Stress levels, coping strategies and job satisfaction among health care assistants in Ireland

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Abstract

Background: Previous research in Ireland has highlighted the ever-increasing need of health care mainly due to an ageing population. Health care assistants (HCAs) are an important part of the health care task force that help meet this demand. However, they are not as researched as others such as nurses despite several problems that they may be facing. *Objective*: This study aims to investigate relationship between stress, coping strategies and job satisfaction in HCAs. *Method:* The sample consisted of 137 participants selected using convenience sampling. They completed a demographics questionnaire and three others that measured perceived stress levels, coping strategies and job satisfaction respectively. Data was then entered in SPSS for analysis. *Results:* Analysis indicated that there were significant correlations between perceived stress and avoidant coping strategy and between perceived stress and job satisfaction levels. Only perceived stress score total was found to uniquely predict job satisfaction levels to a statistically significantly level. HCAs with a more dominant approach coping strategy were found to have lower levels of stress as compared to ones with a more dominant avoid coping strategy. There was no difference in job satisfaction levels in relation to either coping strategy. *Conclusion*: HCAs are a major part of the health care work force who are being faced with several issues affecting this line of occupation, namely stress levels, coping strategies and job satisfaction levels and so it is important to understand the relationship. The current study offers a glimpse at this relationship and how this can be used to improve their well-being and make the occupation more attractive for workers.

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Introduction

Health care providers around the world are facing a challenge of being able to provide care to the increasing number of people who require it (Blendon & Desroches, 2003; Health Education England, 2015). A report by Wren et al., (2017) that was looking at the demand for healthcare in Ireland between 2015 – 2030 stated that due to continued rapid population growth, demand for health and social care is projected to increase across all sectors in the years to 2030. This includes demand for public and private hospitals, long-term and intermediate care, home care and GP visits. The report states the main cause for this projected population growth is due to an ageing population; and older adults tend to have greater healthcare demands than younger people due to diseases such as Alzheimer's where its' prevalence is very low at young age and then almost doubles with every five years of age after 65 years (WHO; US National Institute of Aging, 2011). As a result, the demand of the health service is exceeding the supply of health care workers (Ravenswood, Douglas & Teo, 2014), which is a contributing factor for increasing the workload of workers, especially health care assistants (HCAs) who are on the frontline of providing direct care to the people in need. The work of HCAs includes measuring patients' vitals, food preparation and giving, personal care concerns such as bathing, helping with mobility issues amongst others (Rakovski & Price-Glynn, 2010).

Currently in Ireland, there is a shortage of HCAs as reported on the Independent.ie by O'Regan (2018). The newspaper article states that staff shortages in services such as nursing homes worsen the A&E crisis by escalating hospital overcrowding and trolley gridlock. The article further reports that a review done in 2017 found that there was a high-level turnover and a high number of health care assistants' vacancies being advertised. This could be attributed to the job not being attractive enough for potential candidates due to factors like temporary contracts.

Other issues faced by health care assistants in Ireland, possibly impacting their job satisfaction levels and might explain the high turnover and why other suitable applicants are not entering this profession include; a lack of uniform standards in the private sector (which includes pay rates, employment terms and conditions), more admin work with limited time, insufficient training, lack of job security, no reimbursement for travel expenses or travel time lack of defined roles, promotion and career progression and many more (Healy, 2015; Vail, Bosley, Petrova & Dale, 2010; Spilsbury et al., 2010). These factors in addition to HCAs taking on tasks which are no longer desired by nurses could lead onto job stress and difficulty with coping that is associated with high workloads, low staffing levels and emotional strains of working with clients who have complex care needs (McVicar, 2003; Estabrooks, Squires, Carleton, Cummings & Norton, 2015). This is problematic because not only does stress influence the health care assistant subjective experiences, physical consequences and behavioural changes, it may also affect the worker's ability to providing high quality care to his/her patients and how they perceive and deal with it, leading to preferred coping strategies (Koinis et al., 2015).

Stress

Cranwell-Ward and Abbey (2005) define stress as a physiological and psychological reaction that occurs either consciously or subconsciously in response to a perceived threat or undesirable experience beyond one's immediate ability to deal with the situation (p.28). This can be further described by Walter Cannon's fight-or-flight response theory of homeostasis in which he proposed that stress occurs when feelings of threat to the body place a physiological strain on its abilities hence causing an imbalanced state (McCarty, 2016). Some studies have argued that an increase in workloads is a precedent for an increase in stress (Dawson, Stasa, Roche, Homer & Duffield, 2014; Halpin, Terry & Curzio, 2017; Weiss & Lonnquist, 2017).

Work is seen as a major and important aspect of an individual's life. Studies such as Fryers, Melzer and Jenkins (2003) found that unemployment was one of the factors consistently associated with common mental disorders which comprises of depression and anxiety. Though employment is important for mental health, reports such as the European Agency for Safety and Health at Work report (2007) state that increases in trends of pace of work, high-skilled jobs, and increased need to know and be able to use information and communication technology could be putting more mental pressure on HCAs. According to Karasek, (1979), these trends can be regarded as stressors in a workplace setting which is a reaction to demands. As a result, this is also possibly linked with the prevalence of high levels of psychological distress seen in the working population (Hilton et al., 2008). As well as impacting mental health, other studies have also found stress to be associated with illnesses such as cardiovascular diseases (Backé, Seidler, Latza, Rossnagel & Schumann, 2011), type 2 diabetes (Heraclides, Chandola, Witte & Brunner, 2009) and obesity (Foss & Dyrstad, 2011). In addition to impacting employees' health and causing work-related illnesses if not managed properly, work-related stress has been stated to have a major effect on employees' performance and effectiveness at work (Teigen, 1994). The relationship of stress and performance is described by Tiegen as an inverted U where a little anxiety from time to time helps with task performance according to Yerkes-Dodson law. This goes on until the optimum level of arousal is reached after which it starts affecting performance negatively.

In terms of explanations for the causes of job-stress, the Karasek's job demand–control (D–C) model is a widely researched theory used to explain the relationship between job stress and the work environment (Karasek, 1979; Karasek & Theorell, 1991). The model states that stress is as a result of job demands (for example workload and pace) being high whilst job control and independent decision-making levels are low. Work overload happens when the work demands is more than the HCA's ability to complete the task (Clarke, 2001;

D'Hondt, Kaasalainen, Prentice & Schindel Martin, 2011; Hertting, Nilsson, Theorell & Sätterlund Larsson, 2005). Clarke (2001) report a common finding of HCAs working under the constraint of low 'caregiver to patient' ratios with very few or limited resources within this workforce group. Low levels of job control as a stressor occur when the employees are unable or restricted in making decisions and managing their time whilst at work leading to a sense of helplessness and no power (Clarke, 2001; Gustafsson, Norberg & Strandberg, 2008; Hertting, Nilsson, Theorell & Sätterlund Larsson, 2005; Mininel, Baptista & Felli, 2011). The model was later revised to include emotional and psychological support from supervisors and colleagues (Cieslak, Knoll & Luszczynska, 2007). The inclusion of these two health outcomes is important as it supports two predictions: firstly, having support from supervisors and work colleagues can reduce the adverse effects that both high job demands and inability to make decisions have on the HCAs and secondly that high levels of psychological demands have a negative impact on health when the ability to make decisions is low (Mininel, Baptista & Felli, 2011).

Stress in health care assistants also may occur as a result of continuous interaction with the care recipients and their families/friends which can lead to a range of emotions such as anger, embarrassment, fear, and desperation and especially so when the problems have no solutions (Boumans & Landeweerd, 1996). Previous research has identified that experiencing work related stress or fatigue can have negative effects on the patients' satisfaction, the care being delivered due to errors occurring, decreased treatment adherence and lower levels of empathy towards patients (Drury, Craigie, Francis, Aoun & Hegney, 2013; Fortney, Luchterhand, Zakletskaia, Zgierska & Rakel, 2013). As a result, the symptoms of work-related stress will not only affect the health of the HCA, but also impact the safety of the recipients of care.

Other common stressors are as a result of conflicts between co-workers and other health professionals regarding residents' care, disagreements with supervisors, not being allowed to use all of one's potential, and being underpaid (Schwendimann, Dhaini, Ausserhofer, Engberg & Zúñiga, 2016). Stress at work may therefore result in more burnout which can be described as the inability of being unable to cope with emotional stress at work or feelings of fatigue and failure. As a result of high burnout, the HCA ends up being emotionally exhausted, having a feeling of lost work significance and accomplishment due to not receiving positive feedback hence a reduction in job satisfaction (Embriaco, Papazian, Kentish-Barnes, Pochard & Azoulay, 2007).

Job Satisfaction

Studies have indicated that high levels of stress are related with lower levels of job satisfaction and poor mental health in employees (Landsbergis, 1988; Cummins, 1990). Spector (1997) suggests that this is as a result of a mismatch between what one expects from their job and their actual working environments.

Previously, job satisfaction was regarded from a needs fulfilment perspective and whether it met the employee's physical and physiological needs such as pay (Spector, 1997). Spector (1997) mentions that job satisfaction is more focused on cognitive processes instead of the underlying needs. Job satisfaction can be also regarded as the difference between what an employee expects from their job versus what they get (Price, 2001). This could be in the form of advancement opportunities, salaries etc. as reported by Aiken et al. (2001) when reporting on job satisfaction findings on nurses from five countries.

One of these cognitive processes (Spector, 1997) is stress at work which, as mentioned above, has been reported to influence job satisfaction levels (Gray-Toft & Anderson, 1985; Sehlen et al., 2009; Nam et al., 2016) and is a very important factor in HCAs. A study by Schwendimann, Dhaini, Ausserhofer, Engberg and Zúñiga, (2016) which

was investigating factors associated with high job satisfaction among care workers in Swiss nursing homes found that work stressors such as work conflict negatively correlated with job satisfaction. The high stress and low job satisfaction levels can be brought on by different factors including -the workplace environment not being conducive as reported by carers; that is, HCAs stated that although they perceive their jobs as important, their management overworks, underpays and mistreats them (Diamond, 1992; Foner, 1995; Gass, 2005). They reported that they were mainly dissatisfied with staffing levels which due to shortage of workers, means they are overworked as well as high turnover of staff (Castle, Engberg, Anderson & Men, 2007).

Although HCAs have been a part of the caring team for a while now with the grade being introduced in Ireland in 2001 (HSE, 2018) and the profession representing a good proportion of the health care workforce, there is still a lack of policy and regulation regarding their role, job description and skill set as stated in the report. For example, when the HCA role first emerged, they were meant to perform non-nursing tasks and assist nursing staff. However, nowadays HCAs are the ones who provide most of the direct patient contact care (Bach, Kessler & Heron, 2008). This means that employers can change their job descriptions to match the organisations needs (Bach, Kessler & Heron, 2008). As a result, it may lead to increase in tension levels and poor working conditions for the workers for example due to occupational boundary disputes between HCAs and nurses (Bach, Kessler & Heron, 2012), and ultimately leads to poorer job satisfaction.

Despite HCAs being responsible for most of the care work, as mentioned (Bach et al.,2008), they are still subjected to poor working conditions and pay (Rakovski & Price-Glynn, 2010). Although low wages regularly result in HCAs devaluation of caring work (Berdes & Eckert, 2007) and perception of lower job status in the caring hierarchy as compared to other professions such as registered nurses (Bullock & Waugh, 2004), positive

factors such as being able to have a reciprocal relationship with recipients of care or being able to provide effective care may help mitigate the effect that low pay has on job satisfaction levels (Berdes & Eckert, 2007; Jones, 2001). This means that positive affective care should be encouraged among HCAs as it provides a sense of motivation and satisfaction by acting as an emotional 'currency' where other common promotional factors such as good wages, career advancement and other benefits are lacking.

In health care organisations, not only does job satisfaction matter for the patients being looked after by the health care workers, it also is related with work absenteeism, human relations and work organization as found by Duclay, Hardouin, Sébille, Anthoine and Moret, (2014) study on nurses and nurse assistants (HCAs). The study aimed to investigate the impact that staff absenteeism had on patient satisfaction using the care quality indicators such as ones for measuring patient satisfaction and are available in management reports. The study found that patient satisfaction related to relationships with staff was significantly and negatively correlated with the workers absenteeism and suggests that these absences cause more work for the remaining workers and as a result, a bigger workload. It states that these workloads could leave the workers overworked and they are then unable to cope with pressure more effectively. As a result, it suggests that for patients' satisfaction to be improved, managers must look for solutions in order to reduce absenteeism, avoid burnout, improve the workplace atmosphere and promote better coping skills.

Coping

It is important that the health and wellbeing of HCAs is promoted through positive coping strategies, since they are vulnerable to various stressors as a result of their challenging work environment. Coping can be described as the ability to adjust to demands when under stress (Lazarus & Folkman, 1984). Due to this, it may be an important factor of successful adaptation among health care assistants.

Although there has been a lack of agreement on the coping concept with most studies failing to test the best fit between conceptual dimensions and the data, two comprehensive strategies have been repeatedly identified by a number of coping measures: approach and avoidant coping strategies (Herman-Stabl, Stemmler & Petersen, 1995). Approach strategy involves seeking information and making conscious efforts to maintain or regain control (Curry & Russ, 1985), problem-focused coping (Compas, Malcarne & Fondacaro, 1988), arguing logic (Ebata & Moos, 1991) and problem solving (Glyshaw, Cohen & Towbes, 1989). Avoidant strategy on the other hand includes escape or distancing from problem, unhealthy self-soothing such as binge eating, numbing, compulsive behaviours or self-harm. (Dombeck, 2006).

A study by Schneider, Scales, Bailey and Lloyd (2010) that used participant observation where the researchers took on a HCA role to investigate areas such as: What motivates staff? What obstacles the face in order to provide good care do they face? What stressors they face and ways of coping? Ways in which staff wellbeing is promoted amongst others. The research found that the HCAs used a variety of stress management strategies to cope which included seeking support from others, escaping both physically by leaving the ward, taking a cigarette break and also emotionally, exercising, implying that they will turn to alcohol as well as desensitization which can be seen as a way of self-protection and use of irony, joking and talking about other things apart from the topic of concern.

Previous research indicates that the using of approach coping strategies helps lower the symptoms of fatigue or burnout within HCAs as opposed to engaging in behaviours such as avoidance and denial (Cheng, Kogan & Chio, 2012; Subramanian & Kumar, 2012). Studies also show that by using approach coping strategies, it reduces the impact that stress will have on the worker (Fortes-Ferreiera, Peiro, Gonzales-Morales & Martin, 2006) and also

reduce staff turnover, improve well-being and directly impact patient-care positively (Koeske, Kirk & Koeske, 1993; Holton, Barry & Chaney, 2016).

Graham, Ballard and Sham (1997) study investigating carers' knowledge of dementia, their coping strategies and morbidity found that the carers who knew more about dementia experienced significantly lower levels of depression, but higher rates of anxiety compared to ones with lesser knowledge. The results showed that the carers' level of knowledge on dementia showed no relationship with their physical health. However, the more knowledgeable carers were more likely to have 'reduced expectations' of their dependants' abilities and make 'positive comparisons'; they were also more likely to feel competent and confident as caregivers hence reduced stress levels.

Overall, there has been limited research on coping in HCAs with most research focusing on other health care professions such as nurses although these findings might be applicable to HCAs also. Shiota (2006) suggests that by applying the right coping strategies, it will effectively lead to an increase in well-being and reduced stress levels. Organisations also can use the stress management guidelines laid by the Health and Safety Executive (HSE) and have previously been used to assess good practice by acting as a benchmark. This includes; providing employees with achievable demands e.g. in relation to their workloads, giving employees 'control' where possible, providing adequate information and support, promoting positive relationships, ensuring that employees understand their role within the organization and lastly where there is need for change to ensure employees are engaged with and consulted (Schneider, Scales, Bailey & Lloyd, 2010). By workplaces addressing this, it will promote better working conditions and help in reducing factors that may increase poor coping strategies such as employee sickness caused by workplace stress as a result of increased workloads and low staffing levels. Although this evidence suggests that better coping strategies may result in lower levels of perceived stress and higher job satisfaction,

more research is required to determine the potential effects of positive coping strategies outcomes of job satisfaction and stress in HCAs in Ireland.

The Present Study

To summarise, there has been a lot of research in the areas of stress, job satisfaction and coping strategies with studies reporting on different professions that involve unique circumstances which may present higher than usual stress levels, especially ones that involve direct human contact and quick decision-making skills. One of these professions is health care workers which also includes HCAs (Koinis et al., 2015). Most studies have researched the relationship between stress, coping strategies and job satisfaction among health-care providers in various areas such as physicians, radiographers and nurses (Sehlen et al., 2009; Jordan, Khubchandani & Wiblishauser, 2016). The results from these studies showed that stress correlated with lower job satisfaction and high stress levels negatively affected coping abilities and work performance respectively. However, very few studies have examined the relationship between stress, coping strategies and job satisfaction in HCAs in Ireland; hence the need for this study.

Also, a report on projections of demand for healthcare in Ireland, 2015-2030 (Wren et al., 2017) reported a great unmet demand for acute healthcare services across all health sectors including hospitals, nursing homes and home care. This demand is meant to increase due to projected continued rapid population and an aging population. Unless measures are put in place to ensure that workforce planning and support is implemented, it will be difficult to meet this projected demand. As a result, it is important to research factors that result in burn-out, stress that contributes to depression, anxiety and employee absence (Wittchen et al., 2011), as well as researching factors that may mitigate these effects, such as coping strategies. By researching these factors, it is hoped that evidence-based policy and interventions can be developed to attract more HCAs into the sector in Ireland.

Objectives, research questions and hypotheses

The main objective of this study is to look at the relationship between stress, coping strategies and job satisfaction in HCAs. Considering previous research, the research aims of this current study will be to (1) investigate the relationship between perceived stress, coping strategies and job satisfaction levels in HCAs, (2) determine if stress levels can predict outcomes on measures of job satisfaction among HCAs, and (3) determine if different coping strategies differentially effect outcomes on measures of stress and job-satisfaction.

Based on the above research questions, and by examining prior research, it is hypothesised that (1) there will be a significant relationship between perceived stress, coping strategies and job satisfaction in HCAs, (2) higher stress levels will predict lower job satisfaction among HCAs, and (3) there will be significant differences in levels of stress and job satisfaction between those with high versus low scores on a measure of coping.

Method

A research proposal was submitted to the National College of Ireland ethics committee to seek approval in order to run this study. Once this was granted, an email was sent to the administrator of the HCA & Carers Ireland group on Facebook requesting for permission to post on the group to invite members to partake in the study (see Appendix A). Once permission was granted by the administrator (see Appendix B), a post was put up on the group's Facebook page inviting participants to partake in it voluntarily. The post contained a link with the survey questionnaire that once completed by a participant, the answers would be automatically recorded collected through Google Forms.

Participants

The sample size for this study was 137 participants. This comprised of males (7.3%, *n* = 10) and females (92.7%, *n* = 127). The participants engaged with the study after reading the information sheet that contained details about the study (see Appendix C). The participants' ages ranged between 19 to 63 years (M = 41.89, SD = 11.469). The most frequent age was 48 and 55-year olds (7 participants each). Though all members of the group had to be health care assistants in Ireland, 129 (94.2%) participants were currently employed and paid to work as care assistants at the time of doing the study, whilst 8 (5.8%) participants were unemployed. The highest rate of participants worked 30 – 45 hours a week (51.1%) with most participants having worked in the occupation in the 0 – 5 years range (52.6%). More distributions of demographic variables are as seen in table 1 below.

Table 1. *Frequencies for the sample displaying each demographic variable (N = 137)*

		Frequency	Valid Percent
	Gender		
Male		10	7.3
Female		127	92.7
	Employment Status		
Employed		129	94.2
Unemployed		8	5.8
	Length of time in occupation		
0 – 5 years		72	52.6
6 – 10 years		25	18.2
11 – 15 years		16	11.7
15+ years		24	17.5
	Hours worked per week		
0-15		11	8
15-30		39	28.5
30-45		70	51.1
45+		17	12.4

The participants were selected anonymously to partake in the study through convenience sampling method as posted on the HCA & Carers Ireland Facebook group. Though sharing of the study was encouraged and the original post boosted a few times to maximise exposure, no incentives were offered to encourage participation. The study used a cross-sectional design and all participants had to give informed consent and confirmed that they were aged over 18 years old before completing the questionnaires (see Appendix D).

Measures

The questionnaires used in this study for the purpose of measuring the variables of interest include: a demographics questionnaire, the Perceived Stress Scale-14 developed by Cohen and colleagues, Kamarck & Mermelstein (1983) to assess participant's perception of stressful situations, the Brief COPE (Carver, 1997) used to assess different ways in which

people respond to stress and lastly the Minnesota Satisfaction Questionnaire (1967) used to measure employee's satisfaction (see Appendix E, F, G and H).

The demographics questionnaire that comprises of employment status, length of time in occupation, hours worked per week, gender and age were asked at the beginning to be able to analyse different factors that can influence the hypotheses.

The Perceived Stress Scale-14

The Perceived Stress Scale – 14 is a self-report that consists of 14 questions aiming to measure levels in which the participant has perceived as being stressful during the past month. For example, 'In the last month, how often have you been upset because of something that happened unexpectedly?'. This is by assessing how unpredictable, uncontrollable or overloaded they found their personal circumstances. Respondents rate themselves on the 5-point Likert scale that ranges from '0 - never to 4 - very often'. The questionnaire is scored by reverse scoring items number 4, 5, 6, 7, 9, 10 and 13 and then adding up all the 14 items' scores. The scores range from 0 to 56 with the higher scores indicating greater levels of perceived stress (see Appendix F).

The Perceived Stress Scale has shown high reliability and validity with Cronbach's Alphas scores ranging from .84 to .87 such as seen in the smoking cessation group that had a Cronbach's Alphas score of .86 (Cohen, Kamarck & Mermelstein, 1983). Test/retest reliability scores range between 0.55 to 0.85 (Cohen, Kamarck & Mermelstein, 1983).

The Brief COPE

The Brief COPE is a 28-item questionnaire comprising of 14 scales that measures how a respondent deals with stress using specific coping strategies. Each of the 14 scales contains 2 items. These scales are self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion, and self-blame. An example of a question

includes ‘I’ve been turning to work or other activities to take my mind off things’. The respondent is expected to rate themselves on the 5-point Likert scale that ranges from ‘(1 =I haven't been doing this at all to 4 =I've been doing this a lot)’.

Each of the 14 subscales are included into one of the two overarching coping styles: avoidant coping and approach coping to determine an individual’s primary coping styles (see Appendix H). Avoidant Coping is characterised by the subscales of denial, substance use, venting, behavioural disengagement, self-distraction and self-blame and associated with poorer physical health among those with medical conditions. Compared to Approach Coping, Avoidant Coping is shown to be a less effective at managing anxiety and characterised by the subscales of active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking informational support. Approach Coping is associated with more helpful responses to adversity, including adaptive practical adjustment, better physical health outcomes and more stable emotional responding ("Brief-COPE – NovoPsych Psychometrics", 2018).

Scoring is done by calculating total scores on each of the scale by summing up the items for each scale (see Appendix H). Total scores on each scale are between 2 to 8 with higher scores suggesting that the coping strategy is being used more. Scoring is not done by summing up the scores on all scales, only total scores for each individual scale. For example, total score for self-distraction is calculated by adding up the sup of item 1 and 19.

The Brief COPE has shown high reliability and validity with Cronbach’s Alphas scores ranging from .50 to .97 such as found in a primary care sample that had a Cronbach’s Alphas score of .68 (Finset, Steine, Haugli, Steen & Laerum, 2002). Test/retest reliability scores range between poor (0.05) to excellent (1) (Yusoff, Low & Yip, 2010).

Minnesota Satisfaction Questionnaire

The Minnesota Satisfaction Questionnaire (MSQ – short form) was created to assess employees job satisfaction. It comprises of 20 items which are divided into intrinsic and extrinsic job context items. The respondent selects from a 5-point Likert scale from 1 (very dissatisfied) to 5 (very satisfied) with questions such as, 'Ask yourself: How satisfied am I with this aspect of my job? - Being able to keep busy all the time'. Overall satisfaction total score is calculated by summing or averaging the scores, the lower the score, the lower the job satisfaction level and vice versa.

Validity of the short form can be deduced from the validity of the long form where studies such as Suleman & Hussain (2018) found it to averaging Cronbach's Alpha .86.

Design

This study used a cross-sectional research design as participants were selected based on the inclusion criteria of being health care assistants in Ireland and over 18 years of age. The study was conducted using a quantitative method. Once data was collected in Google forms and exported into excel, it was then imported and was analysed using IBM SPSS statistics software to look at the relationship between job satisfaction, stress levels and coping strategies in health care assistants. The questionnaires were all done online either using a phone or computer. Using SPSS, several statistical analyses were conducted on the data which included a Pearson's correlation, multiple regression and lastly an independent samples t-test.

Demographic variables include employment status (currently employed or unemployed), how long they have been in occupation (0-5, 6-10, 11-15 or 15+ years) amount of hours they worked a week on average (0-15, 15-30, 30-45 or 45+), gender which was either male or female and lastly age which had to be entered as a number.

For the first hypothesis, the variables which include perceived stress levels, coping scores and job satisfaction scores are neither dependent nor independent variables as the

study aims to look at their relationship. For the second hypothesis, the predictor variable (PV) is high stress levels whilst the criterion variable (CV) is low job satisfaction levels. For the third hypothesis, stress levels and job satisfaction scores are the dependent variables (DV) and coping scores is the independent variable (IV).

The statistical analysis conducted on the study include: for hypothesis one, a Pearson's correlations test to investigate a liner relationship between any of the two variables on coping, stress & job satisfaction variables after normality tests showed that they were normally distributed. For hypothesis two, a multiple regression analysis was done to determine if stress predicts job satisfaction scores. Lastly, for the third hypothesis, an independent samples t-test was conducted to determine if there will be a difference in levels of stress between those with a dominant avoidant coping strategy or a dominant approach coping strategy.

Procedure

Once the research proposal had been accepted by the National College of Ireland ethics committee and permission sought and granted by the administrator of the HCA & Carers Ireland group page (see Appendix A and B), the questionnaires including the demographics questionnaire, the Perceived Stress Scale-14, the Brief COPE and the Minnesota Satisfaction Questionnaire were entered onto a Google Forms survey account.

A link was then obtained for the pilot study which was then emailed to four participants who were recruited using convenience non-random sampling. The reason for this was to get feedback on the questionnaires and their difficulty as well as estimating the time it would take for the questionnaires to be completed by the participants in the study. Verbal feedback received included a few tweaks on the layout to make it flow better as well as the length of it would take the participants on average. It was decided that 10 minutes will be enough time for participants to engage and complete the study online.

Once the go-ahead was given, the post was put up on the HCA & Carers Ireland group page where participants were able to engage in the study voluntarily and anonymous. This was done by logging into their Facebook account either from a phone, tablet or computer using their own credentials. Participants were either able to see the post containing the survey link on their newsfeed or by going directly to the HCA & Carers Ireland group page. The post contained general information regarding the study (see Appendix I) and should they wish to continue with the study, they were asked to click on the link provided that will bring them to the more detailed page about the study. This information page contained details such as name of researcher and why they were conducting the study, target audience, aims of the study, length of time it will take to complete, consent that they were over 18 years old, how the data will be handled and stored as well as contact details for support. It mentioned that participation was voluntary, and all data collected will be anonymous (see Appendix C). They were also asked to complete a consent form (see Appendix D) which was used to document all participants willingness to take part in the study. On it, they will be asked to confirm that they are over 18 years old, have read the information sheet, know the purpose of the study and had opportunity to ask any questions. Once they were happy to continue and given their consent, participants were presented with the rest of the questionnaires in the following order: demographics questionnaire, the Perceived Stress Scale-14, the Brief COPE and lastly the Minnesota Satisfaction Questionnaire used to measure employee's satisfaction (see Appendix E, F, G and H). The questionnaires were completed by participants ticking the relevant checkboxes or entering a number for age when prompted. In order to move onto the next questionnaire, one had to complete all questions in the current page of that section.

Once the participant had reached the end of the survey, they were presented with a debrief sheet page which thanked them for taking part, reminded them on the aims of the study, how data will be used and stored and support contact details should they need help (see Appendix I).

The post was refreshed twice by posting it as a new post to enhance exposure and multiple comments made to keep it on the most recent activity of the group. It was live for three weeks until the sample size was reached, and the survey link deactivated so as not to receive any more responses.

Results

Descriptive Statistics

Descriptive data analysis was conducted on one hundred and thirty-seven questionnaires that were completed by health care assistants in Ireland and collected for the study purpose of this study. This included a sample of 10 men (7.3%) and the rest were female (n = 127; 92.7%). Frequencies scores were collected on the demographic variables: employment status, occupation length, hours worked a week and gender as seen on table 2 below. An analysis on age variable was done to determine the means (M), median (MD), range, standard deviation (SD) and variance as seen on table 3.

Preliminary analyses were conducted to satisfy the assumption of normality by inspecting the Q-Q plots total scores of perceived stress, coping strategies and job satisfaction scores were. The data was found to be normally distributed and frequencies scored collected as seen on table 4.

Table 2. *Frequencies for the current sample of health care assistants on each demographic variable (N = 137)*

Variable	Frequency	Percent
Employment Status:		
Employed	129	94.2
Unemployed	8	5.8
Occupation length (years):		
0-5	72	52.6
6-10	25	18.2
11-15	16	11.7

15+	24	17.5
Hours worked a week		
0-15	11	8
15-30	39	28.5
30-45	70	51.1
45+	17	12.4
Gender		
Male	127	92.7
Female	10	7.3

Table 3. *Descriptive Statistics on Age variable for the sample of Health Care Assistants (N = 137)*

Variable	Mean	Median	Range	SD	Variance
Age (years)	41.89	44	44	11.469	131.539

Table 4. *Descriptive Statistics of total scores for perceived stress, coping strategies and job satisfaction*

	Mean (95% Confidence Intervals)	Std. Error Mean	Median	SD	Range
Perceived Stress	30.26 (28.85-31.68)	.71	31	8.37	843
Avoidant Coping	23.42 (22.29-24.56)	.57	24	6.71	29
Approach Coping	28.51 (27.03-29.99)	.74	29	8.74	36
Job Satisfaction	61.34 (58.83-63.85)	1.26	61	14.84	80

Inferential Statistics

Pearson Correlation:

The relationship between perceived stress, coping strategies and job satisfaction levels in HCAs was investigated using Pearson product-moment correlation coefficient.

(Hypothesis 1). Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. There was a significant, moderate, positive correlation between perceived stress and avoidant coping strategy (r = .43 [95% CI = .29 - .56], n = 137, p < .001). This indicates that the two variables share approximately 18.49% of variance in common. Results indicate that higher levels of perceived stress are associated with higher levels of avoidant coping strategies. A significant, moderate, negative correlation was also found between perceived stress and job satisfaction levels (r = -.37 [95% CI = -.52 - -.20], n = 137, p < .001). This indicates that the two variables share approximately 13.69% of variance in common. Results indicate that higher levels of perceived stress are associated with lower levels of job satisfaction scores. Non-significant correlations were found between perceived stress and approach coping strategy, avoidant coping strategy and job satisfaction total and lastly, approach coping strategy and job satisfaction as shown in table 5 below.

Table 5. *Pearson Correlation between variables in the model*

	1	2	3	4
1.Perceived Stress Scale total	1	.43**	.09	-.37**
2.Avoidant Coping Total		1	.52**	-.08
3.Approach Coping Total			1	.04
4.Job Satisfaction Total				1

Note. Statistical significance: *p < .05; **p < .01; ***p < .001

Multiple Regression:

Multiple regression analysis was performed to determine how well higher perceived stress levels could be explained by lower job satisfaction scores. **(Hypothesis 2)**. Other predictor variables included in the analysis were avoidant coping scores, approach coping scores, age and hours on average worked per week.

Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. The correlations between the predictor variables and the criterion variable included in the study were examined (see Table 6 below for full details). Only perceived stress score variable was significantly correlated with the criterion variable (r = -.37). Tests for multicollinearity also indicated that all Tolerance and VIF values were in an acceptable range. These results indicate that there was no violation of the assumption of multicollinearity and that the data was suitable for examination through multiple linear regression analysis.

Table 6. *Correlations between variables in the regression model*

	1	2	3	4	5	6
1.Job Satisfaction total	1	-.37	-.08	.04	.03	.06
2.Perecived Stress total		1	.43	.09	-.19	-.04
3Avoidant Coping total			1	.52	-.11	.07
4.Approach Coping total				1	-.05	.05
5.Age (in years)					1	-.05
6.Hours worked a week						1

Since no a priori hypotheses had been made to determine the order of entry of the predictor variables, a direct method was used for the analysis. The five predictor variables

explained 14.9% of variance in job satisfaction levels ($F(5, 131) = 4.61$, $p < .001$). Only perceived stress score total was found to uniquely predict job satisfaction levels to a statistically significantly level: perceived stress = ($\beta = -.41$, $p < .001$) (see Table 7 for full details).

Table 7. *Correlations between variables in the regression model*

Variable	*β*	*B*	*SEB*	*Cl 95% (B)*
Perceived Stress total	-.41	-.72	.16	-1.04 / -.40
Avoidant Coping total	.06	.13	.23	-.33 / .60
Approach Coping total	.05	.09	.16	-.24 / .41
Age (in years)	-.03	-.04	.10	-.25 / .17
Hours worked a week	.04	.71	1.52	-2.29 / 3.71
R^2	.14***			
F	4.60***			

Note. R2 = R-squared; β = standardized beta value; B = unstandardized beta value; SE B = Standard errors of B; CI 95% (B) = 95% confidence interval for B; N = 331; Statistical significance: *p < .05; **p < .01; ***p < .001

Independent Samples T-test

An independent samples t-test was conducted to determine if there will be a difference in levels of stress between those with a dominant avoidant coping strategy or a

dominant approach coping strategy. **(Hypothesis 3)**. Preliminary analyses were conducted to satisfy the assumption of normality by inspecting the Q-Q plots and assumption of homogeneity of variance was satisfied by assessing the Levene's Test for Equality of Variances where p > .05. There was a significant difference in scores as seen on table 8 below, with approach strategy (M = 29.32, SD = 8.11) scoring significantly lower than avoidant strategy (M = 36.52, SD = 8.16), t (117) = 3.82, p <.001, two-tailed. The magnitude of the differences in the means (mean difference = 7.20, 95% CI: 3.46 to 10.93) was large (Cohen's d = .88). The results suggest that individuals with a more dominant approach coping strategy tend to have lower levels of stress as compared to ones with a more dominant avoid coping strategy.

Table 8. *Independent Samples test showing differences between Avoid and Approach coping styles in relation to Total Stress levels*

	Coping Style						95% CI for Mean Difference	t	df	p	Cohens d
	Avoidant			Approach							
	M	SD	N	M	SD	N					
Perceived Stress total	36.52	8.16	23	29.32	8.11	96	3.46, 10.93	3.82	117	.000	.88

A second independent samples t-test was conducted to determine if there will be a difference in levels of job satisfaction between those with a dominant avoidant coping strategy or a dominant approach coping strategy. Preliminary analyses were conducted to satisfy the assumption of normality by inspecting the Q-Q plots and assumption of homogeneity of variance was satisfied by assessing the Levene's Test for Equality of Variances where p > .05. Although there was a non-significant difference in job satisfaction scores as seen on table 9 below, avoid strategy (M = 57.04, SD = 14.15) was found to score lower than approach strategy (M = 61.71, SD = 14.89), t (117) = -1.36, p = .176, two-tailed. The magnitude of the differences in the means (mean difference = -4.67, 95% CI: -11.45 to

2.12) was small (Cohen's d = .32). The results suggest that there is no difference in job satisfaction levels between individuals with a more dominant approach coping strategy or ones with a more dominant avoid coping strategy.

Table 9. *Independent Samples test showing differences between Avoid and Approach coping styles in relation to Job Satisfaction levels*

	Coping Style						95% CI for Mean Difference	t	df	p	Cohens d
	Avoidant			Approach							
	M	SD	N	M	SD	N					
Job Satis. Total	57.04	14.15	23	61.71	14.89	96	-11.45, 2.12	-1.36	117	.176	.32

Discussion

The main objective of this study was to look at the relationship between stress, coping strategies and job satisfaction in HCAs. Its' aims were to (1) investigate the relationship between perceived stress, coping strategies and job satisfaction levels in HCAs, (2) determine if stress levels could predict outcomes on measures of job satisfaction among HCAs, and (3) determine if different coping strategies differentially effect outcomes on measures of stress and job-satisfaction. Based on previous research, it was hypothesised that (1) there would be a significant relationship between perceived stress, coping strategies and job satisfaction in HCAs, (2) higher stress levels will predict lower job satisfaction among HCAs, and (3) there would be significant differences in levels of stress and job satisfaction between those with high versus low scores on a measure of coping.

As mentioned previously, most of previous similar studies done on health care professions and investigating stress, coping and job satisfaction have concentrated on physicians, general practitioners, radiographers and nurses (O'Sullivan, Keane & Murphy, 2005; Sehlen et al., 2009; Jordan, Khubchandani & Wiblishauser, 2016), and very limited research on health care assistants and so most of the comparisons for this study was done against such groups.

Results for hypothesis one suggests that a statistically significant relationship was found between perceived stress and avoidant coping and perceived stress and job satisfaction levels. This suggests that HCAs who have high levels of perceived stress are also more likely to have high levels of avoidant coping strategies. Also, HCAs that measured to have high levels of stress are stipulated to also have low job satisfaction levels. This finding is quite consistent with most similar research findings such as Gellis (2002) that was investigating the role of both occupational stress, and two coping methods in predicting job satisfaction among

health care professionals and Kaarna, Polluste, Lepnurm and Thetloff (2004) which was investigating hospital's employees' satisfaction and factors that might impact it which included stress. Gellis's study found that avoidance coping scores positively correlated with Job Stress Index but negatively correlated with job satisfaction scores and as perceived stress levels increased, job satisfaction decreased. Non-significant correlational findings were also found between: perceived stress levels and approach coping strategy which supports Lazarus's & Folkman (1984) theory that approach coping is used more than avoidant in stressful conditions, and between both coping strategies, (avoidant and approach) and job satisfaction levels which is not entirely consistent with previous similar research (Golbasi, Kelleci & Dogan, 2008; Kang & Kim, 2014). Kaarna et.al found a significant negative correlation between stress and job satisfaction, similar to the current study.

In addition to stress correlating with job satisfaction as mentioned above, a regression analysis conducted for hypothesis two also found that high stress levels significantly predicted low job satisfaction scores. Also, compared to other variables, the beta coefficient for perceived stress levels had the greatest influence on job satisfaction. This is almost similar to a survey done on Irish (The Irish Nurses Organisation The National Council of Nurses of Ireland, 1993). The survey reported that these stress levels could be attributed to nurses' workloads, nature of the job where nurses who were unsuited for the role were dissatisfied or high levels of the job itself caused the dissatisfaction and career development. These factors can be applied to the present study whereby high turnover of HCAs and absenteeism leads to bigger workloads for present HCAs, inadequate training and lack of standardization of the HCA role could mean employees being recruited that are not suitable and end up being dissatisfied and lastly, a lack of a defined career progression with defined grades and promotion also causes unhappiness.

Like the current study, Gellis's (2002) study also found that perceived stress was the highest contributor to job satisfaction in a study investigating coping with occupational stress amongst social workers and nurses. The other variables in the analysis were two coping methods; problem-focused and emotion-focused, age, gender, education, job tenure, occupation and avoidance. Also, it has been long known that excessive work stress levels can lead onto job dissatisfaction (Gottlieb, 1997).

The third hypothesis analysis found that HCAs more likely to use approach coping (M = 29.32) have significantly lower levels of perceived stress in comparison to ones using avoidant coping (M = 36.52). This finding is very consistent with prior research some of which is mentioned in within the literature review above. Previous studies have also found that health workers who use more active coping approaches, such as approach coping in this study, were able to deal with stress more effectively and as a result, improve their work performance and individual functioning (Folkman, 1997; Janssen, De Jonge & Bakker, 1999; Milne & Watkins, 1986).

Somewhat surprising from the findings is that the beta coefficient for perceived stress levels was significantly larger than the coefficient for either of the coping methods. This was surprising due to previous research that have suggested that coping could potentially be a much more important than the amount of stress itself (Latack & Havlovic, 1992; Lazarus & Folkman,1984). However, in this study it appears that the levels of perceived stress had the greatest impact on job satisfaction using regression analysis and using correlation, there was non-significant correlations between both coping strategies and job satisfaction.

Another interesting and somewhat surprising finding is that there was a non-significant correlation between perceived stress levels and approach coping strategy. This is mainly due to previous research that has suggested that people who mainly use approach

strategies such as strategic planning, active coping and positive reinterpretation experience less stress compared to people who use strategies such as denial, behavioural and mental disengagement that are associated more with avoidant coping strategy, experience more stress. (Kumanova & Karastoyanov, 2013).

Limitations

As mainly found in this type of studies, it is not uncommon to raise more questions that answering them. For example, in this study, causal ordering of the variables could raise questions such as, 'Does the type of coping strategy used cause the individual to have low or high perceived stress levels?'. It could also be argued that rather than job satisfaction being a variable, it could also be a potential job stressor.

Studies of this nature should also be interpreted with caution regarding generalizing the findings to the entire population in this case, of HCAs in Ireland. This is due to the participants engaging in the survey voluntarily rather than controlled, they could be more or less stressed, different ways of coping and levels of job satisfaction which might affect the findings. Also, only participants with Facebook accounts and able to see the post at the time it was posted were able to engage in the survey meaning they were unable to partake in it if one had not joined the HCAs Carers Facebook page, did not have an account or was not active at the time the survey was live.

With the questionnaires also being self-reported, it is a possibility that the participants might have answered with more acceptable responses hence a bias in the research. A work-around to this would have been using interviews though it might not have been feasible due to the number of responses required for the effect sizes.

Finally, there was a very low participation response rate from male HCAs leading there to be a huge difference between the two genders. This was despite two appeals on Facebook urging more male HCAs to take part.

Implications of the present study for future research

Though some of the above results in this current study were found to be non-significant and inconclusive, overall, they are mostly consistent with the hypotheses and support previous research as discussed above. This is that HCAs are subject to a number of stressful situations due to the nature of their role for example when dealing with patients with chronic palliative illnesses together with their families, challenging workloads and lack of job control which also is related with how they cope and their job satisfaction levels. As a result, the current study in addition to providing a more in-depth relationship research of the HCAs stress levels, coping strategies and job satisfaction, should be regarded as an important topic for as many similar future research studies as possible. This is so as to get a better understanding of the impact it has on HCAs in regard to the prevention of stress, coping strategies, increasing job satisfaction levels at work, issues they face and how it all relates. This is especially important seeing as its been reported that the demand for healthcare in Ireland is projected to increase rapidly as mentioned in the literature review above. This is despite it currently already being unmet as a result of lack of enough health care workers with HCAs being a major part of the workforce due to the projected demand (Wren et al., 2017) and the very limited research in this area at the moment, hence the need for this study.

Several recommendations for future research also include getting a bigger male response rate which is more or less equal to the female HCAs and looking at gender differences in regard to stress levels and coping strategies. Previous studies have consistently found that women report higher levels of chronic and daily stressors compared to men

(Ptacek, Smith & Zanas, 1992; Tamres, Janicki & Helgeson, 2002). These studies also supported dispositional level hypothesis that women are more likely to use more emotion-focused coping strategies like talking to others, ruminating and seeking emotional support whilst men rated problem-focused strategies higher. As a result, it would be interesting to investigate if the above are also relative in HCAs.

Future studies could also investigate if there are differences between full-time and part-time HCAs or having permanent contracts versus temporary in levels of stress and it could be hypothesised that those who are temporary or part-time will have higher stress levels as they might have less job control function.

Also, personal attitudes in regard to coping strategies should be researched further in the health care profession depending on the work contexts to investigate if they are interpreted universally. Coping skills in work environments could potentially be improved by providing stress-reduction alternatives such as meditation, yoga class, team building and promoting group discussions and communication.

Conclusion

The purpose of this study was to investigate the relationship between stress, coping strategies and job satisfaction in HCAs. Despite the HCA role being vital in the health care work force in Ireland, it is very limited with most concentrating on other occupations such as nurses, general practitioners and radiographers. With a growing demand for care mainly due to the growing elderly population, there is an even greater need to understand the relationship that stress, coping strategies and job satisfaction have on HCAs so as to curb issues that might otherwise put a strain on being able to meet this demand. This study found a significant relationship between stress and avoidant coping, stress and job satisfaction, that high stress levels predicted low job satisfaction and lastly that the more dominant the approach strategy

is, the lower the stress levels. Although more research in this area is required, the current paper contributes to this area of much needed investigation and provides various constructs to be examined.

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Appendices

Appendix A: Message requesting for permission to post on the HCA & Carers Ireland page

Hi Alison,

As part of my final year project in Psychology at NCI, I need to undertake a study which required me to have access to a sample of HCAs. The study aims to look at the relationship between stress, coping mechanisms and job satisfaction in carers. Participation in it would be voluntary, anonymous and take about 10 minutes to complete.

I would be very grateful if you could allow me to post a survey link on the page so I could access the carers who would be willing to participate in it once it's been granted ethical approval by the college's ethical review board.

If you could please let me know if its ok to go ahead and post it or you can contact me on 26325121 should you have any questions.

Kind regards,

Winifred.

Appendix B: Permission to post on the HCA & Carers Ireland Facebook page

Hi Winifred,

That is no problem and you can go ahead and post.

Kind regards,

Alison.

Appendix C: Information Sheet

Dear Participant,

My name is Winifred Karanja and I would like to invite you to partake in this study as part of my final year project in Psychology at the National College of Ireland.

The aim of this study is to look at the relationship between work stress levels, coping mechanisms and job satisfaction for health care assistants in Ireland and I am looking for participants who work as carers in Ireland and are over 18 years old to take part in it by answering the following questions. The whole process should take no longer than 10 minutes. Once completed and the study has been closed, all data will be collected and analysed. Incomplete and unusable data will be destroyed in a safe manner and all data will be destroyed after 5 years according to NCI's data policy. The results of the study will be found in my final year thesis project.

This study has been approved by the ethical review board of NCI. Participation is voluntary and completely anonymous so it is not possible to withdraw data after it has been submitted as it has be fully de-identified. By engaging in the study, participants willingly are giving their consent and that they are over 18 years old. You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about the effect that stress has on either coping mechanisms or job satisfaction among health care assistants in Ireland.

All data will be anonymous and stored confidentially and safely to be accessible to me and my course tutor only for analyses purposes.

Should you require support or have any questions relating to this study, please contact me on ncihcastressstudy@gmail.com or my supervisor michelle.kelly@ncirl.ie .

If you are comfortable with the information provided above and are happy to partake in this study, please continue by completing the questionnaire below.

Thank you very much in advance for your interest and participation in this study.

Kind regards,

Winifred.

Appendix D: Consent Form

CONSENT FORM

Please tick all boxes

1. I confirm that I am over 18 years old, have read and understand the information sheet dated attached for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that relevant sections of my notes and data collected during the study, may be looked at by individuals from the National College of Ireland, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I agree to take part in the above study. ☐

Appendix E: Demographics questionnaire

1: Are you currently employed and paid to work as a care assistant?
□Yes
□No

2: How long have you been in this occupation?
□0-5 years
□6-10 years
□11-15years
□15+years

3: How many hours on average do you work per week?
□0-15
□15-30
□30-45
□45+

4: What gender do you identify as?
□Male
□Female
□Prefer not to say

5: What is your age (in years):
_____

Appendix F: Perceived Stress Scale-14

The questions in this scale ask you about your feelings and thoughts during the last month. You will be asked to indicate how you felt or thought. For each question, circle one of the following marked 0-4. [0=never; 1=almost never; 2=sometimes; 3=fairly often; 4=very often]

Note: Items 4, 5, 6, 7, 9, 10, and 13 are scored in reverse direction

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control important things in your life?
3. In the last month, how often have you felt nervous and "stressed"?
4. In the last month, how often have you dealt successfully with irritating life hassles?
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
6. In the last month, how often have you felt confident about your ability to handle your personal problems?
7. In the last month, how often have you felt that things were going your way?
8. In the last month, how often have you found that you could not cope with all the things that you had to do?
9. In the last month, how often have you been able to control irritations in your life?
10. In the last month, how often have you felt that you were on top of things?
11. In the last month, how often have you been angered because of things that happened that were outside of your control?
12. In the last month, how often have you found yourself thinking about things that you

have to accomplish?
13. In the last month, how often have you been able to control the way you spend your time?
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Appendix G: Minnesota Satisfaction Questionnaire
Ask yourself: How satisfied am I with this aspect of my job?
5 = Extremely Satisfied
4 = Very Satisfied
3 = Satisfied
2 = Somewhat Satisfied
1 = Not Satisfied

1.Being able to keep busy all the time.
2.The chance to work alone on the job.
3.The chance to do different things from time to time.
4.The chance to be "somebody" in the community.
5.The way my boss handles his/her workers.
6.The competence of my supervisor in making decisions.
7.Being able to do things that don't go against my conscience.
8.The way my job provides for steady employment.
9.The chance to do things for other people.
10.The chance to tell people what to do.
11.The chance to do something that makes use of my abilities.
12.The way company policies are put into practice.
13. My pay and the amount of work I do
14. The chances for advancement on this job
15. The freedom to use my own judgment
16. The chance to try my own methods of doing the job
17. The working conditions
18. The way my co-workers get along with each other
19. The praise I get for doing a good job
20. The feeling of accomplishment I get from the job

Appendix H: Brief COPE Scoring Procedure

The responses are coded in the following manner across all statements:

1= I haven't been doing this at all

2= I've been doing this a little bit

3= I've been doing this a medium amount

4= I've been doing this a lot

Brief COPE Scores

Self-Distraction Cope1 + Cope19 (Avoidant)

Active Coping Cope2 + Cope7 (Approach)

Denial Cope3 + Cope8 (Avoidant)

Substance Use Cope4 + Cope11 (Avoidant)

Use of Emotional Support Cope5 + Cope15 (Approach)

Use of Instrumental Support Cope10 + Cope23 (Approach)

Behavioral Disengagement Cope6 + Cope16 (Avoidant)

Venting Cope9 + Cope21 (Avoidant)

Positive Reframing Cope12 + Cope17 (Approach)

Planning Cope14 + Cope25 (Approach)

Humor Cope18 + Cope28 *

Acceptance Cope20 + Cope24 (Approach)

Religion Cope22 + Cope27 *

Self-Blame Cope13 + Cope26 (Avoidant)

*Humor and Religion are neither Approach or Avoidance coping

Appendix I: Facebook Post

Hi All,

My name is Winnie and I am conducting a survey study as part of my final year project in Psychology at NCI that is looking at the relationship between Work Stress Levels, Coping Mechanisms and Job Satisfaction for Health Care Assistants in Ireland. I would really appreciate if you could take a few minutes to complete it by going here: https://forms.gle/PVyvGiy2vyeMWTUx7 . Many thanks.

Appendix J: Debrief Sheet

Thank you for participating as a research participant in this study. The main purpose of this study is to look at stress and the relationship with coping mechanisms and job satisfaction in health care assistants.

Data collected will be used for the sole purpose of this current study only whereby a report will be compiled as part of my final year college project. Should you be interested in

receiving a copy of this report or have any queries pertaining to this study, please email ncihcastressstudy@gmail.com .

Should you require support or have been affected as a result of answering questions in this study, please find professional support details below. Otherwise, you can also contact me on ncihcastressstudy@gmail.com or my supervisor michelle.kelly@ncirl.ie if you have any questions.

Samaritans

The Samaritans telephone service is available 24 hours a day.

For confidential, non-judgmental support:

Freephone: 116 123

Text: 087 2 60 90 90 - standard message rates apply

Email: mailto:jo@samaritans.ie

Visit: www.samaritans.ie for details of the nearest branch

Aware

1800 80 48 48 - Available Monday to Sunday from 10am - 10pm.

Email: supportmail@aware.ie - Email at any time. You can expect a response within 24 hours.

Thank you again for your participation in this study.

Kind regards,

Winifred.