this compassionate behaviour appeared to be a 'taken for granted' aspect of care. However, acting appropriately received more mixed responses when it came to boundaries between personal and professional spheres, and the extent to which it was inevitable and even desirable. "I'm

not the type of person that can switch off...I'm not that type of person but on the other hand I think that's what makes me good at what I do because I do genuinely care about the people" [DCW2, p.12]. Here too, the potential for blurred boundaries to contribute to stress and burnout were acknowledged: "If you put them [personal and professional lives] together you're in the wrong job because it could get you down make you feel sick, make you poorly" [DCW4, p.9].

Dirty work. Participants' narratives about their work were framed by social and cultural attitudes towards care work and the recognition and values attached to it. In particular, they were conscious of how their work was perceived to be 'dirty', and viewed as undesirable work because of its taintedness. "I mean I've had friends I've explained the job to and it's like 'no way I couldn't do that. I couldn't wipe somebody's bum'" [DCW2, p.4]. Social stigma surrounding care was evident in participants' accounts of care-workers' just doing domestic work as "dog's bodies" [RCW1, p.15], taboos associated with working with those who "are waiting to die" [RCW5, p.14] and physical intimacy required to "wash them and whatever" [DCW3, p.15]. However, the very aspects of work that were seen to be stigmatising were also the aspects of their work to which carers referred positively, and which were seen to capture their unique capabilities. DCW7 described aspects of the work he particularly valued: "the one thing I would say is the most rewarding gift is the last rites." [p.6].

Professional recognition, or lack of it was a theme that reflected a way in which participants perceived how their work was valued. 'Recognition or lack of it' was evident not only in terms of pay and status but also in what the work entailed and the knowledge and skills required to do the job well. "It's no longer 'you're just a home help'. Now it's a career, because everybody's realising that it isn't just an easy job to do. It's not a cop out from school, just go into care or whatever" [DCW5 p.11]. There was some

acknowledgement of the job being professional: “I do think it’s seen as a profession” [RCW2, p.18]. Nevertheless, at the same time that respondents indicated that they liked being defined as professionals, they also downplayed their work:

“When people say oh god you’ve got to be so great to do a job like that. But well it’s nothing really, because you’re just helping... and getting paid for it...not a great deal. But it’s good to be on that professional scale, you know, to have a nice title instead of just carer”. [DCW8, p.10]

Participants spoke enthusiastically about working practices they perceived to enable them to provide good quality of care. In particular, they emphasised the importance of continuity of care and key worker roles, “something constant for the elderly...so they don’t get confused” [DCW7, p.9], referring to the comfort and security it gave their clients and the knowledge they gained about their clients. Furthermore, numerous examples were given of the way in which physical intimacy with clients provided respondents with in-depth knowledge of those clients and enabled them to provide quality care, although they rarely acknowledged it as learned knowledge:

“You know, they might not have been feeling well last night but they didn’t want to bother you. But while you’re doing them they might turn round and say to you, “I felt a bit funny last night, what do you think?”, but if you’re in and out like a conveyor belt system they might be seriously ill and you haven’t been able to pick it up”. [RCW5, p.25].

Pride

Pride was identified as a central theme, both in how participants’ work experience motivates them and in why it matters. Pride was readily evident in interviewees’ accounts of their work. It related not only to ‘*helping clients*’ but also to being prepared to undertake ‘*dirty work*’ and belonging to a ‘*unique*’ group of people who are able to enjoy such work. It related to all three overarching themes: first, to participants’ sense of fulfilment, as

DCW1 explained, “if it wasn’t for people like ourselves and that, then these people wouldn’t be staying in their own homes wouldn’t have their own independence.” [p.9]; second, to participants’ sense of belonging to a unique group of people; and third, to the pride respondents associated with (the neglected) valuing of care work, as evidenced by RCW1’s observation that “I do think they work very hard and the wages are very low and I think you have to be a special person to do this job, you do honestly” [p.7]

Pride was also evident in participants’ suggestions that careworkers’ motivations were driven by *‘love before money’*. All of the participants either explicitly stated or implied that “the money is rubbish” [DCW4, p.19], and did not truly reflect the value of the work undertaken, “why should somebody want to come and do care, when you can sit at a computer for double the money” [RCW5, p.18]. Yet, much of the talk about money was juxtaposed to caring. “You’ve got to be compassionate I think, and passionate as well about care, because you certainly don’t do it for the money. That’s for sure” [DCW8, p.9].

Shared experience

Participants’ experience of the core themes that motivated them at work and went some way to explaining why it mattered to them, (i.e. a sense of fulfilment, belonging, validation and pride) were actualised through their shared experience of the role and work. This shared experience of caring was primarily spoken about as taking place with clients, but participants’ narratives also reflected the shared norms and values of a strong occupational group. The integrity of the shared experience to participants’ narratives about their motivation was evident throughout the data in three distinct ways. The first of these was, *interdependency of feelings* between carers and clients, and between carers and carers: “it was just I feel that the clients didn’t get the satisfaction, so I didn’t get the satisfaction at the end of the day.” (DCW5, p.2). This was also evident in being a carer and being a member of the organisation: DCW6 felt that working for this organisation married her

professional self and her organisational self. “I’m a professional. And that’s why I’ve come here and I haven’t looked anywhere else” (p.3). The second element was *awareness of shared contexts* especially between an in-group of carer and client versus an out-group of other carers or the organisation: “But when you’re going in...it can be very daunting to be with a stranger [another care worker]. And I do find as well I think it’s quite daunting for the client” (DCW2, p.15). This awareness of shared context was also evident when participants spoke of the risk that carers as well as clients could be dehumanised by change that prioritised the task before the person: “because that’s what it used to be, we were numbers as a carer and as a client ... everyone felt we were just numbers and now we’re not” [DCW4, p.15]. The third element was *interdependency of behaviour* between carer and clients; “They have got to have confidence in you before you can get confidence with them and you have got to have confidence in yourself so it’s got to work both ways so to speak” (DCW1, p.11). These examples can also be seen to highlight the ways in which care workers’ integrated the social context (their shared experience) into their self-concept at both a relational and collective level.

Discussion

This study sought to provide in-depth insights into the motivations of care-workers by examining narratives about work experience and looking at the motives, norms and values that were attributed to working in care as aspects of people’s identities as employees in this sector. It did this by conducting a thematic analysis of interviews with care workers with a view to identifying the core themes that captured (a) what it is about care work that motivates people and (b) why this work matters to them. This analysis showed that care workers’ motivation was related to their need for fulfilment, belonging, and validation, which contributed to their strong sense of pride, and was shaped by their shared experience of the social context in which they operate.

Subsequent analysis of these findings through a social identity perspective speaks further to the way in which these core themes capture the essence of care worker motivation.. As indicated in Figure 1 and reflected in the discussion below, these core themes are inter-related and together contribute to care workers' self esteem and work identification. Participants' sense of fulfilment appears to be primarily related to helping clients and the feelings that this generates. In this the "individual is striving to systematically promote the perception that they are worthwhile persons" (Swann 1990, p.410). Feeling needed by, and indispensable to, others not only meets one of the more basic human needs, for love and belonging (Maslow 1945), it also fulfils higher-order needs for enhancement of self-esteem (Ellemers & Haslam, 2004). It is evident in our analysis of the data that self-esteem enhancement is achieved through feelings of worthiness that are associated with a need for belonging. This collective self-esteem is derived from (a) care-workers' relational identity with their clients and (b) their collective identity, as a member of a care team, an occupation, or an organisation, which cares about the needs of the client. In a similar vein, the strong feelings of pride expressed by participants, that are interpreted as an outcome of fulfilment, belonging and valuing, are both related to the 'helping' nature of the work (invoked in the relational identity), and to a sense of belonging to the group which provides the help (i.e., a sense of collective identity; Sturmer & Snyder, 2010; see also Baumeister & Leary, 1995).

In spite of it being acknowledged as essential, care work is not held in high regard, as it is socially and culturally perceived as tainted work, both physically (intimate, personal care) and socially (supporting those who are less able and close to death; Douglas, 1966) and this is reflected in the low wages and low status of care-workers (Himmelwait, 2007). It might therefore be expected that occupational esteem in this group would be low, and that individual workers would not derive much 'pride' from their social identification with it

(Dukerich, Golden, & Shortell, 2002; Tyler, 1999). However, it is apparent from this study and from other research, that this expectation is incorrect as care workers derive high levels of pride from their work, (Skills for Care, 2007; Lucas et al., 2008; 2009). Indeed, this is consistent with Ashforth and Kreiner's (1999) observation that "the stigma of 'dirty work' fosters development of a strong occupational or workgroup culture" (p.413). This is seen to occur in part through a process of redefining 'dirty work' as something that is positive, and which requires special sort of people to do it. Accordingly, a strong occupational culture can be seen in participants' accounts of their work through (a) the pride they express towards the unique attributes and work of fellow carers, (b) the recognition of an in-group of carers 'those who can' contrasted to an out-group of 'those who cannot', and (c) strong group norms about what it means to be a carer. This strong occupational identity helps explain how, in spite of being publicly perceived as a low-status group which receives low remuneration, care-workers have a strong sense of pride in themselves as care-workers. Yet, in addition to the positive consequences of strong identification at work (such as high satisfaction, wellbeing, pride, and commitment; Ellemers & Haslam, 2004; Van Knippenberg, 2000), there is also evidence that this has negative consequences (such as an increased likelihood of exhaustion and burnout; Haslam, 2004). This is particularly evident in participants' accounts of the emotional labour they perform (Hochschild, 1983) — specifically, in their dedication to clients, and in their normative references that 'taking it home with you' is 'appropriate behaviour' and an inevitable and even desirable feature of the job.

Participants' motivation at work also appeared to be shaped by the values they attributed to their caring role and their experience of valuing and being valued. This was particularly evident in their dislike of regulations and organisational activities that were perceived to restrict helping clients and dehumanise care. Similar to findings from research

with nurses (Nelson et al, 2000), participants did not overtly recognise and value the knowledge, skills, and attributes entailed in their work. Indeed, participants were sometimes dismissive of their own effort and skills. Although there is little use of a professionalised or technical language to describe their work, an implicit awareness of the knowledge and attributes required to be a carer is evident in narratives about the value attached to aspects of care work, and preferences for certain care practices (e.g., continuity of care). In addition, their descriptions of the knowledge they acquired and utilised through working closely with clients, is characteristic of forms of “body-knowledge” (Adams & Nelson, 2009).

Yet probably the most notable norm that was inherent in narratives about valuing care work, was the assertion that the lack of material recognition was compensated by the rewarding and virtuous nature of the work (Folbre & Nelson, 2000). Beyond acknowledging pay as a necessary requirement of working, in the main participants were scornful and dismissive of money. This norm reflects the powerful dichotomy of material versus moral reward that permeates socio-cultural discourses surrounding care work. This is a norm which is recognised to be embedded in care workers’ discourse and which, care scholars argue, explains their ambiguity about seeking better pay and working conditions (Himmelweit, 2006; Lepore, 2008; Folbre, 2012; Palmer & Eveline, 2012). Tellingly too, it is also a norm that has been invoked by care organisations to keep wages low (Palmer & Eveline, 2012).

Understanding care-workers’ identification

Overall, these findings illustrate how participants’ work experience and motivation, the degree to which their work provides a sense of fulfilment, belonging, validity and pride contributes to and is shaped by their identification as a care worker. Care-workers’ identification appears to primarily be defined in terms of their identification with their

clients. This refutes the ostensible identity categorisation of care-workers and clients as belonging to two separate groups, each standing as out-group to the other. Instead, it suggests that, in particular contexts, care-workers understand themselves to share in-group status with their clients. Participants' multiple references of 'shared experiences' with clients, their evidently strong 'affiliation to clients' and the value they attached to 'helping' them, conveyed a strong impression of attachment to clients and of belonging with them. From the bottom-up perspective of identity formation (e.g., Baumeister & Newman, 1994; Ibarra & Barbulescu, 2010; Postmes et al., 2005; Scott, Corman, & Cheney, 1998), it appears that much of the way in which care-workers make sense of their work-based identity is at a relational level through identification with clients. This deep-rooted identification is reflective of the way in which "individuals often identify by following their hearts — by seeking to experience a sense of pride, warmth or affirmation and that these thoughts and emotions can drive behaviour" (Harquail, 1998, p11). The intimate nature of the personal support carers give to clients, means that the enactment of this relational identity is intense and engages care-workers' bodies and emotions, as well as their minds. It follows that as physical and emotional labour is such a core component in care work, embodied cognition not only has an important role in care-workers' knowledge and expertise base but also plays a powerful role in their organisational (and other work-based) identification (Harquail & Wilcox King, 2010).

Participants' narratives also illustrate how the relational identity between carer and client in turn feeds into all three levels of identification (collective, relational and personal; Ashforth et al., 2008). The roles of carer and client are defined at the collective level by social and work-based (occupational and organisational) prototypical expectations and norms. The personal level is implicated in the nature of the individuals who occupy the roles of carer and client and this affects the way they enact prototypical role expectations:

“the relationship level is implicated in the juxtaposition of the two roles as enacted by the two individuals” (Sluss & Ashforth, 2008, p. 810). For example, at the collective level, expectations of appropriate behaviour between carer and client are both formalised (e.g. in terms of professional regulations, staff conduct) and implied (e.g. in terms of social norms of being kind and considerate, and occupational norms, “to put on a face regardless of how you feel” RCW6, p.14). Expectations of appropriate behaviour at the personal level are grounded in each individual’s attitudes and beliefs and in their previous experiences. In addition, expectations reside and are generated at the relational level in the behaviour and exchange between each individual carer and client. As Wilson et al., (2009) found in their study on the contribution staff made to improving the quality of care in residential homes through their approach to the development of relationships during care routines; “Staff brought something of themselves to the relationship that enabled them to work more effectively with each other, the resident and the family (p.17).

Our findings indicate that this central caring relationship between carer and client is integral to the content of care workers’ identities, and their accounts of what motivates and matters to them. For instance, participants’ identification with the organisation was largely expressed in terms of the extent to which the organisation was perceived to be a caring organisation, both for carers as well as clients, Thus care-workers’ organisational identification can be viewed as a ‘mutually reinforcing’ conceptual extension of the caring relationship between carer and client.. This is in line with Sluss and colleagues’ work on the congruence between relational and organisational identification (Sluss & Ashforth, 2008; Sluss et al., 2012).

Practical implications

Previous findings from social identity research into work behaviour, suggest that tapping into and strengthening work-based identities that are meaningful to care-workers

will enhance their motivation and improve the quality of their work (e.g., Ellemers et al., 2004; Haslam et al., 2003). On the basis of the patterns we have already discussed, it is likely that the more a care worker feels that the organisation they work for values their identification and affiliation with the client (i.e. by facilitating continuity of care, increasing the amount of time available to spend with each client), the more the carer is likely to identify with the organisation and exhibit positive behaviours and outcomes associated with high organizational identification (i.e. greater motivation, commitment, wellbeing). An additional benefit of supporting care workers' identification with client is that in line with social identity research on helping behaviour, the more the carer identifies with the client the more likely she or he is to provide high-quality empathy-based compassionate care which "values the other's welfare as an end in its own right" (Sturmer & Snyder, 2010, p. 44). It follows too, that in order to maximise this 'identity capital' (Akerloff & Kranton, 2011, p.??) organisations need to ensure that care workers' identification with clients and the organisation are aligned and congruent, by tapping into and instilling shared values and norms. Where identification with clients (or for that matter; supervisors, co-workers or teams) conflicts with, or is misaligned with, organisational identification it is likely to be detrimental to care workers' wellbeing and work motivation, as well as to the quality of care they deliver.

Limitations and Implications for future research

The limitations of this study are primarily related to a critique typically levelled at qualitative research, namely that the size and profile of the sample might affect the extent to which the findings can be generalised to the wider aged care workforce (Crouch & McKenzie, 2006). Nevertheless, the sample size was within the lower end of acceptable numbers for a qualitative study (Mason, 2010; Morse, 1994), and the decision not to add more participants to this sample was made once there was clear saturation in the responses

that interviews elicited (Mason, 2010). Although participants were employed by the same overarching care body, there was nevertheless considerable diversity in age, job title, nationality, gender and geographical location. It should also be noted that the care group had recently been formed by an amalgamation of four different care organisations and a training organisation, and so incorporated a variety of working cultures (albeit all not-for-profit). Moreover, many of our core observations accord with those of other research undertaken with care workers (in particular, Skills for Care, 2007; Lepore, 2008; Lucas & Atkinson, 2009) and in this respect there are no grounds for thinking that our findings are peculiar to the particular sample we studied.

This qualitative analysis has provided a rich evidence base, which has informed our program of research into the dynamics of care-workers' motivation. This further research has consolidated and built on the findings of this qualitative analysis by quantifying patterns of care workers' identification and motivation, and assessing how they influence one another; i.e. measuring the extent to which client or organisational identification leads to increased motivation (Bjerregaard et al., 2014). Future research could also look in more detail at the congruence between client and organisational identification and what factors or activities promote or thwart it. We believe this research has innovatively combined a bottom up approach to examining the content of care workers identities at work that then feeds into a social identity theoretical perspective that explains the process by which this social context is integrated into care workers' self-concept and shapes their motivation to enhance this self-concept. An approach which might also be adopted by other researchers interested in understanding the motivational dynamics of other occupations.

Conclusion

It is not original to suggest that care-workers are primarily motivated by the desire to care (for their clients), and be cared for (by the organisation and society at large). Yet

these findings demonstrate not only that ‘caring’ is a central component of care workers’ motivation, but also that this manifests itself in the content and dynamics of their work-related identities — identities that inform all aspects of the work they perform.

Accordingly, there are strong grounds for asserting that it is by recognising and supporting this ‘caring’ identity that organisations and policy makers will develop, strengthen, and maintain a compassionate caring workforce.

Chapter 6

Study 2

The motivation of care workers: Clarifying the importance of social and relational identification.

In the UK as elsewhere across the industrialised world, the rapidly ageing population has led to a dramatic increase in the size of the adult social care workforce and this is increasingly recognized as an important social and economic resource (Centre of workforce intelligence, 2011; CQC, 2012; Department of Health, 2012, ICF GHK, 2013, Skills for Care, 2011). In the UK, for example, the direct economic value of the adult social care sector in the UK is estimated to be worth more than £20 billion per year. The sector employs 1.5 million people — which is more than either the construction industry or the public administration and defence sectors (ICF GHK, 2013). Moreover, this sector is predicted to grow to between 2.1 and 3.1 billion by 2025 (Centre for Workforce Intelligence, 2011). Nevertheless, there is little, if any, research that has looked in detail at the complexity of care workers' motivation and what sustains their willingness to deliver professional and compassionate care (Adamson et al., 2012; Help the Aged 2007; Heyes 2005; Hussein et al., 2010; Lucas et al., 2008; Nelsen & Folbre, 2006).

The conundrum of care worker motivation is exemplified by the fact that in spite of their low status and poor financial reward, domiciliary and care home workers report high levels of job satisfaction, pride and wellbeing (Cameron & Moss. 2007; Hussein et al., 2010, Lucas, Atkinson & Godden, 2009; Skills for Care, 2007). This is largely attributed to care workers' intrinsic satisfaction with their work. In this context financial and altruistic incentives are frequently cited as polarized aspects of carers' motivation with the “virtuous

reward” of caring (Heyes 2005, p.1) often viewed as compensating for, and even justifying, the lack of financial reward (Equality and Human Rights Commission, 2011; Heyes, 2005). More recently, there have been calls for theories that integrate the ‘love’ and ‘money’ aspects of motivation in this context (Hussein et al., 2010; Nelson & Folbre, 2006; Weicht 2010). For example, a review of the role of rewards and incentives in adult social care in England (conducted on behalf of Skills for Care, 2008) observed that although at a common-sense level one would conclude that there are links between pay, other incentives, and the recruitment and retention of care workers, there very little work has tested for or demonstrated these linkages (Lucas et al., 2008).

Nevertheless, in what work there has been on this topic, care workers’ motivation has consistently been found to be associated with their relationships with clients (Lucas et al., 2009; Moyle, Skinner, Rowe & Gork, 2003; Skills for Care, 2007). Moreover, the quality of this relationship between care workers’ and clients is perceived (by clients and their families) as indicative of the quality of care (Bowers, Fibich & Jacobson, 2001; Wilson, Davies & Nolan, 2009). The centrality of this relationship to the motivation and wellbeing of care workers and clients alike has also underpinned the drive for relationship-centred approach to health and social care (Beach & Inui, 2006; Nolan, Davies & Brown, 2006) and the creation of compassionate care work cultures (Dewar & Nolan, 2013; Adamson, 2012; DoH, 2012; Onyette, 2012). As yet, though, there has been little consideration of the psychological process by which these work relationships contribute to care workers’ motivation.

The context in which the carers work is also likely to shape their motivation. Long-term adult care usually takes place either in residential and nursing homes or as domiciliary care in people’s homes. In the former, carers work closely together to look after a number of residents, whereas in the latter carers might be employed by an organisation but typically

work independently visiting people in their own homes. The two domains require different working styles and often attract people seeking different things from their work (Author et al., 2014; CQC, 2012). In regard to both spheres of activity, the ongoing professionalization of the sector over the last decade, in the UK and elsewhere, has resulted in the setting of standards for workforce training and qualifications, the regulation of care practices and the accountability of the sector to a professional body. Many discussions around this issue emphasise the importance of employee training and qualifications (e.g., Department of Health, 2006, 2007, 2009; Wild, Szczepura, & Nelson, 2010) and studies have found that care workers themselves identify training and development as important determinants of their work motivation (Skills for Care, 2013; Wild et al., 2010). Again, though, very little, if any, research has examined whether and how training relates to the other motivational factors that sustain workers in the care sector. It is therefore pertinent to examine whether care workers' pursuit and acquisition of a qualification enhances their motivation at work, and how this relates to other psychological motivators, in particular those related to different sources of identity.

Understanding care workers' motivation

As noted above, mainstream accounts of employee motivation foreground individualistic considerations and argue that work motivation is driven primarily by personal self-interest or a trade-off between money and altruistic reward. Accounts that go beyond the simple focus on economic (versus other) rewards nonetheless also theorise motivation as largely the outcome of personal factors. For example, self-determination theory, SDT (Deci & Ryan 2000; Gagne & Deci, 2005), distinguishes between different types of motivation on a continuum between extrinsic controlled, "amotivation (which is wholly lacking in self-determination), to intrinsic [autonomous] motivation, which is invariantly, self-determined" (Gagne & Deci, 2005, p.335). One of the key findings that

have been generated by advocates of this approach is that incentives which activate extrinsic controlled motivation (e.g., those which set financial or processing targets) can actually erode intrinsic motivations and individual satisfaction (e.g., Deci, 1971). Indeed, as a corollary of this, Heyes's (2005) economic model proposes that "a badly paid nurse is a good nurse" (p.1). Within the SDT model individuals are understood to differ in the degree to which certain behaviours are externally regulated versus integrated into the personal self, and this is facilitated or thwarted by the context in which they operate. However, it has yet to fully account for the psychological process through which this takes place (Greguras & Diefendorff, 2009; Kovjanic et al., 2012; Sheldon et al., 2003).

In contrast to these individually oriented accounts of motivation, the social identity approach offers an alternative framework that suggests that different levels of identity enactment might contribute to creating a (compassionate) working culture. The social identity approach, which combines SIT social identity theory (Tajfel & Turner, 1979) and SCT self-categorisation theory (Turner, 1985), along with organisational identity research (Ashforth et al., 2008; Ashforth & Mael 1989), focuses on how a person's motivation at work is shaped by their sense of identification with different groups within the organisation (Ellemers et al., 2004; van Knippenburg, 2000), as well as by identification with different role relationships (Sluss & Ashforth, 2008). Critically, rather than defining the self in purely personal terms (as 'I' and 'me') this perspective argues that the self can also be defined in collective terms (as 'we' and 'us'). So in addition to their idiosyncratic personal identity, a person's self-concept also incorporates a range of social identities and role relational identities that become more or less salient depending on the particular context, the fit of the identity within that context, and the contrast with other identities (Oakes, Haslam & Turner, 1994; Turner 1982).

This definition of the self at a collective and at a relational level has distinct implications for individual motivation and behaviour (Ellemers, et al., 2004; Haslam, 2004; Haslam et al., 2000; Sluss & Ashforth 2008) because salient social identities and identification with meaningful social groups and role relationships redefine the nature of the self that is implicated in processes of self-actualization and self-enhancement (Turner, 1985). Thus when group or role-based identities are salient, as is often the case at work, a person can be driven as much by a desire to enhance a collective sense of self (e.g., as a woman, a care worker, or an employee of a given organisation), as they are by a desire to enhance their relational sense of self (e.g., in their role as supervisor or carer) or their personal sense of self (as a unique individual; e.g., Tim, Mary). In a range of circumstances this means that acting in the interests of group membership can override concerns about personal self-interest (Ontario & Turner 1994). As Ellemers et al. (2004) assert “self-conception in collective terms would energise people to exert themselves on behalf of the group, facilitate the direction or effort toward collective (instead of individual) outcomes and help workers sustain their loyalty to the team or organisation through times when this is not individually rewarding” (Ellemers et al., 2004, p. 461).

Speaking to the value of this approach, a broad body of research has shown that organisational identification is positively related to a range of work-related attitudes and behaviours such as job satisfaction, motivation, performance, turnover intentions, and absenteeism (for a review see Haslam, 2004, also Riketta & Van Dick, 2004; Tyler & Blader, 2000; Van Knippenberg, 2000). More recent organisational research on the strength of identification with different foci of attachment, has also found that people typically indicate greater levels of identification with localised identities such as teams (Riketta & Neinaber, 2007; Riketta & Van Dick, 2004) and role relationships (Sluss et al., 2012; Smith et al., 2012). However, organisational identification is the strongest predictor of work-

related outcomes including motivation and wellbeing (Jetten, Haslam & Haslam, 2011; Sluss et al., 2012; Smith et al., 2012). Thus to the extent their identification with different work relationships and work groups is congruent with, or nested within, organizational identification, then workers are likely to be more motivated and satisfied at work (Ashforth, Harrison & Corley 2008, Akerlof & Kranton, 2010; Haslam, Eggins, Reynolds 2003, van Knippenburg 2000, Ellemers et al., 2004, Wegge, van Dick, Fisher, Wecking & Moltzen 2006, Rikette & Neinaber 2007). This is because, in instances of such perceived alignment, by advancing the organization the individual will see themselves to be enhancing aspects of the (collectively defined) self. On the other hand, when they experience incongruence between their role relationships and their team or organisation, they are likely to be less motivated and exhibit greater frustration and stress.

According to Sluss and Ashforth (2008), congruence between relational and collective identities is likely to be strengthened by (1) the degree of task interdependence (a particularly high level of which is evident between frontline care workers and clients; Karlsson & Rydwick, 2013); and (2) the prototypicality of the relational partner of the organisation or the working context. In keeping with this reasoning, it seems likely (a) that care workers will indicate strong relational identification with their clients and (b) that the likelihood of their client and organisational identities converging would depend on the extent to which the care worker perceives their caring role with the client to be supported by the organisation.

To take into account the social and relational context in which care work takes place, the present research seeks to examine the motivation of care workers through the lens of the social identity theorizing. In particular, it seeks to investigate the link between what incentivizes people to work in adult social care and motivation outcomes such as their levels of work satisfaction, pride and wellbeing along with turnover intentions and

positivity about professionalization. More specifically, it seeks to explore the role of financial incentives and social relationships in motivating care workers. Here, rather than dichotomising the ‘love’ and ‘money’ aspects of working in care we argue that they will form integrated elements of care workers’ motivation to the extent they build meaningful work-based identification.

This study also examines how care workers’ motivation might be influenced by the context in which it takes place by looking at (a) the two different working domains in which care workers predominately operate and (b) the process through which care workers are motivated to deliver and sustain professional and compassionate care. In line with recommendations about how to apply social identity analysis in the field (Haslam et al., 2003, 2014) this study focuses on those work identities that were identified as self-relevant by care workers in previous qualitative work in the present programme (Bjerregaard, 2014a) — namely client, care staff, care professional, and organisation identities.

Hypotheses

Based on the above reasoning, this study sought to test six main hypotheses:

H1. Care workers’ social identification with different groups at work will be positively related to their motivation (Ellemers et al., 2004). Specifically, we expected that carers’ work motivation — that is their job satisfaction, pride, and wellbeing, as well as their job attachment (turnover intentions and pro-professionalization) — will be predicted by their identification with (a) the people they care for (*client identification*; H1a) and (b) the care organization they work for (*organizational identification*; H1b). Moreover, we anticipated that although care workers are (c) likely to indicate higher levels of client identification than organisational identification (H1c); their (d) organisational identification is likely to be the more proximal predictor of motivation (H1d).

H2. Care workers will be primarily incentivized to work in care because of their caring relationship with clients (H2a). However, the extent to which valuing relationships with clients leads to higher levels of motivation at work, will be mediated by identification with the organization (H2b). Moreover, this organisational identification was expected to be predicted by client identification (H2c).

H3. Care workers will be less incentivized by pay than other social considerations (H3a). Nevertheless, the extent to which pay does lead to increased motivation will also be mediated by organizational identification (H3b). Here the effects of organisational identity are unlikely to be predicted by client identification (H3c).

H4. Carers' sense of social identity will vary as a function of their place of work (i.e., residential / nursing home or domiciliary care). The nature of independent working involved in the latter will lead domiciliary care workers to have stronger levels of client identification than those working in residential care (H4a) and lower levels of organisational identification than those working in residential care (H4b). This lack of congruence between identities makes it more likely that domiciliary care workers will report lower levels of work motivation compared to those who work in residential care (H4c).

H5. Undertaking a qualification is likely to lead to increased motivation (H5a). Again this is expected to be mediated by organisational identity (H5b). More specifically, the effects of undertaking a qualification on motivation should be explained by the extent to which undertaking a qualification increases and maintains identification with the organisation and other groups at work (H5c; Pidd 2004).

Study context

To test these hypotheses, we administered an organizational survey to carers at two time points, one year apart. The surveys were disseminated across multiple sites (in different locations across the south of England) in a large care organisation that had recently amalgamated a number of smaller organisations. The survey measured carers' motivation, their sense of identity at work, and their feelings about work outcomes, including professionalization. As well as allowing us to examine the relationship between these variables cross-sectionally, the study's longitudinal design also enabled us to examine variation in responses over time as a function of whether or not people had undertaken professional qualifications in the intervening period—so that, in effect, undertaking a professional qualification in the past year constituted an experimental treatment (for similar logic see Lim & Putnam, 2010). In this way, the study had a quasi-experimental longitudinal design, which enabled us to examine the putative impact of exposure to professional training on organizational identification and motivation.

Method

Surveys were administered to care staff who worked for a large not-for-profit organization that operates across the South of England and the Isle of Wight. The care organization, which recently incorporated four different care organizations, runs 28 residential care and nursing homes and delivers domiciliary care services from 6 domiciliary care bases. Its clients are primarily elderly people, yet services are also provided for younger people who need support to live independently on their own and in groups. The studies were conducted at two time points, one year apart, in January 2010 (T1) and January 2011 (T2).

Participants

Table 1 provides a detailed breakdown of sample characteristics. At Time 1, 3280 questionnaires were distributed and 643 were returned completed — a response rate of 20%. The majority of participants ($n=458$; 72%) worked in residential and nursing care (residential care), 28% ($n=172$) worked in the domiciliary (domiciliary care). At Time 2, 4,200 questionnaires were distributed. Of these, 1274 completed questionnaires were returned — a 33% response rate. Most respondents ($n=740$) worked in residential care and 42% ($n=534$) worked in domiciliary care. The substantially higher response rate at Time 2 was primarily the result of effort to raise care staff awareness of the survey, through an article in the organisation's newsletter and presentations to managers. This had an especially notable effect in increasing the response rate from domiciliary care staff. A total of 204 carers participated on both occasions: A majority of respondents (70%) worked in residential care and 30% in domiciliary care. Of these, 51% ($n=103$), undertook a professional qualification over the course of the year (i.e., were exposed to a professionalization treatment) and 49% ($n=100$) did not.

Table 3: Demographics of each sample

	Time 1	Time 2	Longitudinal
No. q'res distributed	3,280	4,200	
No. q'res returned	643	1,274	204
Response rate	20%	33%	
% Residential care	72%	58%	70%
% Domiciliary care	28%	42%	30%
Gender	F = 571 (92%) M = 51	F = 1077 (90%) M = 124	F = 188 (92%) M = 15
Age range	16 — 76 yrs old <i>M</i> =44.8, <i>SD</i> 12.12	16 — 78 yrs old <i>M</i> = 42.57, <i>SD</i> = 14.90	18 — 78 yrs olds <i>M</i> =46.62, <i>SD</i> =14.27
<i>Job role</i>			
Domestic workers	52 (8.5%)	124 (10%)	20 (10%)
Care workers	364 (57%)	885 (69%)	124 (61%)
Snr care workers	115 (18%)	114 (9%)	27 (13%)
Managers	43 (6%)	51 (4%)	21 (10%)
Admin & planners	21 (3%)	36 (3%)	10 (5%)
Undisclosed role	48 (7.5%)	64 (5%)	2 (1%)

Measures

Participants completed a four-page, 51-item questionnaire, in which they indicated agreement with statements on scales ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Work motivation was measured by means of five scales that examined (a) *job satisfaction* (3 items, T1 $\alpha = .79$, T2 $\alpha = .76$, typical items: “I enjoy my work at [the care organisation]”; after Haslam et al., 2006); and (b) *pride* (3 items, T1 $\alpha = .71$, T2 $\alpha = .75$, typical item: “I am proud to work in the care sector”, adapted from Tyler & Blader 2000); (c) *stress* (4 items, reversed scored, T1 $\alpha = .70$, T2 $\alpha = .69$; typical item: “I am able to cope with the demands of my job” adapted from Haslam & Reicher, 2006); (d) *turnover intentions* (2 items, reversed scored, T1 $r = .75$, T2 $r = .72$, typical item: “I would like to stay working at [the care organisation] for as long as possible”; after Ellemers et al., 1999;

(e) *pro-professionalization* (5 items, T1 $\alpha = .76$, T2 $\alpha = .75$, typical item: “I feel positive about the process of professionalization at [the care organisation]”).

Key factors which *incentivize carers* to work for the care organization were measured by the extent to which (a) *pay* and (b) *relationship with clients* were valued. In each case, responses were given to a single item indicating whether “I work at [the care organisation] primarily because I value the [particular incentive]”. At Time 2 this measure was supplemented by an item in which respondents indicated their *satisfaction with incentives* by responding to statements of the form: “Overall I am satisfied with the [particular incentive] at [the care organisation]”: pay, $r = .47$, for relationships with clients, $r = .60$.

Work identification was measured by four three-item scales that asked participants about their prevalent identification in the workplace: (a) clients (*client identification*); (b) staff at the care home or domiciliary base (*staff identification*); (c) *care professionals* (*professional identification*); and (d) their identification with the organisation (*organizational identification*); 3 items, T1 α s = .78, .65, .65, .73, respectively; T2 α s = .70, .76, .72, .71 respectively. For each measure respondents indicated whether “I feel strong ties with [group]”, “I feel good about [group]”, “I am willing to do as much as possible to make life easy for [group]” (adapted from Doosje, Ellemers & Spears, 1995).

At the end of the questionnaire participants were asked to provide demographic information (age, gender, length of service working, and ethnicity), as well as information about the nature of their work, their occupational role (domestic staff, care worker, senior care worker, manager, administrator or planner), and their working domain (residential and nursing or domiciliary care). At Time 2 participants were asked additional questions about

the amount of training days they had undertaken in the past year, whether they had undertaken professional qualification in this time, and, if so, at what level.

Procedure

A questionnaire containing the above scales was distributed to care staff in sealed envelopes via the care homes and domiciliary bases. Prior to administration, the questionnaire was piloted on a small sample of 15 care workers in order to check and refine its terminology and structure. Questionnaires were accompanied by a cover letter from the organisation and the researchers' University that outlined the purpose of the survey and informed participants that completion of the questionnaire was taken as an indication of their consent to take part in the study, but that this was voluntary. Confidentiality and anonymity were assured. Respondents then returned the questionnaire in an enclosed stamped addressed envelope to the University. To enable questionnaires from the same person to be linked, respondents were requested to provide a unique identifying code. The recruitment of participants was intended to cast a wide net such that the sample was representative of all care workers working in domiciliary, residential and nursing care rather than any particular sub-sample.

Results

Analytic strategy

Given the large number of respondents at T2 and the good representation of responses from domiciliary workers as well as residential care workers (that was missing from the T1 and longitudinal data), we decided to conduct our analysis on the cross-sectional T2 data and focused our analysis of the longitudinal data on the changes that occurred over time, primarily around the impact of professionalization. Cross-sectional analysis proceeded in two steps. First, preliminary tests of hypotheses were conducted by

examining bivariate correlations between the various measures administered in the study at each time — in particular, the relationships among (a) work group identification and motivation (H1), (b) perceived incentives and motivation (H2, H3), (c) type of care work and identification (H4), and (d) professionalization activity (undertaking a qualification) and motivation (H5).

Second, we used Structural Equation Modeling to test two integrated theoretical models. Model 1 examined whether different incentives for work in care, namely relationships with clients and pay, are associated with greater motivation to the extent that they build relational identification with clients (H2a) and through this contribute to broader organizational identity (H3a, H3b). Model 2 then considered how the care work context — in this case, working domain and having undertaken a qualification — was associated with motivation at work, and whether any effects could be accounted for by strengthened organizational identification (H4c & H5b).

A second phase of analysis was conducted on the longitudinal data ($n = 204$) and examined variation in responses over time as a function of whether or not respondents had undertaken a qualification in the intervening period. In this analysis, we considered having undertaken qualifications during the intervening period (1 year) to constitute a quasi-experimental intervention. This enabled us to assess whether variation in identification and motivation over time were related to whether or not participants had received a qualification in the previous year (H5c).

Phase 1: Cross-sectional analyses.

Bivariate associations. Means, standard deviations and bivariate correlations for cross-sectional data at T2 are reported in Table 2. As can be seen from this, participants reported positive work experiences and outcomes: they indicated very high levels of

satisfaction, high levels of pride, and low levels of stress. They also reported being attached to their job, as reflected in their low turnover intentions and favourable attitudes about professionalization. As in other studies of the social care workforce (e.g., Heyes 2005), carers attached the least value to pay and highest value to their relationships with clients as incentives for work.

In line with H1, participants indicated strongest identification with clients. They also identified strongly with the other staff where they worked, with care professionals in general, and with the organization itself (all means > 5 on a 7-point scale). As predicted by H1, and as demonstrated in the bivariate correlations, higher identification with different groups at work (clients, organization, staff and care professionals) was associated with higher levels of wellbeing, positivity about professionalisation and lower turnover intentions. Inspection of the bivariate correlations also revealed a clear pattern whereby the strength of association between identification and wellbeing and job attachment increased as the locus of identification became inclusive rather than exclusive. Thus, at the exclusive end of the spectrum, relational identification with clients was positively associated with satisfaction, pride and more positive attitudes towards professionalization ($r_s = .43, .44, .34$ respectively; all $p_s < .01$) and was negatively associated with stress and turnover intentions, ($r_s = -.32, -.34$ respectively; all $p_s < .01$). However, at inclusive end of the spectrum these relationships were all stronger — such that collective identification with the organization was very strongly positively correlated with satisfaction, pride, and positive attitudes towards professionalization ($r_s = .53, .46, .51$ respectively; all $p_s < .01$) and was strongly negatively correlated with stress and turnover intentions ($r_s = -.41, -.61$ respectively; all $p_s < .01$).

Table 4: Bivariate Correlations. Time 2 data.

	M	SD	1a.	1b.	2a.	2b.	3a.	3b.	3c.	3d.	4a.	4b.	4c.	4d.
1a. Qualification taken	1.51	0.50												
1b. Working domain	1.43	0.50	-.08*											
Work incentive														
2a. Pay	3.10	1.46	.02	.03										
2b. Relationship with clients	6.02	0.81	.07*	.07*	.02									
Work Identification														
3a. Client	5.92	0.77	.04	.05	.06*	.64**								
3b. Staff	5.37	0.95	.10**	.09**	.15**	.31**	.46**							
3c. Organisation	5.21	0.99	.10**	.12**	.31**	.34**	.45**	.63**						
3d. Care professional	5.29	0.92	.11**	.14**	.17**	.34**	.52**	.73**	.62**					
Work motivation														
4a. Satisfaction	6.02	0.87	.05	.04	.23**	.37**	.43**	.43**	.53**	.425**				
4b. Pride	5.68	0.97	.08*	.01	.16**	.40**	.44**	.38**	.46**	.42**	.50**			
4c. Stress	2.40	0.85	-.05	-.01	.18**	.20**	.31**	.41**	.43**	-.36**	.57**	.34**		
4d. Professionalization	5.46	0.87	.10**	.10**	.15**	.26**	.34**	.41**	.51**	.39**	.47**	.42**	.49**	
4e. Turnover	2.51	1.40	-.05	.10**	.23**	.26**	.30**	.43**	.57**	-.39**	.56**	.40**	.43**	.42**

** . Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Bivariate correlations also pointed to a variable degree of association between different incentives and workers' motivation. In line with H2 and H3, these ranged from weak correlations between being incentivised by pay and motivation, to very strong correlations between being incentivised by relationships with clients and increased motivation. More specifically, being incentivised by pay was weakly associated with increased satisfaction, pride, pro-professionalization attitudes as well as reduced stress and lower turnover intentions ($r_s = .23, .16, .15, -.18, -.23$ respectively; all $p_s < .01$). However, there were stronger associations between being incentivised by relationships with clients and motivation in terms satisfaction, pride, pro-professionalization attitudes, reduced stress, and reduced turnover intentions ($r_s = .37, .40, .26, -.20, -.26, ,$ respectively; all $p_s < .01$).

Consistent with H4a, undertaking domiciliary (versus residential) care work was generally associated with stronger client identification and weaker colleague, professional, and organisational identification. Consistent with H4c there were also negative associations between domiciliary care work and motivation, reflected in attitudes that were less pro-professionalization and stronger turnover intentions. There was no significant correlation between type of care work and measures of satisfaction, pride and stress.

Finally, and consistent with H5, undertaking a qualification was positively associated with increased staff team identity, care professional identity, and organisational identity. In addition, undertaking a qualification was also positively associated with some measures of wellbeing and motivation — notably increased pride and pro-professionalization. In sum, the patterns of association reveal relationships that are broadly consistent with our hypotheses. However, to explore these patterns of support in more detail, and the linkages between incentivisation, identification and workplace motivation as well as the context of care work, identification and workplace motivation, we conducted structural equation modelling.

Structural Equation Modelling. Two theoretical models were tested by structural equation modelling (SEM) using AMOS 19 software. Model 1 (figure 1) examined the relationship between what incentivizes people to work in care and their motivation at work, and the way in which this is influenced by identification with clients and the organization. Model 2 (figure 2) examined whether working domain and undertaking a qualification was related to motivations and the extent to which any effects were due to the degree to which these things strengthened (or undermined) organisational identification.

Model 1. Two sets of SEM results are reported to test Model 1: (a) the results of confirmatory factor analysis which establishes whether indicators measure the corresponding latent variables within the model and (b) the fit of the relationships outlined in the model between latent variables (following Garson, 2011; McDonald & Ho, 2002). To determine the fit of the proposed models we report three Goodness-of-Fit indices (as suggested by Garson, 2012): the chi-square χ^2 (where values below 5 indicate an acceptable fit, values below 2 indicate a good fit); one incremental fit index, the Comparative Fit Index (CFI; indices range from 0 to 1, with values exceeding .90 indicating a good fit); and one residual fit index, the Root Mean Squared Error of Approximation (RMSEA), which is based on the proportion of variance not explained in the model (where values above .08 indicate poor fit, above .05 indicate good fit, and below .05 indicate excellent fit; see Hu & Bentler, 1999, for further discussion of the appropriate application of Goodness-of-Fit indices to test Model fit see also Garson, 2011; Kenny, 2001).

In order to provide additional support for our models, we test a null model and compare our models to plausible alternative models, which are outlined in greater detail below. The null model (where all the parameters are set to zero) tests the assumption that no co-variation exists among the variables that make up the model and provides a baseline against which to compare the theoretical model (Crabtree et al., 2010). In addition to testing

this model on the largest, most representational sample (the cross-sectional data at Time 2) we further corroborated our proposed theoretical model by conducting the analysis on a different sample, the longitudinal data ($n=204$).

Table 5 provides details of the confirmatory factor analysis and Goodness-of-Fit measures for the Models tested on Time 2 data. Confirmatory Factor Analysis validated the measurement of the model, establishing that the indicators (i.e. the items) in the model measured the corresponding latent variables (i.e. the measures), $\eta_p^2(360) = 4.78$, CFI = .92, RMSEA = .055. As expected, the null model did not fit the data well, with a highly significant chi-square indicating a significant difference between the observed and estimated covariance

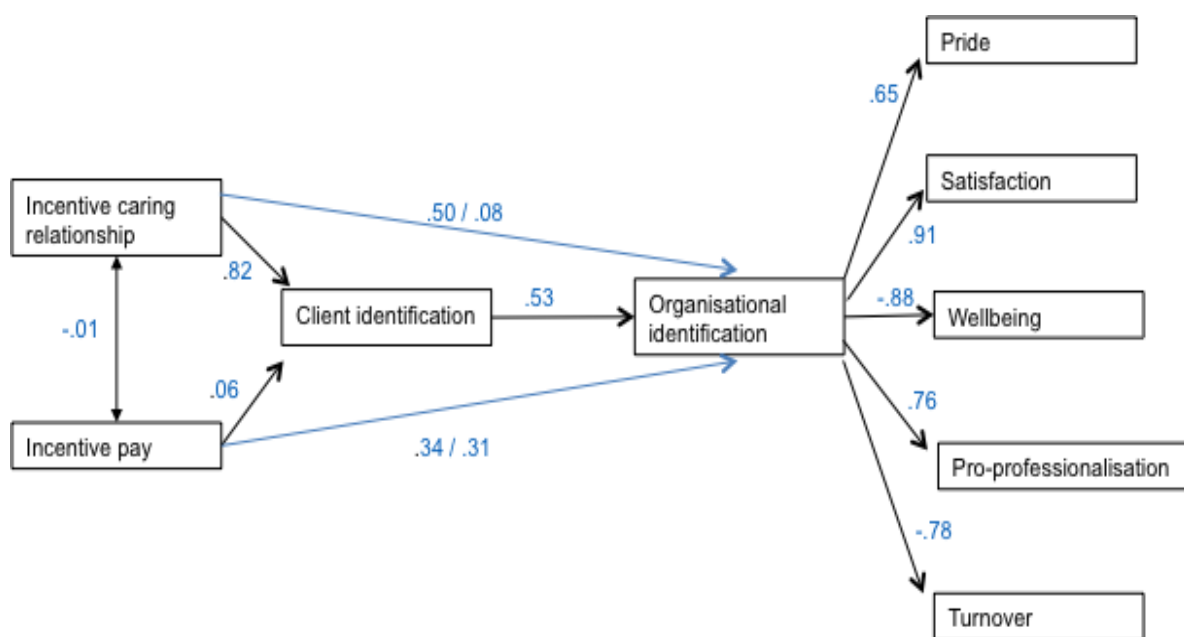


Figure 3: Model 1 Incentives and Motivation, T2 data

matrices, $\eta_p^2(435) = 38.94$, CFI = .001, RMSEA = .18. The hypothesised model then tested our integrated theory (a) that what incentivises people to work in care (relationships with clients or pay) leads to increased motivation outcomes because it builds identification with the organisation (H2 & H3) and (b) that the effects of incentives on organisational identity are mediated by identification with clients (H1).

This theoretical model fitted the data substantially better than the null model, η_p^2 (392) = 5.90, CFI = .89, RMSEA = .060. In line with common practice we also examined how the fit of the model might be improved by inspecting the standardised residual matrix for highly correlated error terms and then allowing these to correlate in the model (Crabtree et al., 2010; Ullman, 1996). Highly correlated error terms were observed among indicators within a number of latent variables (organizational identification, client identification, satisfaction, stress, and pro-professionalization) and so these were allowed to correlate. The adjusted theoretical model also had a good fit to the data, η_p^2 (405) = 4.55, CFI = .92, RMSEA = .054. As shown in Table 5, the application of this model to the other data sample outlined above confirms its robust fit.

Table 5: Model 1. Goodness of Fit Measures

Time 2 data	X ²	Df	CFI	RMSEA
Null model	38.94	435	>.001	.175
Unadjusted theoretical model	5.90	392	.89	.060
Theoretical model	4.55	405	.92	.054
Alternative theoretical model A1	6.05	337	.87	.064
Alternative theoretical model A2	5.72	258	.89	.062
Alternative theoretical model B	14.89	282	.69	.106
Alternative theoretical model C	13.4	194	.73	.10
Alternative data sample				
T1 data (n641)	3.70	350	.91	.065

Notes: N for chi square is 1234. CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation.
Theoretical model = pay and relationship to clients (incentives) leads to increased motivation outcomes (IMO) mediated by ID client to ID organisation (ID org)
Model A = as above except mediated by ID org to ID client
Model B = IMO to incentives mediated by ID client to ID org;
Model C = Incentives direct to IMO

The fit of the adjusted theoretical model was also compared to plausible alternative models. Alternative Model A examined the possibility that organizational identification leads to client identification, and that the latter is mediates the relationship between factors that incentivize participants to work in care and levels of motivation. Alternative Model B turned the hypothesised model on its head and examined the possibility that participants' level of motivation explains what it is that incentivizes them to work in care and that this is mediated by their level of client and then organizational identification. Alternative Model C examines a traditional economic model of motivation which suggests that people are incentivised to work in care as a function of their levels of motivation without any mediating role for processes of identification. As can be seen in Table 5, Model B and Model C had a very poor fit to the data, and Model A did not fit the data as well as the theoretical model. In summary, our theoretical model appears to provide a better representation of our data than other models that propose plausible alternative casual sequences. Our confidence in the validity of hypothesised Model 1 is further strengthened by its robustness when tested on different size sample at Time 1..

Model 2. Structural equation modelling was also used to test theoretical Model 2 — that different working domains and undertaking qualifications would affect motivation to the extent that each of these serves to build organisational identification.

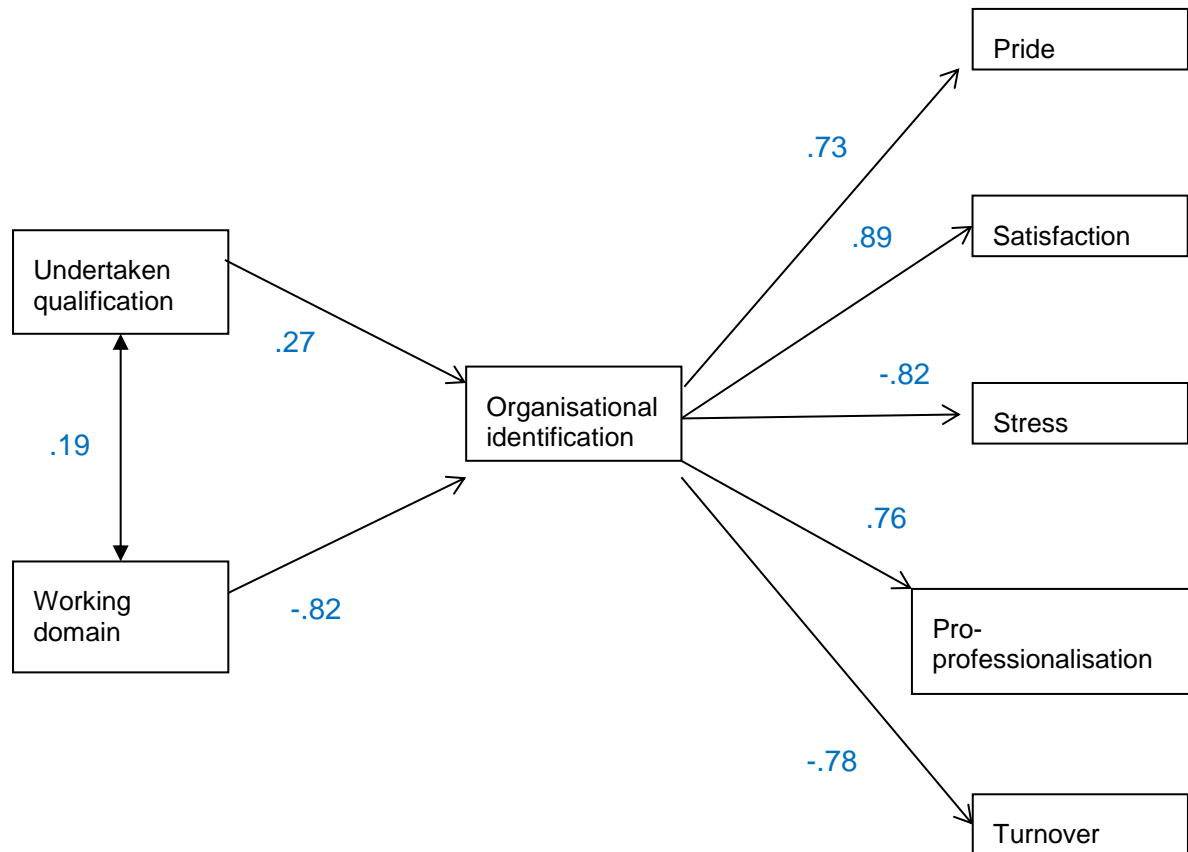


Figure 4: Model 2. The effects of undertaking a qualification and working domain on motivation

This followed the same analytical logic as Model 1 above. Table 6 shows the confirmatory factor analysis and goodness-of-fit measures for the hypothesized model, as tested on cross-sectional data at T2. Confirmatory factor analysis validated the measurement of the model and, as expected, the null model did not fit the data well, as evidenced by a highly significant chi-square. The theoretical model examined the relationship between having undertaken qualifications in the last year, and subsequent motivation, and the extent to which these relationships were mediated through identification with the organization. As Table 6 indicates, the theoretical model fitted the data substantially better than the null model.

After adjusting the model to allow a number of highly correlated items to correlate (organizational identification, satisfaction, and pro-professionalization) the amended theoretical model had good fit to the data, $\eta_p^2(156) = 4.92$. CFI = .92, RMSEA = .056. In line with recommended best practice, to test the robustness of the model we repeated it on a subsample of data comprised of those participants who took part at both times ($n=203$). This also provided evidence of good fit.

We also tested two other plausible alternative theoretical models. Alternative Model A tested the possibility that client identification predicted organisational identification, and that both of these sequentially mediated the relationships between undertaking a qualification and working domain on the one hand and increasing wellbeing and motivation on the other. This model also offered a good fit with the data, but the theoretical model had a superior fit. A second plausible alternative, Model B, assessed whether undertaking a qualification and working domain led directly to increased motivation and wellbeing. This model had poor fit.

Table 6: Model 2. Goodness of Fit Measures

Time 2 data	χ^2	Df	CFI	RMSEA
Null model	43.64	176	>.001	.186
Theoretical model	4.92	197	.92	.056
Unaltered theoretical model	5.91	197	.89	.064
Alternative theoretical model A	5.15	261	.90	.058
Alternative theoretical model B	10.9	136	.82	.090
Alternative data sample				
Longitudinal T2 data (204)	1.61	200	.92	.058
Note: N for chi square is 1234. CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation.				
Theoretical model — Undertaking a qualification (UQ) & working domain (WD) to increased motivation outcomes (IMO) mediated by organisational identification (ID org);				
model A = UQ & WD to IMO by ID Client to ID Org;				
model B = UQ & WD direct to IMO				

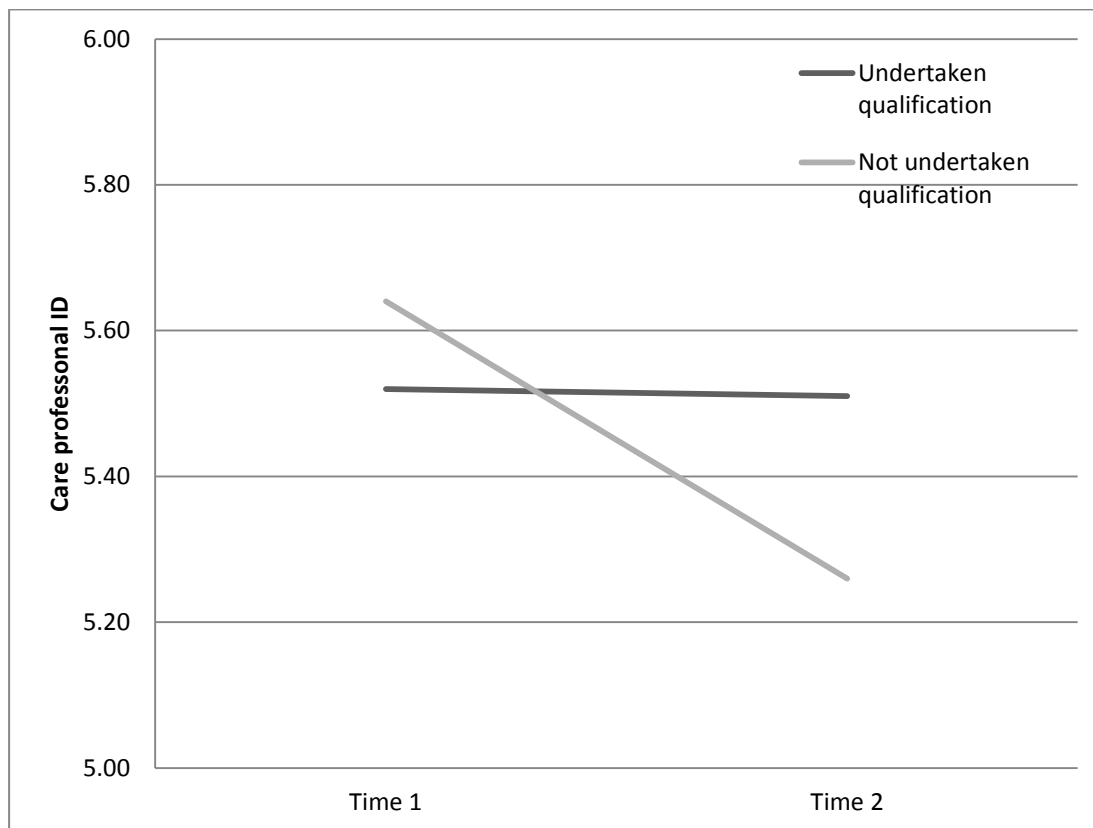
Variation in responses over time: Longitudinal data. To look at the effect of time on participants motivation we conducted an examination of the longitudinal data at T1 and T2 (n

= 204)³. First we conducted a paired samples *t*-test on measures of motivation and identification at the two times. In general, participants' responses were consistent over the year. Nonetheless, (a) participants' level of commitment rose over the course of the year, $t(197) = 2.72, p < .005$, (b) their attitude towards professionalization became more positive $t(186) = 3.2, p < .005$, (c) their identification with care professionals decreased, $t(191) = 1.96, p < .05$, (d) the value they attached to working conditions rose $t(199) = 2.02, p < .05$, as did (e) the value they attached to opportunities for training and development, $t(198) = -2.53, p < .05$. Against this backdrop of evidence that there was little change in motivation and identification over the course of the year, and taking into account the pathway analysis tested in the SEM models (which demonstrated that motivational outcomes were preceded by identification with work groups), we tested the effects of undertaking professional qualification on identification (i.e., H5c).

Phase 2: Longitudinal panel data analysis — the effects of undertaking a professional qualification on identification (H5c). Panel data analysis enabled us to refine our investigation and control for reverse causality and selection bias (following the strategy employed by Lim & Putnam 2010). Here participants' identification with care professionals was examined by means of a 2 (group: gained/did not gain qualifications) X 2 (phase: Time 1/Time 2) ANOVA, with repeated measures on the second factor. This analysis revealed a significant effect for phase, Wilks Lambda = .96, $F(1,201) = 7.37, p = .007, \eta_p^2 = .04$, indicating that participants were less identified with care professionals at T2 ($M = 5.39, SD = 1.0$) than at T1, ($M = 5.51, SD = .81$). However, this effect was conditioned by a significant interaction between group and phase, Wilks Lambda = .97, $F(1,201) = 6.51, p = .01, \eta_p^2 = .03$. This interaction is plotted in Figure 5. Tests for simple effects revealed that there was no difference in identification with care professionals over time for participants who had taken part in training between T1 ($M = 5.52, SD = .81$) and T2 ($M = 5.51, SD = .97$) Wilks Lambda 1.00,

$F(1,201)=.02$ $p=.91$, $\eta_p^2 = .00$. However, there was a significant reduction in the identification of those who had not undertaken qualifications between T1 ($M=5.64$, $SD=.08$) and T2 ($M=5.26$, $SDs =.09$), Wilks Lambda = .94, $F(1,201)=14.08$, $p<.001$, $\eta_p^2 =.06$.

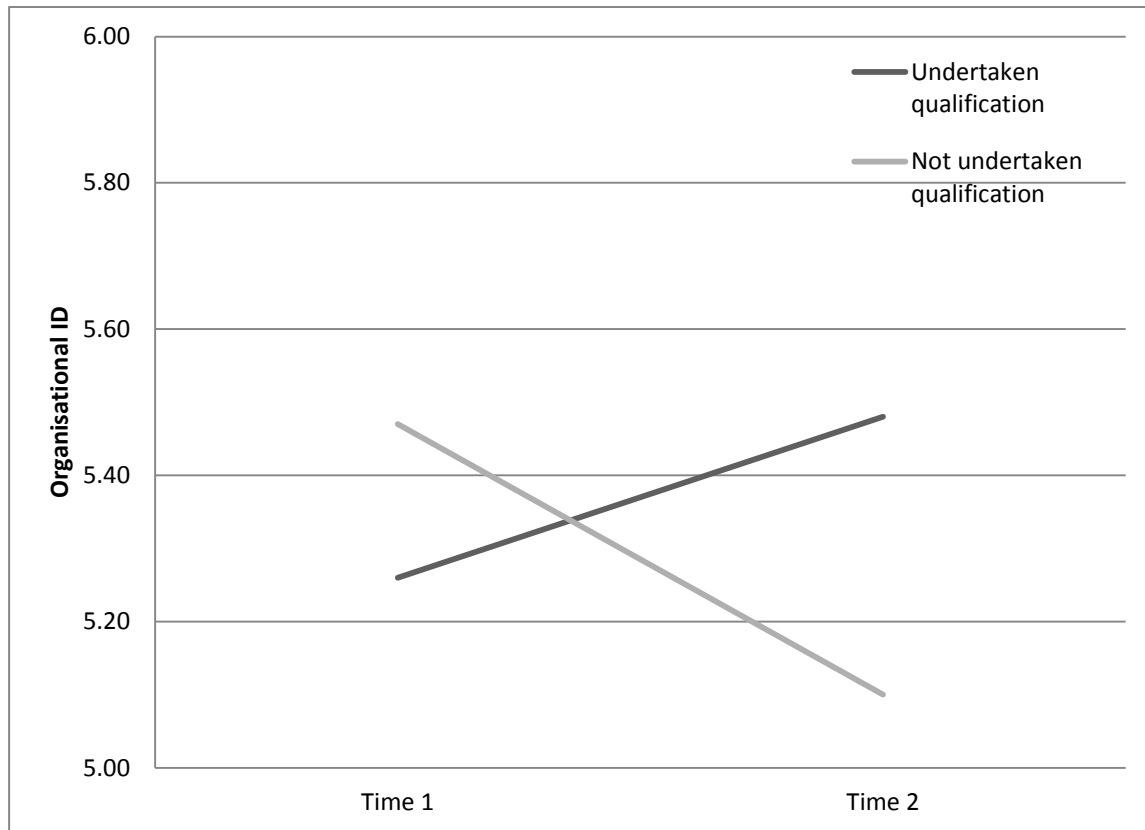
Figure 5: Longitudinal panel data; the effects of undertaking a qualification on care professional identification.



The same analysis was performed on participants' identification with the organization. This revealed no main effect for phase (Wilks Lambda = .99, $F(1, 201)=.10$ $p=.75$) but a significant interaction between group and phase, Wilks Lambda = .97, $F(1, 201)=3.83$, $p=.03$, $\eta_p^2 = .02$. This interaction is plotted in Figure 6. Tests for simple effects revealed that the organizational identification of participants who had undertaken a qualification rose, albeit not significantly, from Time 1 ($M=5.26$, $SD=.09$) to Time 2 ($M=5.48$, $SD=.10$), Wilks Lambda =.98, $F(1,201)=3.1$, $p=.08$, $\eta_p^2 =.02$, whereas the organizational identification of those who had not undertaken qualifications decreased, again not significantly, from at Time

1 ($M=5.47$, $SD=.11$) to Time 2 ($M=3.1$, $SD=.10$), Wilk's Lambda = .99, $F(1,201)=1.78$, $p=.18$, $\eta_p^2=.009$.

Figure 6: Longitudinal panel data; the effects of undertaking a qualification on organisational identification



The same analysis was also performed on participants' identification with clients. Here a similar pattern was observed to that with care profession identification, however there was no significant main effect for phase (Wilks' Lambda = .99, $F(1, 201)=.118$, $p=.28$) and no significant interaction effect between group and phase, (Wilks' Lambda = .99, $F(1, 201) = 2.21$, $p=.14$).

In summary, our findings show that undertaking professional qualifications served to increase carers' identification with the organization, and maintain carers' identification with care professionals, whereas not undertaking professional qualifications was associated with a reduction in their identification with both groups at work. This accords with evidence from

pathway analysis using SEM where Model 2 suggests that undertaking a qualification leads to increased motivation outcomes because it serves to build organisational identification.

Discussion

The purpose of this study was to examine care-workers' motivation with an emphasis on the forces that strengthen or undermine this and the processes through which these effects on motivation occur. More specifically, the study sought to (a) to gain a better understanding of the implications of being incentivised by material (pay) or virtuous (relationships with clients) rewards on care workers' motivation at work, (b) to examine the effects of the working context (i.e. the working domain and the experience of undertaking a qualification) on care workers' motivation, and (c) to consider the role of identity processes in explaining the effects of incentives, professionalization and the working context. Theoretically, this investigation drew on the framework provided by the social identity approach (Haslam 2004). Based on this perspective, we argued that organisational identification provides a critical underpinning for sustainable motivation in the workplace (Ellemers et al., 2004). Consequently, factors that serve to build or reinforce organisational identification (e.g., incentives or specific forms of training) should have a positive impact on individual motivations at work. At the same time, this analysis was supplemented by the proposal (gleaned from qualitative research; Bjerregaard et al., 2014) that for this particular workforce (and arguably many other 'helping' occupations) relational identification with clients, patients or service users is central to the way in which workers define themselves within the broader organisational context. This suggestion also accords with previous research in the social identity tradition (Sluss et al., 2012; Sluss & Ashforth 2008), which illustrates that motivation should be particularly enhanced when these different bases of identification — relational and organisational — align. Accordingly, we also examined the relationships

between relational and organisational identifications and their combined role in supporting carer motivations.

Summary of findings

Consistent with other studies undertaken with care workers (Atkinson et al., 2009; Skills for Care 2007; Hussein et al., 2010) participants in our study reported high levels of satisfaction and pride, and low levels of stress. Participants were motivated to work in care because of their relationships with clients, and they attached high value to training and personnel development, and to working conditions, but relatively low value to pay. Consistent with previous work (Haslam et al., 2003; Riketta, 2005; Van Knippenburg et al., 2003; Van Dick 2001), and with H1, the findings also showed that care workers' identification with different groups at work is positively related to their motivation. In particular, care workers' motivation was predicted by both their identification with clients (H1a) and their organizational identification (H1b). As anticipated, care workers indicated higher levels of identification with clients than with the organisation (H1c), but levels of motivation were best predicted by organisational identification (H1d).

Effects of incentives. The findings from structural equation modelling further confirmed that although care workers were primarily incentivised by “love” (i.e., relationships with clients) rather than “money” (i.e., pay), attaching value to either of these incentives was associated with increased motivation (H2a, H3a). Importantly, and consistent with our hypotheses, these relationships between incentives and motivation were also mediated by patterns of identification (H2b, H3b). Specifically, being incentivised by relationships with clients fed into motivation by increasing relational identification and, through this, organisational identification (H2c). A similar pattern was evident for incentivization by pay, however here the mediating role of organisational identification was stronger (H3c).

Contrary to mainstream economic thinking about care work, these findings suggest that virtuosity and/ or money do not in themselves lead to increased motivational outcomes. Rather, they result in increased motivation largely to their ability to build and reinforce care workers' organisational identification. Thus, rather than being particularly valued in its own right, pay can be seen to play an important role in motivating staff because it helps build organizational identification — for example, by indicating to the individual that they are valued by the organisation (Tyler & Blader, 2000). Likewise, enacting relationships with clients builds motivation because this behaviour reflects the way in which individuals see themselves within the organisation. Indeed, the very weak fit of a model that represented the mainstream economic and individualistic perspectives on motivation — wherein incentives directly affect motivation — suggests that this oft-cited dichotomised explanation for work in this domain fails properly to explain care workers' motivation.

Effects of work domain. In line with H4, care workers' attachment to their job (i.e. pro-professionalization and low turnover intentions) was found to vary as a function of their working domain. Residential care workers displayed generally higher job attachment than domiciliary workers, who tend to be based away from the organisational centre in the community. Moreover, these domain-based differences in motivation could again be accounted for by patterns of identification (H4b & 4c). Specifically, residential care workers evinced higher levels of identification with the organization, staff, and other care professions, whereas domiciliary workers attached higher value to their relationship with clients. Furthermore, structural equation modelling showed that the effects of working domain on motivation were mediated through organisational identification. This showed that both domiciliary and residential care workers identified strongly with clients yet the fact that residential care workers identified more strongly with their organisation suggests that for this

group, client and organisational identity are more congruent, than is the case for domiciliary workers.

Effects of professionalization. In line with other research into the effects of identification on training outcomes (Author et al., 2013; Pidd 2004), our findings indicate that undertaking a qualification increases wellbeing and attachment to one's job. However, consistent with our overall theoretical framework, these effects of training could also be understood in terms of their consequences for organizational identification. Specifically, it appears that undertaking a qualification increased well-being and attachment because this reinforced individuals' sense of identification with their organisation (H5a). Interestingly, although we predicted that organisational identification would be most important for explaining qualification effects, an alternative model that incorporated client identification as a precursor to organisational identification accounted for the data nearly as well. This pattern reflects the pattern observed for incentivisation and further underscores the important linkages between client-based and organisational identification within this domain.

More detailed longitudinal analyses also showed that undertaking a qualification served to maintain individuals' identification over time, whereas identification weakened among those who did not undertake a qualification (H5c). Again, this supports our proposal that impact of professionalization on care workers' motivation can be accounted for by its impact on work-based identification.

Theoretical implications: Identity convergence and the creation of a (compassionate) workforce

Overall, these findings corroborate and strengthen findings from previous organisational studies that have pointed to the positive mediating effects of organisational identification on motivational outcomes (see Ashforth et al., 2008; Ellemers et al., 2005; Jetten et al., 2011; Haslam et al., 2003; Van Knippenburg, 2000). In addition, this research

considered the dynamic relationships between organisational identity and other work-based identities that operate at different levels of abstraction (Riketta & Nienaber, 2007; Sluss et al., 2012; Smith et al., 2012). In particular, we explored the relationship between relational identification with clients (or service users / patients) and organisational identification and found that client identification can become a basis for organisational identification, and accordingly that the forces that strengthen the former also strengthen the latter — with positive consequences for different forms of organisational motivation.

Tests of alternative models that considered reversed sequences of mediators demonstrated poorer fit to the data, suggesting that although there is convergence between different forms of identification (i.e. relational and organisational), it is likely to be the former that builds the latter rather than the other way around. This may reflect the fact that because client identification operates at a relational level of identity it is “a linchpin in overall self-concept at work” (Sluss & Ashforth 2008 p. 11). Drawing on findings from our previous qualitative work with care workers (Author et al. 2013), this convergence between the specific relational identification and broader organisational identification is likely to occur through two processes. First, it may occur through the process of ‘affect transfer’, whereby “affects generated from identifying with a role relationship may directly and unconsciously transfer to the organisation and vice versa” (Sluss & Ashforth, 2008 p5). That is, the positive affect generated from identifying with the carer role is transferred to the assessment of the organization in terms of its capability to care (both for clients and carers themselves; Author et al., 2013). Second, it may also occur through the process of “behavioural sense-making” whereby “what one does, informs and confirms who one is” (Sluss & Ashforth. 2008, p.6). That is, enacting a carer role with which one identifies informs how one thinks both about one’s self as a representative of the organisation and about the organisation itself.

In these ways, this study supports the notion that the different levels of care workers' identification (relational identification with clients and social identification with the organisation) converge around care workers' perceptions that the organisation values (a) their relationship with their clients, (b) the interests of the clients, and (c) the care workers themselves. Equally it explains care workers' disengagement and frustration at the organisation should they perceive it not to be acting in accordance with caring values. Applying this logic further, it could be argued that, in the context of care work, the creation of a compassionate working culture depends on harnessing and supporting the meaningful identities through which individuals understand their work, as well as promoting alignment between work-based identities at all levels (personal, relational, and organizational).

Practical implications

At a practical level, this study has shown how the social identity approach can provide a multi-dimensional, dynamic framework through which to better understand care workers' motivation. First, by integrating the virtuous and financial aspects of caring — that is, by seeing both of these as rewards that speak to workplace identities — this model challenges the simplistic view that care workers' motives are dichotomised between either 'love' or 'money'. Instead, it appears that care workers are motivated by both 'love' of the caring relationships they have with their clients and 'money' as reflective of the caring relationship that exists between them and the organization for which they work. Second, this framework suggests that in order to be successful in building a compassionate culture in health and social care, attention needs to be paid to people's prevalent work-based relational and social identities (e.g., as argued by Haslam, Eggins & Reynolds, 2003; Peters, Haslam, Ryan, & Steffens, 2013).

In particular, the values and behaviours that are attributed to these different identities can make them congruent and mutually supportive (e.g., seeing oneself to be both a caring

professional and member of a caring organisation) or can make them ambiguous, irrelevant and conflicting (e.g., seeing oneself as a member of a family alongside being a number and commodity; Bjerregaard et al., 2014). The degree of alignment between multiple meaningful workplace identities should also have consequence for sustained employee motivation. Hence, third, participating activities to promote professionalization and compassionate practice, in this case undertaking a qualification, is likely to motivate care workers to the extent these activities build on or sustain organisational and professional identifications that are meaningful to participants and encourage them to see alignment between the values and goals represented by different foci of organisational identification.

Conclusion

This study provides detailed cross-sectional and longitudinal evidence of the way in which careworkers' motivation is shaped by the dynamics of collective and relational identities at work. In this context the application of the social identity approach offers a theoretical framework for understanding the nuanced ways in which care workers are motivated by both 'love' and 'money' and of the way in which this feeds into increased motivation by building and maintaining meaningful work-based identities, in particular organisational identity. Thus, to the extent that particular incentives validate individual identities at work, they will serve to make individuals more motivated to engage with their work. Conversely, when incentives negate valued identities, this is likely to result in detrimental outcomes for both the individual, in terms of their motivation and commitment, and the organisation, in terms of increased burdens of stress, burnout and high turnover.

In light of our findings we would argue that in the context of care work, as with many helping professions, the relationship and identification with client, patient, service user or beneficiary group is central to understanding and harnessing worker motivation. Indeed, we believe this study goes some way to addressing calls to "examine the team and organisational influences

that contribute to compassionate care and determine how they can be strengthened” (Adamson et al., 2012, p. 32). It does this by confirming that compassionate behaviour and values are enacted and sustained by care workers to the extent they make sense in terms of their salient social, relational and personal identities. It is therefore by recognising, harnessing, and developing these identities that care organizations can encourage those they employ to play their part in enacting a culture of compassionate care.

Chapter 7

Study 3

How identification facilitates effective learning: The evaluation of generic versus localised professionalization training.

Every year organisations across all sectors invest large amounts of money in employee training. For instance, total employer expenditure on training in the UK was estimated at £49 billion in the year 2010/2011 (UK Commission for Employment and Skills, 2011), and in the US it is estimated that every year organisations spend over \$125 billion on employee training and development (Paradise, 2007). Yet, from reported ongoing organisational dissatisfaction with employees' level of skills, it would appear that much (perhaps most) of this expenditure does not translate into improved employee performance (Grossman & Salas, 2011). Indeed, this led to fears that during the global recession (triggered by the financial crisis of 2007/8) there would be a wholesale reduction in organisational investment in training. It appears that this did not in fact materialize, but nevertheless there has been a notable increase in organizations' emphasis on 'training smarter', and there is widespread commitment to this as an important agenda for the future (Felstead, Green, & Jensen, 2011).

A key challenge for workforce training research and practice is therefore to better understand the factors and approaches that increase the likelihood that the content of training will be transferred to, and sustained in, the workplace. At the same time, though, this is a question upon which prior research sheds relatively little light. Across the broader spectrum of all types of employee training, the deficit of empirical evidence is, in part, the result of organisations typically relying on evaluations of their training programs that fail to account for the extent to which training is transferred to the workplace. In this regard, empirical

examination of the efficacy of training, along with organisational training assessments, frequently rely on data that are collected from participants at the end of, or immediately after, the training course (typically through satisfaction questionnaires — often pejoratively referred to as “happy sheets”; Patterson & Hobbey, 2003). However, because they have a “feel-good” function and focus on participants’ subjective evaluations of immediate, short-term impact, it is debatable whether these can or do fully capture the extent to which training is actually transferred to the workplace (Alliger, & Janak, 1989; Edkins, 2002; Kirkpatrick, 1987; Litterell et al., 2006; Wang, 2006).

Nevertheless, a number of meta-analytical studies conducted over the past decade have demonstrated that training activities can have a positive impact on the performance, attitudes, and motivation of individuals and teams (Aguinus & Kraiger, 2009). These include Arthur et al.’s (2003) analysis of 1152 effect sizes from 165 sources; Collins and Holton’s (2004) meta-analysis of 83 studies that looked at the benefits of managerial leadership programs, and Morris and Robbie’s (2001) analysis of 41 studies that investigated the effects of cross-cultural training on expatriate performance and adjustment. These and other analyses of training studies have found that training is effective in improving performance particularly when it is appropriately targeted and delivered in an appropriate environment. However, there is little theoretical analysis of the factors that might shape this ‘appropriateness’ (Aguinis & Kraiger 2009; Grossman & Salas 2011, Salas & Cannon-Bowers 2001). In particular, research related to the ‘transfer problem’ — that is, the problem associated with understanding what leads trainees to effectively transfer skills and knowledge acquired during training into the workplace (Michalak 1981) — continues to be “characterised by mixed findings and lack of empirical synthesis” (Blume et al 2010, p.1089). Moreover, what research there is on the transfer of training to the workplace demonstrates that a significant portion of training knowledge and benefit is typically lost in transferral (Eraut 2000). Indeed, it is estimated that only 10% of learning transfers into job performance (Holton & Baldwin, 2003).

Training effectiveness: The ‘motivation to transfer’

A critical factor that determines whether or not trainees transfer their new-found knowledge and skills into the workplace is their *motivation* to do so. Noe (1986) coined the term ‘motivation to transfer’ to describe “trainees’ desire to use the knowledge and skills mastered in the training program on the job” (p.743). Numerous studies have demonstrated that trainees’ motivation to transfer their training (pre-training readiness, in-training engagement, and post- training commitment) positively influences training effectiveness (Axtell et al., 1997; Colquitt, 2000; Lieberman & Hoffman, 2008). It therefore follows that attention to trainees’ motivation to transfer should be a prerequisite of professionalization training if it is to have any transformative effect on attendees.

Research on motivation to transfer (including the development of a Learning Transfer System Inventory; Holton et al., 2003), has established that both individual-level characteristics (e.g., locus of control, cognitive ability, self-efficacy, valence of training, and relatedness) and situational characteristics (organisational context and culture) are powerful predictors of whether training is transferred to the workplace (Egan et al., 2004; Gegenfurtner et al., 2009, Grant, 2000; Holton et al., 2003; Pidd 2004). However, research on transfer motivation has been criticised for incorporating a one-dimensional and rather individualistic notion of motivation which has mainly been informed by outdated and limited theoretical notions. The most notable of these are related to Vroom’s (1964) expectancy framework and propose that whether or not a person is motivated to transfer their learning into the workplace is dependent on a self-interested calculation in which benefits outweigh cost (i.e. effort; Aguinis & Kraighner, 2009; Gegenfurtner et al., 2009; Simosi, 2012). Seeking to develop a more nuanced understanding of the motivation to transfer, recent studies have applied a more multi-dimensional perspective to the individual characteristics that affect transfer motivation (e.g., drawing on self-determination theory’s conceptualisation of intrinsic and extrinsic

motivation; Deci & Ryan, 2000; Gagne & Deci, 2006; Gegenfurtner et al., 2009) and place more emphasis on the importance of localized context in shaping motivation.

For example, Gegenfurtner and colleagues (2009) examined how attitudes towards training content, relatedness, and instructional satisfaction together affected two different dimensions of trainee motivation: *autonomous motivation*, which is more akin to intrinsic motivation and has been shown to be a more stable predictor of high performance and wellbeing over time (Deci & Ryan, 2000); and *controlled motivation* which is more akin to extrinsic motivation. Contrary to the researchers' predictions, attitudes towards training were not only positively related to autonomous motivation but were also positively related to controlled motivation. The authors suggest that this finding is likely to be explained by the "contextualised nature of the attitude–motivation relation in explaining individual transfer performance" (Gegenfurtner et al., 2009, p.133). They propose that the extent to which individuals' attitudes towards training content will predict different types of motivation is likely to be related to the context in which people are undertaking the training and whether it facilitates or thwarts intrinsic motivation — for example, whether people are engaging in occupational training or recreational pursuits. Yet while the key findings of this study were that trainees' motivation-to-transfer consists of multiple dimensions, including interaction within a particular organisational context, it also draws attention to the absence of a theoretical explanation for the collective and contextual dimensions of training-related motivation.

The importance of the work environment as a factor that determines the likelihood of trainees transferring their skills and knowledge has been empirically demonstrated in other work (Burke & Hutchins, 2007; Ford & Weissbein, 1997). This has primarily been understood in terms of the *training transfer climate* (i.e., "those situations and consequences in organisations that either inhibit or facilitate the use of what has been learnt in training back on the job"; Pike, 2012, as cited in Kinessa, 2012, p.1). Key features of this climate have been

identified as (a) the opportunity to perform, (b) performance feedback, and (c) supervisor/peer support (Ford et al., 1992; Kontoghiorghes, 2004). Yet, despite being recognised as important, “these organisational context factors (as compared with trainee characteristics and training design) have received limited attention in training transfer research designs” (Simosi, 2012, p.94).

It is notable, then, that a key part of the rationalisation and support for work-based training is the recognition that contextual characteristics determine the effectiveness of training. More specifically, training that takes place in the working context has been found to increase the perceived relevance of the training and bypass risks associated with training transfer (Eraut, 2007). This is attributed to the critical role that managers and peers play in facilitating, motivating and legitimising the learning, with Eraut arguing that “the real assessment will be whether your performance meets the expectations of significant others in your workplace” (2008, p.1). Moreover, there is a general consensus that the transfer climate in general, and the support of supervisors and co-workers in particular, influences the extent to which training transfers to the workplace (Pidd, 2004; Rouiller & Goldsten, 1993; Smith-Crowe et al., 2003).

Together, the above research findings suggest that it is essential to understand the interplay of individual and situational characteristics in determining training effectiveness. Yet perhaps unsurprisingly — given the limited empirical work on the impact of work environments on trainees’ motivation to transfer — the increasing attention given to the interaction between trainee and environmental characteristics is primarily evidenced by qualitative literature reviews rather than by quantitative empirical evidence (Burke & Hutchins, 2007; Lim & Morris, 2006).

To address this lack of empirical evidence, Simosi (2012) examined the combined effects of trainee self-efficacy and organisational culture on employees’ (self-reported) transfer of training to the workplace. She found that high self-efficacy strengthened training

transfer in both an achievement-orientated organisational culture and a humanistic support-orientated culture, whereas low self-efficacy weakened these relationships. Simosi's explanation for these patterns is that when trainees feel confident in their ability to perform, it becomes more likely that they will take advantage of the organisational cultural context to apply the skills and knowledge acquired through training. She goes on to propose that "in both achievement and humanistic work environments, 'positive' group norms are still likely to induce employees' training transfer; however, such tendency is likely to be less strong in the case of trainees who [do] not feel that they could succeed in their tasks" (Simosi, 2012, p.102). At the same time, though, Simosi acknowledges the limitations of the "the eclectic nature of the framework proposed here", which was based on a combination of social cognitive and social exchange theories, and calls for "a more comprehensive model [that] would warrant inclusion of a more theoretical construct" (2012, p.103). The findings of this study further highlight the need for the training literature to develop and test a plausible, multi-dimensional, theoretical framework to account for the interrelationships between trainee and organisational characteristics that promote the transfer of training into the job (Aguinis & Kraiger, 2009; Korte, 2007; Pidd, 2004; Simosi, 2012).

Work place identification and training transfer

One plausible way of reframing and integrating the interaction between trainee characteristics and the features of the organisational environment is to understand this in terms of trainees' social identification at work (Korte, 2007; Pidd, 2004). As a specific form of social identification, workplace identification speaks to the issue how an employee's self-concept at work is shaped by their sense of belonging to their particular organisation or workgroup (Ashforth & Mael, 1989, Haslam, 2004). For employees high in workplace identification, the dynamics of their work team, department or organisation become an important aspect of their own self-concept leading them to orient their motivations toward

that work team, department or organisation. As such, workplace identification is an important lens through “which people perceive new information, attribute cause, make meaning, and choose to undertake new learning” (Korte, 2007, p.177). Indeed, through a social identity lens, professionalization and training can be understood as key mechanisms that build and consolidate workplace identification at a variety of levels, be it team, sub-unit, organisation, or occupation.

Yet, to date, few studies have sought to apply a social identity approach in order to understand learning and training effectiveness at work. One notable exception is a study by Pidd (2004) which set out to examine why social cues and consequences in the supervisor/ co-worker support environment are influential for some trainees but not for others. In his study on drug and alcohol safety training in Australia, he convincingly demonstrated that the effect of social support (from supervisors and co-workers) on training transfer was present only to the extent that trainees identified with the workplace groups that provided this support. On this basis he concluded that “the degree to which workplace support facilitates training transfer is strongly influenced by the characteristics of individual trainees, specifically [their] identification with the workplace” (Pidd, 2004, p.285). This pattern is consistent with a long tradition of research which has shown that social identification (as a member of a group) plays a key role in how individuals make sense of themselves and the world around them in a variety of different domains (Haslam & Ellemers, 2005; Van Dick, 2001; Van Knippenberg, 2000).

The social identity approach (combining social identity theory, Tajfel, 1974; Tajfel & Turner, 1979 and self-categorisation theory, Turner, 1985; Turner, 1986; see Haslam, 2004), understands that a person’s self-concept incorporates both individual (personal) and collective (social) identities. That is, people can define themselves in terms of their personal uniqueness as distinct from other individuals (Postmes & Jetten, 2006) and equally, they can conceive of themselves in terms of group memberships that they share with others (Tajfel and Turner

1979; Ontario & Turner, 2001). However they define themselves (be it as an individual or as a member of a group), a person will endeavour to develop and maintain a positive, distinctive and enduring sense of self (Oakes, Haslam & Turner 1994). Accordingly, if I define myself as an individual then I am more motivated to achieve this positive and distinctive sense of self through individualistic pursuits (i.e., through personal self-enhancement), whereas if I define myself primarily as a member of a workgroup then I will be motivated to achieve positive distinctiveness by acting on behalf of that group, and promoting its norms, values and interests (i.e. through collective self-enhancement).

Within this theoretical perspective, the self-concept incorporates different forms of self-categorisation that exist at different levels of abstraction. For example, a care worker attending a multi-disciplinary training course might define herself in terms of a variety of self-categorisations ranging from the more to the less abstract: as a trainee, a care worker, as an employee of a given organization, as a dementia-trained care worker, as a colleague, and as Sue. Understanding who Sue is as an individual or as a colleague, however, is always set against the backdrop of the more abstract and inclusive categorisation that contains these lower-level identities, for example in terms of her team, profession, or current role. Within the social identity framework, context (i.e. the social environment) determines which level of self-categorisation will be more meaningful to the trainee care-worker's self-concept and, therefore, more defining of the self at any given moment (Haslam et al., 1996; Oakes et al., 1991).

More specifically, the salience of a given self-category (i.e., the extent to which it is meaningful and hence is a basis for social identification) relates to its *accessibility* and *fit* in a particular work context (Millward & Haslam, 2012). For example, the longer someone works with their supervisors and co-workers, the more accessible and therefore more meaningful the shared workgroup identification is likely to become. The strength of a care-worker's workgroup identification will also be affected by the fit of the social self-category (or social

identity) in question, specifically (a) the extent to which it is perceived as providing a *normatively fitting* basis for self-definition (i.e., consistent with one's content-related expectations); and (b) the extent to which it is perceived to be *comparatively fitting* in helping to make sense of similarities and differences between oneself and salient others. So, for example, our care worker Sue is likely to feel a greater sense of workgroup identification if she perceives the values and aspirations of her workgroup to be aligned with her own (normative fit). She is also likely to feel a greater sense of identification if the workgroup is clearly differentiated from other groups with which she comes into contact (e.g., managers, clients, or other teams; comparative fit).

By focusing attention on the influence of social groups on a person's self-concept, the social identity approach provides novel insights into a range of topics that are central to organisational life (Ashforth & Mael 1989; Haslam 2004). Related to the issues at hand, these include motivation and performance (Ellemers et al., 2004; Hewapathirana 2012; Riketta & Nienaber, 2007; Van Knippenberg, 2000), communication (Bartel et al., 2007, Morton et al., 2012; Tanis & Beukeboom, 2011; Wright et al., 2011), knowledge transfer (Child & Rodrigues 1996; Kane, 2010), leadership (Haslam et al., 2011), participation at work (Haslam, 2009), relatedness (Korte, 2009), and new-comer socialisation (Ashforth, Sluss & Saks, 2007; Smith et al., 2012). When it comes to a more specific understanding of learning in the workplace, the key value of the social identity approach is that it offers an integrated theoretical framework through which to understand the interplay of trainee and situational characteristics at each stage of the training process. As outlined above, previous research has identified these trainee and situational characteristics as key factors that contribute to trainees' motivation to transfer their learning, which in turn effects whether or not learning is transferred to workplace performance. However, according to the social identity framework the influence of these characteristics should be contingent upon the way that they structure the trainee's self-concept at each stage of the training process: in pre-training preparation and

orientation; during in-training *engagement*; and in post-training *enactment*. Drawing on empirical evidence from social identity research, we suggest that many of the key trainee characteristics that have been found to contribute to trainees' motivation to transfer are likely to be affected by the extent to which trainees identify with salient workgroups, both in the pre-training environment, the learning environment, and training transfer climate.

In this regard, several previous studies shed light on the way in which work-based identification might affect different stages of the learning process. Particularly relevant to the influence of identification on trainees' pre-training orientation and engagement with the training, is Ashforth, Sluss & Sak's (2007) conclusion that the "affirmation of new-comers' incoming identity (i.e. investiture) had particularly salutary effects on their subsequent adjustment — independent of content" (p.459). Hence a trainees' motivation to transfer learning is likely to be affected by their perception of the relevance and usefulness of the training, and this perception is itself likely to be shaped by the nature and strength of their work-based identity. Moreover, a sense of shared identification with the trainer is likely to positively influence a trainee's engagement in the training and a related increase in the acquisition of knowledge and skills because under these circumstances the trainee is more likely to follow the trainer's instructions and take his or her advice (Wright et al., 2011; Morton et al., 2012). In addition post-training motivation to enact the learning is likely to be mediated by organisational identification (Bjerregaard et al., 2014) and also facilitated by the organisational culture and supervisor/peer support environment, to the extent that the trainee identifies with it (Korte, 2007; Pidd, 2004). Along related lines, affirmative feedback from co-workers and supervisors gives social validation and encouragement of the skills and knowledge gained in the training (Ashforth et al., 2008; Smith et al., 2012). Thus it seems likely that the newly learnt behaviour of trainees, like that of newcomers, will be enacted to a greater or lesser degree to the extent their work-based identity receives meaningful social validation and recognition.

Following on from this logic, we suggest that a primary purpose of professional training should be to build, develop, and consolidate meaningful work-based identifications. More specifically, workers are more likely to be motivated to transfer their learning (i.e. to believe that that training is relevant, engaging and valid) to the extent that training fits with, and therefore makes sense in terms of, their salient work group identification. In addition, we anticipate that the sense of ‘relatedness’ social identification provides could mediate the relationship between increased workgroup identification, generated from the type of training, and improved motivation to transfer training.

The present study: Examining the efficacy of different forms of care worker training

The task of improving the effectiveness and efficiency of training is particularly relevant to the adult social care workforce — a sector that is currently responding to increased calls for its professionalisation. For while it is typically characterised by low investment (related to low financial return, and the low value attached to caring skills) there is nevertheless an on-going emphasis on improving the quality of workforce training in order to meet escalating demands for high-quality care (CQC, 2012; DoH 2009; Wild 2010). As in other sectors, workforce training is viewed as playing a pivotal role in professionalisation, yet there is a pronounced paucity of research that assesses the impact of this training on the quality of care (Meyer 2008; Wild et al., 2010). As Meyer notes, “the literature on education and training in care homes is sparse, fragmented and made up of small-scale studies, largely qualitative in nature” (2007, p.133). Questions have also been raised about the effectiveness of social care training and whether it is fit for purpose. In particular, social care organisations have been accused of offering “training as a panacea to all the ills of health and social care work,” without clear evidence that it actually changes the way care workers do their job (Kinessa, 2012, p.1)).

In line with the broader training world, care specialist training organisations seek to provide novel training approaches that involve experts from afar and draw on a range of communication technologies (e.g., interactive television and e-learning) in order to meet increasing demand from clients (i.e. care organisations) to increase training effectiveness while simultaneously reducing costs. Again, though, few (if any) empirical studies have assessed the impact of these training approaches on the provision of care. In particular, no work, to the best of the authors' knowledge, has examined how the efficacy of these new modes of training compares with that of standard localised training.

The purpose of the present study was to examine the effectiveness of these different two types of training programs —a non-standard generic training program (NGP; which can be seen as oriented to distal workgroup identities), and a standard localised training program (SLP; which can be seen to be oriented to local identities). Moreover, the study sought to examine the efficacy of these different training programmes through a social identity lens, by examining whether (and how) their effects might be explained through their impact on workgroup identification.

In this regard, it is notable that while the two training programmes had very similar goals and content⁹, the formats of training delivery, outlined in Table 1, meant that they engaged with participants' workplace identities in quite different ways. In particular, while the SLP engaged closely with these identities (being delivered on-site by senior colleagues), the NGP did not (being delivered remotely by experts who were unknown to participants). In line with previous research, as well as the other studies included in this thesis, (Ashforth et al., 2007; Bjerregaard, Haslam, Morton & Ryan, 2013; Ellemers et al., 2004; Haslam et al., 2009; Smith et al., 2012), this led us to anticipate that participants would respond less positively to the NGP than to the SLP and that — at least in part — this would be explained by the fact that

⁹ In spite of overall common training themes and content the data showed differences in content between the training so this was controlled for in the analysis.

the former is less directly relevant to their identification with groups in their immediate workplace. The logic of this prediction is summarized in Table 7, which outlines the different delivery methods and approaches of each training program, and the degree to which various practices are likely to increase meaningful work-group identification.

Table 7: The components of the different types of training programs and their predicted bearing on relevant workgroup identities

<i>Training process and components</i>	<i>Non-standard generic training (NGP)</i>	<i>Standard localised training (SLP)</i>
Pre-training readiness: The extent to which care-workers anticipate that training will be self-enhancing will be shaped by their social identities.	Training topics and timetable of training is pre-determined from afar.	Training courses are provided with reference to the needs of the majority of care-workers within the care home or the care organisation.
Training design: The extent to which training harnesses care-workers' existing identities; develops and strengthens appropriate new identities.	<p>Training focuses on country-wide best practice, national standards, norms and approaches .</p> <p>Emphasis is placed on the generic workgroups with which care-workers might identify: learners, care professionals, supervisors, team players, service users.</p>	<p>Training meets national standards and is tailored to the specific needs of staff in each, or in a group of care homes .</p> <p>Emphasis is placed on localised workgroups with which care staff might identify: the organisation; the care home; dementia residents in a care home; the management team..</p>
Training delivery: The extent to which delivery methods and instructors tap into trainees' identities.	<p>Training is delivered by experts from afar and an in-house facilitator</p> <p>Training is delivered in live television programmes at set times each fortnight, then afterwards via recordings. Post-show interactive discussion, between experts and viewers, and within care homes, quizzes.</p>	<p>Training is delivered face-to-face by local experts and in-house trainers.</p> <p>Training is delivered using mixed media, presentations, discussions, group work, realistic practice scenarios, quizzes.</p>
Trainer's role: The extent to which trainees relate to and feel identified with the trainer will affect their motivation and learning.	One of the care home staff (typically the deputy manager) facilitates the televised training session.	The trainer is a local expert who is likely to be involved in most of the stages of assessment, design, delivery and follow up of the training.
Post-training, transfer climate: The extent to which training is followed up in a supportive work environment that enhances identification.	Nothing formally arranged, learning could be reinforced at staff briefings, meetings, through supervision and peer group behaviour.	Learning is likely to be reinforced at staff briefings, meetings, through supervision and peer group behaviour.

Hypotheses

More specifically, this study sought to test five key hypotheses:

- H1. That NGP training will be associated with a reduction in workgroup identification whereas SLP training will maintain or strengthen work group identification.
- H2. That NGP training will be associated with a reduction in trainees' perception of the relevance and usefulness of the training, (as measured by the perceived utility of training, PUT), whereas SLP training will maintain or strengthen PUT.
- H3. That NGP training will be associated with a reduction in motivation to enact training (as measured by participation at work), whereas SLP training will maintain or strengthen participation at work.
- H4. That NGP training will be associated with a reduction in trainees' immersion in the training; as measured by the level of relatedness experienced on the course, whereas SLP training will maintain or strengthen trainees' sense of relatedness.
- H5. That support for H2 and H4 will be explained, at least in part, by support for H1 and H3. That is, the reduction in motivation to transfer learning associated with the NGP training (relative to the SLP training) will be explained by (a) the reduced work identification that it engenders (relative to SLP training) which (b) in turn will predict reduced relatedness on the course (relative to SLP training).

Method

A quasi-experimental study was conducted with workers in two groups of residential care homes: a test group of four care homes in which staff undertook new NGP training and a comparison group of four care homes in which staff continued to undertake SLP training. Participating care homes were selected in consultation with the care organisation, so that each condition contained care homes that ranged in their level of performance and the quality of

their training provision. The real-life nature of this experiment meant that it was not possible to randomly assign care homes to each group. Accordingly, our analytic strategy involved reporting baseline differences between the groups and then controlling for these differences in subsequent analyses.

Participants

At Time 1 questionnaires were distributed to 400 care staff working at eight different care homes (four homes in each condition). The homes were selected in consultation with central office management staff so that each condition included low- and high-performing homes situated in both urban and rural settings. A total of 226 questionnaires were returned completed, approximately half from the NGP group ($n=107$) and the remainder from the SLP group ($n=119$). 400 identical questionnaires were distributed 6 months later at Time 2 to care staff working at the same eight different care homes. A total of 176 were returned completed, 68 from the NGP group and 107 from the SLP group. Although it had not been anticipated, participants in the NLP group were thus somewhat less likely than those in the SLP group to complete the Time 2 survey ($\chi^2(1)=2.89, p = .09$). A full demographic breakdown of participants is presented in Appendix A.

A total of 66 carers responded at both times (NGP, $n = 35$ and SLP, $n = 31$). Of the respondents from the SLP group, 30 indicated they were female and 1 that they were male. 5 of the respondents were under 20 years of age, 5 were aged between 21-30, 7 between 31-40, 11 between 41-50 and 8 were over 51 years old and over. This group also included respondents who were domestic workers ($n=7$), care support assistants ($n=4$), care assistants ($n=10$), supervisors and nurses ($n=8$), managers ($n=2$). Four had worked in care for less than a year, 5 between 1-5 years, 5 between 5-10 years, 6 between 10-20 years and 5 had worked in care for over 20 years; 6 chose not to respond. Of the respondents from the NGP group, 34 indicated they were female and 1 that they were male. 7 of the respondents were aged

between 31 — 40 years old, 9 were 41-50 and 15 were aged 51 years old or over. This group also included respondents who were domestic workers ($n=4$), care support assistants ($n=5$), care assistants ($n=15$), supervisors and nurses ($n=8$), managers ($n=3$). Four had worked in care for less than a year, 12 between 1-5 years, 10 between 5-10 years, 7 between 10-20 years and 2 had worked in care for over 20 years.

Training programmes

The NGP described itself as helping “care homes to improve care by engaging, informing and inspiring their care staff...through high-quality training at significantly lower costs than other training methods” (CareTrain, 2012). CareTrain (a pseudonym) is a leading UK training organisation that uses an approach to delivering social care training that was originally developed in Australia, where the challenges of local delivery in remote communities are profound. These training program courses are delivered fortnightly by experts using the format of a live interactive television show. A designated member of staff from the care home facilitated the training and led discussion with staff following the television program and also administered a quiz. The intention was that by recording the program, all staff within the care home would be able to attend the training. The training courses included statutory training topics and met relevant care industry standards. Content was designed by experts and the show was presented by leading care professionals. The television programs were presented from participating care homes by UK care and nursing experts.

In contrast, the SLP was run partly from care homes with support from the care organisation’s training department and partly by the training department in a variety of local venues. It consisted of statutory in-house training courses along with courses on dementia awareness, palliative care, and person-centred care. Courses were primarily delivered by qualified trainers either within the care home, or from the wider organisation and the training

division. The training was interactive and practical, delivered using more conventional media such as presentations, hands-on-practicals, group work, and quizzes. Most of the training took place within the care homes or at the care organisation's training centre.

Measures

At both times participants completed a four-page, 43-item questionnaire in which they indicated agreement with statements on 7-point Likert scales ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The questionnaire was initially piloted on a small sample of care-workers ($n=6$). For the sake of brevity, only measures used for this specific design are reported in this present study. Scale reliability of the key constructs at both times is reported in Table 5.2. All scales had satisfactory reliability (i.e. $\alpha \geq .70$) at each time.

Participants' 'motivation to transfer' was measured by (a) their *perception of the utility of the training* which encompassed measures of perceived relevance and effectiveness (7 items, T1 $\alpha = .77$, T2 $\alpha = .88$, typical items: "The content of the training course was important for my work", "I found the training course very engaging", "Since attending the training course I feel more confident doing my job"), and (b) by the likelihood that they would enact the learning in the workplace as measured by participants' reported level of *workplace participation* (3 items, T1 $\alpha = .69$, T2 $\alpha = .69$, typical items: "I am involved in decisions about my work", "I feel able to ask questions about why we work in the way that we do"). Moreover motivation to transfer was likely to be effected by the extent to which employees felt immersed in the training, which was measured (c) by their sense of *relatedness* (4 items, T1 $\alpha = .86$, T2 $\alpha = .81$, typical items: "at the course I valued being able to interact with my colleagues", "the training course improved my ability to contribute to my team"). The questionnaire also asked about participants' (d) *workgroup identification* on the training course (3 items, T1 $\alpha = .89$, T2 $\alpha = .87$, typical items: "as a result of attending this course I feel stronger ties with Somerset Care / care home colleagues / clients.").

As the research was conducted in the context of existing training programs, training content was distinguished between training type 1 which focused on ‘hard’ skills (physical, technical and medical) and training type 2 which focused on ‘soft’ skills (person-centred care, people management). In spite of the overall common training themes and content the results showed differences in content between the training so this was controlled for in subsequent statistical analysis (see below).

Participants were then asked to provide demographic information (age, gender, length of service working at the organisation and ethnicity), as well as information about the nature of their work, their occupational role (domestic staff, care worker, senior care worker, manager, administrator or planner), and whether it was part-time or full-time). Although the majority of research into work-based identification distinguishes between identifying with different groups at work and/or different levels of identification (i.e. the organisation, team, supervisor, client), for the purposes of this study we report these as one aggregated measure of work-group identity. This is partly for conceptual reasons: in this study we are interested in how identity and identification are mechanisms which generate learning and motivation outcomes rather than the content of the identities per se. It is also partly because, in line with a growing amount of research on the compatibility, congruent and nested nature of multiple identities at work (Ashforth et al., 2008; Riketta & van Dick, 2005; Sluss et al., 2012) our findings reveal high correlations between the different work groups and no significant differences in the effects of identifying with each separate work group on the outcomes.

Procedure

The questionnaire was distributed to all care staff working in the eight care and nursing homes. At Time 1 it was distributed two weeks before the start of the new generalised professionalization training program and at Time 2 it was distributed six months into the new training program. On neither occasion were the questionnaires distributed immediately after a

training session. Therefore, at Time 1 participants from both groups reported on their experience of the existing standard localised training program. At Time 2, participants from each group reported on their respective training programs (i.e., either NGP or SLP). Participants returned their completed questionnaires in sealed envelopes to a post box in the care home. Questionnaires were accompanied by a covering letter from the organisation and the researchers. This outlined the purpose of the study and informed participants that completion of the questionnaire was taken as an indication of their consent to take part in the study, but that this was voluntary. Confidentiality and anonymity were assured. To enable questionnaires from the same person to be linked, respondents were requested to provide a unique identifying code. After the study a summary of the findings was disseminated to care-workers in each of the participating care homes.

Results

Analytic strategy

Our process of data analysis involves four steps. First, we report on the descriptive statistics and check for baseline differences between the groups. Second, we analyse H1, H2, H3, H4 by means of 2 (condition: NGP, SLP) X 2 Phase (pre-intervention, post-intervention) mixed analyses of variance (ANOVAs), with repeated measures on the second factor. Simple tests are then conducted to decompose interactions further. Finally we examine H5 by means of path analysis.

Descriptive statistics and baseline differences

The means and standard deviations for the measures for each of the groups at Time 1 and Time 2 are presented in Table 8. As noted above, an unexpected (but understandable) consequence of conducting an experiment in real-life conditions was that the experimental groups differed significantly in age, $t(65)=3.32$ $p = .001$). We therefore controlled for age in all analyses. On a conceptual level, it is also important to show that any effects of training

delivery methods are distinct from training content. As there was a significant variation in training content between the groups at Time 2 (NGP group: $M=1.28$ $SD=.53$; SLP group: $M=1.58$ $SD=(0.50)$; $t(63)=-.2.40$ $p=.02$) we therefore also controlled for training content in all analyses.

Table 8: Bivariate correlations, Means and Standard Deviations for the Training programs

	NGP		SLP		1	2	3	4	5
	T1	T2	T1	T2					
<i>Measures</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>					
1. Condition (d)						-.32**	-.17	-.20	-.26*
2. Perceived utility of training (relevance & engagement)	6.03 (.74)	5.55 (.95)	5.74 (1.11)	5.82 (1.03)	.03		.69**	.33**	.60**
3. Relatedness on training course	6.10 (.77)	5.56 (1.16)	5.05 (1.25)	5.34 (.88)	.20	.75**		.52**	.64**
4. Participation at work	6.13 (.80)	5.43 (1.12)	5.50 (.82)	5.61 (.98)	.18	.16	.40**		.33**
5. Identification on training course	5.63 (.91)	5.21 (1.23)	5.84 (.77)	5.95 (.70)	.06	.66**	.74**	.30**	

Notes: **: $p < 0.01$, * $p < .05$ (both 2-tailed).

(d = dichotomous variable; 1=SLP, 2=NGP)

Tests of Hypothesis

H1 pertained to participants' responses on the measure of their *workgroup identification* on the training course. Specifically, it was predicted that NGP would weaken identification across time, whereas SLP would maintain, or even strengthen, this. Consistent with this hypothesis, ANOVA revealed a significant main effect of time, Wilks Lambda = .82, $F(1, 61)=13.87$, $p < .001$, $\eta_p^2 = .19$, and a significant interaction between time and condition, Wilks Lambda = .87, $F(1, 61)=8.74$, $p=.004$, $\eta_p^2 = .13$. Tests of the simple effects of time within each training group showed that the workgroup identification of the NGP group significantly reduced from Time 1 ($M=5.62$, $SE=.22$) to Time 2 ($M=5.05$, $SE=.20$), Wilks Lambda = .91, $F(1,61)=6.20$, $p=.016$, $\eta_p^2 = .06$. In contrast, workgroup identification for the SLP group marginally increased from Time 1 ($M=5.06$, $SE=.20$) to Time 2 ($M=5.60$, $SE .18$), Wilks Lambda = .94, $F(1,61)=3.61$, $p=.06$, $\eta_p^2 = .06$.

H2 related to participants' motivation to transfer learning and was examined by means of an ANOVA on *perceived utility of the training* (PUT). Specifically, it was predicted that, over time, NGP training would result in a reduction in PUT, whereas SLP training would maintain or even strengthen PUT. Consistent with this hypothesis, ANOVA revealed a significant main effect of time, Wilks Lambda = .80, $F(1, 61) = 15.76$, $p = .000$, $\eta_p^2 = .21$ and a significant interaction between condition and time, Wilks Lambda = .89, $F(1, 61) = 7.85$, $p = .007$, $\eta_p^2 = .11$. Tests of the simple effects of time within each training group showed that there was a significant reduction in the NGP group's PUT between Time 1 ($M=6.07$, $SE=1.60$) and Time 2 ($M=5.44$, $SE=1.6$), Wilks Lambda = .88 $F(1,61)=8.50$ $p=.005$, $\eta_p^2 = .12$. In contrast, the SLP group reported similar levels of PUT at both Time 1 ($M=5.50$, $SE=.14$) and Time 2 ($M=5.69$, $SE=.16$), Wilks Lambda = .98 $F(1,61)=1.36$ $p=.25$, $\eta_p^2 = .02$.

Our third hypothesis pertained to participants' motivation to transfer training at work, as measured by their level of *participation* at work. Specifically, it was predicted that the NGP training would lead to a reduction in participants' participation at work, whereas SLP training would maintain or even strengthen it. In line with H4, ANOVA revealed a significant interaction between condition and time, Wilks Lambda = .85, $F(1, 61) = 10.64$, $p = .002$, $\eta_p^2 = .15$. Tests of the simple effects of time within each training group showed that the NGP group reported reduced participation at work between Time 1 ($M=6.24$, $SE=.20$) and Time 2 ($M=5.33$, $SE=.22$), Wilks Lambda = .81, $F(1, 61) = 14.44$, $p = .000$, $\eta_p^2 = .20$. In contrast, within the SLP group, participation remained stable across Time 1 ($M=5.67$, $SE=.17$) and Time 2 ($M=5.88$, $SE=.19$), Wilks Lambda = .99, $F(1, 61) = .81$, $p = .37$, $\eta_p^2 = .01$.

H4 pertained to participants' sense of *relatedness* on the training course. Specifically, it was predicted that NGP training would result in a reduction in a sense of relatedness, whereas SLP training would maintain or even strengthen it. Consistent with this hypothesis, ANOVA revealed a significant main effect of time (Wilks Lambda = .82, $F(1, 61) = 13.19$, $p = .001$, $\eta_p^2 = .18$), and a significant interaction between condition and time, Wilks Lambda = .85, $F(1, 61) = 10.74$, $p = .002$, $\eta_p^2 = .15$. Tests of the simple effects of time within each training group showed that NGP participants' sense of relatedness decreased significantly between Time 1 ($M=6.20$, $SE=.16$) and Time 2 ($M=5.41$, $SE=.17$), Wilks Lambda = .84, $F(1,61)=11.90$, $p=.001$, $\eta_p^2 = .16$. In contrast, the SLP group's sense of relatedness remained stable (increasing slightly) across Time 1 ($M=5.70$, $SE=.14$) and Time 2 ($M=6.04$, $SE=.15$), Wilks Lambda = .97, $F(1,61)=1.7$, $p=.19$, $\eta_p^2 = .03$.

The above analyses point to a consistent reduction in key positive indicators over time within the NGP group, whereas within the SLP group, these positive indicators were maintained or (non-significantly) strengthened. A social identity framework would suggest that employees in the SLP group were able to maintain positive perceptions of the utility of

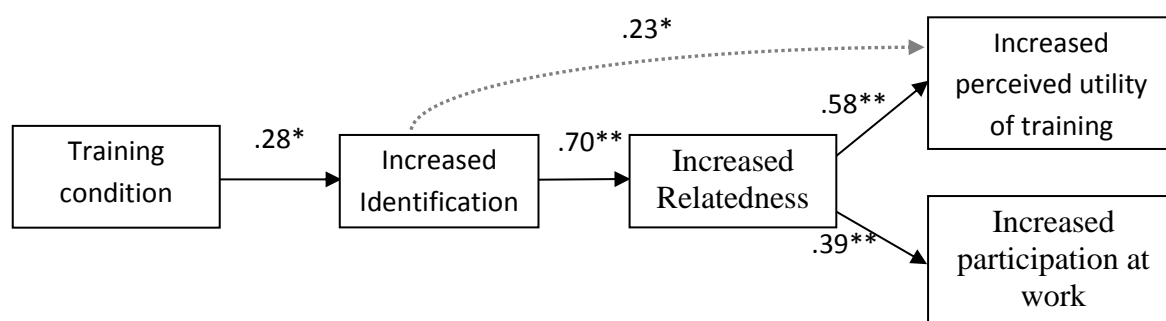
training and participation across time because this form of training spoke to, and thus also maintained, a form of work-group identification that was meaningful to them and therefore contributed to a sense of relatedness within the training context. In contrast, we anticipated that the NGP, by virtue of being generic and remote, would not speak to the meaningful work-related identities of participants and hence would be more likely to erode feelings of relatedness, leading to reduced perceived utility and participation after the training.

This reasoning identifies identification and relatedness as mediating mechanisms between training type and motivational and learning outcomes. To test this logic more formally, path analysis was conducted to investigate whether the relationship between the type of training and changes in the learning and motivation measures (H2, H4) was mediated by increased workgroup identification (H1) and relatedness (H3). To perform this analysis, we first computed across-time difference scores for each of the measures (where positive scores reflect increases across time and negative scores reflect decreases). These difference scores capture the findings reported above and allow for mediational tests to be performed via regression. To explore the mediational pathways between training group and outcome, we tested the specific sequential pattern whereby training group is theorised (a) to have consequences for organisational identification, then (b) through this to impact on feelings of relatedness in the training setting, and finally (c) to flow through to motivation to transfer learning outcomes (PUT and participation).

This two-step mediational path is represented by Model 6 in the PROCESS macro (Hayes, 2012), and outcomes are represented schematically in Figure 7. Testing this model in relation to PUT using 1000 bootstrapping resamples revealed 95% confidence intervals of .0848 & .7892 for the two-step mediated pathway. As these do not span zero, this indicates that the indirect path between training group and PUT was significantly mediated through identification and relatedness. With all variables included, this model explained a significant

amount of variance in PUT, $R^2 = .63$, $F = 20.00$, $p < .001$. The same analysis on participation revealed 95% CIs of .0217 and .7231. Again, because these values do not span zero, this indicates that the indirect pathway between training group and participation was significantly mediated via identification and relatedness. Moreover, with all variables included, this model explained a significant amount of variance in participation, $R^2 = .25$, $F = 4.02$, $p = .003$.

Figure 7: The sequential role of identification and relatedness in mediating the positive outcomes of the different types of training programs.



Note: ** = $p < .01$, * = $p < .05$

In sum, in accordance with H5, NGP training led to a reduction in motivation to transfer learning (measured by perceived utility of training and participation at work), relative to the SLP training, largely because it also reduced (and failed to capitalize) on trainees' identification with their workgroups (H5a) and thereby compromised more specific feelings of relatedness (i.e., with the trainer and other learners) in the training environment (H5b) which were the basis for effective motivation and learning.

Discussion

This study tested the hypothesis that non-standard generic professionalization training (NGP) is less likely to tap into, and strengthen, meaningful work-based identification than standard localised professionalisation training (SLP). This was further predicted to result in the NGP training being less effective than the SLP training — both in motivating trainees to learn

and in motivating them to transfer their learning into practice. We also anticipated that the reduction in work group identification associated with the NGP would lead to reduced learning and motivation outcomes because it reduces the amount of relatedness that employees experience on the training course. In addition, more broadly, the study sought to demonstrate how a social identity approach might enhance theoretical understanding of the factors that contribute to improved learning and increased motivation to transfer training.

As predicted by H1, the NGP was found to be associated with a reduction in workgroup identification, whereas the SLP strengthened workgroup identification. The NGP training was also associated with a reduction in motivation to transfer learning (as measured by the perceived utility of the training, PUT; supporting H2; and participation at work, supporting H3); (b) The NGP was also associated with reduction in trainees' immersion in the learning (as measured by the amount of relatedness participants experienced on the course, supporting H4). On the other hand, the SLP training maintained or increased these measures of motivation to transfer.. In addition, evidence supporting H5 shows that the NGP training led to a reduction in motivation to transfer learning (relative to the SLP) largely because it brought about a reduction in workgroup identification which in turn contributed to a reduction in participants' sense of relatedness within the training context.

In accordance with findings from our previous research on care workers' motivation outlined in chapters 5 and 6, we understand the reduction in workgroup identification associated with the NGP to be related to the way in which careworkers find meaning, and derive much of their working fulfilment, through their relational identification with their clients and co-workers, and through their identification with their organisation. Whereas SLP training taps into these localised identities by utilising in-house expert trainers and relating the training content to situations, conditions, and leaders in the immediate working environment, NGP training draws on the knowledge and expertise of professionals from afar, and places greater emphasis on

relating the training content to national occupational standards. The observed patterns thus corroborate our assertion that style and type of training do indeed affect the level of trainees' workgroup identification. More specifically, it appears that training which is more generic and distal is less likely to tap into, and thereby less likely to support or enhance, meaningful workgroup identification compared to training which is more localised and proximal.

Given that PUT, relatedness, and participation at work have been shown to contribute to improved learning and increased motivation to transfer training (Baldwin et al., 2009; Burke & Hutchins, 2007; Grossman & Salas, 2011; Holton et al., 2003), it appears from these results that NGP training undermines trainees' motivation to transfer their learning into workplace performance, whereas the SLP training maintains this motivation. Moreover, the trend towards a different response rate for NGP and SLP training groups at Time 2 (with the former group being less likely to complete the survey) speaks further to the fact that NGP training resulted in reduced motivation and engagement.

Thus, in line with research by Pidd (2004), and the large body of empirical studies showing that increased workgroup and organisational identification leads to improvement in a variety of work-related skills and outcomes (e.g.. motivation, knowledge transfer, learning, performance: Ellemers et al., 2004; Haslam et al., 2006; Hewapathirana 2012; Morton et al., 2012; Riketta & Nienaber, 2007; Van Knippenberg & Ellemers, 2003), these findings suggest that training is more likely to instil motivation to transfer learning into the workplace to the extent that it is attuned to, and enhances, trainees' work-based identities. In accordance with the social identity approach, and in particular work conducted by Wright and colleagues (2011), the less that professionalization training spoke to trainees' meaningful identities (in this case localised identities) the less likely trainees were to experience relatedness on the course and thereby take on board the learning and to enact it in practice. More specifically, these findings provide support for the assertion that knowledge and skills are more likely to be transferred from

training to the workplace when training increases (rather than compromises) workgroup identification. This is because tailoring the training to trainees' workplace identification serves to enhance its perceived utility, to strengthen trainees' sense of relatedness, and to increase the likelihood they will enact the learning through their increased participation at work.

Theoretical implications

The general pattern of results is consistent with previous social identity research which has examined the importance of localised identities (be they relational identities with supervisors and clients or collective identities with teams and work-groups) for structuring organisational behaviour (Ashforth, Harrison, & Corley, 2008; Riketta & Van Dick, 2005; van Knippenberg & van Schie, 2000; Smith et al., 2012). At the same time it is consistent with other work which has shown that alignment and compatibility between meaningful localised identities and broader organisational identities can facilitate uptake of the norms and values associated with the broader identity (e.g., see Ashforth, Rodgers & Corley, 2011; Haslam, Eggin & Reynolds, 2003). In these ways, the present research demonstrates how the social identity approach can offer a plausible and comprehensive theoretical framework through which to understand factors that determine learning effectiveness and the likelihood of training being transferred into the workplace. For example, based on the above arguments, a reinterpretation of Simosi's (2012) findings through a social identity lens would suggest that the extent to which trainees feel confident in their ability to perform (i.e., their self-efficacy), and therefore the likelihood that they will take advantage of the organisational transfer climate is likely to be affected by both (a) the extent to which they feel the training enhances a meaningful workgroup identity (and thereby enhances their self-efficacy); and (b) their workgroup identification in the organisational transfer climate which will shape 'positive' group norms.

What is more, social identity-based research into the effective socialisation and retention of newcomers provides valuable insights into the process of identification (Ashforth, Sluss &

Harrison, 2007; Smith et al., 2012). These insights could usefully be drawn on to explain the influence and activation of work-based identification at all stages of the training cycle. For example, they point (a) to the advantage of tuning into and acknowledging existing work-based identities at the pre-training orientation stage (Korte 2007; see also Eggins et al., 2008); (b) to the benefit of engaging with existing work-based identities to generate new or modified work-based identities (Pratt 2006) in the training stage; and (c) to the importance of social validation from co-workers within a shared workgroup identity (Smith et al., 2012) for the enactment of learning in the post-training transfer climate.

Practical implications

Our findings show that training which engages with and strengthens participants' work-based identities will be more likely to result in participants' transferring their learning into work-based practice. It therefore follows that the creation of a "positive training culture and transfer climate" (Kinsella, 2012) in the workplace and the embedding of the particular training within it, through practices such as coaching and mentoring, will be contingent on the extent to which meaningful work-based identities are harnessed, and capitalized on, in the workplace. On this basis, we would argue that consideration of the identities that are relevant to workers *in situ* will help practitioners better understand how to enhance the targeting and delivery of training, as well as how to make the transfer environment, 'appropriate' and conducive to improvement in performance (for a possible process for achieving this understanding, see the ASPIRe model of *actualising social and personal identity resources*; Haslam, Eggins & Reynold, 2003). Likewise, attention to the (lack of) congruence in content, values, and norms at different levels of workgroup identity (e.g., as a frontline care-worker, a member of a care team, a manager, an employee of a care organisation, a care professional) will help to enhance the transfer environment and the likelihood of training (change in behaviour, skills etc.) being embedded in working practice.

Strengths and limitations

A particular strength of this study is that its quasi-experimental design, which benefited from pre- and post-assessment, enabled us to track change in response to different models of training and show that the success of training is determined by the extent to which it taps into and strengthens workgroup identities. A further strength of this study was that it took place in a real-life context. Yet, inevitably, this also meant that it was not fully controlled as a result of our inability to randomly assign participants to the two conditions. At the same time, it should be noted that there were no (obvious) systematic differences between the two groups — and certainly none that would provide a straightforward alternative explanation for our findings. Moreover, it was not possible to fully control for differences between the training conditions, and hence alternative factors (e.g., the virtual or face to face nature of the training) might be seen to explain the difference in training outcomes across conditions. However, (based on evidence from social identity research) we would argue that the effect of these differences on trainees' learning experience and motivation is itself likely to be explained by the extent to which they resonate with, and make sense to, employees meaningful identities. This, though, is certainly an issue that future research needs to address directly.

As in most other studies, our conclusions are also based on participants' self-reported reflections on their behaviour during and after the training. To address these limitations, further research might be carried out in more controlled laboratory conditions in which participants are randomly assigned to conditions and where the transfer of training is directly observed. It would also seem useful for future field research to supplement the insights gained from our self-report data with more objective indicators of training transfer (e.g., actual changes in workplace behaviour

Conclusion

We believe that the findings reported here have at least three important implications. First, they challenge the (hitherto untested) assumption that undertaking specialised generic professionalization training will necessarily improve care workers' performance at work. Indeed, our results suggest that this is unlikely to be the case unless such training also enhances meaningful work-based identities. Second, they support the direct application of a social identity perspective (which accommodates individual and situational characteristics) to provide better predict, and provide a clearer explanation of, the effectiveness of workplace training (Aguinis & Krainer 2009, Pidd 2004). Third, they speak to the importance of attending to the level at which employees identify within their organisation, and to the process of workgroup identification, at all stages of the training cycle — from pre-training trainee readiness to the post-training transfer climate.

These findings are important because in contrast to much of the research undertaken on training effectiveness and motivation (which is generally gathered at one time point immediately following a training course) our study directly compares the effects of different types of training on trainees' learning and motivation over an extended period of time. Moreover, and of particular importance in light of the observed absence of any theoretical framework through which to understand the transfer of training, the present research supported a novel theoretical model of this process derived from social identity theorizing. While there is much to be done to elaborate and test this model further, the study thus lays down an important marker for future research.

Chapter 8

Review and Discussion

The aim of this thesis was to gain a better understanding of the processes that sustain individual motivations to work in care. Through this deeper understanding of the psychological contract that individuals develop with their work, it is also hoped that this research will contribute to efforts to improve the retention of the adult social care workforce, and to meet the ever-growing demand for a care workforce that is both professional and compassionate. This research started from the observation that mainstream motivational theories (Chapter 2) are likely to fall short of fully accounting for care workers' motivation because these present an individualistic and relatively fixed understanding of motivation. In contrast to this perspective, the current research adopted a social identity approach (Chapter 3). This approach seeks to understand individual motivations in ways that acknowledge the role of the collective self, as well as the personal self, in determining what energises people and how this directs and sustains their behaviour at work. In addition, the research presented here has considered how this alternative theoretical perspective might offer a pragmatic framework through which to understand, harness, develop and sustain care workers' motivations.

These aims have been addressed through a mixed-methods approach, incorporating both qualitative and quantitative methods. The empirical work began in Study 1 with a qualitative analysis of semi-structured interviews with residential and domiciliary care workers (Chapter 4). The goal of this study was to examine care workers' motivations by attending to what matters to them in their work. The study revealed the content and nature of their work-based identities, and examined the inter-relationships among these. Care workers'

narratives about themselves at work were subjected to thematic analysis and found to be structured within the broader themes of *fulfilment*, *valuing*, *belonging* and *pride*. These feelings and motives were also actualised through respondents' shared experience of caring, with clients, co-workers and within the organisation overall. The findings showed how this shared experience was comprehended through a collective rather than individualistic sense of self. Moreover, the nature of people's experience of care work suggested that the SIA interpretation of care workers' experience had the potential to provide insights relevant to the explanation of care workers' motivations. For instance, the adoption of the SIA perspective on the above findings would view *fulfilment*, *valuing*, *belonging* and *pride* as being achieved through the pursuit of collective and relational, as well as personal self-enhancement, distinctiveness and validation. Such an analysis of care workers' motivation — which incorporates its collective as well as individualistic nature — may also help to explain the remarkably high levels of satisfaction, pride, and wellbeing reported in research on care workers (Lucas et al., 2009; Skills for Care, 2007; see also Study 2).

It was clear from the analysis of these interviews that participants' self-definition as care workers was primarily couched in terms of their relational identity with clients as well as, to a lesser degree, their collective identity as part of a staff team, a care home, and an organisation. The importance of the carer-client relationship in care workers' motivation emerged clearly from the interviews, in terms of their affinity with clients vis-a-vis the organisation, and their sense of the way in which this validated the helping quality of their work. Findings also pointed to the high value carers attached to their relationship with their clients, and the explicit link they made between (a) this relationship and their level of fulfilment, as well as (b) the centrality of the caring role in their identification with clients and (c) their identification with the organisation, in terms of whether the organisation cared for them as well as its clients.

Study 2 (Chapter 5), built on the findings of the first study by measuring care workers' motivation and identification over the course of one year via a longitudinal organisational survey. In this study, we analysed the relationship between the factors that incentivise care workers and their individual motivational outcomes. Here we showed that the effects of incentives – that is, love and/ or money – on individual care worker's motivation were mediated through patterns of identification, specifically identification with clients (i.e., relational identity) and with the organisation as a whole (i.e., organisational identity). Similarly, we considered the impact of undertaking a professionalization activity on individual motivation and again found that this was mediated by identification. Finally, the apparent synergies between client and organisational identity in mediating effects on motivation was taken to reflect the importance of the congruence between these foci of identification for supporting positive individual and work-related outcomes.

More specifically, findings from this study demonstrated that participants were far more incentivised by their relationship with clients, associated with intrinsic and virtuous rewards of 'love', rather than external and materialistic rewards of 'money'. In fact, though, the extent to which valuing either of these incentives led to increased motivation appeared to be dependent on it serving to build organisational identification. Moreover, and particularly in the case of being incentivised by relationships with clients, client identification predicted organisational identification. These findings make a valuable contribution that extends beyond hitherto limited research testing linkages between what incentivises care workers and their sustained motivation to work in care.

Considered as a whole, these findings (a) support the widely accepted view that care workers are more motivated by intrinsic than extrinsic rewards (Atkinson & Lucas, 2009; Skills for Care, 2007); yet (b) they also demonstrate that love and money are integrated elements of care workers' motivation because the likelihood of either incentive leading to

improved work experience, retention and increased professionalization is mediated by the extent to which they increase organisational identification. Therefore, (c) they challenge the premise that care workers are incentivised either by ‘love’ or ‘money’ and suggest instead that they are incentivised to varying degrees by both to the extent they contribute to building a sense of meaningful identification at work. The meaningfulness attributed to the incentive is given by the norms and values of the predominant social, relational or personal identity. In this way, the social context (implicated through the collective self) affects the degree to which incentives are valued and meaningful and therefore results in increased motivation.

Additionally, this study further extends our understanding of the influence of incentives on care staff motivation and retention by demonstrating that the degree to which incentives increased participants’ motivation and retention was determined, in part, by a convergence in client and organisational identification. Given that the central component of care workers’ identity is their caring relationship with clients, it seems logical that the likelihood of any incentive leading to increased motivation will relate to its capacity to reflect and signal an act synonymous with a caring relationship. This caring act could take place between the organisation and the staff, the organisation and its service users, or between care staff and their clients. Accordingly, the findings showed that money is not valued directly in its own right but as an indicator of the organisation’s caring relationship with its staff. This is in keeping with Lepore’s (2008) findings that care workers’ perspectives on their motivation are framed within a moral rather than a materialistic dialogue.

Study 3 (Chapter 6) employed a quasi-experimental design in which the effect of professionalization interventions on individual motivational outcomes was examined. Corroborating results from Study 2 which had shown that undertaking a qualification led to increased motivation because it built or maintained organisational identification, this third study found that the extent to which professionalization training programs increased

motivation was contingent on the degree to which they advanced meaningful work-based identities. Specifically, a generic professionalization training program was found to undermine identification and through this to not support individual motivation, whereas a localised training program was found to support identification and motivation.

These results emphasise the importance of localised identities in shaping care workers' self-concept and influencing their motivation. This is not only in keeping with the findings from Studies 1 and 2, but also echoes findings from other research that has looked at the importance of organisational nested and localised identities in determining people's work behaviour (Ashforth, Harrison & Corley, 2008; Ritekka & Van Dick, 2005; Sluss et al., 2012; Smith et al., 2012; van Knippenberg & van Schie, 2000). Moreover, in accordance with research by Pidd (2004) and Korte (2007) the study showed that professionalization training is more likely to instil motivation to learn and enhance motivation to transfer learning in the workplace to the extent that it is attuned to, and enhances, trainees' work-based identities.

Drawing on the findings from identity research undertaken on the socialisation and retention of newcomers (Ashforth et al., 2007; Smith et al., 2012; Sluss et al., 2012), it is likely that recognition, activation and engagement with identities which are meaningful to trainees at all stages of the training cycle will ensure the best learning and performance outcomes. This therefore points to the importance, *inter alia*, of acknowledging existing identities at the pre-training orientation stage (Korte, 2007; Eggins et al., 2008), the benefit of engaging with existing identities to generate new or modified identities during the training (Pratt, 2006), and the added value of support and validation from co-workers with whom one identifies in the post-training transfer climate (Eraut, 2007; Smith et al., 2012). As Haslam and colleagues (2009) propose, "learning is critically structured by the perspective of the social self on the potential learning experience. This means that whether or not something is perceived as, and becomes, a learning opportunity depends on its relationships to a person's

social identity” (p. 443). Furthermore, this evaluation of professionalization training through the lens of the social identity approach demonstrated how individual characteristics and situational characteristics (in particular, organisational climate, supervisory and peer support), interact to shape the effectiveness of training. Thus professionalization activities and organisational interventions which seek to increase care workers’ motivation, performance and retention, need to consider their effects on staff identification, and reflect on how best to go about utilising and developing this identity resource. This is a subject we will return to below.

Together, the findings reported in this thesis demonstrate the importance of understanding work-based identities in order to understand the motivation and performance of care workers and to increase their retention. In line with the SIA which informed our theorising, the three studies we report show that what care workers seek from their work, and why this work matters to them, is shaped by their relational and social identities. Together they also reveal the content and dynamics of care workers’ work-based identities and show how the outcomes of professionalization interventions are affected by these identities. More specifically, our various findings indicate that care workers are likely to be motivated and supported to provide quality care when, and to the extent that, care organisations and other relevant bodies acknowledge and value the importance of the work they undertake in striving to build and maintain caring relationships with their clients.

The importance of relationships and relational identification in the creation of a compassionate working culture

The key insights that emerge from these studies of care workers’ motivation relate to the importance of relationships in care work and their significance in the creation of a compassionate working culture. A core finding that emerges from this research is that role

identification with clients plays an important role in shaping the motivation of individual care workers. More significantly, this relational identification not only underscores the work they do with clients, but it also feeds into broader feelings of organisational identification and supports the organisational motives and behaviours that go with that. Thus, in this context, both the relational and the organisational are mutually reinforcing.

The importance of relational factors has been emphasised in other studies on care workers' motivation. These studies demonstrate that the relationship between care workers and clients determines the quality of care provided (Bowers et al., 2001; Grau et al., 1995; Nolan & al., 2004; Wilson et al., 2009), and predicts job satisfaction and retention (Atkinson & Lucas, 2013; Lucas et al., 2009; Parsons, 2003). Indeed in Study 1 the context of the 'shared experience of caring' was found to underpin care workers' motivation and to make a significant contribution to care workers' work-based identification. This emphasis on the relationships in care provision is endorsed by the increasingly advocated relationship-centred approach to improving the quality of care practices (Help the Aged, 2007; Nolan et al., 2006; Wilson et al., 2009). It also accords with literature surrounding the development of a compassionate culture of care (Bridges, Flatley & Meyer, 2010; Onyette, 2012), as exemplified in recent calls for there to be "a shift from care 'delivery' to the co-production of care through relationships" (Onyette, 2012; p.3). As Lepore (2008) concluded from his study on the motivation of long-term care workers in America, "given the importance of staff-resident relationships for job satisfaction and care quality, strategies are needed to support these relationships" (p.196). Moreover, the ways in which care workers expressed their shared experience of care work, as an inter-dependency of feelings and behaviours, resonates with other arguments offered by scholars and practitioners as to why elderly care provision should aim to enable interdependence rather than independence (Baldwin, Harris & Kelly, 1993; Evan, 1999; Wilson et al., 2009). As well as more realistically reflecting the fragility

and vulnerability of many elderly people, “interdependence encourages reciprocity and promotes mutual exchange in social relationships which creates a sense of belonging and recognises the contribution older people make to the social life of their community or residential setting (Wilson et al., 2009, p.16). Correspondingly, a body of social identity research work has shown that the health and wellbeing of residents is affected by their strength of social identification with their care home and the groups and activities that operate within it (Gleibs, Haslam, Jones et al., 2011; Haslam, Jetten, Haslam & Knight, 2012; Jetten, Haslam & Haslam, 2012; Knight, Haslam & Haslam, 2010). Thus, both care worker and client wellbeing and motivation can be seen to be affected by a collective sense of identity.

By the same token, the findings from Study 2, showed that the shared experience of caring, and the relational identity associated with this, can contribute to care workers’ motivation by building up their identification with the organisation as a whole. This research contributes to findings from other studies of care workers’ motivation, and of the importance of relationships in care provision, by helping to understand the psychological process through which relationships contribute (or not) to care workers’ motivation as well as clients’ wellbeing. In particular, this application of the SIA offers a comprehensive psychological account that explains why a relationship-centred care approach is likely not only to improve the provision of support to clients but also to help energise and sustain care worker motivation. As already demonstrated by the large body of social identity research (Chapter 3), the greater people’s sense of oneness with a collective, the more likely one is to observe patterns of positive collective behaviour and positive wellbeing outcomes connected to this. Thus the “something of themselves” that care staff attach to the care routines that “enabled them to work more effectively with each other, the resident and the family” (Wilson et al., 2009, p.17), reflects that part of their self-concept that is informed by both their relational (dyadic) and social (collective) identity.

The key finding from this thesis is that care workers' relational identification with clients acts as the fulcrum for their identification at work. This is significant because "research has shown that the particular level at which employees identify with the organisation has distinct implications for organisational functioning" (Millward & Haslam, 2013, p.51; van Dick, 2001, 2004; Haslam & Ellemers, 2005; Millward & Postmes, 2010; Riketta & van Dick, 2005). In line with the findings from this thesis, it is likely that in order to energise, support and sustain care workers' motivation, organisations need to pay greater attention to the relational level of identification. Moreover, and as particularly evidenced in previous socialisation research (Korte 2010; Sluss & Ashforth, 2007; Sluss et al., 2012; Smith et al., 2012), attention also needs to be given to the congruence (or lack of it) between relational identity and other collective identities, in particular organisational identity.

The evidence that congruence between identities leads to better wellbeing and work outcomes (Ahearne, Haumann, Kraus & Wieseke, 2013; Meyer et al., 2006; Riketta & Nienaber, 2009), is something also observed in the present studies. Although there has recently been a considerable amount of work undertaken on the role of relational identification between supervisor/supervisee in generating organisational identification (Kammayer-Mueller, Wanberg, Rubenstein & Song, 2013; Korte, 2010; Sluss et al., 2012; Smith, 2012), to date, there is still little, if any, work on the connection between relational identification with clients, customers or service users and collective work identification with the work team or organisation. It is therefore useful to draw on the findings from this thesis to better understand the possible effects of congruence between relational identification with clients and organisational identification. For instance, Sluss and colleagues (2012) found that "relational identification does converge with organisation identification through affective, cognitive and behavioural mechanism — yet only when a newcomer perceives the relational other as prototypical of the organisation" (Sluss et al., 2012, p.969). Accordingly, the above

suggests that relational identification with clients might be more likely to converge with organisation identification to the extent that relational identity is perceived to be prototypically representative of the organisation — in this context, the degree to which the organisation is itself perceived to be caring or (more damagingly) neglectful.

Moreover, and importantly, the emphasis care workers clearly place on the importance of the caring relationship (as observed in these and other studies; Wilson et al. 2009; Nolan et al., 2004; 2006), suggests that they would be more likely to identify with work-based identities, such as the team, organisation or professional if they perceived them to demonstrate, value, and enable, caring relationship(s). Furthermore, as demonstrated in Study 2, a care worker who has strong client identification, as well as strong organisational identification, is more likely to also have greater motivation than a care worker who indicates strong client identification but low organisational identification. Conversely, a lack of convergence between relevant work-based identities offers a possible explanation as to why care workers might be more likely to experience stress and burnout. For instance, a care worker is likely to experience higher levels of stress when they perceive themselves to be constrained (e.g., by time pressures) in expressing relational identification with clients and providing what they perceive to be acceptable care (Maben, May 2013). This feeling of constriction may also map onto a pattern of high client identification but low organisational identification. Equally, care workers are likely to experience stress in response to changing and last-minute demands from clients if they have high organisational identification but low client identification. In general, then, the psychological costs of the emotional labour associated with providing a caring relationship are likely to be higher where there is an incongruence between an individual's personal, relational and collective identities (Cheng, Bartram, Karam & Leggat, 2013).

Furthermore, as discussed in Chapter 2, the quality of helping behaviour is also related to the carer's capacity for empathy and compassion. Such empathic feelings have also been positively related to social identification (Leeuwen & Tauber, 2010; Sturmer & Snyder, 2010). Nevertheless, high identification is likely not only to increase the quality of helping in terms of 'putting the other first', but may also increase the likelihood of burnout. As Sturmer & Snyder (2010, p.44) observe, this is because:

When a common group membership with a person in need is salient, people come to value the other's welfare as an end in itself. Accordingly, if they feel empathy because the welfare of the other is threatened, they are likely to follow this emotional signal and help, and this irrespective of the costs ensuing from this behaviour for themselves.

Thus, it is important to recognise that, as much as it could be a motivational tool, relational identification could equally become a tool of exploitation.

Broader healthcare literature on the relationship between doctor and health professional empathy and patient experience suggests that empathetic behavior leads to improved patient experience yet it can also result in an increased likelihood of compassion fatigue and burnout related to emotional exhaustion (Cole-King & Gilbert 2014; Derksen, Bensing & Lagro-Janssen, 2013; Johnson, 1992). The strength and outcome of relational identification is likely to vary between different helping professions and be affected by the working context. The research studies undertaken in this thesis, show that the strength of relational identification indicated by care workers is shaped by the particular nature and conditions of care work. The long-term nature of care work, that it takes place within people home environments and the intimate, familial relationships care workers have with their clients and residents contribute to this strong sense of relatedness. These conditions affect the

interrelatedness of care workers and clients' motivation and wellbeing. Although there are some similarities, it is likely that the working context of health care providers (including Drs) will differently affect the shape and strength of their relational identification with the patients and the outcome it has on their wellbeing and motivation. Future research into the nature and strength of health care professionals relational identification with patients and other colleagues is likely to enhance our understanding of what supports or undermines their capacity to be compassionate and their resilience to burnout.

The value of the social identity approach for improving understanding of care workers' motivations

As outlined in Chapter 3, the value of the SIA is that it offers a meta-theoretical framework through which to understand the way in which people's motivation (i.e., what energises, directs and sustains their behaviour) is constituted in interaction with the environments in which they operate. This occurs at the broad macro level of social and cultural context, the meso level of organisations and work groups, as well as the micro level of relationships and unique personal attributes. Furthermore, the SIA incorporates individual attributes and characteristics (personal identity) as a component of a person's self-concept that contributes to determining their motivation alongside the norms and values they perceive themselves as sharing with others (collective identities).

By applying this broad framework to the context of care we have been able to explore how care workers' motivations are influenced by the economic, social and culturally value-laden contexts surrounding their individual work. More specifically, our approach offers an analysis of care workers' motivation that incorporates the psychological implications of providing care (effort and reward) and considers how this is affected by the quality of the relationships in which such work is embedded and interactional. This broad perspective has a

number of implications for specific questions about what motivates care workers, how this is maintained or undermined, and how motivation might be harnessed by organisations. It is to these questions that I now turn.

As noted in Chapter 2, dominant theories of workplace motivation, draw distinctions between intrinsic versus extrinsic incentives. From a more nuanced analysis self-determination theory posits “that intrinsic motivation and the internalisation of extrinsic motivation are determined by the degree to which people satisfy three basic psychological needs for autonomy, competence and relatedness in the environment in which the activity takes place” (Gagne et al., 2010, p.632). However, although SDT acknowledges that a person’s motivation is affected by the extent to which they internalise and integrate extrinsic incentives into their self-concept, it does not offer a theoretical explanation of the process through which this happens. Speaking to this lacuna, the SIA provides an interpretation of the process through which a person’s psychological motivations are shaped within the (work) environment, and of the conditions that might influence whether or not something is perceived as internal or external to one’s self and therefore motivations. The basic premise of the SIA is that the self-concept is fluid and informed by personal, relational and collective aspects of the self, and that the salience of different bases of self-definition shifts the ideals, norms and values on which motivation, thought and action are based (Onorato & Turner, 2006). Drawing on this perspective, the extent to which incentives are considered to be extrinsically versus intrinsically motivating is likely to be determined by the degree to which those things are separate from, or part of, the individual’s salient sense of self (Morton, van der Bles & Haslam, under review). For example, while economic rewards might typically be considered extrinsic motivators from an SDT perspective, these may be experienced as self-affirming, internal motivators when the self is defined strongly in economic terms (e.g., if one is a banker and one’s professional identity is salient).

This identity-based analysis of motivation can also be applied to the context of care, and addresses recent demands in this domain for a theory that considers ‘love’ *and* ‘money’ as integrated elements of care workers motivations. Essentially, the SIA perspective liberates the debate surrounding care workers’ motivation from the rigid dichotomy between ‘love *or* money’ (Folbre, 2012; Nelson & Folbre, 2006). As observed in Study 2, depending on the basis of one’s self-definition or identity, both love and money can be relevant to one’s self-worth and motivation. In recasting motivation in this way, the perspective also offers a broader conceptual field wherein the principles of self-determination theory can operate without being overly deterministic or insensitive to context.

If social identification is the process by which a person’s sense of self, their norms and values become merged with that of the group or relationship, then depending on the specific norms and values of the group, this can have both negative and positive implications for the self and for behaviour. For example, identification with a workplace or profession that values aggression and competitiveness might lead to negative interpersonal behaviours in the workplace as well as isolation and burnout for the individual. Along these lines, the SIA also offers an explanation as to why systemic, flagrant acts of neglect and abuse often go unreported (Francis report, 2013). For instance if a care worker has low relational identification with clients but strong identification with an organisation that values profit making and efficiency above care, since this would tend to make them more likely to provide task-focused rather than person-orientated care.

Furthermore the SIA perspective suggests that organisations seeking to develop or maintain caring cultures need to be particularly cautious of (inadvertently) taking advantage of care workers’ strong relational identification with clients. This could occur through over-reliance or over-emphasis on care workers’ sense of responsibility to clients to provide a caring service, without modelling congruent caring behaviour towards staff and clients (e.g.

through remuneration and concern for wellbeing). This is likely to result in incongruence between the relational level of identification with the client and organisation (split loyalties) and to contribute either to stress and burnout or to lone wolf behaviour. This speaks to the reasons why several widespread care workforce practices, outlined earlier in Chapter 1, have a detrimental effect on the quality of care and care workers' motivations, such as 15-minute care slots and the lack of continuity of care. Both organisational practices undervalue the contribution the development of care workers' relational identification with clients makes to the provision of quality care by not investing time and resources into it and instead relying on care workers' 'natural inclination' to create this resource.

Practical implications: Harnessing and developing care workers' identities to increase and sustain their motivation

As outlined earlier, the overall findings presented in these are in line with, and contribute to, the broad body of work on organisational behaviour and motivation that points to the importance of social and relational identification. The practical implications that have emerged from this body of SIA work on improving staff motivation and increasing retention focus on recognising, tapping into, strengthening and developing employee's meaningful work-based identities (e.g., Ellemers et al., 2004; Haslam et al., 2003). In line with this, Study 1 examined and *recognised* the nature and contents of what made care workers' identities meaningful to them. This qualitative analysis of care workers' narratives about their work provided a rich illustration of what was meaningful to them about being a care worker and how, because of the shared experience of caring, this was predominantly experienced at relational and collective levels of identification. Study 2 went on to demonstrate that the positive effect of incentives, the working domain and professionalization interventions on care staff motivation and wellbeing arose because, and to the extent that, these all *tapped into* and built identities which were meaningful to care workers. Finally Study 3 showed that the

effectiveness of professionalization training programs was explained by the degree to which these serve to *strengthen* and maintain meaningful identities.

Although these studies did not directly examine the development of care workers' identities, it is useful to draw on this empirical work and on the broader organisational identity research outlined in Chapter 3, to consider how organisational practices and activities might develop as well as harness and strengthen care workers' identification. To assist with this, in Figure 8 I have adapted Ashforth et al.'s model of identification to accommodate the findings from this research and incorporate the influential role of relational identification in this process. As will be recalled from Chapter 3, Ashforth et al.'s, (2008) model describes a process of identification which combines the top down 'sense breaking' and 'sense giving' activities of the organisation with the bottom up 'sense making' activities of the individual in relation to their new or changing identity. According to this perspective employees' continuous need to know 'who am I?' drives their search for identity validation that occurs through their enactment of identity. 'Sense breaking' happens when the individual's enactment of identity is not aligned with the organisation's values and expectations of the individual. Concurrently organisations, and the units nested within them, also provide 'sense giving' to organisational life, and recognise and validate the individual's identities at work, thus providing an answer of the form "you are...". The individual's interpretation of the organisational answer leads into a process of 'sense-making' whereby the individual reconstructs an identity narrative that incorporates their past experience, as well as their present experience. The enactment of their adapted identity results in identity validation or deprecation and so the process continues.

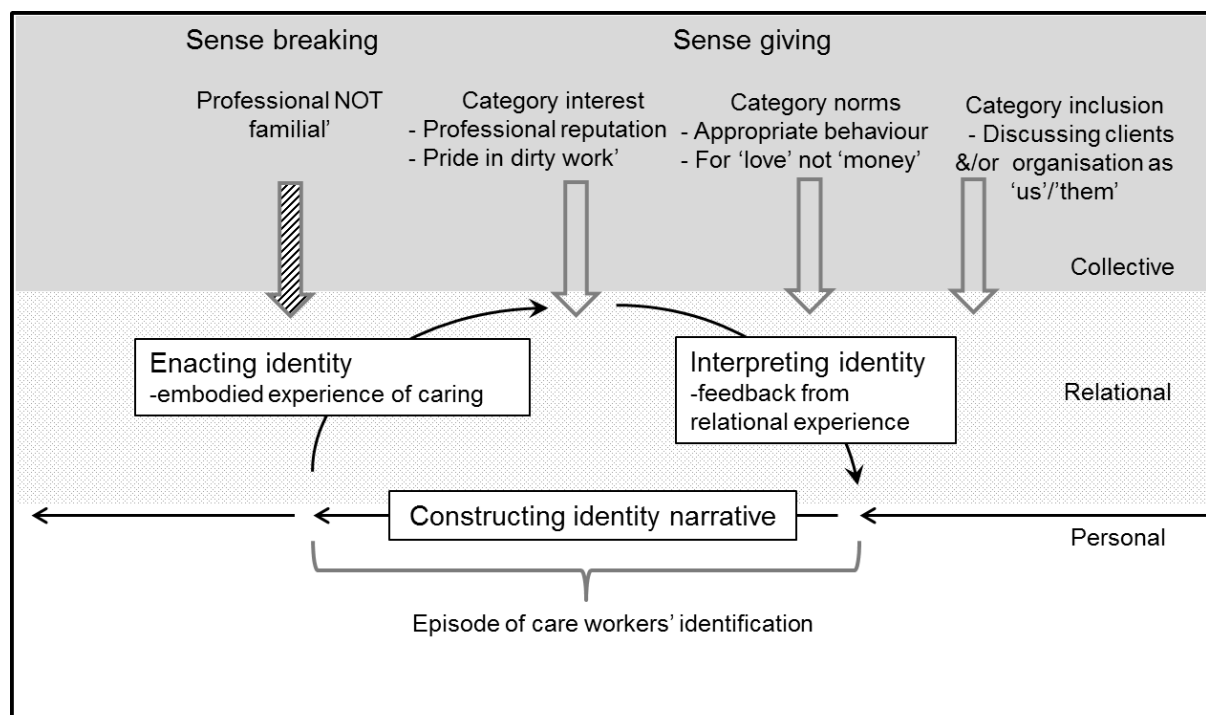


Figure 8: The central role of relational identity in an episode of care worker's identification at work (adapted from Ashforth et al., 2008, p.341, model of the process of identification).

As adapted here, this model draws on the findings from Study 1 to provide an example of an episode of the construction of care worker's identification at work. In accordance with the analysis of participants' narratives in Study 1, the model also points to the way in which top-down and bottom-up processes of identification impact care workers' identities. Specifically, the model illustrates the process whereby a new care worker who is enacting a caring intimate role that they might have previously experienced as taking place within a familial context, is likely to be provided with *sense-breaking* information from the organisation or occupation that this is professional rather than familial behaviour. The collective simultaneously is likely to provide *sense-giving* information about why it is in the interests of the collective self-category to behave in this way. Here Reicher et al.'s (2006) model of groups' engagement in helping behaviour has informed our understanding of the

top-down collective processes that shape care workers' identification as evident in their discourse about their work. This included narrative evidence of '*category interest*', such as when care workers spoke about their professional reputation and their pride in undertaking dirty work, as well as the evidence of (group) *category norms* such as in how their references to 'appropriate behaviour' or 'doing it for love rather than money'. Moreover, top down collective narratives also defined *category inclusion*, through the modelling of inclusive language that discusses clients and/or the organisation as either 'we' and 'us' or 'them' when talking about care work experiences in relation to the organisation or the wider context of care. How the new care worker engages in *sense-making* of this collective sense-giving is through the relational context in which they are enacting their role and by feedback from their experience with client and co-workers. Therefore this episode of identity construction is also shaped by their personal characteristics and histories. The bottom-up processes of identification that inform an individual's sense-making are related to the cognitive and behavioural mechanisms through which an individual interprets new or adapted identities. These are experienced and learnt through the embodied enactment of caring (Harquail & Wilcox King, 2010) and are evident in participants' narratives about the physical and emotional intimacy of their work.

Overall, this amended model highlights the "formative and sense-making role that relationships typically play in shaping one's experience with the organisation and occupation" (Sluss & Ashforth, 2008, p.2). By bridging the personal and organisational levels of identification, relational identity incorporates the interaction between the attributes and characteristics of two individuals' personal identities, alongside the norms and values attached to the organisational role identity within which each individual operates, and the particular relational identity that emerges from this interaction (Sluss & Ashforth, 2008). The importance of the relational level of identification is that it has been shown to be the most

influential context in which a person enacts an identity and receives feedback about their identity, as well as in which he or she interprets the sense-giving provided by the organisation (Kammayer-Mueller et al., 2013; Korte, 2010; Sluss & Ashforth, 2008; Sluss et al., 2012; Smith et al., 2012). The influential power of care workers' relational identification with clients on their self-concept is likely to be exemplified by the personal, intimate and embodied nature of the interaction (Harquail & King, 2010).

This adapted model enhances our understanding of care workers' identification because it incorporates the centrality and significance of relational identity in shaping care workers' experience of work. In line with findings from the present research it illustrates that in order to harness and develop identification care organisations need to engage with workers at a relational level of identity and consider how sense-breaking or sense-giving activities are to be attuned to, and where possible, delivered at this level. Looked at in the round, this framework of care workers' identification processes can also serve as a tool through which organisations could consider the potential impact of activities and interventions on the development and strengthening of workbased identification.

Organisational practices to harness and sustain care workers' motivations

A consideration and awareness of the processes through which work-based identities are constructed and adapted provides a good place from which organisations can start to look at how best to design and implement activities and practices that maximise opportunities to align and enhance care workers' work-based identification and motivation. For instance, strategies to develop and maintain a caring and compassionate organisational culture at all levels of the organisation are likely to benefit from considering how peoples' psychological contract with this culture is maintained through engagement with, and strengthening of, meaningful identities. To achieve this, organisations could adopt practices that inquire as to

which identities are most meaningful to staff (and clients) and what it is about them that makes them meaningful (i.e. the contents of their identities). They could then seek to incorporate this knowledge into structural processes for change, as proposed in the ASPIRe model (Haslam et al., 2003; see Chapter 3), thereby engaging with existing identities in order to promote and advance them. Furthermore, a systematic inquiry into peoples' existing identities is likely to be a particularly useful tool for socialising newcomers (staff and clients: Kammeyer-Mueller et al., 2012). It could be undertaken as part of the recruitment process and inform and shape supervisory support. This could facilitate newcomer identity development and encourage identity congruence between different levels of identification.

Another key way in which organisations could support congruence between identities is by instigating mechanisms wherein organisational core values, beliefs and norms are jointly developed and reviewed, and actualised (articulated and enacted) in day-to-day practices. In line with the model outlined in Figure 8 organisations could seek to develop top-down activities that instigate sense-giving, and validate identities which are sensitive to the bottom-up sense making processes (i.e., role enactment and embodied cognition). Such activities might include communication tools (i.e. newsletters, websites, e-mails etc.) which speak to a multitude of work-based identities (that have been found to be meaningful to workers and clients) in ways which simultaneously celebrate differences and acknowledge the superordinate umbrella identities (or broader social categories) in which they operate. Induction programs have also been shown to offer good opportunities for sense-breaking and sense-giving (Smith et al., 2012; Sluss et al., 2012). These can incorporate activities that occur within different work groups to encourage the development of a multitude of work-based identities such as with organisational open days, team meetings, shadowing co-workers, etc. Other activities which tap into and validate meaningful identities might include

360-degree appraisals which include feedback from clients and a range of staff, as well as training and awareness raising activities which actively involve care workers and clients.

In accordance with the results of Study 3, which suggest people are most likely to transfer what they learn on training courses into work-based practice when all stages of the training process activate and develop identities that are meaningful to them, it makes sense to consider how all types of training interventions might best acknowledge, enhance, and develop participants' identities so as to increase congruence between all levels of their work-based identities and across the organisation and occupation as a whole. In particular, our findings suggest that organisations should pay greatest attention to practices that harness the power of identification at a relational level because (as observed above) this combines collective, personal and social identities. For instance, as referred to earlier, there is substantial and growing evidence of the power of relational identification developed (or not) between the supervisee and their supervisor to potentially generalise, or undermine, organisational identification (Kammayer-Mueller et al., 2013; Korte, 2010; Sluss et al., 2012). The more the supervisor or manager is perceived to be prototypical of the organisation (i.e., representative of organisational core values and traits), the more likely relational identity experienced with them will generalise to organisational identification. Equally, the less a supervisor or manager is perceived to be prototypical of the organisation the less likely it is that this relational identification will converge with organisational identification (Sluss et al., 2012). In this case strong relational identification may thwart organisational identification. The strong influence of care workers' relational identification with clients (that is evident in our studies) suggests it is equally important for organisations to consider how this relational identification is likely to generalise to organisational identification or how it might thwart organisational identity. This is likely to be achieved through clear indication and evidence that the organisation cares for clients as well as staff, and that it values and supports the

caring relationship — for example, through practices that reduce the emotional labour exerted by the carer and indicate commitment to the quality of caring (i.e. supervisory support, continuity of care, sufficient time for listening).

Relational identification with clients is likely to be particularly powerful for domiciliary care workers, who primarily work on a one-to-one basis with clients. Therefore organisations need to pay particular attention to developing ways which harness this identification and enable it to generalise to and from other work group identification. A practice that can achieve this is the establishment of small teams of domiciliary care workers to work with a particular group of clients. This is likely to enable the generalisation of relational identity to a sense of localised collective identity (i.e., as sense of being part of a team of clients and carers). Moreover, this would also facilitate the provision of continuity of care. Again, the development of a consistent organisational way of being ‘caring’ or ‘compassionate’ which operates at all levels of organisational life and identities is likely to have the most influence if it is operationalised at a relational level (e.g. in conversations between supervisors and supervisees, co-workers, clients and carers etc). In other words, as Sluss (2012, p.69) observes, “managers of newcomers need to pay attention to not only the opinions shared but also the mood and emotion engendered in their relationships with their subordinates, so positive identity transfer can take place”. The establishment and maintenance of a consistent organisational way of being may also be achieved through the establishment of an organisation-wide coaching scheme. Indeed, the training of a broad spectrum of staff to become in-house coaches who provide high-quality peer coaching to facilitate an organisational way of being, is likely to be particularly influential because it is actualised through conversations at a relational level and transcends functional or location based work teams and groups.

Broader theoretical implications

The majority of research undertaken in the realm of organisational identification has focused on identification with the organisation as a whole or with sub-groups nested within the organisation or workplace structure (i.e. work teams, departments, care homes). More recent perspectives on organisational identity have also focused on the importance of relational identification with supervisors and managers in generating organisational identification, yet little research (at least as far as this author is aware) has been undertaken on relational identification with clients, service users or patients, and how this might also feed into organisational identities. Considering client or patient identification as an integral and important component of care workers' or other helping occupations' identities, acknowledges and incorporates the client or service user as an active, co-constructor of organisational life (Wilson et al., 2009). This is particularly pertinent to contexts in which the quality of service delivery directly impacts on the lives of service users — for example, in health and social care, social services, education, community development, or the humanitarian sector — as these are contexts in which workers are more likely to be incentivised by 'helping' others. In settings like this, where there is long-term interaction between clients, patients or service users (such as in long term care), it is likely that a shared, relational identity will be more accessible or 'deep rooted' to the worker, and therefore more influential in terms of it generating or thwarting organisational identification.

Another key theoretical implication of utilising a social identity approach to understand workers' motivations, is that it does not predetermine the nature or content of workers' motivation, rather "it draws attention to the contextual processes which determine the adoption of any one identification" (Hopkins & Reicher, 2011, p.37) and which, in turn, shape motivation. Accordingly, this approach relies on investigating the particular cultural contexts and social situations that frame peoples' motivations. Similarly with respect to the

motivation to transfer learning, the SIA does not prescribe particular trainee characteristics or environmental conditions which lead to motivation to transfer. Instead it outlines the psychological process through which the two factors — person and situation — interact to increase the likelihood that learning will transfer into performance.

As referred to in Chapter one, it is inconceivable, given the extremely high proportion of women working in care and the strong socio-cultural associations of caring with female nature and role, to comprehend the dynamics of caring without considering the exceptionally gendered nature of care work. The social identity approach offers an interpretation as to how this broader (higher) self-categorisation as a woman is profoundly and implicitly integrated into a care worker's self-concept about what is meaningful and validating to them about their work. As Lepore (2008) purports, nowhere is this more evident than in care workers' subscription to the notion that they work more for the love than the money. Care workers' (mainly women's) work related motivation, satisfaction and wellbeing is bound up in, and perpetuates, socio-cultural gender norms and values. Therefore, it stands to reason that any change in the valuation and recognition of care work is intrinsically tied to broader societal change in attitudes towards women and what is considered to be naturally women's work. Hence feminist scholars, among them Folbre, 2012; Himmelwait, 2008; Nelson & Folbre, 2006, call for the skills and aptitudes evident in care work to be formally acknowledged and validated in professional discourse and training; such as through references to emotional labour and body knowledge. The increased attention been paid to the importance of the quality of relationships in providing effective health and social care services (e.g. in the NHS Compassionate healthcare agenda, 2012) has gone some way to raising the profile and increasing the value attributed to this 'women's work'. However, as yet it has not translated into a corresponding increase in economic recognition and remuneration. Taking this into account, the promotion of relational identification between care workers' and clients as a

means to generate compassionate care could risk being exploitative of the ‘female’ role unless it is fully integrated into the organisational culture and working conditions. The power of relational identification to support a caring context (i.e. the embodiment of caring norms, values) and behaviours), and to create and sustain a compassionate work culture, relies on relational identity being congruent with broader workbased and organisational identities.

Chapter 9

Conclusion: Research refinement and next steps

In this final chapter, I explore the limitations of the present research and consider its potential for refinement. After this I suggest possible ways to maximise its impact and extend its findings in future work, before drawing some general conclusions. A fundamental aim of this thesis, and a passion of the author, was that the findings should have practical application to the workplace and contribute to improving the retention of quality care workers. In this, the research benefited enormously from being conducted in the field, in the real-life complex contexts of providing care. However, this inevitably meant that there were many naturally occurring limitations in the design and measures, which could have potentially compromised the reliability and validity of the findings. Here, I run through some of the key factors that contribute to the research's limitations, and consider how they might be addressed in future work.

A key factor that might affect the research's reliability is the representativeness of the population sample to the wider long-term, adult care workforce. The population sample was recruited from the same umbrella organisation: a large care organisation (referred to as a care group), which had recently been developed from the amalgamation of four different care organisations and a training organisation. At the time of the research, the organisation provided residential and domiciliary care services across the south of England, through 28 residential and nursing care homes, and 6 community bases. The not-for-profit organisation took on social service referrals as well as private clients, and took pride its investment in research, staff training and development. The broad nature of the care group meant that participants were recruited from a wide spectrum of care establishments, with their own particular working approaches and cultures, across a large, varied geographical area. The

demographic breakdown of participants was reflective of the organisation as a whole as well as the demographic makeup of the national adult social care workforce. Nevertheless, compared to studies undertaken with populations in urban centres, there is less ethnic diversity (Hussein et al., 2010). That notwithstanding, the similarity of the descriptive findings of Study 2 to those obtained in research with other groups of care workers (in particular, see Hussein et al., 2010; Lucas et al., 2009; Skills for Care, 2007, 2013; discussed in the previous chapter) suggests that these findings are transferrable to the broader population. Ideally, however, future research into care worker identification should include care workers from a range of care organisations, representing both profit and not-for-profit parts of the sector and working in both urban and rural areas. To the extent that these sites are associated with identities that have different content, this would allow for a broader exploration of the implications of a broader set of organisational identities on care workers' motivation and patterns of identification.

The utilisation of different methodological approaches to examine care workers' motivation; through the SIA framework (including qualitative analysis, longitudinal analysis, and quasi-experimental testing) contributed to the robustness of this thesis's research. Nevertheless all studies relied on self-report measures, and future research might address this by incorporating objective measures related to motivation, for example turnover and sickness rates. Future research might also conduct knowledge and skills tests (pre- and post-training interventions) to further assess the effects of identity-sensitive interventions on motivation.

As mentioned above, a core strength of this thesis is that it draws on field-based research, which is typically under-represented in social psychology studies (McCarthy & Haslam, 2014). Social psychology, and social identity theorists in particular have been criticised for overrelying on laboratory-based experiments (Ashforth et al., 2008), more over

the experiments conducted in laboratories by social psychologists have been shown to have limited external reliability when applied to real life contexts (Mitchell, 2012). Although to be applauded in one sense, the real-life context of the research did mean that there was an inevitable limited amount of control over the extraneous variables, this contextual ‘noise’ does make the results of the individual studies open to other alternative explanations. However, the repetition and development of results that demonstrated the important role of work-based identity in three studies that applied different methodological approaches; along with the studies and investigation of the data being designed in accordance with empirically tested social identity theorising, goes some way to validating the interpretation of the findings given in this thesis. Nevertheless it is difficult to assess the extent to which the observed differences in outcome variables, (i.e. the levels of identification, and measures of motivation) can be attributed to the treatment effects (of undertaking qualifications (study 2) and different training programs (study 3)). Thus the robustness of these field-based research findings would benefit from further testing in laboratory settings, where a fully controlled experiment on the causal effects of different patterns of identification could take place. In particular, laboratory research could include testing scenarios that manipulate the quality of care routines as well as care workers’ salient identities. Another direction for future social identity research would be to conduct simultaneous research with both care workers and clients to examine the potential implications of a shared sense of identity (identification with the care home or organisation) for the wellbeing and motivation of both groups.

Notwithstanding the call for further laboratory based testing, the strong theoretical basis of our interpretations along with the convincing applicability of the social identity approach to better understanding the social context of care work suggests that the findings outlined in this thesis are more than plausible and ready to be applied (albeit in a highly monitored way) in organisational settings.

Indeed we assert, that taken together, the three studies presented in this thesis provide a coherent and compelling picture of the way in which care workers' motivations are informed by their social and relational identities. This analysis takes account of the multi-dimensional and dynamic nature of their work experience but it also lends itself to being replicated by exploring the motivation of other occupational groups — particularly those in the 'helping' professions. In order for the SIA to be recognised as providing a comprehensive framework through which to comprehend and develop motivation, further research also needs to be undertaken to test and refine its application, with a particular eye to attempts to translate theoretical understanding into practical intervention. The translation of this research into practise could be achieved through undertaking joint ventures with organisations to design or identify human resource practices and activities that actualise and harness identity resources, and then measure their impact.

By way of example, based on the findings from this thesis, the author has (a) designed future research on the effects of a leadership and coaching program on identification in a large health and social care organisation, and (b) designed an organisational intervention to develop and support care workers' relational identification (with clients and supervisors) and activate its generalisation to organisational identification. The overarching aim of this intervention is to contribute to creating and supporting an organisational culture of compassion (Adamson et al., 2012; Maben, 2012). The intervention seeks to do this by (a) engaging with, and supporting workers' sense of themselves at all levels of identity (personal, relational and organizational) and (b) targeting strategic leaders at the top, or centre, of the organisation as well as front line staff. The form of the intervention is a narrative coaching program which aims to create a shared language and generate conversations that occur at every level of organisational behaviour, between the care worker and client, the care worker and their supervisor, and the managers with the supervisors. The applicability of the narrative

approach to coaching to actualise and harness identity resources is that it recognises peoples' existing identity narratives (Brown, 2006) and works on transforming these stories (for more information see White, 2007; White & Epston, 1990; www.narrativecoaching.com). The coaching occurs at a relational level of identification between the care worker and supervisor, between senior managers and the executive board, and, in time, between peers. During the process of coaching, the individual worker is supported in the process of identity sense-making. This enables them to make sense of their identity by acknowledging and valuing their identity narratives as being generated at all levels of the work environment (including social, organisational, professional, as well as co-worker and client relationships). The language generated at a relational level of identification is generalised to organisational identification through it being viewed to be prototypical of the organisation as a whole. This might occur, in part, because it is viewed to be structurally implemented by the organisation, and because the coach is viewed to be prototypical of the organisation.

Moreover, an adoption of this intervention is likely to enhance care workers' capability to provide high-quality care provision, because it gives voice to their relational identity with clients, both in terms of their work with clients being valued and in terms of it providing language through which to acknowledge and work with clients' identities. Thus the integration of a narrative coaching approach into an organisation's human resource practices, and for that matter its staff training, could be seen as a mechanism by which to maximise its 'identity capital' (Akerlof & Kranton, 2010) and create a working culture in which staff and clients / patients or service users are mutual beneficiaries. McCormack's (2001) findings on the provision of compassionate care are not only equally true for the relationship between care workers and their clients, but also, in keeping with the findings of this thesis, can equally be applied to the development of a caring relationship between the organisation and its staff.

As she observes:

“It is important that the values that both patients and nurses bring to an encounter are made explicit, and are used to underpin a process of negotiation that results in mutual recognition of each other’s beliefs. On this basis a reciprocal relationship develops in which both parties grow as a result. For this to happen it is essential that practitioners account for and value the multiple voices within caregiving relationships”. (McCormack, 2001; p.21).

As Suchman and colleagues (2011) explore in their book *Leading Change in Health Care*, organisations are the manifestation of collective conversations wherein “we are creating the organisation anew in each moment by what we are saying about it and how we are relating to each other as we carry out its work” (p.23). Moreover, as the finding from this thesis suggest these conversations about compassionate care need to take place at all levels of organisational practice and tap into collective and relational levels of identification. For in spite of the common references people make in their conversations to individualistic idiosyncratic characteristics and personality traits, and the dominant ideology of individualism that permeates our worldview; peoples’ experience of work and, arguably of social life, is defined by their collective identification with different social groups and roles.

Concluding comment

This thesis has sought to develop our understanding of care workers’ motivations with a view to improving the quality and sustainability of the care they provide. In this regard, the research shows that what energises, directs and sustains people is bound up with the central component of their work — the act of caring. More often than not the act of caring also lies at the core of what it means to be part of a collective or group, and the thesis has therefore sought to examine care workers’ motivation from a perspective that takes the psychology of

group membership seriously, the social identity approach. This approach enabled us to understand how peoples' motivation is integrated within the cultural contexts and social situations in which they operate and bound up in a sense of who they are in personal, relational and collective terms.

Empirically, care workers' shared experience of caring was found to be especially powerful in their relationships with clients. The physical and social intimacy of their work behaviour shaped the psychological intimacy of these relationships, and this in turn played an important role in defining peoples' sense of themselves as care workers. Building on work undertaken on the role of relational and social identification in shaping peoples' work experience and motivation, the thesis also shows how relational identification with clients acts as the lynchpin in care workers' identification with the organisation and the profession as a whole. The research also demonstrated that although pivotal, valuing the relationship with clients does not in itself lead to increased motivation. Rather it is the sense that relational identification converges with organisational identification that leads to wellbeing and positive motivation outcomes. Finally, and speaking to the development of a compassionate organisational culture, the work has shown that high levels of organisational identity predict greater wellbeing and motivation in the workplace. Thus, given the well-established links between quality of the relationship and the quality of care provided (Wilson, 2009; Wilson et al., 2009), this thesis suggests that to develop compassionate care environments organisations need to demonstrate caring behaviour to their staff as well as their service users or clients. By doing this, organisations validate the relational identities that operate at the centre of carers' work.

This analysis is echoed in the finding that organisational incentives — whether for money or love — increased individual motivations because these built identification with the organisation. That is, incentives demonstrate to care workers that the organisation cares about

them and their clients, and because of this, they are willing to care about their organisation in return. Similarly, interventions that seek to improve care workers' capacity to do their job (e.g., professionalization training, undertaking qualifications) were also found to increase motivations to the extent they support and develop care workers' identification. Accordingly, interventions that connected to care workers' valued identities were most likely to sustain motivation, and interventions that disconnected from these identities were most likely to undermine motivation. In these ways, the social identity approach provides a framework through which an understanding of individuals' experience and behaviour at work is bound up with the social contexts (the group and relationships) in which these experiences and behaviours occur, and with the sense of identity associated with this.

Although the focus here has been on care work, because SIA does not specify the content of peoples' self-concept or identities, this analysis of work motivation should be equally applicable to other occupational domains. In translating the current insights to other contexts, it would be particularly helpful to start, as we did here, by examining what is meaningful to people about their work and why it matters to them rather than by making assumptions about these things. Attending to these things also provides a practical framework through which organisations can acknowledge, transform and regenerate identity capital.

Although there are good reasons for thinking that this approach will have broad applicability, there are few occupations (other than those associated with helping) where this understanding is more important than in the realm of care work. For here the process of identification — and the sense of oneness with others that this entails — is clearly central to the content of work performance and to the reciprocal act of caring. Accordingly, in this domain especially, it seems that the goal of creating and sustaining a workforce that is motivated and able to provide high-quality care is only likely to be realised through an understanding and appreciation of the importance of relational and social identification.

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APPENDICES

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