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The Shared Experience of Caring: A Study of Care workers' Motivations and Identification at Work

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Abstract

This article presents an analysis of long-term care workers' work motivation that examines the way this is shaped by the social contexts in which they operate. We conducted a thematic analysis of 19 in-depth interviews with care-workers. Three core themes were identified as underpinning their motivation: those of 'fulfilment', 'belonging' and 'valuing', and together these contributed to a central theme of 'pride'. We also found an overarching theme of 'shared experience' to be integral to the way in which care workers made sense of their motivation and work experience. We draw on the social identity approach to provide a conceptual framework through which to understand how this shared experience shapes care-workers' motivation and the quality of care they deliver. In particular, we note the importance that care-workers' attach to their relationships with clients/patients and highlight the way in which this relational identification shapes their collective identification with their occupation and organisation and, through this, their motivation.

Key words: motivation; care workers; thematic analysis; social identity approach

The consequences of a rapidly aging and healthier population are well documented (Centre for Workforce Intelligence, 2011; Care Quality Commission 2012; Department of Health. DoH, 2007, 2009; Helpaged International 2012). Amongst other things, this is increasing the size, as well as the economic and social importance, of the adult social care workforce (ASCW) in the UK and in other industrialised countries. In response to this, in the UK over the past decade there has been an increasing emphasis on the professionalisation of the ASCW with the aim of ensuring a consistently high quality of care. Moreover, following on from the increasing 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. We therefore draw on the plethora of research undertaken on nursing, which has both contributed to and resulted from the recent professionalisation of this occupation (Adams & Nelson, 2009; Ousey & Johnson 2007; Rytterstrom et al., 2009; Woodward 1996), as a basis for understanding workers' experiences in social care in the context of the current professionalisation of this sector. Here too, however, available research is also seen to lack a

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robust theoretical analysis of what activates and sustains nurses' motivation to work in a

professional and compassionate manner (Folbre, 2012).

To address the widely acknowledged 'data desert' of the ASCW, the National Survey

of Care Workers (Skills for Care, 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 also 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). Indeed,

previous research has found that 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 also consistently been found to be key contributors to job

satisfaction and wellbeing (Moyle, 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

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been damaging to, and misrepresentative of, the workforce (Himmelwait, 2007; Lepore, 2008; Nelson & Folbre 2005). For example, some economists have sought to justify continuing to give 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 a dominant social discourse surrounding care work that dichotomises material rewards and moral values, and which inhibits 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, dominant 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, 2003; Nolan et al., 2003, 2006; Wilson & Davies, 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). In light of these various points, it would appear that a holistic understanding of the motivations of care workers needs to take account of the collective, relational, and personal contexts in which care work is performed and of the way in which these contexts relate to the psychology and self-concepts of care workers.

Identification, motivation and helping behaviour

In trying to address some of the shortcomings that are evident in individualistic models of motivation, our understanding of work motivation is guided by theorizing in the social identity tradition (SIA; Ellemers et al., 2004; Haslam 2004). This combines principles

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of social identity theory (SIT; Tajfel & Turner, 1979) and self-categorisation theory (SCT;

Turner 1985; Turner, Hogg, Oakes, Reicher & Wetherell 1987) and argues that motivation in

the workplace derives from employees' desire to enhance the self, but that the self can be

defined in different ways and at different levels of abstraction (Turner 1985). According to

SCT a person's self-concept is fluid, dynamic, and context-dependent and it incorporates

multiple identities which can be defined at a personal, relational and collective level (for

more detail, see Ashforth, Harrison & Corley, 2008; Haslam 2004).

A large body of prior research informed by the social identity approach has shown

that the more a person identifies with a particular group or relationship at work (such that

they internalize it into their sense of self), the more the person's perceptions and behaviour

will be informed by the norms and values associated with the group or relationship in

question (e.g., as a care worker, an organisational representative, a supervisee, or a carer;

Haslam, 2004; Ashforth & Mael, 1989; Van Knippenberg, 2000). Moreover, greater

identification with the organisation as a whole and greater congruence between other work-

based identities (e.g., the team, the profession, and with individual supervisors and

colleagues) has been shown to underpin more positive work experiences. It has also been

shown to result in greater motivation to act on behalf of the relational or collective entity and

to advance its goals (Ellemers et al., 2004; Haslam, Postmes & Ellemers, 2003; Hogg &

Terry, 2000; Van Knippenberg & Ellemers, 2003).

SCT argues that, at any particular moment, the salience a particular identity — and

hence its impact on behaviour and motivation — will be determined by the accessibility of

the identity as well as its perceived fit (Oakes et al., 1994; Turner et al., 1987). In this way the

theory also explains how people's sense of themselves, their self-esteem, motivation, and

wellbeing is bound up with the various relationships and group memberships that they

develop in the workplace (Haslam et al., 2000). Accordingly, care workers' motivation can

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be understood to be driven as much (if not more) by an individual's need to enhance a

collective and relational sense of self ('us') as it is by his or her need to enhance a personal

sense of self ('I'). Supporting this point, previous research on helping and pro-social

behaviour has found that where a helper and the person they help perceive themselves to

share social identity this serves not only to increase the likelihood of helping (Levine,

Prosser, Evans & Reicher, 2005) but also to increase the (perceived) quality of any help that

is provided (Leeuwen & Tauber, 2010; Sturmer & Snyder, 2009).

Aims of the present study

        In line with the above arguments we suggest that care-workers' explanations of (or

narratives about) their work motivation will (a) be tied to enduring identity narratives that

connect the contents of relevant personal, relational and social identities and (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). In order to explore these

hypotheses, the present research sought to gain an in-depth, holistic and dynamic

understanding of care-workers' motivations which takes into account the social context of

their work. More specifically, the study sought to answer two key research questions: First,

what features of their work motivate care workers? Second, why does care work matter for

care workers?

                                            Method

        In order address the above questions, the study had two stages. First, a thematic

analysis of interviews with care workers and, second, an analysis of the findings from the

thematic analysis informed by a social identity perspective. As noted above, 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

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which particular group memberships are psychologically meaningful and form the basis of

shared self-definition (a sense of 'we-ness'; Turner, 1987).

As a first stage in a more extensive programme (Author, 2014; Author et al., 2014a,

2014b), we chose to initiate research through a qualitative approach that allowed for open

inquiry into the question of how care workers' identities were made meaningful and which

did not impose particular definitions of identity upon them. Accordingly, we chose to avoid

closed questions about a given identity as well as quantitative measure of identity that might

have been constraining or reactive in this respect. This involved using a thematic analysis

approach (Braun & Clarke, 2006; see also Haslam & McGarty, 2014) to ascertain the themes

and sub-themes underlying participants' narratives about their work-related selves. This

started by examining the content of care workers' identities (as revealed in narratives about

work behaviour and the associated norms and values) and then went on to focus on the nature

of those identities which were found to be meaningful in the context of performing care work.

Participants

Participants were care staff drawn from a large care organisation responsible for

delivering care services across the south of England. This was 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 working contexts

that varied on a range of dimensions (e.g., 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 invite to

interviews. In liaison with care home and care base managers, participants received a letter

from the researcher to take part in the study. They were informed that interviews would be

conducted in work time but that it was their choice as to whether they participated or not.

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In each setting interviews were conducted until data saturation was achieved (i.e., such that new interviews were generating no new themes; Pidgeon & Henwood, 1997). Of the 19 participants included in the final sample, 9 worked in domiciliary care and 10 in care and nursing homes.

Interviews

Semi-structured, tape-recorded interviews were conducted by the first author with 20 care and senior care staff. One interview with a domiciliary care worker was omitted from the study because of the recording was inaudible. Interviews were 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), 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. After 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 the study was granted by the relevant University ethics committee, and participants were informed that their responses would remain anonymous and that they were able to withdrawal from the research at any stage in the process. After the interviews, a letter was sent to all participants providing an anonymised summary of the

findings and offering them the chance to withdrawal from the study if they wished. None did.

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, 2014).

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 the

way in which the interaction between researcher and participant played an active role in

shaping the latter's accounts of their experiences (Nightingale & Cromby 1999; Smith &

Osborn, 2003), and kept reflective notes. More specifically, it appears that interaction was

likely to have been affected by both (a) the context in which the interviews were conducted,

(i.e., domiciliary care homes — where the pressure of limited time and the need to return to

work was particularly apparent) and (b) the nature of the interviews (i.e., as conducted by an

external researcher from a university and involving care workers who had varying

experiences of research). In this regard, it is worth noting that in self-categorisation terms, 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 and in line with suggestions that research involves "a constant interplay between data and the researcher's developing conceptualisations" (Pidgeon & Henwood, 1998, p. 252) in addition to the two key research question (What motivates care workers? Why does care work matter to them?), two further questions were driven by the interview process: "Why care?" and "What is important about care work?"

The interview recordings were listened to in full and then transcribed. The resulting transcripts were re-read several times. Specific thoughts, feelings and observations were identified in the verbatim data and coded in terms of their representing "some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p.82). These meanings were then translated into 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 was 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.

The quotations selected for presentation below were those seen to best represent the data that contributed to a particular sub-theme. To ensure anonymity, quotes are referenced according to whether they were made by a domiciliary care worker (DCW) or a residential care worker (RCW).

Results

1. Thematic analysis

Three core themes were identified as reflecting what care workers' find meaningful about their work. These themes of 'fulfilment', 'valuing' and 'belonging' contributed to the fourth theme, of 'pride', which was identified as reflecting why care work mattered to them. As Figure 1 illustrates, the overarching theme of 'shared experience' was also identified as integral to the way in which interviewees made sense of and understood their work-related behaviour and motivation.

— Insert Figure 1 about here —

A number of themes and sub-themes relating to norms and values were identified as contributing to these core themes, reflecting interviewees' thoughts and feelings about working in ASC. In an attempt to mirror the bottom-up approach through which we analysed the data, we first report the data as it related to our 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]

Interviewees also expressed 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 too 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 was 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?

Another core theme that was identified as representing and explaining why

participants were motivated to care was 'belonging'. This again had several sub-themes.

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 with 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'. Families 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), and 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 in terms of whether they were

seen to be part of an 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 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] and 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 the 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 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. This was a theme that reflected the 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 as a motivator of participants' work and as a factor that makes care work matter. 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 care workers' 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' articulation of the core themes that motivated them at work also went

some way to explaining why that work mattered to them, (i.e. a sense of fulfilment,

belonging, validation and pride) and this was actualised through the 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 importance of shared experience for 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 respondents' sense of 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.

2. Social identity analysis

The forgoing analysis 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 were inter-

related and together contribute to care workers' self esteem and work identification.

Fulfilment of collective self-esteem. Participants' sense of fulfilment appeared 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), but also fulfils higher-order needs

for enhancement of self-esteem (Ellemers & Haslam, 2004). It is evident in the foregoing

analysis that self-esteem enhancement is achieved through feelings of worthiness that were

associated with a need for belonging. This collective self-esteem was 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, were 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 was also evidence that this has negative consequences (such as an increased likelihood of exhaustion and burnout; Haslam, 2004). This was 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.

Valuation of the caring role. 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. Along the lines of findings from research with nurses (Nelson et al., 2000), participants did not overtly valorise the knowledge, skills, and attributes entailed in their work. Indeed, they were sometimes dismissive of their own effort and skills. Nevertheless, although there was 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 was 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 discourse surrounding care work. This is a norm which is recognised as 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).

Discussion

Overall, the above findings illustrate how care workers' 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 care workers. In this regard care workers' work-related identities appear to be primarily defined in terms of their identification with their clients. More specifically, 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. In line with the bottom-up perspective on identity formation (e.g., Baumeister & Newman, 1994; Ibarra & Barbulescu, 2010; Postmes et al., 2005; Scott, Corman, & Cheney, 1998), it thus 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 also 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 and, thereby acts as a conduit for 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) 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 to their accounts of what motivates and

matters to them. For instance, participants' identification with the organisation was largely

articulated 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 observation aligns with Sluss and colleagues'

previous 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 seems 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 clients is that in line with social

identity research on helping behaviour, it appears that 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.1) 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. It follows too that 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 directions for future research

The limitations of this study are primarily related to its qualitative nature — in particular, the fact 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 also provides a rich evidence base which can be used to inform further research into the dynamics of care-workers' motivation (Author, 2014).

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Indeed, research that builds upon the present analysis consolidates and builds upon the above

findings by quantifying patterns of care workers' identification and motivation, and assessing

how they influence one another. In particular, it does this (a) by examining differences in

patterns of client and organizational identification between domiciliary and residential care

workers and showing how these feed into distinct patterns of work motivation (Author et al.,

2014) and (b) by showing how professionalization impacts on work motivation through its

impact on different forms of identification.

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 the

present 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. In this it can

be seen that the social identity perspective offers a theoretically coherent psychological

account of the importance and influence of a relationship-centred approach to the motivation

and wellbeing of care workers. This in turn leads us to suggest that it is by recognising and

supporting this 'caring' identity that organisations and policy makers will develop,

strengthen, and maintain a compassionate caring workforce.

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Statement of ethical approval

Ethical approval for this research was granted by the University of Exeter, and data collection

followed the University guidelines for collecting data, this included asking permission from

participants and informing them of the right to withdrawal from the research at any given time.

Declaration of contribution of authors

All of the authors named made a significant contribution to this article.

Statement of conflict of interest

The authors declare no potential conflicts of interest with respect to the research, authorship,

and/or publication of this article.

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Table 4.1 *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/actor	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

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Table 2. A *summary of themes from participant interviews*

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

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Figure 1. A schematic representation of the key themes identified as contributing to care-workers' motivation
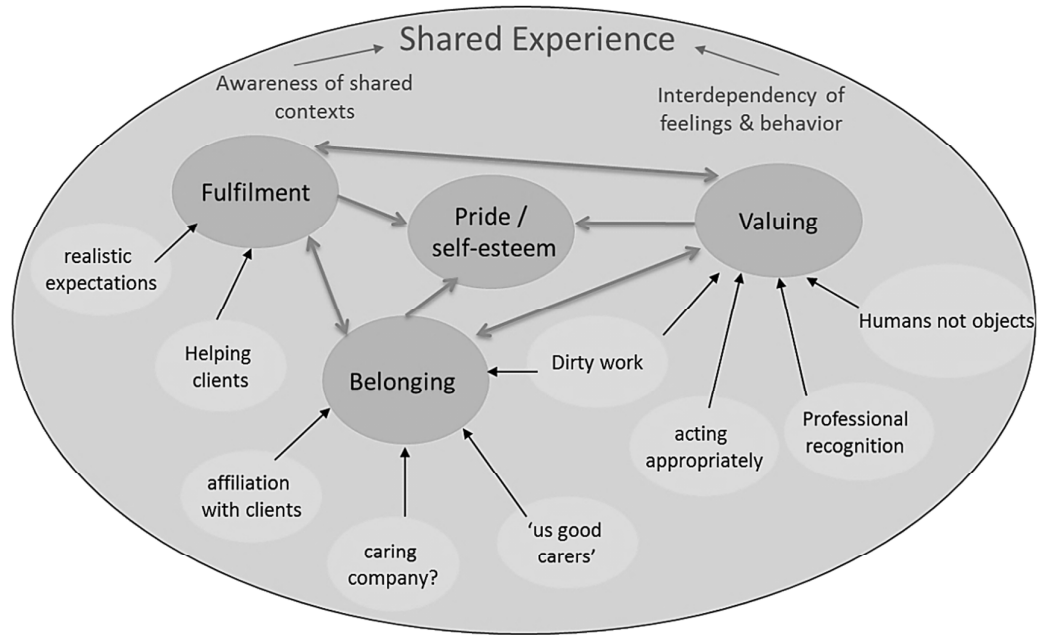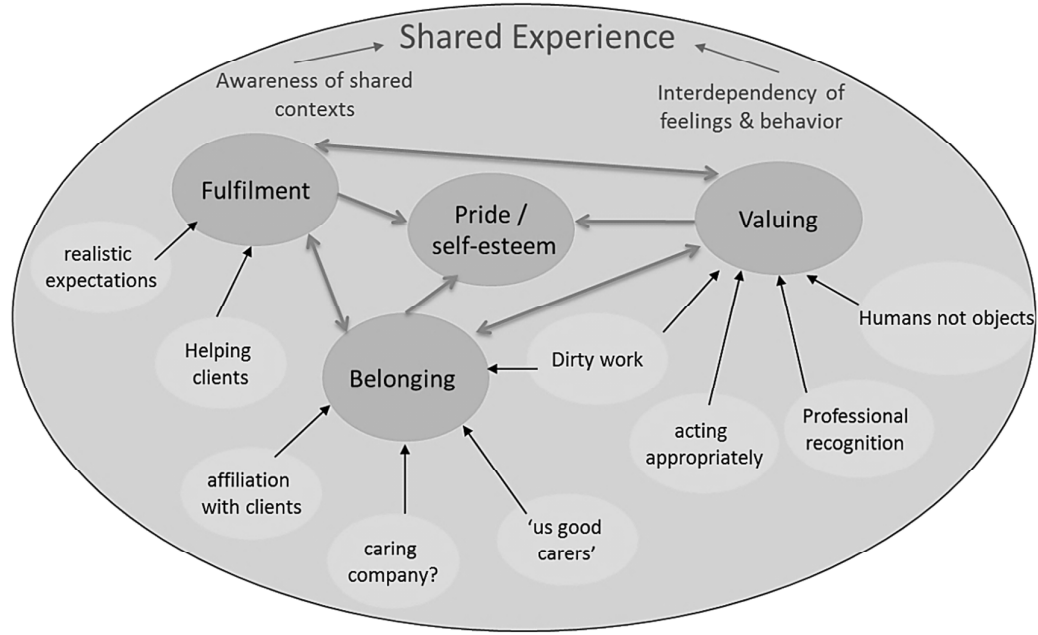
Figure 1. A schematic representation of the key themes identified as contributing to care-workers' motivation

PSYCHOLOGY DEPARTMENT ETHICAL APPROVAL FORM

Tick one box: **POSTGRADUATE Project**   √   **TRACK A**

Title Of Project: The motivation of people working in social care

Name of researcher(s) Kirstien Bjerregaard

Name of supervisor (for student research) Alex Haslam   Date 26/2/08

		YES	NO	N/A
1	Will you describe the main experimental procedures to participants in advance, so that they are informed in advance about what to expect?	Yes		
2	Will you tell participants that their participation is voluntary?	yes		
3	Will you obtain written consent for participation?		no	
4	If the research is observational, will you ask participants for their consent to being observed?			n/a
5	Will you tell participants that they may withdraw from the research at any time and for any reason?	yes		
6	With questionnaires, will you give participants the option of omitting questions they do not what to answer?			n/a
7	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	yes		
8	Will you debrief participants at the end of their participation (ie. give them a brief explanation of the study)?	yes		

If you have ticked **No** to any of Q1-8, but have **ticked box A** overleaf, please give any explanation on a separate sheet. (Note: N/A = not applicable) *explanation in text box overleaf*

		YES	NO	N/A
9	Will your project involve deliberately misleading participants in any way?		No	
10	Is there a realistic risk of any participants experiencing either physical or psychological distress or discomfort? If **Yes,** give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g. who they can contact for help).		No	

If you have ticked **Yes** to 9 or 10 you should normally **tick box B** overleaf; if not, please give a full explanation on a separate sheet.

			YES	NO	N/A
11	Does your study involve work with animals? If yes, and your study is *purely* observational, please **tick box A.** All other studies should **tick box B** and provide supporting information.			No	
12	Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and **tick box B** overleaf. **Please note that you may also need to gain satisfactory CRB clearance or equivalent for overseas participants.**	School children (under 18 years of age)		No	
		People with learning or communication difficulties		No	
		Patients		No	
		Those at risk of psychological distress or otherwise vulnerable		No	
		People in custody		No	
		People engaged in illegal activities (e.g. drug taking)		No	

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee projects with ethical implications not clearly covered by the above checklist.

PLEASE TICK **EITHER** BOX A or BOX B BELOW AND **PROVIDE THE DETAILS REQUIRED** IN SUPPORT OF YOUR APPLICATION, THEN SIGN THE FORM.

Please tick:

A. I consider that this project has **no** significant ethical implications to be brought before the Departmental Ethics Committee.	√

In less than 150 words, provide details of the experiment including the number and type of participants, methods and tests to be used (i.e. the procedure).

Aim
To gain an understanding of care staff's views on the changing nature of social care work and the impact it will have on them and their colleagues.

Methodology
To conduct semi-structured interviews with staff in caring roles in domiciliary care and in residential and nursing home settings. The interviews will be conducted until we have obtained a saturated sample which captures the range of views of care staff working in the different settings and roles. The total number of interviews is likely to be around 20.

Interviews are likely to take around 20 minutes and will be conducted at 3 residential care homes and 3 community care bases.

A thematic analysis of the data will provide a detailed picture of staff's views on the changing nature of social care. This will then be used to design a staff survey and experimental interventions.

Question 3
Participant consent will be obtained verbally. The recording of the interview will be transcribed and and consent will then be available in writing.

This form (and any attachments) should be submitted to the Departmental Ethics committee where it will be considered by the Chair before it can be approved.
Attached is the interview protocol

B. I consider that this project **may** have ethical implications that should be brought before the Departmental Ethics Committee, and/or it will be carried out with children or other vulnerable populations.	

Please provide all the further information listed below in a separate attachment.

1. Title of project.
2. Purpose of project and its academic rationale.
3. Brief description of methods and measurements.
4. Participants: a) Human research: Recruitment methods, number, age, gender, exclusion/inclusion criteria.
   b) Animal research: location of study site, method of obtaining / marking / identifying subjects, handling procedures for field experiments.
5. Consent and participant information arrangements, debriefing. (Not relevant for animal research) *Please attach intended information and consent forms.*
6. A clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.
7. Estimated start date and duration of project.

This form should be submitted to the Departmental Ethics Committee for consideration.
If any of the above information is missing, your application will be returned to you.

I am familiar with the BPS Guidelines for ethical practices in psychological research (and have discussed them with other researchers involved in the project.)

Signed……………………………………….………… Print Name……Kirstien Bjerregaard Date…26/2/08…………
(UG/PG Researcher(s), if applicable)   Email…kb283@exeter.ac.uk

Signed…………………………………………………. Print Name……Alex Haslam……… Date…………..
(Lead Researcher or Supervisor)   Email…a.haslam@exeter.ac.uk……

STATEMENT OF ETHICAL APPROVAL

This project has been considered using agreed Departmental procedures and is now approved.

Signed…………………………………………Print Name…………………………………………..Date………………..
(Chair, Departmental Ethics Committee)