Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

March 2022

Doctoral Thesis

The Experiences of Staff who Support People With Intellectual Disabilities

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Statement of Total Word Count

	Main text	Appendices (including tables, figures, and reference lists)	Total
Abstract	298	n/a	298
Literature review	7990	12826	20816
Research paper	7987	5284	13271
Critical appraisal	3987	2121	6108
Ethics section	4903	9477	14380
Total	25165	29708	54873

Abstract

This thesis offers a contribution to the research on staff who support people with intellectual disabilities. The first section is a systematic review of studies which have measured the psychological construct of Emotional Intelligence (EI), of staff in services for people with intellectual disabilities. Six academic databases were searched and 15 empirical studies were identified for inclusion. The results gave an indication that staff EI may relate to aspects of their wellbeing, but the heterogeneity and variable quality across studies limited the extent to which meaningful conclusions could be drawn. There was minimal evidence on the effects of training which aims to improve staff EI, and a notable lack of investigation into how staff EI relates to service-user outcomes. The issues which future research needs to address, in order to determine if EI is a useful target for service development, are discussed.

The second section describes a qualitative research project, which explored the experiences of working relationships for staff who provide direct support to adults with intellectual disabilities. Six support workers, from supported living services in England, participated in semi-structured interviews, about their relationships with service-users and colleagues. An interpretative phenomenological analysis was conducted, from which six interconnected themes emerged: (A) The essence of good relationships; (B) A trusting relationship as the vehicle for meeting service-users' needs; (C) Belonging to the support team; (D) The organisational context of relationships; (E) The social context of relationships; (F) "A fine balancing act". The paper discusses how these findings build on existing research on the wellbeing of direct care staff, along with potential implications for service providers.

The third section is a critical appraisal which considers links between the literature review and research paper findings, discusses some future research directions which arise, and explores personal reflections on conducting the research project.

Declaration

The work presented in this thesis is the author’s own, except where due reference has been made, and has not been submitted in support of any other academic award.

Name: Rachel D’Sa

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Date: 10th March 2022

Acknowledgements

I would firstly like to thank all of the support workers who participated in the research project, for your time and willingness to share your experiences. Your passion and commitment to your work is evident, and I have been able to learn so much from you.

Thank you also to the managers at the participating organisations for your assistance with planning and advertising the project, and to the Learning Together advocacy group, for your feedback on my proposal.

Special thanks are due to the residents and staff of Beech Gardens with whom I worked during my time there, for being the original inspiration behind this project.

None of this would have been possible without the support and guidance of my supervisors. Thank you to my research tutor, Ian Fletcher, for your patience and encouragement, to my clinical tutor, Ian Smith, for your wisdom and confidence in me, and to my field supervisor, Stephen Field, for your motivating enthusiasm and generosity with your time.

A huge thanks to my friends and family who have given me unconditional love and support throughout the ups and downs of the last few years. To Mum and Dad, thank you for nurturing in me the love, faith, and values, which led me to this work. To Becca, thank you for providing so much containment and comfort, and for always sorting it.

And to Mark, the best friend, husband, and teammate that I could ever ask for. Thank you for your unwavering belief in me, and your willingness to uproot and move 200 miles so that I could do this. We are both so thankful that "… if we love one another, God lives in us and his love is made complete in us … There is no fear in love. But perfect love drives out fear …"

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SECTION ONE: LITERATURE REVIEW

Emotional Intelligence of Staff in Services for People With Intellectual Disabilities: A Systematic Review

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Prepared for submission to *Journal of Applied Research in Intellectual Disabilities* (see Appendix 1-D for JARID author guidelines).

Abstract

Background: Emotional Intelligence (EI) has become a popular professional development target in health and social care. This systematic review explored variables associated with EI of staff in services for people with intellectual disabilities, and effects of EI training.

Method: Studies measuring staff EI with a validated tool, between 1990 and 2022, were identified from Academic Search Ultimate, AMED, CINAHL, MEDLINE, PsycInfo, and SocINDEX. Studies were quality appraised using the AXIS tool and findings were synthesised narratively.

Results: 15 studies met inclusion criteria. Findings gave an initial indication that EI relates to aspects of staff wellbeing, but conclusions were limited by the heterogeneity and variable quality across studies. Evidence for EI training effects appeared minimal, and investigation into service-user outcomes was notably lacking.

Conclusions: Substantially more rigorous research, investigating meaningful staff and service-user outcomes, is needed to determine if EI is a useful tool in services for people with intellectual disabilities.

Keywords: intellectual disabilities, staff wellbeing, emotional intelligence, service delivery

Background

Since major inquiries into UK health and social care failings, such as the Mid Staffordshire NHS Trust or Winterbourne View scandals (Department of Health [DoH], 2012; Francis, 2013), there has been renewed focus on factors which influence compassionate care, and the quality of relationships between staff and service-users. Already a popular target for improving the delivery of person-centred care and facilitating effective service leadership (e.g. Hurley & Linsley, 2012), Emotional Intelligence (EI) has been proposed as one of these factors, across various care professions (e.g. Holbery, 2015; Ingram, 2013; Nightingale, Spiby, Sheen, & Slade, 2018). Research suggests that the related concept of empathy, positively influences care outcomes (Moudatsou, Stavropoulou, Philalithis, & Koukouli, 2020), and one might reasonably expect that the capacity to recognise and manage emotions in self and others will impact on caring behaviour. Birks and Watt (2007) called for a more rigorous examination of whether EI is a useful tool for healthcare settings, arguing that further research was needed to determine whether EI makes a difference to service-user and staff outcomes, and to what extent EI can be developed, as this has implications for staff training and recruitment. Multiple reviews have since been published, which examine EI in relation to various aspects of medical practice (e.g. Arora et al., 2010; Cherry, Fletcher, O'Sullivan, & Dornan, 2014; Dugué, Sirost, & Dosseville, 2021; Mintz & Stoller, 2014; Nightingale et al., 2018; Powell, Mabry, & Mixer, 2015; Toriello et al., 2021), but not specifically regarding staff in services for people with intellectual disabilities.

Emotional Intelligence

Popularised by Daniel Goleman in 1995, EI is a prominent concept in the field of organisational psychology and is argued, on the basis of empirical research, to play a critical role in effective job performance across many occupational sectors (Cherniss, 2000). EI has been considered a meaningful psychological construct since its definition by Salovey and

Mayer (1990) as “the ability to monitor one’s own and others’ feelings and emotions, to discriminate among them, and to use this information to guide one’s thinking and actions” (p.189). It evolved from theoretical ideas on social intelligence; the concept that particular mental abilities are required for effective social functioning. Based on empirical findings, Salovey and Mayer proposed that individual differences exist in three distinct areas of skill: (a) appraising and expressing emotions in oneself and others, (b) regulating emotions in oneself and others, and (c) using emotions adaptively. Despite a clearly defined theoretical model, subsequent EI research was plagued by the challenge of how the construct should be measured, due to the highly subjective nature of emotional experience. Petrides and Furnham (2000) proposed a conceptual distinction between “trait EI”, concerning self-reported behaviour in emotion-related situations, and “information-processing EI” (otherwise known as “ability EI”), which can be assessed in the same way as cognitive abilities, via tests of maximal performance. EI measures have tended to fall into categories according to one of these models, with a further “mixed EI” model emerging for measures comprising a mixture of personality and behavioural variables which go beyond the original definition (O'Connor, Hill, Kaya, & Martin, 2019).

A recent systematic review identified 40 different measurement instruments which have been used to measure EI in a professional context, with variable psychometric properties (Bru-Luna, Martí-Vilar, Merino-Soto, & Cervera-Santiago, 2021). A detailed theoretical critique of the EI construct, and its measurement, is beyond the scope of the current review. It is worth noting however, that several of the instruments which Bru-Luna et al. (2021) classified as ability-based measures, on the grounds that they were developed according to the facets of the Salovey and Mayer (1990) model, are in fact questionnaires of self-reported behaviour, rather than the type of performance measures argued to be necessary for objective assessment of ability (Petrides, 2011); this highlights the ongoing challenges and lack of consensus in the EI research field.

Services for People With Intellectual Disabilities

Since the turn of the century, there have been a number of significant developments in UK policy relating to the rights of people who have a “Learning Disability” (e.g. DoH, 2001, 2012; Kennedy, Long, Parkin, & Powell, 2021), defined as “A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with; A reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development” (DoH, 2001, p.14). This definition is comparable to that of the more widely recognised term, “Intellectual Disability” (World Health Organisation, 2010), used in this thesis. The provision of support for health, social, and educational or vocational functions, may overlap in services for people with intellectual disabilities, owing to the nature and complexities of their needs. Whilst working with this client group is often considered rewarding (e.g. Lunsky, Hastings, Hensel, Arenovich, & Dewa, 2014), it may also be demanding, with research linking staff stress levels to issues with care quality and continuity (Buntinx, 2008; Skirrow & Hatton, 2007). It is estimated that a significant proportion of people with an intellectual disability may display behaviour that is “challenging” (Bowring, Totsika, Hastings, Toogood, & Griffith, 2017; NHS England, 2017); that is, behaviour which puts that person, or others, at risk of physical harm, or limits access to community facilities, thus posing a challenge to the services supporting them. It is acknowledged that such behaviour communicates unmet need and is often the result of care practice and environmental factors, rather than being inherent to the individual (DoH, 2007). With evidence to suggest bidirectionality in the relationship between behaviour that challenges, and staff stress (Hastings, 2002; Ryan, Bergin, & Wells, 2021), there is a drive to develop interventions which improve staff wellbeing and the quality of their interactions with service-users.

Investigation of EI, in the population of staff supporting people with intellectual disabilities, is a growing research area. Knotter et al. (2018) conducted a meta-analysis, of the effects of training aimed at helping staff cope with service-user behaviour that challenges. They found that although identified training packages (which varied in approach and content) have overall been moderately effective in contributing to staff behaviour change, the content of the training itself did not significantly influence its effects, and there was lack of evidence for an influence on service-users' behaviour. Of the 11 studies which contributed to these findings, three involved EI-focused training, suggesting a need for further research into the mechanisms by which EI is postulated to influence staff behaviour. Given the general paucity of literature investigating EI with this staff population, a thorough overview of that which does exist, is needed to inform any further use of the concept for interventions, and to identify where further research is required. Thus, a systematic review will contribute to assessing the utility of EI as a tool for intellectual disability services.

Research Aims

This systematic review aims to characterise and critically appraise the research which has measured EI of staff in services for people with intellectual disabilities. The specific questions to be addressed are:

1. What staff and service-user variables have been associated with staff EI?
2. What effects have been found for training aimed at improving staff EI?

Method

This review was conducted according to internationally endorsed guidelines, the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement' (Page et al., 2021; see checklist in Appendix 1-A).

Search Strategy

The databases Academic Search Ultimate, AMED, CINAHL, MEDLINE, PsycInfo, and SocINDEX, were searched for relevant literature. These sources were chosen to cover the range of academic disciplines relevant to the review topic, and as they are all hosted by the EBSCO Information Services platform, facilitating a systematic approach to searching. A search query, combining free-text keywords with database subject headings, was developed to cover the three main concepts: staff, people with intellectual disabilities, and EI. Scoping searches were conducted in the identified databases to inform the terms. In several databases, literature on people with intellectual disabilities was classified under the subject heading of “mental retardation”; therefore this term was included in the search query although it is no longer the accepted language. Keywords for the concept of EI were derived from commonly used measures identified in the comprehensive review by O'Connor et al. (2019). The search strategy was refined through consultation with a specialist librarian and the author’s two research supervisors. Table 1 shows the range of keywords identified and Appendix 1-B contains the full search syntax.

[INSERT TABLE 1 HERE]

Screening and Selection

Studies were included if: (a) all participants were staff in services for people of any age with an intellectual disability; (b) participant EI was measured using a validated psychometric tool; (c) any quantitative design was used (e.g. descriptive, quasi-experimental or experimental; cross-sectional or longitudinal; cohort or case study); d) an English full-text was available; e) they were made publicly available between 1990 (the year when EI was formally defined in Salovey and Mayer’s seminal paper) and 2022. Preliminary scoping searches highlighted that most peer-reviewed studies had been conducted by the same research group in the Netherlands. Therefore, it was decided to include unpublished academic theses which met criteria, to give a more balanced overview and identify any publication bias. During scoping searches, it became apparent that in some countries, services for people with intellectual disabilities do not necessarily distinguish between the types of support offered (i.e. whether healthcare, social support, or education). Organisations often support both children and adults, recognising that the nature of an intellectual disability means that the transition from childhood to adulthood is not as clear cut as the traditional marker of 18 years. It was therefore decided that these distinctions would not be made within the eligibility criteria. Studies in settings not exclusively supporting people with intellectual disabilities, such as special educational schools, were excluded.

The review author conducted the final search in all databases on 14th January 2022 and exported results to the referencing software, Endnote. All titles and abstracts were screened to identify those meeting eligibility criteria, and where this was unclear then the full-text was reviewed. Following this stage, references and citations of the eligible peer-reviewed publications were hand-searched, to identify any additional studies meeting inclusion criteria. Any uncertainties about eligibility were resolved through discussion with supervisors.

Data Collection and Synthesis

A data extraction spreadsheet was used to capture information about study methodology, sample characteristics, EI measurement, and outcomes relevant to the review aims i.e. any staff or service-user variables investigated in relation to staff EI, and outcomes assessed in relation to EI training. Effect measures and effect sizes were extracted for significant results of the most relevant statistical analyses, where clearly reported. Where possible, attempts were made to contact authors of peer-reviewed studies (using the correspondence email provided), to obtain missing data or resolve ambiguities in reporting.

Due to the heterogeneity of research aims, study designs, and samples, only narrative synthesis of the results was appropriate.

Quality Appraisal

The AXIS tool (Downes, Brennan, Williams, & Dean, 2016), developed for use with cross-sectional research in health-related disciplines, was predominantly used to evaluate study quality. The tool was designed to assist in qualitative critical appraisal of research, for a variety of purposes, rather than providing a criterion for study inclusion, and was therefore appropriate for the broad aims of this review. Furthermore, it has the advantage of assisting researchers to consider both methodological and reporting quality, and it was suitable for use with the varying designs of included studies. Scoping searches indicated that most eligible studies were cross-sectional, but to ensure that any with longitudinal outcomes could be adequately evaluated, three additional questions, taken from the JBI Critical Appraisal Checklist for Cohort Studies (JBI, 2020), were included. Appendix 1-C contains the full set of questions used. For each study, each item was assessed on a traffic-light grading system: reasonable quality (green); moderate quality/ not reported (amber); or poor quality (red). Data extraction and quality appraisal were conducted by the author, with any uncertainties being resolved through discussion with supervisors.

Results

The search returned a total of 63 unique records across the six databases. Of these, 13 studies were eligible for inclusion, and a further two were identified from hand-searching. Figure 1 summarises the selection process.

[INSERT FIGURE 1 HERE]

One study retrieved from the first stage of searching, investigated EI-focused staff training (Embregts, Zijlmans, Gerits, & Bosman, 2019) but did not include measurement of participant EI, and was therefore not eligible for inclusion. However, as it investigated outcomes for a subset of the sample from a study of the same intervention, which did meet inclusion criteria (Zijlmans, Embregts, Gerits, Bosman, & Derksen, 2015), the relevant results are briefly considered in the narrative synthesis.

Study Characteristics

Table 2 summarises the general characteristics of included studies.

[INSERT TABLE 2 HERE]

Of the 11 peer-reviewed studies, seven were conducted in the Netherlands (Gerits, Derksen, & Verbruggen, 2004; Gerits, Derksen, Verbruggen, & Katzko, 2005; Willems, Embregts, Bosman, & Hendriks, 2014; Willems, Embregts, Hendriks, & Bosman, 2012; Zijlmans, Embregts, & Bosman, 2013; Zijlmans, Embregts, Gerits, Bosman, & Derksen, 2011; Zijlmans et al., 2015), three in Spain (Durán, Extremera, & Rey, 2004; Guerrero-Barona, Guerrero-Molina, García-Gómez, Moreno-Manso, & García-Baamonde, 2020; Guerrero-Barona, Rodríguez-Jiménez, & Chambel, 2020), and one in the UK (Shead, Scott, & Rose, 2016). All four of the unpublished doctoral thesis studies were from the USA (Karriem, 2010; Keesler, 2016; Phillips, 2019; Tolson, 2015). The majority of studies employed a non-experimental survey design, which were mostly cross-sectional, excepting two which included longitudinal outcomes (Gerits et al., 2004; Gerits et al., 2005). Of the two experimental studies, Zijlmans et al. (2015) purported to use a fully randomised design, whereas Zijlmans et al. (2011) was semi-randomised.

Table 3 summarises the participant characteristics reported in each study.

[INSERT TABLE 3 HERE]

Contact with authors identified that Willems et al. (2012) and Willems et al. (2014) used the same sample, whilst Zijlmans et al. (2015) used an almost identical sample to Zijlmans et al. (2013), with seven additional participants. The description of the samples in Gerits et al. (2004) and Gerits et al. (2005) appeared very similar, but with slight reporting discrepancies.

This was also true of the studies by Guerrero-Barona, Guerrero-Molina, et al. (2020) and Guerrero-Barona, Rodríguez-Jiménez, et al. (2020). Although attempts to contact these authors were unsuccessful, it was assumed that the same samples had been used, given the extent to which characteristics overlapped. Thus, this review included outcomes for a minimum of 11 unique samples. Of these samples, five consisted entirely of direct care workers (Karriem, 2010; Keesler, 2016; Tolson, 2015; Zijlmans et al., 2013; Zijlmans et al., 2011, 2015), and one entirely of "nurses" (Gerits et al., 2004; Gerits et al., 2005), although it was unclear if this was a professional registration as there appeared to be variation in the type of training they were reported to have received. Three samples consisted of staff in varying roles but with the greatest proportion being direct care workers (Phillips, 2019; Shead et al., 2016; Willems et al., 2014; Willems et al., 2012). The sample of Durán et al. (2004) was described simply as "professionals", and requests to authors for clarification received no response. The sample of Guerrero-Barona, Guerrero-Molina, et al. (2020) and Guerrero-Barona, Rodríguez-Jiménez, et al. (2020) appeared to consist predominantly of staff providing vocational support, whose qualification status was unspecified. Four of the samples were reported to work in services which provided "treatment" specifically for people considered to present with psychiatric or behavioural concerns (Gerits et al., 2004; Gerits et al., 2005; Willems et al., 2014; Willems et al., 2012; Zijlmans et al., 2013; Zijlmans et al., 2011, 2015).

Regarding participant EI, only one study used a maximal performance measure of ability, the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer, Salovey, & Caruso, 2002). All studies in the Netherlands used the Dutch version of the Bar-On Emotional Quotient Inventory (EQ-i; Bar-On, 1997; Derksen, Jeuken, & Klein Herenbrink, 1998a). This self-report measure is designed to assess behaviour relating to a range of emotional and social competencies (Bar-On, 2006), thus falling into the category of mixed model EI (O'Connor et al., 2019). Only one other study used a measure based on the same mixed model, employing the Short Form version of the EQ-i (Bar-On, 2002). Two studies used the Short Form version of the Trait Emotional Intelligence Questionnaire (TEIQue-SF; Petrides & Furnham, 2006), which is based on a model of trait EI as a “constellation of emotion-related self-perceptions and dispositions” relating to personality factors (Petrides & Furnham, 2000, 2001). Of the remaining studies, two used the Emotional Intelligence Scale (Wong & Law, 2002), one used the Schutte Self-Report Emotional Intelligence Test (SSEIT; Schutte et al., 1998), and one used a Spanish version of the Trait Meta-Mood Scale (TMMS; Fernández-Berrocal, Extremera, & Ramos, 2004; Salovey, Mayer, Goldman, Turvey, & Palfai, 1995). Although these three measures are structured around the ability domains of the original EI framework (Salovey & Mayer, 1990), as self-report questionnaires they are generally considered to be trait-based measures.

Study Quality

The AXIS tool highlighted significant reporting limitations across studies, making it difficult to accurately assess their methodological quality. Table 4 shows the ratings given, indicating that aspects of good and poor quality were often present within the same study. Tables 5-7 contain full details of the quality appraisal, with comments for each checklist item.

[INSERT TABLES 4-7 HERE]

In general, research aims were clearly stated, along with an appropriate choice of design and outcome variables. As shown by the participant characteristics in Table 2, there was some variability in how clearly defined the samples were, regarding the nature of their work, with reporting discrepancies evident for some studies which appeared to use the same sample. The quality of sampling and data collection procedures were correspondingly variable. All studies purposively recruited participants via identified service providers, with Keesler (2016) additionally recruiting via social media. Keesler (2016) and Phillips (2019) indicated that recruitment sites were chosen to be representative of the direct care worker population nationally, although their use of online advertisement and data collection methods may have introduced some selection bias. The large number of organisations approached for recruitment by Gerits et al. (2004) and Gerits et al. (2005), suggested that the sample had the potential to be broadly representative of the target population. Only Willems et al. (2012) and Willems et al. (2014) explicitly reported that the sample characteristics were representative of the target population, of direct care staff nationally. Most studies gave little indication of whether recruitment sites were typical examples of that service type within the region, or to what extent participants might represent the target population. For some, attempts had evidently been made to minimise selection bias, by distributing surveys to all eligible staff at recruitment sites and giving participation time within working hours (Gerits et al., 2004; Gerits et al., 2005; Guerrero-Barona, Guerrero-Molina, et al., 2020; Guerrero-Barona, Rodríguez-Jiménez, et al., 2020; Tolson, 2015). Others did not provide enough information about the selection process to determine whether this was a likely source of bias. Only four studies gave justification for the sample size and these were all adequately powered (Karriem, 2010; Phillips, 2019; Shead et al., 2016; Tolson, 2015).

Most studies used validated measures to assess intended outcomes, with the limitations of self-report measures being generally acknowledged. Although many provided some justification of the choice of EI measurement instrument, based on its psychometric properties, there was little discussion of the underlying theoretical constructs and how these might relate in practice to the service setting. Most studies described statistical methods in sufficient detail but reporting of actual data was more variable, with only two giving a full description of all analysis results, including confidence intervals and effect sizes (Karriem, 2010; Shead et al., 2016). Most reported the internal consistency of results, and considered how this might affect interpretation, but the extent to which authors considered general methodological limitations when interpreting the results was far more variable. Only seven studies explicitly reported that ethical approval or informed consent was obtained, and only five declared no conflicts of interest.

Study Outcomes

Table 8 summarises the analyses of interest and the key findings.

[INSERT TABLE 8 HERE]

To provide an overview of the range of variables that have been investigated, the reported results are described according to their main themes. However, it is suggested that findings be interpreted cautiously, with reference to specific concerns about individual study quality (as detailed in Tables 5-7).

Relationship between EI and staff variables.

All of the observational studies explored the relationship of staff EI to self-reported psychological variables. Five also investigated associations between EI and participants' demographic characteristics.

Work-related stress.

Most commonly explored was the relationship of EI to burnout; a state characterised by emotional exhaustion, depersonalising attitudes towards service-users, and reduced feelings of personal accomplishment (Maslach & Jackson, 1984). Personal accomplishment was found to be significantly positively associated with mixed model EI (Gerits et al., 2004), overall trait EI (Shead et al., 2016), and the emotional understanding and self-regulation aspects of a different trait EI measure (Durán et al., 2004), all with small to moderate effect sizes. Significant relationships between EI and the other two burnout dimensions were less consistently found, and differences in sample characteristics may have contributed to this variation. Within the same sample as the earlier study, Gerits et al. (2005) identified distinct clusters of EQ-i profiles for nurses of each gender, reporting that females with generally low scores across all EI domains had the greatest symptoms of burnout, whilst for males, only the problem-solving and stress-tolerance aspects of EI were positively associated with personal accomplishment. Tolson (2015) however, found no significant association between ability EI and overall burnout for direct care workers, although relationships with individual burnout dimensions were not explored.

The relationship between EI and other measures of work-related stress was investigated in three different samples. Keesler (2016) found that direct care workers with higher trait EI had significantly lower scores on the Burnout dimension of the Professional Quality of Life Scale (ProQOL; Stamm, 2010), which explores a similar concept to that defined by Maslach and Jackson (1984). Those with higher EI also reported significantly fewer symptoms of Secondary Traumatic Stress on this measure, with effect sizes of these findings being moderate and small respectively. Using a measure of burnout which encompasses feelings of guilt, in addition to Maslach and Jackson's original definition, Guerrero-Barona, Guerrero-Molina, et al. (2020) found in their varied sample, that higher trait EI significantly predicted lower overall burnout, when controlling for participant age and gender, with moderate effect size. Those with higher EI reported significantly fewer psychosomatic symptoms in relation to work stress. Higher mixed model EI was also found to predict lower scores on an alternative work stress measure, for direct care workers (Karriem, 2010). Effect sizes were small for these latter two findings.

Work-related wellbeing.

Several studies investigated associations between EI and indicators of staff wellbeing. In two of the samples for which burnout was measured, its hypothesised antipodal state, known as work engagement (Bakker, Schaufeli, Leiter, & Taris, 2008), was also explored in relation to aspects of different trait EI measures. Durán et al. (2004) found significant positive associations between emotional self-regulation and all three engagement dimensions, with small to moderate effect sizes, whilst Guerrero-Barona, Rodríguez-Jiménez, et al. (2020) found that more adaptive use of emotion significantly predicted higher overall engagement, with moderate effect size. The latter study also found that staff's perceived self-efficacy significantly predicted all EI dimensions, with small to moderate effect sizes. In the same sample, Guerrero-Barona, Guerrero-Molina, et al. (2020) found that those with higher trait EI reported significantly greater job satisfaction, and more social support at work, with small effect sizes. Ability EI was also found to have a significant positive correlation with job satisfaction in a more homogenous sample (Tolson, 2015), albeit using different psychometric tools, and the effect measure was not clearly reported. In a comparable sample, Keesler (2016) found that those with higher trait EI reported significantly greater Compassion Satisfaction on the ProQoL and had a more positive view of the organisational culture, with moderate effect sizes. Phillips (2019) found that for staff in varying roles, higher trait EI was significantly associated with better self-reported job performance, with moderate effect size. From a mixed model perspective, Gerits et al. (2004) found that nurses with higher EI reported using a significantly more active, and less avoidant or passive, coping style for problems at work, whilst female nurses also reported a significantly higher social support-seeking style; findings all with small to moderate effect sizes. For this same sample, Gerits et al. (2005) found no significant association between EI and illness-related absence rate (as reported by participants' managers) in the subsequent two years, although follow-up methods were ambiguously reported.

Responses to service-users.

In two samples of direct care staff supporting people with behaviour that challenges, responses to service-users were explored in relation to the five dimensions of the Bar-On (1997) mixed model of EI: Intrapersonal (understanding own emotions), Interpersonal (understanding others' emotions), Stress Management, Adaptation (problem-solving with emotional or social information), and General Mood (generating positive mood and self-motivation). Willems et al. (2012) found their newly developed measure, of self-reported behaviour towards service-users, to have a degree of convergent validity with individual EQ-i scales. However, when controlling for participant demographic variables, and a measure of interpersonal attitude, only higher EQ-i Intrapersonal scores significantly predicted more “proactive thinking” and less “assertive control” (Willems et al., 2014). Meanwhile, Zijlmans et al. (2013) found that staff with higher Adaptation and Stress Management scores reported significantly fewer negative emotions and feelings in response to behaviour that challenges, whilst those with higher Intrapersonal scores reported fewer negative feelings only. They proposed that EI appears more strongly related to feelings than to emotions, offering theoretical justification for distinguishing these two constructs, but as they did not pilot their adaptation of the outcome measure used, one might argue this categorisation to be only semantic, rather than empirically based. Effect sizes for all described findings were small, and it is noted that staff completed these measures of self-reported behaviour with regard to an individual service-user; therefore the results may not represent more general responses toward behaviour which challenges.

Demographics.

Relationships between mixed model EI and various demographic characteristics were reported for two samples of staff supporting people with behaviour that challenges. Gerits et al. (2004) found that male nurses had significantly higher EQ-i Intrapersonal and Stress Management scores than female nurses, whereas the reverse was true for Interpersonal scores, although effect sizes were not reported. They also explored the relationship of EI to a measure of general intelligence, finding a significant positive correlation, of small effect size, for females only. For direct care workers, Zijlmans et al. (2013) found that those with higher General Mood and Intrapersonal scores had worked for a significantly longer period with the client group. Intrapersonal score was also significantly positively correlated with staff age; however, as one might expect age and work experience to be related, it is unclear what underlay these relationships, for which effect sizes were all small. Contrastingly, for staff not specifically supporting people with behaviour that challenges, no significant associations were found between various demographic variables and the ability or trait EI measures used (Keesler, 2016; Phillips, 2019; Tolson, 2015).

Relationship between EI and service-user variables.

Exploration of the relationship between staff EI and service-user variables was very limited, with no studies assessing direct outcomes for service-users. Two studies investigated associations between trait EI and staff-reported behaviour of service-users. For direct care workers, Keesler (2016) found no significant relationship between EI and exposure to behaviour perceived as challenging. Using different measures in a more varied sample, Shead et al. (2016) found that trait EI did not moderate the relationship between exposure to aggression, and burnout. A direct association between EI and aggression exposure was not explored.

Effects of EI training.

The two intervention studies, conducted by the same research group, tested a training programme aiming to improve EI, which they themselves developed. This involved receiving didactic teaching on the Bar-On (1997) model, using the EQ-i profile to formulate goals for personal development and for responding to a service-user whose behaviour was perceived to challenge, receiving oral feedback on EQ-i profiles, and video-feedback coaching on interaction with the identified service-user. In a pre-posttest design, Zijlmans et al. (2011) reported that on the Adaptability and Intrapersonal scales, score increases were significantly greater for the experimental group, than for the control group who received no training. Overall score changes were judged, by expert review, as generally desirable in relation to participants' individual training goals. With a comparable sample, Zijlmans et al. (2015) found significantly greater score increases for the experimental group than for two control groups on all EQ-i scales except Interpersonal. As can be seen from results summarised in Table 8, the effect of training, on self-reported coping style and on emotional reactions to behaviour that challenges, was fairly limited. Effect sizes were not reported for any results in either study. Although some steps were taken to reduce selection bias, (see quality appraisal in Table 6), these are likely to be outweighed by significant methodological concerns, calling the utility of the findings into question. Firstly, lack of an active control comparison group, limits the extent to which conclusions can be drawn about the effects of the specific EI training programme, as opposed to general effects of receiving training. Secondly, it could be argued that the training goals, involving focus on the EQ-i measure itself, were somewhat leading for staff to give more favourable posttest responses. Thirdly, Zijlmans et al. (2015) reported that effects were maintained for the experimental group at four months post-training, but as follow-up measures were not administered to the control group, between-groups comparisons cannot be made for this time point. The authors acknowledged the need for a much longer follow-up period to assess durability of training effects, and for more objective assessment of any impact on staff or service-user behaviour. Subsequently, Embregts et al. (2019) published data on a small subset of this sample (17 from the experimental group and 12 from the control group), where video recordings of interactions between staff and service-users had been assessed with a validated measure. They reported that for participants who received training, there was a significant increase in their display of behaviour rated to facilitate service-users' sense of autonomy, relatedness and competence, whereas in the control group, this type of behaviour actually decreased over time. However, as concurrent changes in EI were not investigated for this sub-sample specifically, then it cannot be concluded that the impact of training on staff behaviour was the result of the improvements in

EI which Zijlmans et al. (2015) reported for the experimental group overall. Furthermore, as no service-user outcomes were assessed, it is unknown how meaningful was the impact of staff behaviour changes.

Discussion

Summary of the Findings

Regarding the first review question, on variables associated with EI of staff supporting people with intellectual disabilities, considerable heterogeneity across the reviewed studies, in terms of sample characteristics and outcomes investigated, limits direct comparison of results, and the extent to which meaningful conclusions can be drawn. Staff EI has been predominantly investigated in relation to aspects of work-related stress and wellbeing. Overall the findings point towards higher scores on self-report EI measures being associated with lower stress levels, and increased satisfaction and coping at work. There is minimal indication that aspects of the Bar-On (1997) mixed model, may be associated with emotional and behavioural reactions to service-users whose behaviour is perceived as challenging. Elements of this same EI measure may also be related to particular demographic variables, in staff supporting service-users presenting with behaviour that challenges, whereas no evidence has yet been found for relationships between EI and demographics of staff supporting people with intellectual disabilities in general. Effect sizes for the reported findings have generally been small to moderate, and the cross-sectional nature of the research prevents any causal relationships being inferred. Moreover, the validity and generalisability of many results may be called into question by concerns about methodological quality.

Regarding the second question, on effects of training aimed at improving staff EI, only two studies were identified, which tested a training package based around the Bar-On (1997) model (Zijlmans et al., 2011, 2015). The authors suggested that findings indicated the training could improve staff EI but again, significant methodological limitations cast doubt on this conclusion, with the magnitude, durability, or clinical meaningfulness of training effects being unclear. Thus, it has not been possible to arrive at any definitive answers to the review questions, with the general observation being, that research on EI in the population of staff supporting people with intellectual disabilities, has so far lacked cohesion and consistency in its approach.

Limitations of the Research

A primary contributor to the difficulty in synthesising findings of the reviewed studies, was variation in the approach to defining and measuring EI. This review identified that at least six different tools have been used to investigate EI in staff supporting people with intellectual disabilities, covering the three main theoretical frameworks which underlie EI research, but predominantly using self-report measures. Amongst the peer-reviewed studies, there was a strong bias towards the Bar-On (1997) mixed model, whilst others used measures based on theories of EI as both a trait (Petrides & Furnham, 2001), and ability (Salovey & Mayer, 1990). Only one study, from an unpublished thesis, was identified which used the type of maximal performance measure that Petrides (2011) argues to be necessary for investigating a true ability-based model. Thus, there is insufficient evidence to determine whether the three EI models might be differentially associated with outcomes for staff or service-users, and this question does not appear to have been on the research agenda to date. The issue of variability in theoretical orientation and measurement is not unique to research on staff providing services for people with intellectual disabilities, having been highlighted by reviews in different populations of caring professionals (Dugué et al., 2021; Powell et al., 2015; Toriello et al., 2021). Given the challenges characterising the wider field of EI research, seeking consensus on a definition and measurement tool, for staff supporting people with intellectual disabilities, is unlikely to result in much progress; however, future research needs to critically engage with the conceptual debates, in order to generate a better understanding of how the different models might apply to this staff population. Although the unpublished theses included in this review offered some critique of the EI construct, and associated justification of the measure used, there was little consideration of how the alternative measures available might relate in practice to the nature of the work undertaken by their sample; this discussion was even less apparent in the peer-reviewed studies. Whilst it may be impractical for clinical researchers to thoroughly review all theoretical literature on EI, it seems important to pay greater attention to selecting an appropriate tool for the research objectives, given the diverging purposes and properties identified for various measures (Bru-Luna et al., 2021; O'Connor et al., 2019). In addition to consulting the guidance offered by O’Connor et al. (2019), researchers might also aim for a more unified approach to any one line of inquiry within the field. For example, a meta-analysis by Martins, Ramalho, and Morin (2010) indicated that trait EI is a stronger predictor of mental health outcomes than ability EI, identifying a strong association for the Trait Emotional Intelligence Questionnaire (Petrides, Pérez-González, & Furnham, 2007) in particular; therefore, researchers might consider this tool for exploring mechanisms underlying staff experience of work-related stress. If, on the other hand, one wishes to investigate whether training can improve EI, then this implies it is being conceptualised as an ability, for which a maximal performance measure would arguably be more appropriate.

A second difficulty that arose in trying to draw meaningful conclusions, was the variability in participant characteristics, both between and within studies. Only two studies made it clear that the sample consisted entirely of staff in a single type of role, working within the same setting (Karriem, 2010; Tolson, 2015). Often samples included participants in a mixture of roles, amongst which one might expect considerable differences in the tasks and responsibilities involved. For instance, Keesler (2016) and Shead et al. (2016) included both managerial and direct care staff in residential services; given differences have been highlighted in the levels and sources of stress reported by these two groups (Rose, Jones, & Elliott, 2000), it could be hypothesised that this will influence relationships between EI and other variables. Similarly, different factors have been associated with job satisfaction for staff working with people with intellectual disabilities, depending on the type of service being provided (Chou, Kröger, & Lee, 2010; Ineland & Starke, 2020). Therefore, to increase its validity, future research needs to aim for greater homogeneity within samples. Research on care interactions also needs to bear varying service-user characteristics in mind; for example, Knotter et al. (2018) highlighted that behaviour which challenges occurs on a broad spectrum, which may influence the effectiveness of different interventions. Although achieving sample homogeneity in this regard may be impractical, researchers should consider how service-user characteristics may affect the interpretation of their findings. It is also suggested that greater specificity in defining the target population, and its demographics, will enable more accurate determination of the extent to which findings can be generalised. In samples of direct care staff, Willems et al. (2012) reported that 43% held a professional qualification, which is the norm for the Netherlands, whereas for a study in the USA, only 17% had reportedly received college-level education (Karriem, 2010). Such differences between countries, as well as differences in the policy context and legislative frameworks underlying service provision for people with intellectual disabilities, are an important consideration when seeking to compare studies. Future research would therefore benefit from improved clarity of reporting in this regard. A related concern is how outcomes may be influenced by sampling biases and response rate variability. Whilst it is acknowledged that recruitment and selection methods are often subject to practical constraints, researchers might give greater attention to the suitability of different approaches for particular populations; staff working irregular shifts for instance, might be more likely to respond if offered a survey to complete during working hours than if it is sent via email.

Although most studies selected outcome measures which were appropriate for their objectives, a general consideration for future research is how meaningful the investigated variables are. Part of the rationale for conducting this review was to examine if EI can usefully contribute to delivering support services for people with intellectual disabilities, but significant lack of investigation into service-user outcomes prevents much assessment on this matter. The few studies which did aim to explore how staff EI might relate to interactions with service-users, focused on contexts where behaviour is perceived to challenge, reflecting a bias that appears to exist in wider literature on people with intellectual disabilities. A pressing issue for future research therefore, is to explore whether staff EI has any influence on service-user outcomes, considering a range of wellbeing indicators, including outcomes reported directly by service-users. Research might also benefit from taking a broader perspective on how staff outcomes are assessed. Outcome variables of the reviewed studies were predominantly investigated via self-report measures, the limitations of which were often acknowledged. Zijlmans et al. (2013) highlighted the issue of socially desirable responding, with anecdotal report from one participant that it could be difficult to acknowledge feeling fear, in response to service-user behaviour, because of dominant organisational narratives. Thus, future research should continue to be aware of potential influences on how participants respond to different measures, perhaps taking organisational climate into account, given evidence to suggest the impact of this factor on staff burnout in intellectual disability services (Thompson & Rose, 2011). Furthermore, whilst self-reported outcomes are of course important for exploring staff wellbeing, they provide limited insight into how EI may affect actual behaviour. Although most studies discussed reported outcomes in terms of their clinical utility, the interpretation of what psychometrics might mean in practice was sometimes questionable; for instance the assumption that the “feelings” and “emotions” staff endorse on a questionnaire represent distinct affective and physiological responses to service-user behaviour (Zijlmans et al., 2013). In a review of the impact of EI on caring behaviour of healthcare professionals, Nightingale et al. (2018) identified studies which had assessed staff behaviour through external observation, patient report, and medical records; although they noted that care was often poorly defined within the literature, their findings may inform future research methods for staff supporting people with intellectual disabilities, to facilitate understanding of how EI relates to practical outcomes. The issue of choosing meaningful outcome variables is particularly pertinent to research aiming to explore the effects of EI training programmes. For the two studies which met inclusion criteria (Zijlmans et al., 2011, 2015), staff self-report measures were the only outcomes assessed, and so it was unclear if training had any influence on actual practice. Embregts et al. (2019) went some way towards investigating this by using an observational measure of staff behaviour, but they also noted the limitation of direct service-user outcomes not being assessed. It will be important for future research on EI training to explore the impact on service-user wellbeing, as well as on staff practice, and to investigate whether effects are mediated by changes in staff EI.

Future Directions

Despite their limitations, the studies reviewed are useful in opening up avenues for further research, which may contribute to enhancing service delivery for people with intellectual disabilities. Given the indication of possible associations between staff EI and wellbeing or performance at work, it would be interesting to continue this line of enquiry by exploring the potential underlying mechanisms. In addition to the methodological issues already discussed, more research with a longitudinal design would enable firmer conclusions to be drawn about these relationships, which might contribute to understanding how services can improve care quality. Nightingale et al. (2018) suggested that particular aspects of EI may be more or less beneficial for different elements of care in general nursing practice; it would be useful to explore this in staff supporting people with intellectual disabilities, given the wide range of support functions provided by some samples of the studies included in this review. However, it is important to consider that ‘care’ fundamentally involves interactions between people, which arguably cannot be fully understood by researching individual attributes (e.g. Wyer, Alves Silva, Post, & Quinlan, 2014), even those such as EI which encompass an interpersonal element. Hastings (2010) argued that a fuller understanding of support staff wellbeing, and its resulting impact, could only be gained through taking a bi-directional perspective on staff and service-user interactions, proposing that research should explore how the support relationship is experienced by both parties. Furthermore, Knotter et al. (2018) highlighted the need to recognise the function of service-user behaviour, and the significant role played by ecological variables, in order to develop effective staff training, not least taking service-user views into consideration. Thus, any further research on staff EI should be undertaken in the context of a more holistic view on the nature of the caring relationship, with attention to its qualitative, as well as quantitative facets.

Kerasidou, Bærøe, Berger, and Caruso Brown (2021) argued that the wider healthcare system plays a vital role in creating conditions that facilitate empathetic interactions between professionals and patients. The scope of future research on staff EI might be broadened by taking such a systemic perspective, investigating how EI relates to variables at an organisational level. In a meta-synthesis of studies exploring nurses’ perceptions of the general concepts of emotional intelligence and competence, Lu and Shorey (2021) found that ideas around these terms were often used to guide practice, but there was diverse understanding of their meaning and application, with lack of education, and environmental constraints, identified as barriers to emotionally intelligent behaviour. This research highlights the importance of gaining staff views on the relevance of EI to their everyday practice, when seeking to determine its utility as a professional development target. Reviewing evidence on how cultural differences influence EI, Pathak and Muralidharan

(2020), presented a strong case for conceptualising EI as a culturally embedded phenomenon. Thus, it is also important for researchers and policy-makers to be mindful of the cultural context when looking to apply research findings to different settings.

Limitations of This Review

The search was confined to studies for which a full-text was available in English; therefore it has not been possible to represent the entire body of literature which exists on EI in the reviewed population. During searching, two Spanish studies were identified where the English abstract indicated they would otherwise have met criteria for inclusion (Extremera, Durán, & Rey, 2005; Gavín-Chocano & Molero López-Barajas, 2020), perhaps providing an additional perspective on staff variables associated with trait EI. Time constraints prevented exhaustive attempts to contact authors of every included study, to resolve reporting ambiguities, and thus this review may not give an entirely accurate reflection of methods and results in all cases. However, this may serve to remind researchers of the importance of clear reporting, in order for investigations to make a useful and valid contribution to the literature. Although there was a rationale to include studies across a range of service contexts, as addressed in the methods section, it was perhaps inevitable that taking such a broad approach would result in the heterogeneity, across research aims and sample characteristics, limiting their comparison. Nonetheless, undertaking this review has highlighted that very limited evidence exists for any particular setting, and that there are significant methodological issues to be addressed in future research on EI of staff providing healthcare, social care, and other types of support to people with intellectual disabilities.

Conclusion

This systematic review sought to characterise the existing literature which has measured EI of staff in services for people with intellectual disabilities, with a view to assessing the utility of EI as a tool for staff and service development. The findings gave an initial indication that EI relates to aspects of work-related wellbeing in this staff population. However, considerable heterogeneity between and within studies emerged, as well as various concerns about methodological and reporting quality across the reviewed literature, which limited the extent to which meaningful conclusions could be drawn. The discussion offered, on issues which future research needs to address, maps onto the questions posed by Birks and Watt (2007) in their call for a more rigorous and systematic approach to research, in order to determine if EI is a useful tool for delivering services:

1. What do we measure when we measure EI?
2. How do we measure EI and when?
3. Do staff EI levels make a difference to service-user outcomes?
4. Does EI have an impact on staff and their working environment?
5. To what extent can EI be developed or taught?

In addition to using these questions to inform further investigation, it is suggested that researchers consider the socio-cultural and systemic context in which interactions between staff and service-users occur, being mindful of the limits of the concept of EI when seeking to understand and improve the quality of care relationships.

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Table 1

Keywords Identified for the Search Strategy

Concept	Keywords
Staff	staff worker employee personnel professional
People with intellectual disabilities	intellectual disability/disorder developmental disability/disorder learning disability/disorder mental handicap mental retardation
Emotional Intelligence	emotional intelligence emotional competence emotional understanding emotional management emotional quotient

Table 2

General Characteristics of Studies

Study	Country	Publication status	Design	Sample description	General aims	Emotion Intelligence (EI) measure
Observational studies						
Duran et al. (2004)	Spain	Journal article	Cross-sectional survey	n=112 Professionals in “institutions” for people with intellectual disabilities	Exploring relationships between EI, work engagement, and burnout.	Spanish version of Trait Meta-Mood Scale (Fernández-Berrocal et al., 2004)
Gerits et al. (2004)	Netherlands	Journal article	Cross-sectional and longitudinal survey	n=380 Nurses in residential services for people with intellectual disabilities and behaviour that challenges	Exploring relationships between EI, gender, and adaptive success.	Dutch version of Bar-On Emotional Quotient Inventory (EQ-i; Derksen et al., 1998)
Gerits et al. (2005)	Netherlands	Journal article	Longitudinal survey	As above†	Exploring relationships between EI, burnout, turnover, and absence rate.	Dutch EQ-i
Guerrero-Barona, Guerrero-Molina et al. (2020)	Spain	Journal article	Cross-sectional survey	n=311 Professionals in various services for people with intellectual disabilities	Exploring relationships between psychosocial factors, burnout, and EI.	Emotional Intelligence Scale (Wong & Law, 2002)
Guerrero-Barona, Rodríguez-Jiménez et al. (2020)	Spain	Journal article	Cross-sectional survey	As above†	Exploring relationships between self-efficacy, work engagement, and EI.	As above

Study	Country	Publication status	Design	Sample description	General aims	Emotion Intelligence (EI) measure
Karriem (2010)	USA	Unpublished thesis	Cross-sectional survey	n=117 Direct care staff in group homes for adults with intellectual disabilities	Exploring relationship between EI and job stress.	Bar-On EQ-i Short Form (Bar-On, 2002)
Keesler (2016)	USA	Unpublished thesis	Cross-sectional survey	n=480 Direct support professionals in residential and day-care services for people with intellectual disabilities	Exploring influence of personal and organisational factors on professional quality of life.	Schutte Self-Report Emotional Intelligence Test (Schutte et al., 1998)
Phillips (2019)	USA	Unpublished thesis	Cross-sectional survey	n=134 Staff in various services for people with intellectual disabilities	Exploring relationships between demographics, EI and job performance.	Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF; Petrides and Furnham, 2006)
Shead et al. (2016)	UK	Journal article	Cross-sectional survey	n=86 Staff in residential services for adults with intellectual disabilities	Exploring relationships between EI, self-efficacy, exposure to violence, and burnout.	TEIQue-SF
Tolson (2015)	USA	Unpublished thesis	Cross-sectional survey	n=39 Direct care staff in group homes for adults with intellectual disabilities	Exploring relationships between EI, burnout, turnover, and demographics.	Mayer-Salovey-Caruso Emotional Intelligence Test (Mayer et al., 2002)
Willems et al. (2012)	Netherlands	Journal article	Cross-sectional survey	n=158 Staff in residential and community services for people with intellectual disabilities and behaviour that challenges	Psychometric evaluation of newly developed self-report measure of staff interaction with service-users.	Dutch EQ-i
Willems et al. (2014)	Netherlands	Journal article	Cross-sectional survey	As above‡	Exploring the influence of service-user behaviour, staff interpersonal attitude, and EI, on self-reported interaction with service-users.	Dutch EQ-i

Study	Country	Publication status	Design	Sample description	General aims	Emotion Intelligence (EI) measure
Zijlmans et al. (2013)	Netherlands	Journal article	Cross-sectional survey	n=207 Staff in residential services for people with intellectual disabilities and behaviour that challenges	Exploring relationships between EI, emotions, and feelings.	Dutch EQ-i
			Experimental studies			
Zijlmans et al. (2011)	Netherlands	Journal article	Semi-randomised control trial	n=60 Staff in residential services for people with intellectual disabilities and behaviour that challenges	Exploring whether EI can be improved by training.	Dutch EQ-i
Zijlmans et al. (2015)	Netherlands	Journal article	Randomised control trial	n=214§ Staff in residential services for people with intellectual disabilities and behaviour that challenges	Exploring whether EI can be improved by training, and associated effects on responses to behaviour that challenges.	Dutch EQ-i

†Sample appears to be same as for row above, despite reporting discrepancies.

‡Author confirmed both studies used same sample.

§Author confirmed same sample as Zijlmans et al. (2011) with seven additional participants.

Table 3

Participant Characteristics

Study	Female:Male	Age	Job role	Service setting	Other details reported
			Observational studies		
Duran et al. (2004)	69:42 1 unreported	*M*=33 *SD*=8.6	not specified	not specified	none
Gerits et al. (2004)	234:146	*M*=33.3 *SD* not reported	nurses	group homes 83.7% residential day-care 13.3% both settings 2.8%	education level contract type time working with client group
Gerits et al. (2005)†	234:146	*M*=33.1 *SD*=7.6	nurses	group homes 84.4% residential day-care 13.2% both settings 2.4%	as above
Guerrero-Barona, Guerrero-Molina et al. (2020)	224:87	*M*=37.98 *SD*=10.3	careers education 36% teachers 13.5% remainder not specified	day-care services 22.2% occupational services 20.52% residential services 19.22% educational services 16.61%	proportion married proportion with children
Guerrero-Barona, Rodríguez-Jiménez et al. (2020)†	224:87	*M*=37.97 *SD*=10.17	teachers, educators, support, physiotherapists, occupational therapists, psychologists, or social assistants (distribution not reported)	not specified	proportion married proportion with children contract type time with employer
Karriem (2010)	94:23	modal range 45-54	direct care workers	group homes for adults	education level

Study	Female:Male	Age	Job role	Service setting	Other details reported
Keesler (2016)	401:79	modal range 30-39	direct support workers	residential services 66.6% day-care, educational, or other services 33.4%	ethnicity education level full or part-time work time in sector time with employer time in current role
Phillips (2019)	90:42 2 unreported	modal range 18-35	direct support 53.7% management 34.3% senior management 10.4% executive staff 6%	not specified	education level
Shead et al. (2016)	55:31	*M*=39.7 *SD*=13.7	support workers 61.63% senior support workers 15.12% managers 9.30% psychologists 3.49% occupational therapists 3.49% psychiatrists 2.33% speech and language therapist 1.16% teacher 1.16% nurse 1.16% social worker 1.16%	residential services for adults	time in professional role time at organisation time working with client group
Tolson (2015)	30:9	modal range 30-39	direct care workers	group homes for adults	training level ethnicity time worked (unclear if in current role or in sector)
Willems et al. (2012; 2014) ‡	124:34	*M*=35.6 *SD*=9.9	direct care worker 81% occupational therapist 19%	residential treatment 51% community-based treatment 49% 90% worked with adults and 10% with children§	education level time in role

Study	Female:Male	Age	Job role	Service setting	Other details reported
Zijlmans et al. (2013)	151:56	*M*=32.87 *SD*=9.27	direct support workers§	residential treatment for children and adults	time working with client group hours per week
			Experimental studies		
Zijlmans et al. (2011)	Experimental group 27:7 Control group 17:9	reported separately for each individual recruitment site	direct support workers§	residential treatment for children and adults	none
Zijlmans et al. (2015) ¶	Experimental group 56:7 Control group one 49:22 Control group two 48:19	*M*=32.6 *SD*=9.2	direct support workers§	residential treatment for children and adults	none

†Sample appears to be same as for row above despite reporting discrepancies.

‡Author confirmed both studies used same sample.

§Information supplied or by author.

¶Author confirmed same sample as Zijlmans et al. (2011) with seven additional participants.

Table 4

Quality Appraisal Ratings

Abbreviated checklist item (see Appendix 1-C for full set of questions)	Study														
	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
Clear aims/objectives?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🟢	🟢	🟢	🟢
Appropriate design?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🟡
Sample size justified?	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟢	🟢	🟢	🟡	🟡	🟡	🟡	🟡
Target population clearly defined?	🔴	🟠	🟠	🔴	🔴	🟢	🟡	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Sample taken from appropriate population base?	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟢	🟡	🟡	🟢	🟢	🟡	🟡	🟡
Selection process likely to select participants representative of target population?	🟡	🟡	🟡	🟢	🟢	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟢	🟡
Measures taken to address non-responders?	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡
Appropriate risk factor and outcome variables for stated aims?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🟢	🟡	🟢	🟡

	Study														
Abbreviated checklist item (see Appendix 1-C for full set of questions)	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
Variables measured correctly using piloted/published instruments?	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢
Clear how statistical significance and/or precision estimates determined?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Methods sufficiently described?	🟢	🔴	🔴	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟡
Data adequately described?	🟡	🟡	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🟡	🟡	🟢	🔴
Does response rate raise concerns about non-response bias?	🔴	🟢	🟢	🟡	🔴	🟢	🟡	🟡	🔴	🔴	🟢	🟢	🟢	🟢	🟡
Information about non-responders described?	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡
Results internally consistent?	🟢	🟡	🟡	🟢	🟢	🟢	🟡	🟢	🟢	🟡	🟡	🟡	🟡	🟡	🟢
Results presented for analyses described in the methods?	🟢	🟡	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟡	🟢	🔴
Discussions and conclusions justified by the results?	🟡	🟡	🟡	🟢	🟡	🟢	🟡	🟢	🟢	🟡	🟢	🟡	🟡	🟡	🟡

	Study														
Abbreviated checklist item (see Appendix 1-C for full set of questions)	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
Study limitations discussed?	🟡	🔴	🟡	🟡	🔴	🟢	🟢	🟢	🟢	🟡	🟢	🟡	🟡	🟡	🟡
Any funding sources or conflicts of interest that may affect interpretation?	🟡	🟡	🟡	🟢	🟢	🟡	🟡	🟢	🟢	🟡	🟡	🟡	🟡	🟢	🟡
Ethical approval or consent of participants attained?	🟡	🟡	🟡	🟢	🟡	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟡	🟢	🟢
Additional for longitudinal outcomes:															
Follow-up long enough for outcomes to occur?	n/a	🟢	🟢	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	🔴
Follow-up complete, and reasons explored if not?	n/a	🟡	🟡	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	🟡
Strategies to address incomplete follow-up?	n/a	🟡	🟡	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	🟡

🟢 Green: reasonable quality

🟡 Amber: moderate quality/ not reported

🔴 Red: poor quality

Table 5

Details of Quality Appraisal

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)
Clear aims/objectives?	yes	yes	yes	yes	yes
Appropriate design?	yes	yes	yes	yes	yes
Sample size justified?	unreported	unreported	unreported	unreported	unreported
Target population clearly defined?	unclear	reasonably	reasonably	unclear	unclear
Sample taken from appropriate population base?	unclear	unclear	unclear	unclear	unclear
Selection process likely to select participants representative of target population?	unclear how recruitment pool identified; recruitment method may have introduced bias	reasonably	reasonably	yes	yes
Measures taken to address non-responders?	unreported	unreported	unreported	unreported	unreported
Appropriate risk factor and outcome variables for stated aims?	yes	yes	yes	yes	yes

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)
Variables measured correctly using piloted/published instruments?	yes	yes	yes	yes	yes
Clear how statistical significance and/or precision estimates determined?	yes	yes	yes	yes	yes
Methods sufficiently described?	yes	type of correlations, or methods for analysing gender differences not explained	unclear whether all measures administered at both time points; unclear if post-hoc tests conducted	yes	yes
Data adequately described?	exact p-values and confidence intervals (CIs) unreported	specific test statistics not identified; CIs unreported	CIs and effect sizes (ESs) unreported	CIs unreported	CIs unreported
Does response rate raise concerns about non-response bias?	yes (24.2%)	no (83%)	no (83%)	unreported	yes (59%)
Information about non-responders described?	unreported	unreported	unreported	unreported	unreported
Results internally consistent?	almost all	invalid Emotional Intelligence (EI) scores excluded from analyses; unreported for other measures	invalid EI scores excluded from analyses; unreported for other measures	almost all	yes

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Duran et al. (2004)	Gerits et al. (2004)	Gerits et al. (2005)	Guerrero-Barona, Guerrero-Molina et al. (2020)	Guerrero-Barona, Rodríguez-Jiménez et al. (2020)
Results presented for analyses described in the methods?	yes	unclear if all results presented	results presented for some additional analyses	yes	yes
Discussions and conclusions justified by the results?	somewhat over-generalised	somewhat over-generalised	unclear as post-hoc tests not described	reasonably	intervention recommendation too strong for cross-sectional evidence
Study limitations discussed?	somewhat	not sufficiently	somewhat	somewhat	not sufficiently
Any funding sources or conflicts of interest that may affect interpretation?	unreported	unreported	unreported	no	no
Ethical approval or consent of participants attained?	unreported	unreported	unreported	yes	unreported
Additional for longitudinal outcomes:					
Follow-up long enough for outcomes to occur?		yes	yes		
Follow-up complete, and reasons explored if not?		unclear	unreported		
Strategies to address incomplete follow-up?		unreported	unreported		

Table 6

Details of Quality Appraisal (continued)

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)
Clear aims/objectives?	yes	yes	yes	yes	reasonably
Appropriate design?	yes	yes	yes	yes	yes
Sample size justified?	yes	unreported	yes	yes	yes
Target population clearly defined?	yes	reasonably	reasonably	yes	yes
Sample taken from appropriate population base?	unclear	likely	yes	unclear	unclear
Selection process likely to select participants representative of target population?	unclear how recruitment pool identified; recruitment method may have introduced bias	reasonably but recruitment method may have introduced bias	reasonably but recruitment method may have introduced bias	reasonably but unclear how recruitment pool identified	yes
Measures taken to address non-responders?	unreported	respondents categorised by missing data	unreported	unreported	unreported
Appropriate risk factor and outcome variables for stated aims?	yes	yes	yes	yes	job satisfaction used as proxy for turnover intent; actual turnover not explored

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)
Variables measured correctly using piloted/published instruments?	yes	measure of service-user behaviour not piloted	yes	yes	yes
Clear how statistical significance and/or precision estimates determined?	yes	yes	yes	yes	yes
Methods sufficiently described?	yes	yes	yes	yes	yes
Data adequately described?	yes	confidence intervals (CIs) unreported	CIs unreported	yes	some data ambiguously described; CIs and effect sizes not fully reported
Does response rate raise concerns about non-response bias?	no (97.5%)	cannot determine response rate for recruitment via social media	survey response rate unreported but proportion of missing data is reported	yes (43%)	yes (54.9%)
Information about non-responders described?	unreported	information about missing data reported	unreported	unreported	unreported
Results internally consistent?	yes	variable	yes	yes	unreported
Results presented for analyses described in the methods?	yes	yes	yes	yes	yes
Discussions and conclusions justified by the results?	reasonably	somewhat but corrected significance level not consistently applied	reasonably	reasonably	somewhat but turnover intent may not predict actual turnover
Study limitations discussed?	reasonably	reasonably	reasonably	reasonably	somewhat

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Karriem (2010)	Keesler (2016)	Phillips (2019)	Shead et al. (2016)	Tolson (2015)
Any funding sources or conflicts of interest that may affect interpretation?	unreported	unreported	no	no	unreported
Ethical approval or consent of participants attained?	yes	yes	yes	yes	yes

Note. Additional items for longitudinal outcomes not applicable to these five studies.

Table 7

Details of Quality Appraisal (continued)

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
Clear aims/objectives?	yes	yes	yes	yes	yes
Appropriate design?	yes	yes	no active control	yes	no active control
Sample size justified?	unreported	unreported	unreported	unreported	unreported
Target population clearly defined?	yes	yes	yes	yes	yes
Sample taken from appropriate population base?	yes	yes	unclear	unclear	unclear
Selection process likely to select participants representative of target population?	unclear how recruitment pool identified or if recruitment method may have introduced bias	unclear how recruitment pool identified or if recruitment method may have introduced bias	reasonably likely but full randomisation not possible for practical reasons	yes	participating team selection method (to ensure high completion rate) may have introduced bias but full randomisation within teams
Measures taken to address non-responders?	unreported	unreported	yes	unreported	unreported
Appropriate risk factor and outcome variables for stated aims?	yes	yes	no objective measures of staff behaviour	yes	no objective measures of staff behaviour

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
Variables measured correctly using piloted/published instruments?	yes	yes	yes	adapted version of outcome measure not piloted	yes
Clear how statistical significance and/or precision estimates determined?	yes	yes	yes	yes	yes
Methods sufficiently described?	yes	yes	yes	yes	post-hoc test methods not explicit
Data adequately described?	confidence intervals (CIs) unreported	CIs and effect sizes (ESs) unreported	CIs and ESs unreported	CIs unreported	CIs and ESs unreported post-hoc test data not fully reported
Does response rate raise concerns about non-response bias?	no (70%)	no (70%)	no (82.2% completed intervention)	no (98.6%)	variable response rate across outcome measures, with reasons unclear
Information about non-responders described?	unreported	unreported	yes	unreported	unreported
Results internally consistent?	invalid Emotional Intelligence (EI) scores excluded from analyses; unreported for other measures	invalid EI scores excluded from analyses; unreported for other measures	unreported	yes for EI but questionable for newly adapted measure	invalid EI scores excluded from analyses; reasonable for other measures
Results presented for analyses described in the methods?	yes	yes	specific statistical analyses described in results section	yes	specific statistical analyses described in results section; post-

Abbreviated checklist item (see Appendix 1-C for full questions)	Study				
	Willems et al. (2012)	Willems et al. (2014)	Zijlmans et al. (2011)	Zijlmans et al. (2013)	Zijlmans et al. (2015)
					hoc analyses not fully explained
Discussions and conclusions justified by the results?	reasonably	somewhat	non-specific training effects not considered	somewhat	non-specific training effects not considered
Study limitations discussed?	reasonably	Somewhat	somewhat	somewhat	somewhat
Funding sources or conflicts of interest that may affect interpretation?	unreported	unreported	unreported	no	unreported
Ethical approval or consent of participants attained?	unreported	unreported	unreported	yes	yes
Additional for longitudinal outcomes:					
Follow-up long enough for outcomes to occur?					probably not
Follow-up complete, and reasons explored if not?					unreported
Strategies to address incomplete follow-up?					not reported

Table 8

Main Outcomes of Studies

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Observational studies				
Duran et al. (2004)	Associations between individual dimensions of trait Emotional Intelligence (EI), work engagement, and burnout dimensions: Emotional Exhaustion (EE), Depersonalisation (DP), and Personal Accomplishment (PA).	Spanish Maslach Burnout Inventory (Seisdedos, 1997) Utrecht Work Engagement Scale (Schaufeli, Bakker, & Salanova, 2006)	Bivariate correlations	Emotional Clarity (understanding own emotions) positively associated with PA (r=.25, p<.01) and with Dedication dimension of engagement (r=.25, p<.01). Repair to Moods (regulating own emotions) positively associated with PA (r=.31, p<.01) and with all engagement dimensions: Vigour (r=.20, p<.05), Dedication (r=.03, p<.01), and Absorption (r=.36, p<.01).

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Gerits et al. (2004)	Associations of mixed model EI with coping styles, burnout, general intelligence, psychiatric symptoms, illness-related absence, and job change.	Utrecht Coping List (Schreurs, Van de Willige, Brosschot, Tellegen, & Graus, 1993) Dutch version of General Ability Measure for Adults (GAMA; Derksen, Jeuken, & Klein Herenbrink, 1998b) Utrecht Burnout Scale (Schaufeli & Van Dierendonck, 2000) Dutch version of Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Derksen, De Mey, Sloore, & Hellenbosch, 1995)	Bivariate correlations Binary logistic regression for job change likelihood	Males had higher mean scores on Intrapersonal and Stress Management Emotional Quotient Inventory (EQ-i) scales, whereas females had higher mean score on Interpersonal scale (all $p<.05$). No significant difference for Total EQ-i means. Total EQ-i positively associated with Active Dealing coping style and negatively associated with Avoidance and Passive Reaction styles, for both genders. Total EQ-i positively associated with Social Support Seeking style for females only (all $p<.01$). Total EQ-i positively associated with GAMA score for females only ($r=.20$, $p<.01$). Total EQ-i positively associated with PA for males ($r=.25$, $p<.01$) and females ($r=.38$, $p<.01$). Total EQ-i negatively associated with EE ($r=-.33$, $p<.01$) and DP ($r=-.32$, $p<.01$) for females only. Total EQ-i negatively associated with Depression, Psychasthenia, and Social Introversion clinical symptom scales of MMPI-2 for females and with Social Introversion only for males (all $p<.01$). Total EQ-i significantly negatively associated with majority of MMPI-2 content scales for both genders. EQ-i not significantly associated with absence rate or likelihood of job change in subsequent two years for either gender.

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Gerits et al. (2005)	Associations of mixed model EI score profiles with burnout and illness-related absence.	Utrecht Burnout Scale (Schaufeli & Van Dierendonck, 2000) Job turnover at two year follow-up Absence frequency and duration over follow-up period	Hierarchical cluster analysis Three-way analysis of variance (ANOVA) on each burnout dimension (EQ-i cluster and turnover between-subjects; time point within-subjects) All analyses conducted separately by gender	Seven distinct clusters of EQ-i score profiles identified for males and a different set of seven for females. Males: Main effect of EQ-i cluster on PA (*F*=2.41, *p*<.05). Those with "median scores, median social skills" EQ-i profile had lower PA whereas those with "high scores, high social skills" profile had higher PA. Interaction effect of EQ-i cluster x turnover on DP (*F*=3.94, *p*<.01). For those with "median scores, low social skills" or "low scores, median social skills" profiles, those who had left the job had lower DP than those who remained. Females: Main effect of EQ-i cluster on EE (*F*=4.05, *p*<.01), DP (*F*=2.79, *p*<.05), and PA (*F*=5.25, *p*<.01). Those with "high scores, median social skills" EQ-i profile had lower EE, lower DP, and higher PA. Those with "low scores, median social skills" profile had higher EE, higher DP, and lower PA. Those with "low scores, low social skills" profile had higher DP and lower PA. Those with "high scores, low social skills" profile had lower EE. Interaction effect of EQ-i cluster x turnover not significant.
Guerrero-Barona, Guerrero-Molina et al. (2020)	Associations of trait EI with psychosocial resources/demands, and burnout. Whether EI predicts burnout level.	Questionnaire to Evaluate the Burnout Syndrome at Work (Gil-Monte, 2011) Individual scales from UNIPSICO battery (Gil-Monte, 2016) measuring psychosocial resources (social support, job satisfaction) and demands (psychosomatic symptoms, work-family conflict) in relation to work.	Bivariate correlations Multiple linear regression	EI negatively associated with psychosomatic symptoms (*r*=-.203, *p*<.001) and work-family conflict (*r*=-.27, *p*<.001). EI positively associated with job satisfaction (*r*=.220, *p*<.001) and social support (*r*=.268, *p*=.004). EI negatively predicted burnout when controlling for age and gender (β=-.319, *p*<.001, *r*=.324).

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Guerrero-Barona, Rodríguez-Jiménez et al. (2020)	Whether trait EI mediates relationship between self-efficacy and work engagement.	Spanish adaptation of the General Self-Efficacy Scale (Baessler & Schwarzer, 1996) Utrecht Work Engagement Scale (Schaufeli et al., 2006)	Structural equation modelling	Self-efficacy positively predicted all EI dimensions: Self Emotion Appraisal (β=.34, *p*<.01), Others' Emotion Appraisal (β=.33, *p*<.01), Use of Emotion (β=.30, *p*<.01), Regulation of Emotion (β=.48, *p*<.01). Use of Emotion was the only significant predictor of work engagement (β=.073, *p*<.01) and fully mediated relationship between self-efficacy and engagement (Sobel's test *Z*=3.22, *p*<.01).
Karriem (2010)	Whether mixed model EI dimensions predict job stress severity.	Job Stress Survey (Vagg & Spielberger, 1999)	Multiple linear regression	Total EQ-i negatively predicted job stress (β=-.098, *p*=.002, R^2=.071). General Mood was the only individual EQ-i scale to independently predict job stress (β=-.278, *p*=.03, R^2=.038).
Keesler (2016)	Whether trait EI mediates or moderates relationship between adverse childhood experiences and professional quality of life. Whether organisational culture, or exposure to behaviour that challenges, moderate relationship between EI and professional quality of life.	Adverse Childhood Experiences measure (ACE; Felitti et al., 1998) Professional Quality of Life Scale (ProQol; Stamm, 2010) Trauma-Informed Organizational Culture measure (Waldrop et al., 2009) Intensity of Behavioural Exposure measure (devised for this study)	Bivariate correlations Stepwise regression analyses	EI positively associated with organisational culture (*r*=.338, *p*<.001) but not significantly associated with any demographics (gender, ethnicity, age, education, work experience, working hours), or ACE score. EI did not mediate or moderate relationship between ACE and ProQoL scores. EI associated with all ProQoL dimensions in expected directions: Compassion Satisfaction (*r*=.424, *p*<.001), Burnout (*r*=-.474, *p*<.001), Secondary Traumatic Stress (*r*=-.184, *p*<.001). EI significantly predicted all ProQoL dimensions (*p*<.01) in regression models for each different aspect of behaviour that challenges (direct exposure, observation, physical intervention, physical injury). None of the relationships moderated by organisational culture or overall behavioural exposure.
Phillips (2020)	Whether demographic variables predict trait EI. Association between EI and job performance.	Job Performance Scale (Goodman & Svyantek, 1999)	Multiple linear regression Bivariate correlations	None of the demographics (work role, age, education level, gender), significantly predicted EI, independently or combined. EI positively associated with self-reported job performance (*r*=0.31, *p*<.001).

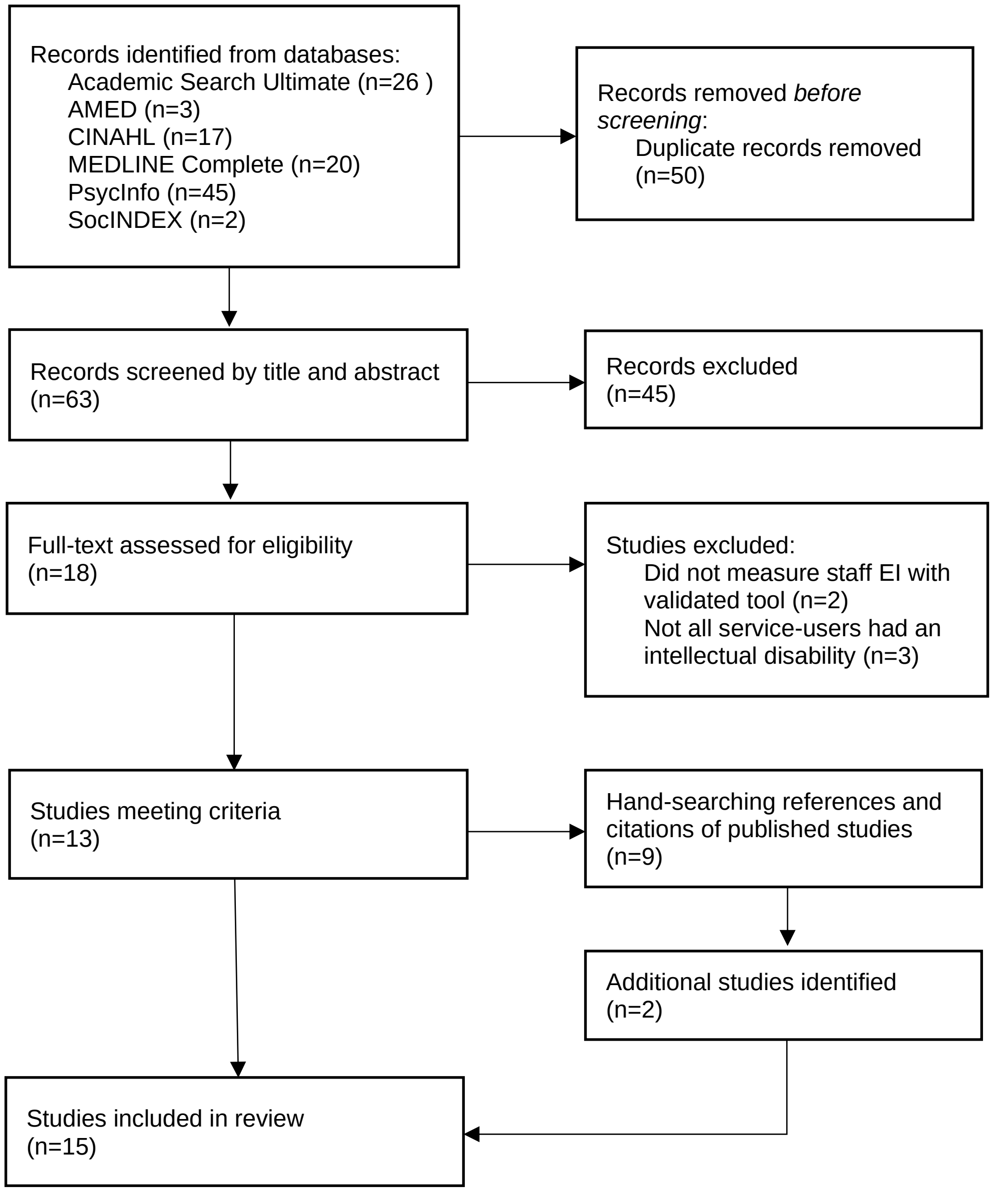
Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Shead et al. (2016)	Whether trait EI predicts burnout, or moderates relationship between exposure to violence and burnout.	Violence Scale (Howard, Rose, & Levenson, 2009) Difficult Behaviour Self-Efficacy Scale (Hastings & Brown, 2002) Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1997)	Hierarchical multiple regression	EI negatively predicted EE (β=-.203, *p*=.049) in combination with self-efficacy and exposure to violence (R^2=.132). EI alone positively predicted PA (β=.379, *p*<.001, R^2=.116). EI did not moderate relationship between exposure to violence and burnout.
Tolson (2015)	Association of ability EI with burnout and job satisfaction (proxy for turnover intent). Whether EI predicts job satisfaction, or demographic variables predict EI.	Job in General Scale (Smith, Kendall, & Hulin, 1969) Maslach Burnout Inventory (Maslach et al., 1997)	Bivariate correlations Multiple linear regression	Job satisfaction positively associated with EI (*r* unreported, *p*<.001). Neither burnout nor demographics significantly associated with EI (age, training level, ethnicity, gender, work experience).
Willems et al. (2012)	Associations of mixed model EI dimensions with intrapersonal domains of staff behaviour towards individual service-user whose behaviour challenges.	Staff-Client Interactive Behaviour Inventory (SCIBI; Willems, Embregts, Stams, & Moonen, 2010)	Bivariate correlations (non-parametric)	SCIBI Proactive Thinking domain positively associated with two EQ-i scales: Interpersonal (r_s=.28, *p*<.001) and Adaptation (r_s=.22, *p*<.01). SCIBI Critical Expressed Emotion domain negatively associated with four EQ-i scales: Intrapersonal (r_s=-.24, *p*<.01), Interpersonal (r_s=-.21, *p*<.01), Stress Management (r_s=-.27, *p*<.01), and Adaptation (r_s=-.28, *p*<.001).
Willems et al. (2014)	Whether mixed model EI dimensions predict staff responses to service-user whose behaviour challenges.	SCIBI (Willems et al., 2010) Dutch Interpersonal Adjectives Scales (Rouckhout & Schacht, 2008)	Hierarchical multiple regression	In addition to the variance explained by staff demographics and interpersonal attitude, only the Intrapersonal EQ-i scale predicted two out of seven SCIBI domains: Assertive Control (β=-.027, *p*<.05, R^2=.06) and Pro-active Thinking (β=-.027, *p*<.05, R^2=.07).

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Zijlmans et al. (2013)	Associations of mixed model EI dimensions with responses to behaviour that challenges, and with demographic variables.	Emotional Reactions to Challenging Behaviour Scale (ERCBS; Mitchell & Hastings, 1998) n.b. items from two of original subscales (fear/anxiety and depression/anger) re-categorised into new subscales: negative emotions and negative feelings.	Bivariate correlations (non-parametric)	Negative emotions domain negatively associated with two EQ-i scales: Stress Management ($r_s=-.22$, $p<.001$) and Adaptation ($r_s=-.15$, $p<.05$). Negative feelings domain negatively associated with three EQ-i scales: Intrapersonal ($r_s=-.23$, $p<.001$), Stress Management ($r_s=-.18$, $p<.05$), and Adaptation ($r_s=-.20$, $p<.001$). Intrapersonal scale positively associated with participant age ($r_s=.21$, $p<.01$) and working experience ($r_s=.16$, $p=.03$). General Mood scale positively associated with working experience ($r_s=.14$, $p<.05$).
Experimental studies				
Zijlmans et al. (2011)	Effect of training on mixed model EI dimensions.	The trainer and a blind reviewer independently judged whether EQ-i score profiles changed desirably or unfavourably with respect to each participant's personal development goals.	Two-way ANOVA (experimental condition between-groups; EQ-i scale within-groups) Post-hoc independent samples t-tests and one-way ANOVA (EQ-i scale within-groups)	Main effect of experimental condition on pre-posttest EQ-i score differences ($F=6.49$, $p=.01$). Mean scores of experimental group increased significantly more than those of control group. Interaction effect of condition x scale on score differences ($F=3.53$, $p=.01$). Experimental group had greater score increases than control group on two EQ-i scales: Adaptability ($t=3.65$, $p=.001$) and Intrapersonal ($t=2.52$, $p=.01$). For the experimental group, a greater % of EQ-i scores were judged to change desirably than to change unfavourably ($\chi^2=21.14$, $p=.001$).

Authorship	Outcomes of interest	Other measures used	Analysis methods	Key results
Zijlmans et al. (2015)	Effect of training on mixed model EI dimensions, and on responses to behaviour that challenges.	ERCBS (Mitchell & Hastings, 1998) Coping Inventory for Stressful Situations (Endler & Parker, 1994)	Three-way multivariate ANOVAs (experimental condition and recruitment site between-groups; individual dimensions of each outcome measure within-groups) repeated measures multivariate ANOVAs to investigate maintenance of experimental effects	Main effect of experimental condition on pre-posttest EQ-i score differences (F=4.92, p<.01). Mean scores of experimental group increased significantly more than those of control group one (p<.05) and control group two (p<.01). Within the experimental group, scores for all EQ-i scales were significantly greater at four months follow-up than at pre-test (p<.05). Regarding other outcomes, reported that experimental group had significantly greater increase in task-oriented coping style than control group two only. No effect of condition on emotion-oriented and avoidance-oriented coping styles. Experimental group had significantly greater increase in confidence/relaxed-type reactions than control group one only. No effect of condition on other types of emotional reactions. Improvements in coping styles and positive emotional reactions somewhat evident for the experimental group at follow-up.

Figure 1

PRISMA Flow Diagram Showing Study Selection Process



Appendix 1-A

PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.1
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.3-6
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.6
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.7
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.7-8
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.7-8; Appendix 1-B
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.7-8; Figure 1
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.8-9
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.8
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.8

Section and Topic	Item #	Checklist item	Location where item is reported
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.9
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	p.8
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	n/a
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	n/a
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	n/a
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	n/a
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.11; Figure 1
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.9-10
Study characteristics	17	Cite each included study and present its characteristics.	p.10-12; Tables 2 and 3
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.12-14; Tables 4-7
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Table 8
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.14-20

Section and Topic	Item #	Checklist item	Location where item is reported
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.20-21
	23b	Discuss any limitations of the evidence included in the review.	p.21-25
	23c	Discuss any limitations of the review processes used.	p.27
	23d	Discuss implications of the results for practice, policy, and future research.	p.25-26; 28

Note. Table reproduced from Page et al. (2021).

Appendix 1-B

Full Systematic Search Syntax

Database	Search query
Academic Search Ultimate	(staff OR worker* OR employee* OR personnel OR professional*) AND (((DE "MENTAL disabilities") OR (DE "PEOPLE with mental disabilities") OR (DE "DEVELOPMENTAL disabilities") OR (DE "DEVELOPMENTALLY disabled")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND (((DE "EMOTIONAL intelligence") OR (DE "EMOTIONAL competence")) OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))
AMED	(staff OR worker* OR employee* OR personnel OR professional*) AND (((ZU "Intellectual Disability") OR (ZU "Developmental Disabilities") OR (ZU "Mentally Disabled Persons")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND ((ZU "Emotional Intelligence") OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))
CINAHL	(staff OR worker* OR employee* OR personnel OR professional*) AND (((MH "Intellectual Disability") OR (MH "Developmental Disabilities") OR (MH "Mentally Disabled Persons")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND ((MH "Emotional Intelligence") OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))

Database	Search query
MEDLINE Complete	(staff OR worker* OR employee* OR personnel OR professional*) AND (((MH "Intellectual Disability") OR (MH "Developmental Disabilities") OR (MH "Mentally Disabled Persons")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND ((MH "Emotional Intelligence") OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))
PsycInfo	(staff OR worker* OR employee* OR personnel OR professional*) AND (((DE "Neurodevelopmental disorder") OR (DE "Intellectual Development Disorder")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND ((DE "EMOTIONAL intelligence") OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))
SocINDEX	(staff OR worker* OR employee* OR personnel OR professional*) AND (((DE "DEVELOPMENTALLY disabled") OR (DE "PEOPLE with mental disabilities")) OR (DE "DEVELOPMENTAL disabilities")) OR ((intellect* OR learning OR development*) N1 (disab* OR disorder*)) OR (mental* N1 (handicap* OR retard*))) AND ((DE "EMOTIONAL competence") OR (emotional W0 (intelligence OR competence OR understanding OR management OR quotient)))

Appendix 1-C

Full Quality Appraisal Checklist

AXIS tool questions (Downes et al., 2016):

1. Were the aims/objectives of the study clear?
2. Was the study design appropriate for the stated aim(s)?
3. Was the sample size justified?
4. Was the target/reference population clearly defined? (Is it clear who the research was about?)
5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?
6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?
7. Were measures undertaken to address and categorise non-responders?
8. Were the risk factor and outcome variables measured appropriate to the aims of the study?
9. Were the risk factor and outcome variables measured correctly using instruments/ measurements that had been trialled, piloted or published previously?
10. Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, CIs)
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?
12. Were the basic data adequately described?
13. Does the response rate raise concerns about non-response bias?
14. If appropriate, was information about non-responders described?

15. Were the results internally consistent?

16. Were the results for the analyses described in the methods, presented?

17. Were the authors' discussions and conclusions justified by the results?

18. Were the limitations of the study discussed?

19. Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?

20. Was ethical approval or consent of participants attained?

Additional questions for longitudinal studies, taken from the JBI Checklist for Cohort Studies (JBI, 2020):

a. Was the follow-up time period reported and was it long enough for outcomes to occur?

b. Was follow-up complete, and if not, were the reasons for loss to follow-up explored?

c. Were strategies used to address incomplete follow-up?

Appendix 1-D

JARID Author Guidelines

1. SUBMISSION

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2. AIMS AND SCOPE

JARID is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.
In order for a paper to be considered for publication, it must be about people with intellectual disabilities. Manuscripts which focus upon autism will be considered only when the focus is also upon intellectual disabilities. Papers which focus upon autism and exclude people with intellectual disabilities will not be considered.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision.

Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles, including Clinical Trials (see guidance within section 5), ***Review Articles*** and ***Brief Reports*** are accepted by the Journal. ***Theoretical Papers*** are also considered, provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Authors who are submitting original articles where qualitative methods have been used must ensure that their choice of method is well justified and issues relating to methodological rigor are effectively addressed.

Articles and ***Theoretical Papers*** should not exceed 6000 words;
Review Articles should not exceed 7000 words;
Brief Reports should not exceed 2000 words.

All word limits are inclusive of the abstract. References, Words in Tables, Captions/Legends, Figure and Figure captions/legends are excluded from the word limits.
Please note that papers submitted for Special Issue volumes should also not exceed 6000 words.

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JARID recommends using person-first and/or identity-first language thoughtfully and appropriately. For example, the language used to describe both people with intellectual disabilities and autistic people has evolved based on recent advocacy efforts. When referring to people with autism, it is acceptable to use either identity-first language (e.g., “autistic people”) or person-first language (e.g., people with autism”), while identity-first language is not used to describe people with intellectual disabilities, where person-first language is preferred. Thus, people with intellectual disabilities should be referred to as people with intellectual disabilities.

We have consulted with over 40 self-advocates through Learning Disability England which included the North West Self-Advocacy Group, as well as Self-Advocacy Together and asked them what language we should use when writing about people with intellectual disabilities.

People with intellectual disabilities said that they do not like to be referred to by acronyms or abbreviations. Authors must therefore not use an abbreviation to describe intellectual disabilities such as "ID" or "LD". Instead, use person-first language such as children, teenagers, adults, or people with intellectual disabilities, avoiding acronyms or abbreviations.

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Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

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Author Guidelines Updated December 2019.

SECTION TWO: RESEARCH PAPER

Exploring the Experience of Working Relationships for Support Workers of Adults With Intellectual Disabilities

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2018 Intake

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Prepared for submission to *Journal of Applied Research in Intellectual Disabilities* (see Appendix 1-D in section one for JARID author guidelines).

Abstract

Background: Research suggests that a better awareness of how staff who directly support people with intellectual disabilities, experience their working relationships, will contribute to understanding staff wellbeing and the quality of care they offer. This study aimed to explore the lived experiences of support workers in supported living services in England.

Method: Six support workers participated in semi-structured interviews, about their working relationships with service-users and colleagues. Data was analysed using interpretative phenomenological analysis.

Results: Six interconnected themes emerged: The essence of good relationships; a trusting relationship as the vehicle for meeting service-users' needs; belonging to the support team; the organisational context of relationships; the social context of relationships; "a fine balancing act".

Conclusions: The findings provide insights into staff wellbeing, indicating that developing supportive, trusting relationships with both service-users and colleagues, plays an important role in delivering effective care. The potential implications for service providers are discussed.

Keywords: intellectual disabilities, staff wellbeing, working relationships, supported living, qualitative

Background

The UK government's Transforming Care (TC) programme aims for all adults with an intellectual disability to reside in appropriate, community-based housing, rather than institutional environments which impinge on human rights (Department of Health, 2012, p.75). Policy recommends offering "a choice of housing, including small-scale, supported living" (NHS England, 2015, p.25). Approximately 30,000 adults with intellectual disabilities live in supported accommodation services in England (Public Health England, 2020). In such settings, people are supported to manage activities of daily living by paid staff, who play a vital role in their safeguarding. Supporting service-users who often have complex physical or mental health needs, requires a diverse range of practical and interpersonal skills (Antonsson, ÅStrÖM, LundstrÖM, & Graneheim, 2013; Dodevska & Vassos, 2013; Hatton, Wigham, & Craig, 2009), yet qualification requirements are typically minimal, and pay rates low (Skills for Care, 2021, pp.94-104). In England's social care services for people with intellectual disabilities and/or autism, a high turnover rate of 36.1% has been reported for direct care-providing roles (Skills for Care, 2018), which are distinguished from managerial roles, regulated professions, and non-care roles. Data suggests that the Covid-19 pandemic has exacerbated retention problems in the social care sector generally (Skills for Care, 2021), which may impact negatively upon the TC programme, given direct care staff's significant role in providing the recommended model of supported accommodation. Giesbers, Hendriks, Jahoda, Hastings, and Embregts (2019) found that people with intellectual disabilities, living with paid support, perceived turnover as a barrier to building positive relationships with staff. Thus, there is pressing need to better understand support staff experiences, so that they can be facilitated to undertake their role effectively.

Research on direct care staff in services for people with intellectual disabilities identifies organisational and environmental issues, inequality in workplace relationships, demands of the job role, and individual staff or service-user characteristics, as contributors to stress (Rose, 2009; Ryan, Bergin, & Wells, 2021). Stress and burnout have been linked to poor retention and care quality outcomes (Buntinx, 2008; Skirrow & Hatton, 2007). Hastings (2010) argued that how staff perceive their positive contributions and relationships with service-users were future research priorities. Ryan et al. (2021) reviewed findings suggesting that positive aspects of the work enhance staff wellbeing but highlighted the stressful impact of low reciprocity between staff and service-users, colleagues, or the organisation. Devereux, Hastings, and Noone (2009) suggested application of the job demands-resources model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) to advance research in this area. This model proposes that the various physical and psychological characteristics of any job can be classified either as “demands”, which lead to stress and burnout, or as “resources”, which help reduce demands and facilitate personal development. There are research examples of staff relationships with service-users (e.g. Lunsky, Hastings, Hensel, Arenovich, & Dewa, 2014; Whittington & Burns, 2005), and colleagues (e.g. Judd, Dorozenko, & Breen, 2017; Thomas & Rose, 2010), being sources of both stress and support, suggesting that different aspects of working relationships may function as demands or resources. Hatton, Dagnan, and Disley (2009) alternatively suggested equity theory as a framework for developing staff research, which posits that individuals focus on maintaining fair resource exchange within relationships. Disley, Hatton, and Dagnan (2012) found that staff, in various roles, identified a range of things which they bring to, and gain from, relationships with service-users, colleagues, and the organisation. Deeper understanding of how direct care staff experience working relationships may therefore contribute to developing interventions which enhance staff wellbeing and their capacity to deliver compassionate care.

There is increasing focus on using qualitative research to understand some of the mechanisms underlying care quality in intellectual disability services (e.g. Clifford, Standen,

& Jones, 2018; Hermsen, Embregts, Hendriks, & Frielink, 2014; Hutchison & Stenfert Kroese, 2016; Judd et al., 2017; McEwen, Bigby, & Douglas, 2021; Quilliam, Bigby, & Douglas, 2018). Three studies in particular have explored how staff experience their roles in various types of residential service. Hutchison and Stenfert Kroese (2016) conducted an interpretative phenomenological analysis (IPA) with direct care staff, identifying themes about perceived reciprocity in working relationships, the value congruence and rewards of the work, and the influence of environmental constraints. A thematic analysis of support and managerial staff experiences highlighted ideological and systemic issues perceived to impact on delivering the TC agenda (Clifford et al., 2018). Using grounded theory, Quilliam et al. (2018) found that support workers and supervisors believed they had valuable knowledge and experience to contribute but often felt powerless and excluded from organisational dialogue, resulting in high stress levels.

The present study aimed to further understanding of the wellbeing of staff supporting people with intellectual disabilities, by exploring how staff make sense of their working relationships. None of the samples in previous qualitative studies consisted solely of staff in direct care roles within the UK's *supported living* service model; therefore this study sought to explore experiences of this specific population.

Method

IPA has theoretical foundations in phenomenology, hermeneutics, and idiography (Smith, Flowers, & Larkin, 2009, Chapter 2), making it appropriate to address the research aim of capturing the nuance of staff's lived experience of their working relationships, and to probe the range of individual differences suggested to play a role in staff wellbeing (Ryan et al., 2021). Its concern with individual meaning-making, could enable exploration of how aspects of different relationships might function as demands or resources from a staff perspective.

Ethics

The study was granted ethical approval by Lancaster University's Faculty of Health and Medicine Research Ethics Committee. The research proposal was informed by consultation with two stakeholder groups. Full details are contained in section four of this thesis. All participants have been given pseudonyms throughout, to protect their anonymity.

Sampling and Recruitment

Participants were recruited from independent organisations registered with Local Authorities in North-West England to provide supported living (in line with national guidance) to adults with intellectual disabilities. To enable exploration of convergence and divergence, within and between individual experiences of a particular phenomenon, it is suggested that samples for IPA be relatively small and homogenous (Smith et al., 2009, pp.49-52); thus, criteria were set for inclusion:

- Staff in an unqualified direct care role, commonly termed *support worker*
- Employed in current post for a minimum of three months (regardless of any prior experience in a similar role)

and for exclusion:

- Job title including the word 'senior'
- Providing domiciliary support as a lone worker (i.e. not part of a staff team)
- Employed by an external agency or by multiple providers.
- Working only in a 'bank' capacity (i.e. providing temporary cover for vacancies or absences).

Recruitment packs including a project summary, advertisement flyer, ethical approval confirmation, participant information, and consent form, were emailed to each organisation, with a request to distribute relevant documents to all eligible staff. Where possible, the researcher made direct contact with service managers, to explain the project and address any concerns, such as potential impact on staff and service-users. Staff were requested to contact the researcher directly, to express participation interest. The researcher requested verbal confirmation of eligibility criteria being met, from those expressing interest.

Participants

The final sample consisted of six staff from two organisations which provide a mixture of shared and individual tenancies for people with intellectual disabilities. Three participants were part of a team supporting people in individual flats within a shared complex, two provided flexible support across multiple dwellings, and one worked within a team supporting a two-person tenancy. Demographic characteristics of participants are summarised in Table 1.

[INSERT TABLE 1 HERE]

Data Collection

Offering the flexibility to explore issues which participants consider most important, one-to-one semi-structured interviews are held to be a fitting data collection method in IPA (Smith et al., 2009, p.57). In the context of the Covid-19 pandemic, five interviews were conducted via video-call and one via telephone. An interview topic guide (contained in the ethics proposal section) was used to prompt exploration of participants' experience; where additional topics arose which appeared pertinent to the research aim, they were followed up spontaneously. Interviews, lasting between 45 and 90 minutes, were audio-recorded then transcribed verbatim by the researcher, and anonymised.

Data Analysis

The steps described by Smith et al. (2009, Chapter 5) were used to guide analysis. Table 2 provides explanation of how these were implemented, with examples in Appendices 2-A and 2-B. In practice, the process was continuous and iterative, according to the hermeneutic principle of IPA.

[INSERT TABLE 2 HERE]

Reflexivity

IPA explicitly recognises the double hermeneutic in qualitative data analysis: that the researcher brings their own sense-making process to participants' understanding of personal experiences (Smith et al., 2009, p.3). Shaw (2010) argues it is essential for researchers to adopt a reflexive attitude within this; that is, to acknowledge how one's presuppositions may shape data interpretation. This was particularly important for the present study, given the researcher's previous work experience in a similar role to participants. Reflexive journaling and supervisory discussion are established techniques for bracketing preconceptions (Tufford & Newman, 2010), which the researcher used to facilicate awareness of their personal impact on the whole research process. At each analysis stage, they reflected on how their own experiences and assumptions might be influencing the themes identified. This journal extract gives an example whilst analysing an individual transcript (corresponding to the initial coding example in Appendix 2-A):

> *I've realised Declan's phrase "come out of his shell" reminded me of how a colleague described changes they'd seen in me over the time we worked together. As this experience was about my personal growth in confidence, I originally assumed Declan meant a passive waiting for the service-user to gain confidence before he could develop rapport with them, but reviewing other points in the interview where he describes giving "time" and "listening", it suggests a theme of facilitating the service-user to step outside their comfort zone, in which he plays a more active role.*

Regular discussion with two supervisors added rigour by contributing multiple perspectives towards theme development. These selected notes from a supervision record, illustrate how one of the final themes was reached:

> *Discussed potential theme I identified of 'Psychological Impact' – captures how all participants identified relational aspects of the work as both highly rewarding and demanding; also strain of navigating various boundaries and balances within relationships (e.g. appropriate boundary between meeting service-users emotional needs and maintaining professionalism)? [Supervisor] noted continual sense of an emotional rollercoaster in participant accounts; also repeated theme of balance/conflict within tight margins when describing how they support service-users. All agreed that psychological impact is more of a thread running throughout other themes, but repeated references to "balance", "fine lines" etc. reflects unique theme not captured elsewhere.*

Results

Six themes about the experience of working relationships emerged from the analysis. Figure 1 represents connections between themes, integral to understanding participants' overall experiences.

[INSERT FIGURE 1 HERE]

Arrows from theme A to themes B and C depict how their relationships with service-users, and the staff support team, were influenced by common guiding principles. The central bidirectional arrow represents how the quality of relationships with these two groups had reciprocal influence. Participants expressed awareness of the organisational and broader social contexts within which these relationships existed, with factors at both levels influencing relationship quality, depicted by the oval layers. The arrow containing theme F represents participants' experience of navigating a complexity of considerations in relating to service-users, at the intersection of service-user needs, organisational expectations, and societal issues. Table 3 provides additional quotes to support the following explanation of each theme.

[INSERT TABLE 3 HERE]

A: The Essence of Good Relationships

This theme captures the fundamental principles which participants applied to building and maintaining all working relationships.

Participants described the values-driven attitude which they aimed to bring to interactions, being “approachable”, showing “respect”, and “listening”. They spoke of actively seeking to learn about others and find opportunities for shared experiences, or “common ground”, from which relationships could “grow”. This could enable insight into others’ experience of the world:

> *spending bit a bit of, time together [...] getting a sense of, what that person, thinks and feels about certain things you know it helps you understand what makes sense to them* (Declan, 642-646).

Openness to learning and new experience was identified as important for facilitating relationship development:

> *I find that, I'll watch things at work that I would never, in a million years watch at home [...] that allows for us to sort of, all be involved in one mutual conversation erm and allows for us to sorta like f-friendship to grow and you can have a laugh* (Marcus, 149-153).

Marcus’ apparent hesitation to acknowledge “friendship” with service-users, indicates the current theme’s interaction with theme F, later described. Nonetheless, the informality of shared fun and humour was a key component of relationship-building for participants:

> *we’ve got erm a small communal room [...] tha-that's where all the giddiness happens [...] we do have a laugh in there* (Elaine, 458-461).

The context of “we” suggests that the communal space, and relaxed activity, facilitate a sense of equality and collective identity, important for the wellbeing of both staff and service-users.

Whilst participants recognised the need for active investment in relationships, most also expected natural variation in how easily connections formed:

> *there's obviously people that you connect with, more than others but, t-to me that's pretty normal* (Declan, 574-575).

Declan's matter-of-fact tone here, demonstrates participants' attempts to bring an attitude of acceptance and understanding to interpersonal difficulties encountered within work.

B: A Trusting Relationship as the Vehicle for Meeting Service-users' Needs

This theme represents the fluidity in the nature of how participants related to service-users, driven by the interdependent processes of building trust, and meeting their needs.

It was evident across accounts, that participants strove to meet the full range of service-users' needs, including promoting their physical and mental wellbeing, championing their rights and community participation, and ultimately improving their quality of life. Some labelled relational roles they might adopt, such as "advocate" (Marcus), "enabler" (Declan), or "counsellor" (Nikki), whilst all suggested flexible shifting between different styles of relating, adapting to individual preferences. Trust and closeness were considered essential for meeting needs holistically, particularly when supporting service-users to make informed decisions:

> *when you do have the good relationship they are more likely, to listen to your advice, erm if you don't get on with them [...] they will learn less and go against it* (Nikki, 271-273).

Fostering a sense of safety in the relationship, could give service-users confidence to step outside their comfort zone and participate in fulfilling experiences:

> *he loves football but he never, never picked a ball up with anybody so I gradually [...] introduced him to walking football [...] it must have been daunting for him [...]*

> *playing in a team, but he loved it […] so he trusted me so the next thing erm, I would try something else and gradually […] you get him to maybe try it* (Ron, 127-136).

This account particularly illustrates how participants found that building trust with service-users enabled meeting of their needs, in turn promoting further trust, in a virtuous cycle. Ron later describes feeling “privileged”, to have facilitated this personal growth for the service-user but acknowledged that the interaction could sometimes be “testing”. Others similarly spoke of a “rewarding” experience from the trust-building process, alongside need for perseverance:

> *give them time to come out of their shell […] tryna push a certain relationship could definitely put people off […] you've gotta have that patience* (Declan, 173-178).

Meeting emotional needs was understood to play a significant role in gaining trust:

> *you can see him building up the anxiety the anxiety the anxiety […] he will look at me in a certain way and I will step in and help him and er, and he knows […] that’s how it works.* (Ron, 181-187).
>
> *when I first started and I saw him get a bit distressed it affected me, I-I maybe played into that a little […] before he would sort of swallow me up but, now […] he knows he can trust me* (Elaine, 267-276; 284-285).

Whilst Ron suggests an instinctive understanding of the service-user, Elaine explains how she learnt to respond containingly to emotional expression. The psychological impact of offering emotional support was evident:

> *he's constantly in your ear all the time er wanting reassurance about this that and the other and that can be really wearing […] you’ve gotta er have the answers […] so that can be really wearing* (Wendy, 87-90).

> *you're going through the same problem and the same problem and the same problem, day in day out [...] even though you deal, you, you dealt with it, it can still come back [...] you feel like you're ears are bleeding* (Nikki, 420-423).

The repetition in these accounts conveys the exasperation felt, whilst the impression of physical assault on the ear, further emphasises the emotional demands. Despite these visceral images, Nikki states elsewhere, that to promote service-users' wellbeing is "worth everything". Bringing the extremes of her emotional experience together, she exemplifies participants' acknowledgement that building relationships involved high reward alongside high demand:

> *if they've got problems [...] I'm trying to help'em with then I can go home and I can sit there for the rest of the night thinking [...] i-it does affect your mental health a lot, but if you, this is why, you know I love my job, I go to work every day and [...] I get immense satisfaction, from knowing y'know that I've just helped them a little bit, but like I say it can also weigh very heavily on your mind* (404-411).

C. Belonging to the Support Team

This theme captures participants' perceived identity as team members, which enabled them to provide the best possible support to service-users, and to cope with the associated demands.

Participants described how support workers relied on each other to recognise and meet service-user needs. Collective knowledge and understanding, of each individual, were understood to arise from "sharing" perspectives, facilitated by team cohesion:

> *I might struggle with one client but somebody has a better way of dealing with'em. So then you adopt their strategy, but if you have got a good working relationship with your er colleagues you will, find that out.* (Nikki, 604-606).

Conversely, poor “communication”, disagreement, and particularly “inconsistencies” in practice, were identified as being detrimental to service-users’ welfare and relatedly, to the quality of relationships between staff:

> *that can be a real, sticking point for staff relationships [...] service-users can pick up on that as well definitely there’s, tension within their home [...] they’ll go really quite erm, introverted* (Marcus, 722-732).
>
> *you're only as strong as your weak link and if you've got a weak, member of the team it does have a, spiralling effect* (Declan, 327-328).

Declan’s metaphor highlights participants’ general awareness of the inter-dependence of different relationships. Effective teamwork was also identified as influencing the quality of relationships with service-users. Participants emphasised the necessity of staff being on the “same page”, with some experiencing frustration that not all staff shared their attitude of aiming to maximise service-users’ independence. Equally however, all expressed appreciation for shared understanding with other staff, of psychological challenges encountered in the work. Being able to “compare notes”, recognise that “it happens to everyone”, and “offload” to colleagues, enabled management of difficult emotions. As in theme B, it was accepted that costs and gains of relationships come hand-in-hand, again exemplified by Nikki’s description, of “swings and roundabouts”. A sense of mutual support, whereby staff would “pick each other up”, was essential for coping with job demands and stress, whilst sharing “banter” fostered a sense of belongingness and solidarity, epitomised by Declan’s statement that:

> *my team is my team [...] at the end of the day you’re all in it together* (577-579).

D. The Organisational Context of Relationships

This theme describes how participants identified various aspects of the organisational structure, culture, and practice, which influenced the experience and quality of their relationships with service-users and the support team.

Although the degree to which participants felt supported by managerial staff varied, desire for a supportive supervisory relationship was commonly evident. A manager with whom one could “get things of your chest” was highlighted as an important resource for coping with emotional demands of the work, and with tensions in other relationships. Participants appreciated being able to “approach” managers who demonstrated the same relational attitude and investment as themselves; this was contrasted with experiences of “management” as a distant, impersonal entity whom they did not “know”. It was conspicuous when participants felt unheard or unsupported by managerial staff; perhaps experienced all the more acutely because of the degree of contrast in the relational investments made:

> *it gets me really really angry, really really angry. Cos they’re all willing to jump in and, be on your back and tell you what you're doing wrong but then they're not willing to, come in and help [...] there's no help coming from anywhere! And yeah it really does make me angry [...] the way they want to do it I feel like we're being forced, to support people in ways that we shouldn't* (Nikki, 879-890).

This vehement account conveys Nikki’s outrage at the audacity of senior staff to impose their views when not investing themselves. It suggests she feels her relationship with service-users is somewhat shaped against her will by organisational hierarchy, revealing the emotional burden of complying with job expectations that transgress one’s values. Others spoke of their best efforts, to meet service-users’ needs, going unrecognised, or being undermined by organisational attitudes, with “paperwork” viewed as a bureaucratic task which obstructed spending time with service-users:

> *we've all said that for years but, y'know nobody's taken any notice […] they're all covering their backs in case something goes wrong but, at end of the day this is supposed to be about, supporting people to live their life, not ticking the boxes* (Wendy, 828-832).

Whilst significant frustration was experienced when organisational processes were felt to adversely impact on relationships, policies or initiatives which facilitated relationship-building with, and between service-users, were valued:

> *my, company have a lot of social things […] they do their best […] I know all the other people in all the other houses, and it's nice that when we go out, me and my client we might meet'em on the high street and just, stop and chat* (Ron, 827-832).

This account evokes the same sense of collective wellbeing found in Elaine's description of communal activity quoted under theme A, demonstrating how participants did not experience relationships with individual staff and service-users to occur independently of their position within the organisational community.

E: The Social Context of Relationships

This theme captures participants understanding of working relationships being influenced by factors within the wider social context, which could interact with the organisational context.

A prominent issue was the impact of restrictions associated with the Covid-19 pandemic. Some participants highlighted loss of opportunities for connection with other staff, whilst others explained how service-users' difficulties, in understanding disruptions to routine activities, brought relationships with them under strain:

> *it's hard if you've got someone that's down and grumpy and, obviously not fully understanding the situation […] not fully understanding their feelings […] staff get*

> *her shopping, and that's, really something that she loved to do so [sighs], she is down about that and she'll blame us* (Elaine, 577-579; 610-612).

There was apparent psychological toll for participants, of being perceived as responsible for circumstances outside their control whilst also trying to provide emotional containment to service-users. Some reflected on how difficult it had been to see service-users lose opportunities to develop their independence. Wendy expressed indignance about how infection-control measures, although well-intended, had been imposed:

> *a lot of people I support are not allowed in shops […] I know they're only protecting'em but for me it's been absolutely ridiculous, y'know they haven't been able to have anybody in the house […] that's just being OTT for me because at end o'the day […] we're all bending the rules a little bit, er but they haven't been able to at all* (664-673).

Wendy seems keenly aware of the contrast, in her own freedom to choose whether she follows the "rules" whilst service-users have been deprived of this right. It is not entirely clear whether "allowed" refers to organisation-specific precautions, or guidance from external service regulators; it is perhaps not a clear distinction for her either, reflecting the general sense, present in others' accounts, of the disempowerment experienced by service-users as formal recipients of care, and how staff too could feel helpless within this system.

In addition to risk aversion in the care system, participants were aware of societal attitudes, and over-protectiveness from family, which could "disable" service-users and hinder attempts at promoting their independence:

> *they can just be, so protective, erm that they don't want them to do things […] families make it difficult sometimes I know they're, they want the best but, sometimes they're looking at them like they're children and they're not* (Wendy; 292-299).

Interestingly, Wendy later describes herself as feeling “protective” of service-users, as a result of working so closely with them, revealing the complexities encountered in how to approach the relationship.

Another systemic issue identified as affecting the quality of relationships with service-users, was the psychological impact of staff turnover:

> *it might take a certain gentleman, a lot longer to feel more comfortable, with, me […] throughout his life, he’s used to carers coming and going […] for that reason it might take him a bit more time because he's, he's used to seeing people come and go, so […] he might feel that it’s not even worth bothering* (Declan, 161-167).

The use of “people” suggests Declan’s recognition of the impact of needing life-long support on service-users’ relationships beyond just those with “carers”. The account reflects how participants often tried to empathise with service-users, to manage relational challenges encountered, linking to the importance held of seeking to understand others’ perspectives, as captured under theme A. Suggesting an explanation for high turnover, Marcus highlights the importance of staff needing to feel a sense of relational rewards:

> *people want to come in and, have that rapport with service-users straight away […] when that doesn’t happen, it can, put people off […] to the point where the-they’ll just leave and I think if you can overcome the first few, first few weeks […] it suddenly becomes a lot easier.* (418-423).

As portrayed in accounts under theme B, there is recognition that perseverance is needed to reap the rewards of building trusting relationships with service-users.

F. “A Fine Balancing Act”

This theme captures the challenges which participants encountered in balancing all the different considerations and demands in their working relationships, at the interface between meeting service-users' needs, and the organisational and social context of providing formal care.

Accounts of interactions with service-users, were characterised by participants constantly searching for the appropriate way in which to relate, balancing human instinct to show "friendship" and affection, with the organisational pressure to maintain a "professional" boundary:

> *naturally you do build a kind of connection [...] I-I feel like that's fair and normal [...] it wouldn't be right if I didn't [...] address them on that same level* (Declan, 121-123).

Here, Declan indicates awareness of the power differential existing within the paid care relationship, and his desire to try and reduce this; yet he also carries a sense of responsibility not to replicate service-users' previous experiences of loss:

> *you don't wanna, get too close [...] y'know if I was to ever move on [...] it must be quite painful for that person who's, y'know built that connection over these years and then it can just stop immediately [...] you gotta kind of approach it with. With a care-with a careful eye [...] Drawing the line on on certain aspects [...] it's finding the balance between that, alongside having a healthy relationship i-i-it, it is tough it is tough because [sighs].* (199-213).

His tone reveals the mental strain of remaining alert to these different considerations, whilst his inability to verbalise a reason in the last sentence perhaps reflects a relentless uncertainty as to where the balance lies. By contrast, Marcus' language implies the relationship is subject to a definitive, unquestionable boundary; yet what this means in practice remains somewhat vague, evidently lacking clarity from the service-users' perspective:

> *it's a friendly relationship erm but obviously there are, firm boundaries in place that er sometimes can, be overstepped [...] sometimes they will er see you as more of a*

> *friend [...] when you have to put the boundaries back in place and remind them that actually y'know I'm here, as a support worker for you to keep you safe err sometimes you can have a bit of erm, firm resistance from them* (106-115).

There is a sense that taking on the more parental role, of implementing safety boundaries, sits uncomfortably with Marcus. He later describes the conflict that can arise, when trying to support service-users to make wise decisions by reminding them of possible consequences:

> *it can, quickly flip from being a friendship to, you're, er yeah y-you're sorta the bad cop.* (187-188).

The shift from describing a "friendly relationship" to explicitly labelling "friendship", somewhat conflicts with Marcus' earlier implication that a "friend" and "support worker" are mutually exclusive, indicating the relational boundary is not as "firm" as originally stated. That things can "flip", implies trying to maintain a fragile balance, the mental strain of which was apparent in others' accounts. Marcus also described the difficulty of guiding service-users to make informed decisions as an "ethical grey area". This challenge of trying to promote choice and liberty, according to best practice guidelines, whilst maintaining their safeguarding duties, was another aspect of balance-finding within the relationship that other participants highlighted:

> *it's their choice and everything [...] sometimes though we have to try and put our foot down a little bit and advise, against doing certain things especially if it's not within their interests [...]it's learning that balance of how far you can actually go and say it because we're not allowed to say no* (Nikki, 262-266).

Another balance which participants highlighted as challenging, was managing competing demands on their time and attention, such as meeting all service-users' needs in a communal setting, or interacting directly with service-users alongside ensuring household tasks and "paperwork" were completed.

> *you do get a bit tired […] there's always so much paperwork to catch up, so you're tryna do some and they're, demanding this that and the other and, y-y-you just gotta take your ear out and, you know that's quite difficult erm [sighs]. What was the question?* (Wendy, 488-493).

So caught up in thinking about how overwhelming the multiple demands can feel, Wendy seems to momentarily lose sight of her present situation as an interview participant. Yet elsewhere she speaks warmly of how "appreciated" she feels when coming to work, attesting to the strong contrast of the emotional rewards and demands which participants concurrently experienced within relationships.

Discussion

This study provides insights into the relational experiences of support workers in supported living services for people with intellectual disabilities. Participants expressed a passion for support work, viewing the relationship as the vehicle for carrying out their job role, of holistically meeting each service-user's particular needs. Their capacity to fulfil this was dependent on belonging to a supportive team. Some fundamental principles were applied to all working relationships, which were understood to be multi-influential, as well as being influenced by the organisational and social contexts. Participants found themselves trying to execute "a fine balancing act" in weighing up the many considerations and needs within relationships, with intense emotional reward and demand being simultaneously experienced. The overlap of these findings with many aspects of other qualitative studies on direct care staff experiences will now be explored, alongside arising implications for practice and further research.

The current results strongly echo findings of Hutchison and Stenfert Kroese (2016), that "degree of positive relationship reciprocity" was salient in staff's experience, lending support to their proposal that this factor contributes to care quality variation across services.

One of their sub-themes, describing how valued or empowered staff felt in relationships with managers, is reflected under the present findings about perceived organisational influences on working relationships, which additionally suggest that disempowerment is particularly experienced when direct care staff perceive managers to be less emotionally invested than themselves. This resonates with the finding of Quilliam et al. (2018), that frontline staff experienced a sense of powerlessness in everyday practice, due to feeling disregarded by the managing organisation. The current results support Hutchison and Stenfert Kroese's finding of an important narrative about collaborative team working, and further indicate its role in meeting service-user needs and managing job demands. Accounts of relationships with service-users in the current study also reflect Hutchison and Stenfert Kroese's other sub-themes, about the reward gained from interactions with service-users, and how providing quality care depended on being able to relate to them as equals with individual needs. Overall, these studies provide important insights on quantitative research suggesting that lack of perceived reciprocity in working relationships contributes to burnout in direct care staff (Thomas and Rose, 2010). Of note in that research, degree of reciprocity with service-users was rated as lower than with colleagues and the employing organisation yet had the weakest association with burnout. In the current study, participants alluded to service-user reticence being an initial barrier to developing relationships but thought this was understandable, given service-users' repeated experiences of privacy invasion and loss in relationships with carers. This suggests that reciprocity disparities may have greater impact on wellbeing when staff perceive that the other is in a position to rectify it.

Similarly to the findings of Clifford et al. (2018), participants of the current study experienced conflict in trying to facilitate service-users' rights, choice, and independence, whilst maintaining safeguarding duties within a system sometimes felt to have a risk averse, blaming culture. These findings perhaps shed light on research suggesting that role conflict is a predictor of burnout in direct care staff in residential settings (Kozak, Kersten, Schillmöller, & Nienhaus, 2013). Role ambiguity versus clarity has been associated with staff wellbeing outcomes (Hatton et al., 1999; Mascha, 2007), which may link to the present findings that participants experienced continual uncertainty about how to relate to service-users, captured in theme F: "A fine balancing act". Pockney (2006) found that whereas people with intellectual disabilities often considered support staff to be within their circle of close relationships, describing them as "friends", staff rarely reciprocated this sentiment. She suggested that confusion exists for both parties about how to approach the ill-defined relational boundary, with staff experiencing conflict in trying to redress the power imbalance whilst also treating all service-users equally. Such confusions and conflicts were apparent in the present study, with accounts highlighting the psychological demand of navigating these challenges, and the reliance on team support to manage this. Interestingly, in one quantitative study, staff identification with "servant" or "parent" roles was associated with experiencing lower personal accomplishment, whereas identification with an "advisor" role was associated with higher personal accomplishment (Outar & Rose, 2017). The current findings appear consistent with these results, as facilitating service-users' independence was clearly a priority for participants, and the reward from fulfilling this aspiration evident.

A distinctive feature of accounts in the current study, was the intensity of emotional highs and lows, with some noting that the rewarding aspects of relationships could not be gained without the inevitable demands resulting from the level of investment. Simultaneous experience of emotional reward and challenges have been reported for staff supporting people with intellectual disabilities in other contexts (Ineland, Molin, & Sauer, 2018; Judd et al., 2017; Leyin & Wakerly, 2007). Judd et al. (2017) explored experiences of staff providing supported employment services, with some striking similarities noted in language used by their participants and those of the current study; for example, the happiness experienced when one “put a smile on [the service-user’s] face”, feeling “proud” of one’s work, and awareness of potential consequences of getting things “wrong” in their safeguarding responsibilities. Judd et al. found that participants drew on colleague support as a coping strategy when experiencing imbalance between positive and negative aspects of the work, which was somewhat the case for the current study’s participants. However, it was also indicated that reaping rewards from building close working relationships in general, could in itself bring about an increased emotional burden, due to increased empathy with others’ experiences.

The current results complement those of Giesbers et al. (2019), who explored experiences of people with intellectual disabilities living with community-based support. Two of their themes captured the meaning of participants’ relationships with staff, within the context of their personal history, and within an organisational context, echoing understandings held by the current study’s participants, of contextual influences on the quality of relationships with service-users. Giesbers et al. highlighted how participants experienced staff to fulfil varied emotional needs, and described the importance of staff continuity for building the trust required, emphasising the psychological impact of high turnover and repeated care transitions. The impact of disability stigma, and being a recipient of paid support, on participant’s identity and self-worth was noted, alongside the frustration experienced when staff related with formality and did not fulfil participants’ need for close relationships. In the current study, participants appeared sensitive to these issues but faced significant conflicts in how to manage them. This has important practical implications, firstly for renewed focus on how service-users can be supported to develop fulfilling relationships in their wider social networks, and secondly for how staff can be supported to navigate these complexities and manage the psychological impact of executing “a fine balancing act”.

The findings regarding costs and gains which participants experienced in relationships, and the relative inequalities, may be understood in the context of the job-demands resources model, and equity theory, respectively. However, these theories alone do not account for all nuances of their experiences. Participants view of the relationship as the vehicle for meeting service-users' needs, their apparent attunement with service-users' feelings, and particularly their experiences of providing emotional containment, are features reminiscent of the psychological theory of attachment (Ainsworth & Bowlby, 1991; Main, Kaplan, & Cassidy, 1985). Furthermore, the importance of being able to share their own emotional experiences with other staff, and receive validation, indicates this theory's applicability to colleague relationships also. The relevance of attachment theory to understanding the mental health of people with intellectual disabilities, given the particular challenges they may face throughout their lives, has been thoroughly explored in clinical literature (e.g. Division of Clinical Psychology [DCP], 2017; Fletcher, Flood, & Hare, 2016). Examining care staff's role in providing secure attachment experiences for service-users, Schuengel, Clegg, de Schipper, and Kef (2016) highlighted the importance of attending to attachment processes of both, proposing that these principles should inform research and policy around staff-client relationships. The current results provide support for this argument in the context of supported living services, additionally highlighting the interplay between the experience of emotionally supporting service-users, and the support which staff themselves receive, from colleagues and the organisation. The need for regular clinical supervision, to help manage the emotional challenges of working with people presenting with attachment difficulties, is well established in psychological professions (DCP, 2017, pp.36-37; Seager, 2014, p.223). A similarly informed approach to supervising staff directly supporting people with intellectual disabilities may be indicated, given the experiences of meeting complex relational needs which participants of this study described. Seager (2014) suggested that to provide effective mental healthcare in general adult services, professionals need "a sense of secure attachment and belonging to their place of work". He explored how this organisational culture can be cultivated through formal and informal mechanisms; this may hold relevance for supported accommodation services for people with intellectual disabilities, given the current finding that participants experienced the quality of working relationships to be influenced by the organisational context. The results strengthen the case which Hutchison and Stenfert Kroese (2016) made for offering regular clinical supervision to support workers, additionally indicating specific areas which supervision might be used to address, such as improving understanding of how to meet service-users' emotional and relational needs, navigating conflicts and uncertainties encountered in the role, and managing associated psychological impacts.

The present findings suggest that participants viewed relational investment as central to fulfilling their job role, echoing results of Hermsen et al. (2014), who explored the views of staff working in intellectual disability services in the Netherlands. Several of the factors which their participants identified to facilitate "professional loving care", such as building trusting relationships with service-users, an open and respectful team atmosphere, shared aims, and organisational support, were important concepts for the current study's participants. In both studies, participants experienced bureaucratic administrative processes, such as excessive health and safety "paperwork", as a barrier to directly spending time with service-users, and consequently to cultivating supportive relationships. Whilst Hermsen et al. reported that some participants identified a gap between the care vision on paper and their daily practice, the current participants similarly observed that simply reading person-centred care plans was not sufficient for building the rapport and trust required to meet all service-users' needs. Hermsen et al. suggest that an increasing "commercialisation" of social care, driven by political and economic forces, threatens care quality; given the overlaps with the present findings, this concern may be of note to UK service providers, commissioners, and policy-makers. Building on the relevance of an attachment-informed perspective for supported living services, the current results have practical implications, for organisations to facilitate relationship-building amongst staff and service-users, to improve care quality. In addition to fostering a culture which invests in, and values relationships, organisations might consider increasing attention to interpersonal elements of support work, in job descriptions, training, and supervision. Furthermore, the present findings indicate links between relational aspects of the work and staff turnover; for example, with Marcus' suggestion that being unable to build rapport with service-users quickly could "put people off". Given participants' recognition that experience of people "coming and going" could make it difficult to gain service-users' trust, a vicious cycle can be envisaged, whereby staff turnover makes it harder to build relationships with service-users and reap associated rewards, which further increases the likelihood of staff leaving. Thus, it is important for organisations to acknowledge challenges that may be experienced on both sides, in developing the support relationship, and to consider ways to help manage these issues, so that high quality care is provided. Some participants also suggested that low pay, and feeling under-valued by the organisation, were demands which could outweigh the relational rewards which originally attracted staff to the role, resulting in higher turnover rates.

In interpreting the current study's results, it is important to consider its limitations, which also generates further research directions. Firstly, IPA is recognised to produce results which are a collaboration between participant and researcher (Smith et al., 2009, p.92), and whilst every attempt was made to increase methodological rigour through reflexivity, the researcher's own frame of reference inevitably shapes the interpretation. Secondly, owing to recruitment difficulties encountered as a result of the Covid-19 pandemic, the sample consisted of a small number of staff from only two organisations in the same geographical region. IPA takes an idiographic stance, seeking to capture the depth and nuance of individual experience, rather than trying to establish conclusions generalisable at a population level;

however, a slightly larger sample, from across more organisations, might have provided better insights into the support worker experience per se, rather than the experience of working for particular organisations. As data collection took place over a period of considerable change in national restrictions associated with the pandemic, there will have been significant differences in participants' salient experiences of opportunities for building and maintaining working relationships, evident in the varying extent to which the pandemic was mentioned. The researcher therefore chose not to emphasise the topic in this discussion, but the findings may serve to alert organisations to how service-user and staff wellbeing can more generally be influenced by social context.

All participants appeared to hold a strong view that the purpose of their role was to "enable" service-users, identifying behaviour from other staff which could hinder this, which suggests possible participation bias. As it was made clear that the research objective was to understand more about working relationships, it is likely that those who participated consider relational aspects to be an important part of their role, which may have influenced how they spoke about their experiences, and thus the emerging themes. Nonetheless, the significant overlaps with findings of other studies, which qualitatively explored the experience of supporting people with intellectual disabilities in various service contexts, indicates that the themes are worth consideration within the body of research which informs policy and practice for the direct care worker population.

Relationships are by nature an intersubjective experience, and the present findings highlighted participants' awareness of the network within which their different relationships existed, and the multi-directional influences. Further research on this topic could be enhanced with developments in IPA methodology, such as multi-perspectival designs (Larkin, Shaw, & Flowers, 2019), and the relational mapping interview technique (Boden, Larkin, & Iyer, 2019). This could fulfil the research agenda which Hastings (2010) called for: exploring relationships between staff and service-users from both perspectives, to gain a fuller understanding of each’s wellbeing. As Larkin et al. (2019) note, the voice of people with intellectual disabilities has often been absent in research on care interactions; therefore it is imperative this neglect does not continue. Another avenue for further research is to explore how relationships may be affected by service design. Fyson, Tarleton, and Ward (2007) reported considerable variation in how organisations interpret the recommended supported living model, which may impact on service-user outcomes. This issue was touched upon by some participants in the current study, linking to their experience of seeking the appropriate way to relate to service-users. Rose (2009) speculated that changes in the design of residential services for people with intellectual disabilities, as a result of social housing policy change in the UK, could present new challenges for direct care staff wellbeing, but this issue appears to have received little attention in subsequent research. Given various policy developments since, including the ever-evolving TC programme, further investigation into how physical and conceptual differences in service design may influence staff and service-user outcomes is warranted.

Conclusion

This study explored how staff who directly support people with intellectual disabilities in their daily living, experience their working relationships. The results give support to existing research on experiential aspects of the direct care worker role, helping to illuminate previous research findings regarding influences on wellbeing for this staff population. The current results additionally highlight the multi-influential nature of different relationships within supported living services, suggesting that developing supportive, trusting relationships with service-users and with colleagues are equally important for providing compassionate care. These findings indicate that placing greater emphasis on relational aspects of the work is worth consideration by service providers, and suggest avenues for further research, to develop understanding of the wellbeing of people with intellectual disabilities and the staff supporting them.

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Table 1

Demographic Overview of Participants

Participant (pseudonym)	Identified gender	Age	Time in current role (years)
Marcus	male	24	1
Elaine	female	55	1
Wendy	female	55	3
Declan	male	26	2
Ron	male	63	6
Nikki	female	46	3

Table 2

Explanation of Data Analysis Stages

Step	Summary of description from Smith et al. (2009, Chapter 5)	Explanation of how the guidance was implemented
1. Reading and re-reading	Immersing oneself in the original data through repeated reading.	Listening to audio-recording of the interview whilst reading the transcript. Noting down initial observations and reflections as they arose.
2. Initial noting	Detailed exploration of semantic content and language use throughout whole transcript.	Descriptive, linguistic, and conceptual exploratory comments made in margin alongside each line of transcript (see example in Appendix 2-A).
3. Developing emergent themes	Analysing meaning and patterns within exploratory notes to identify possible themes.	Reading through exploratory comments for entire transcript. Noting thematic interpretations alongside the transcript in opposite margin to exploratory comments (see example in Appendix 2-A).
4. Searching for connections across emergent themes	Mapping patterns and connections between emergent themes to arrive at a set of super-ordinate themes for the transcript.	Reading through emergent themes and reconfiguring these where a subsequent part of the transcript shed new light on the original interpretation. Schematic diagram drawn to depict links between, and grouping of, emergent themes. Re-coding entire transcript with final set of super-ordinate themes.
5. Moving to the next case	Repeating steps 1-4 independently with the next transcript, bracketing off ideas from previous analysis.	Using reflexive journal to note down any observations of where transcript content resonated with recollections from any previous data collection and analysis undertaken.
6. Looking for patterns across cases	Reconfiguring emergent themes and identifying higher-order concepts to arrive at a set of themes for the whole dataset.	Grouping themes from all participants into broader categories and identifying any overlapping concepts and new emergent themes (see interim stage of theme development in Appendix 2-B). Schematic diagram drawn to aid development of set of overall themes. Recoding all transcripts with new set of emergent themes and reconfiguring where necessary to arrive at final set of themes.

Table 3

Additional Quotes to Illustrate Each Theme

Theme	Supporting quotes
A: The essence of good relationships	*it's natural that some people you may gravitate towards more than others, and some people you'll have more in common er with than others […] there's always a level of common ground that I try and find with people that, I support which then, from there the the relationship can kind of grow* (Marcus, 137-142) *finding out things that the client likes and, you know d-doing things that you know interests them erm, one client wanted to change his flat around and decorate it and do all sorts so for weeks we spent, [laughs] I spent a lot of time studying the IKEA catalogue* (Elaine, 237-240) *you just have to go in and find out for yourself [...] I suppose I just ask questions [laughs], I ask questions and I, watch the reactions and it-. Just generally pick things up* (Wendy, 231-235) *the main one is just, spending time with I suppose and, as you would with, say a friend you know, if you first met someone you wouldn't be, you wouldn't kind of know what makes them tick and it would take, it would take time to build that relationship it's exactly the same* (Declan, 113-115) *obviously you get on better with some staff than you get on wi'other […] we'll go for a drink on a Friday or […] we'll have a curry night, we can have ten pin bowling nights stuff like that* (Ron, 741-744) *you can be doing this job for 25/30 years and there's still something new to l- to learn, and so I think that helps with relationships because when you come in they can see […] you accept people for who they are you're not looking down your nose* (Nikki, 730-734)
B: A trusting relationship as the vehicle for meeting service-users' needs	*it kind of comes back to the the friendship side of it […] now I know them better I feel a bit more confident to challenge them on things* (Marcus, 213-215)

Theme	Supporting quotes
B (continued)	*I think its continuity erm staff maintaining the same sort of boundaries errm, because then, these, clients know that they're in a safe environment they know what's gonna happen at certain time* (Elaine; 176-178) *because I know their ins and outs, and maybe because they know my ins and outs and the way I work erm, I feel that I get on really well wi'em* (Wendy, 118-120) *I-it's hard to know in the first instance but, over the last coupla years as I've built, a relationship with, some of the people I support erm. You kind of get, get a grasp of, you know what ma- what, what they need help on most.* (Declan, 97-99) *I'm there to help him, to have a. Best, as er life that c- he can, in the circumstances erm, to sho- to show him things a-and do things, that he's never done before, and to er, experience things* (Ron, 211-213) *you've got to keep at it, keep working with the relationships if somebody's take- being funny, being funny with you remember not to, take it personally […] just back off a bit and then go back, back off a bit and go back, and just show'em that you're there to help'em, you know not to hurt'em in any way.* (Nikki, 565-570)
C. Belonging to the support team	*it can be good to, be able to like I said offload with them but then there's also that, we we can have a laugh about certain things […] workplace jokes and so on that other people may not get because they don't work in that same same environment […] it can just be good to to know that it's not, me going crazy it [laughs], it happ- it happens to everyone! Err, and certain things that may, frustrate me, also frustrate other members of staff* (Marcus, 702-708) *if, a client is sat in the lounge and maybe just puts the telly on and it's them, whoever goes past or whoever's not on somebody's one to one will go in and er just sit down and start talking erm, so that's, quite good but I think all th- all the staff team tend to do that so so nobody sort of left on their own.* (Elaine, 529-533) *you've got inconsistencies with staff, it's like, we're supposed to be promoting her, to do what she can for herself not doing it all for her. Erm, which is what I try to do but then you've got another member of staff who will do everything […] yeah that's what I get irritated about* (Wendy, 390-397) *say if I had a problem with, the way someone did something […] I-I feel like I could go up to them and […] speak my mind, and you know, they would underst- y'know, we'd talk about it openly y'know we'd be very, kind of subjective about it erm, and that er to me it's just very important, […] being honest with each other* (Declan, 603-608)

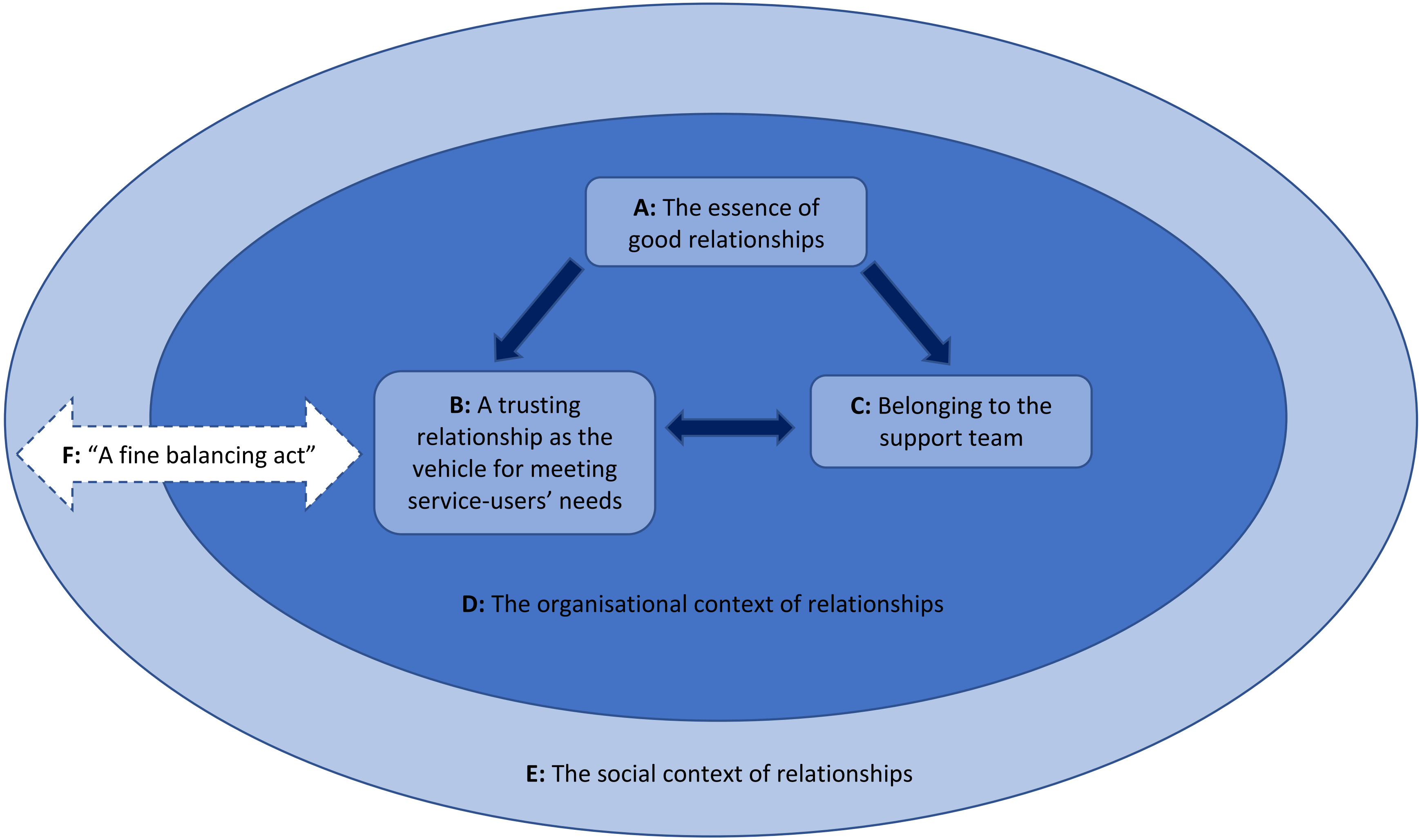
Theme	Supporting quotes
C (continued)	*our team bring different qualities to the table […] if I've got an idea what I'll say to y'know er, the other work colleague that I get on really well with […] he'll give me his point of view and that's how he's we'll work things out cos, y-y-you can just get, when you're thinking I've got I'm gonna do this, you might miss something* (Ron, 702-703; 769-773)
	we all look after each other we all have that little bit of banter with each other, you know we all, like I said pick each other up […] even if it's personal stuff you know sometimes when you come to work if you've got nobody else, to offload off. You offload it off your colleagues you know and that's what we've always said we can always talk to each other, we always support each other. (Nikki, 685-692)
D: The organisational context of relationships	*training days are a good thing to, see people although it's, in work it's outside of our usual area of work […] that can, allow for you to get get to know them a bit more personally and er, on a on a more, rather than just being a friend from work just being a friend erm and th-that can help, strengthen the team definitely.* (Marcus, 759-763)
	I-I've had support from my, project manager at the service but from up above, not really it's erm. Different contract hours l-lots of little things that shouldn't have happened that have happened erm. And no support (Elaine, 370-373)
	the company I work for are pretty good […] the senior managers, most of them are really good you can talk to them […] not saying that you always get somewhere but […] they'll make time to listen to you (Wendy, 838-843)
	both my team leaders, […] y'know really really good, I-I never feel like in a position where, you know I couldn't approach them with anything, erm, because I-I, I just feel comfortable around them they've always made me feel welcome […] y'know even when I was, fresh meat in the company (Declan, 461-465)
	let's just say they all come in and they all wanna do it different just when we've got a nice, way of doing stuff and, if you don't do it his way then it's my way or the highway, and that just don't work, because at the end of the day I know, my chap now better than anybody (Ron, 577-580)
	we've got a good boss here […] he always says "Right come in, come into the office, have a scream if you need to y'know just all, let it out, and then go back out there with a smile on your face!" and I think that is a fantastic philo-philosophy it really is I think a lot of other managers should do that especially within this environment. (Nikki, 445-450)

Theme	Supporting quotes
E: The social context of relationships	*I remember the first time it happened I I just wanted the ground to swallow me up because I felt like everyone was staring and, sort of judging how I was working in that situation and obviously […] nobody knew that I was there as as a support worker as a carer* (Marcus, 265-269) *we have to say to her, that, the activities are not there at the moment […] we try and explain in words that she'll understand why they've been stopped. But then, you could go in another day, and, she's, maybe got mixed messages and, she wants to d-, it's hard really in those situations er because she would go she would get on the bus on her own and go to places but now I've found that she's regressed a little bit* (Elaine, 602-608) *no-one's been able to meet up so yeah it's been, quite isolating f-for, not just, the clients but for us as well […] Y-you have to keep telling them why they can't do this and why they ca- cos some of them do get frustrated […] we get it took out on us I suppose so that's affected, affected things* (Wendy, 656-657; 677-682) *there's a lot of, people that I've been unable to see there's a lot of people that might, the service-users, you know friends and, what have you that they they haven't been able to see either* (Declan, 702-704) *ever since he's born he's been kept in a bubble […] h-he's never had a drink in his life, not one […] he's never, had a lady friend erm. But he doesn't know any different so it doesn't bother him, er he wonders yes he wonders, erm y'know and erm and, i-it's hard sometimes to, explain certain things* (Ron, 81-85) *you know with having disabilities, you know the way they get treated, off parents and stuff from a, young age can sometimes disable them […] an-and that then, can be really really difficult* (Nikki, 459-463)

Theme	Supporting quotes
F: “A fine balancing act”	*I am conscious sometimes that, it I don’t wanna overload them with choice by reading out the complete menu to them but then I don’t wanna restrict it by, not reading enough out, so it’s finding that fine line* (Marcus, 370-373) *sometimes you maybe you're in the communal lounge talking to one client and we have another client who keeps butting in and, and she knows that she shouldn't and then, er things get a bit harder* (Elaine, 249-252) *I suppose there is a bit of friendship that’s in there because you see’em so much and, you work wi’em so much I suppose you do become a bit, protective of’em […] you try and help them whatever situation it is, but I- but on the flip side like I say, you can't be too, erm friendly you still got to, er I still put’em into place kind of thing* (Wendy, 151-155) *being able to, you know have a laugh like when y- when you're out supporting someone and it, it almost doesn't feel like you're supporting someone y-you, that's one thing you gotta remember though that you are but, it gets to a point where, y’know it doesn't feel like “Oh I'm supporting you to do XYZ”, i-it ends up being like “Oh we’re just going out to do XYZ” […] almost like you got a, it is it is like a friendship, i-i-in that respect. But any- li-like I say you gotta be careful, drawing the line* (Declan, 236-242) *it's sometimes very tiring when, […] you've got stuff going on in your head and somebody’s competing with it you’re tryna do the books, er cos there is a lot a lot of paperwork that's another thing that, er and somebody’s chuddering on at you* (Ron, 444-447) *I-it’s a very fine balancing act, it really really is a fine balancing act because like I said with some a-a lot of it is lack of understanding, you can say something and they take it wrong, and then that's it then, they won’t speak to you, they won't help you, and it can leave you so frustrated.* (Nikki, 470-474)

Figure 1

Schematic Representation of Themes



Appendix 2-A

Example of Initial Coding

Exploratory comments *Key:* descriptive; linguistic; conceptual	Transcript (excerpt from Declan)	Emergent themes
Battle = struggle, fight Reservation of SU can be an obstacle in building relationship Reserved = holding back Shell = protective, armour 'Come out of his shell' suggests not hiding, outside comfort zone Relationship-building process needs active involvement from both sides but quality is about how comfortable SU feels Obstacle = something to be removed SUs vary in how long it takes to feel comfortable with SW – may depend on age Respond = acknowledge Looking for recognition of attempts to connect, wants to build ease and familiarity of relating Acceptance of external 'factor' of age Empathising with SU's experience SU used to seeing carers come and go so may not feel it is worth building relationship Come and go = bypassing, transience All 'people' coming/going, not just 'carers' Bothering = taking trouble, investment Can depend on SU's personality – what exactly 'depends'? Time taken to build relationship? Effort needed? Everyone is different Adapting to individual styles of relating	P: Erm. I'd say you know half the battle is definitely comes from them, you know erm for example, one gentleman in particular is quite quiet quite reserved, erm and it can be quite hard to kind of he- I'd say recently he's definitely come out of his shell with me but, for at least the first year h-he, he would barely say a word to me and, I couldn't tell you why that is he's just, quite quite a reserved fella so, that can be kind of er an obstacle but, again it's, some people will respond quicker than others you know so, it might take a certain gentleman, a lot longer to feel more comfortable, with, me for example than as opposed to, I think age might play a factor y'know maybe like, this particular gentleman is-is a bit older erm, maybe it's because he's throughout his life, he's used to carers coming and going, and i-it might for that reason it might take him a bit more time because he's, he's used to seeing people come and go, so he might not fee- he might feel that it's not even worth bothering cos they'll be gone in a year you know what I mean it, it might be that erm. It may, it depends on their, obviously personality traits erm. R: Yeah. P: I think like everybody's different aren't they so, mmm.	Building relationship is a two-way process Needs perseverance Giving each SU time they need to feel comfortable Needs perseverance Giving each SU time they need to feel comfortable Accepting factors affecting the relationship which can't be altered SU may hold back from relationship due to past experience of loss Accepting factors affecting relationship which can't be altered Adapting to each individuals' needs

Exploratory comments *Key:* descriptive; linguistic; conceptual	Transcript (excerpt from Declan)	Emergent themes
	R: Mmm. Erm and how do you manage it when those challenges, come up then?	
Giving SUs time to get used to him Repeated image of coming out of shell; Push = a force Has awareness of SU’s relational needs Physical sense of separation if ‘distant’ Wanting closeness, connection ‘time’ is external ‘factor’ (like ‘age’), not within either’s control, acceptance of this ‘come round’ implies changing mind, deliberate, being persuaded Need to be patient in allowing SUs to approach you Speaking in third person but reminding self? Uncontrolled, freeing process to ‘let it roll’ Consistently showing his availability to SU SU also feels need to maintain a boundary? Would take him a long time to start trusting a stranger Empathising with SU’s experience – to help accept difficulties, not blame self ‘Trust’ is vital component of relationship, needed to receive care that is being offered Carer goes from being like a stranger to being like a family member It goes = passive, automatic Extremes of levels of intimacy but a gradual process of change; extent to which this is outside either’s control and can’t be rushed?	P: I’d say. Again just, give them time to come out of their shell y’know tryna tryna push a certain relationship could definitely put people off, especially if they’re not, socially inclined, you know some people who can be a lot more reserved and, erm, kind of distant but, like anyone with wi-with with the with the right amount of time, th-the-they'll come round y’know that then that, is but, looking at it from my perspective you've gotta have that patience to give them the time to do that whereas some people might, be like “Oh he doesn't like me what have I done?” and it’s like “Nothing” you know you just gotta, you just gotta let it, let it go let it roll and just see, y’know down the line they might be, more willing to kind of involve you in their personal life, you know I mean I-I, i-if I was in kind of in that position it would probably take me quite a long amount of time to start trusting carers that I don't know because again again they’re strangers, to start with and you know, it goes from being kind of strangers and it, it's almost like, having an extended family, because they’re then, a lot of these people they’ll see their carers a *lot* more than their own real family, so it, that that-that's kind of the way I see it.	Giving each SU time they need to feel comfortable Accepting factors affecting relationships which can’t be altered Giving each SU time they need to feel comfortable Showing consistent patience and availability Acceptance Letting SU take the lead Trust as the key ingredient Process of transition from stranger to family

Appendix 2-B

Interim Stage of Theme Development Across Participants

Reconfigured emergent themes from stages 1-4 of analysis	Participants	Overarching concept identified
Assistance with activities of daily living	All	Tasks involved in the support work role – meeting service-users' needs
Safeguarding/duty of care	All	
Facilitating access to/interaction with external world	Marcus, Wendy, Ron	
Providing emotional support or containment	Marcus, Elaine, Wendy, Ron	
Supporting to step outside comfort zone	Declan, Ron, Nikki	
Providing routine and predictability	Marcus, Elaine, Ron, Nikki	
Supporting to build positive relationships	Elaine, Declan, Nikki, Ron	
Supporting to understand complex information and make informed decisions	Marcus, Wendy, Declan, Nikki	
Providing meaningful activity and purpose	Elaine, Declan, Ron	
Supporting to develop new skills	Elaine, Declan, Ron, Nikki	
Providing opportunities for typical life experiences	Declan, Ron, Nikki	
Supporting to assert own preferences	Marcus, Wendy, Ron, Nikki	
Facilitating independence	All	Fluid nature of how the support worker relates to the service-user
Friendly vs parental/supervisory	Marcus, Elaine, Wendy, Nikki	
Maintaining professional boundary	All	
Influenced by individual service-user's capability	Marcus, Elaine, Declan	
Instinct gained with time and experience	Marcus, Wendy, Declan, Ron	
Understanding of what behaviour communicates	Elaine, Ron, Nikki	
Adapting to differences in individual needs and personalities	Elaine, Wendy, Declan, Nikki	
Time taken to build trust	All	
Giving praise and encouragement	Marcus, Declan, Ron, Nikki	
Impact of tensions or conflicts in different relationships on each other	Marcus, Elaine, Ron, Nikki	Challenges encountered in relationships
Calls of judgement needed e.g. friendly vs. parental, ethical dilemmas	All	
Being on receiving end of service-users' frustration	Marcus, Elaine, Wendy, Nikki	
Implementing behavioural boundaries	Marcus, Elaine, Wendy, Declan	
Managing multiple demands of service-users and organisation	All	

Reconfigured emergent themes from stages 1-4 of analysis	Participants	Overarching concept identified
Psychological demand of giving emotional support	Elaine, Wendy, Nikki, Ron	Challenges encountered in relationships (cont.)
Impact of Covid restrictions on wellbeing and relationships	Marcus, Elaine, Wendy	
Hypervigilance to service-users’ vulnerability and consequences of mistakes	Wendy, Declan, Ron	
Over-protective attitude of family and society	Wendy, Nikki, Ron	
How the job role is perceived by others	Marcus, Wendy, Ron	
Learning and personal development	Marcus, Wendy, Ron, Nikki	Rewards which help to manage the challenges
Friendship and shared enjoyment	All	
Feeling appreciated and cared for	All	
Sense of self-esteem and pride from helping others	Wendy, Declan, Ron, Nikki	
Gaining service-users’ trust	All	
Shared activity and humour	All	Ways of building relationships
Time and space to get to know each other	Marcus, Elaine, Nikki	
Actively seeking to learn about the other	All	
Trying to understand others’ perspectives	Marcus, Declan, Ron, Nikki	
Acknowledging natural variation in level of connection	Marcus, Elaine, Ron	
Showing approachability and listening	All	
Treating others with respect and fairness	Declan, Ron, Nikki	
Frustration about differences in work ethic/approach	Elaine, Wendy, Ron	Working with the team
Inconsistent practice causing problems with service-users	All	
Importance of good communication	All	
Teamwork needed to provide the best support	All	
Showing willing and sharing the workload	Elaine, Wendy, Declan, Nikki	
Needing support from management	All	Organisational issues
Policies may help or hinder	Marcus, Elaine, Ron, Nikki	
Feeling undermined by managerial decisions or risk averse culture	Wendy, Ron, Nikki	
Bureaucratic paperwork limits time with service-users	Wendy, Ron	
Responsibility and commitment unrecognised	Wendy, Elaine, Ron, Nikki	
Organisational politics	Elaine, Wendy, Ron, Nikki	

SECTION THREE: CRITICAL APPRAISAL

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This critical appraisal will provide an overview of the findings from the literature review and research project, then consider links between them. I will discuss directions for future research, and some implications for practice, which arise from an overall consideration of these findings. A discussion of personal reflections on various aspects of the research process will follow, in which I will consider strengths and limitations of the project, with suggestions for alternative approaches that could have been taken.

The Research Findings

With the ever-intensifying drive to identify how the delivery of compassionate, person-centred care can be facilitated in health and social care services, Emotional Intelligence (EI) has become a popular intervention target, including in services for people with intellectual disabilities (e.g. Zijlmans, Embregts, Gerits, Bosman, & Derksen, 2015). Given the cautions raised against incorporating the concept into professional development agendas without sufficient research evidence (Birks & Watt, 2007; Cherry, Fletcher, O'Sullivan, & Dornan, 2014), an examination of the literature which explores EI in staff supporting people with intellectual disabilities was warranted. A systematic review of 15 studies, which have measured EI in this staff population, revealed that research in this area has been somewhat lacking in rigour and cohesion. Although there are indications that EI may be related to aspects of work-related stress and wellbeing, a great deal more research, which addresses the methodological issues highlighted, is needed before meaningful conclusions can be drawn about the utility of EI as a focus for improving service delivery to people with intellectual disabilities. Of particular note is the dearth of investigation into whether staff EI has any influence on service-user outcomes. It has been argued that research needs to explore how staff perceive their relationships with the people they support, in order to better understand how staff wellbeing may relate to outcomes for service-users (Hastings, 2010). Given evidence to suggest that aspects of various workplace relationships can influence staff wellbeing, in different service contexts (e.g. Disley, Hatton, & Dagnan, 2012; Hutchison & Stenfert Kroese, 2016; Thomas & Rose, 2010), a research project was conducted to explore how direct care staff, specifically in supported living services for people with intellectual disabilities, experience their working relationships with service-users and colleagues. From an interpretative phenomenological analysis (IPA) of semi-structured interviews with six participants, several interconnected themes emerged: (A) The essence of good relationships; (B) A trusting relationship as the vehicle for meeting service-users' needs; (C) Belonging to the support team; (D) The organisational context of relationships; (E) The social context of relationships; (F) "A fine balancing act". The findings build on existing understandings of staff wellbeing, by highlighting the multi-influential nature of different working relationships, as well as indicating that developing supportive, trusting relationships with both service-users and colleagues can play an important role in effective care provision.

The methodological limitations notwithstanding, results of some studies included in the systematic review suggest that higher EI may be associated with lower levels of stress and burnout, alongside increased satisfaction, for direct care staff in residential services for people with intellectual disabilities (Karriem, 2010; Keesler, 2016; Shead, Scott, & Rose, 2016; Tolson, 2015). With the finding of the research paper, that intense emotional highs and lows were involved in participants' experience of their working relationships, one might begin developing hypotheses about the mechanisms underlying the findings of the EI research. Despite varying conceptual and theoretical understandings of EI, a common theme across models, is the capacity to recognise and regulate emotions in oneself and others (Rastogi, Kewalramani, & Agrawal, 2015). The demand of managing constant emotional fluctuations might be expected to increase likelihood of experiencing the emotional exhaustion proposed to be a feature of burnout (Maslach & Jackson, 1984), and it is conceivable that those who are better able to regulate these fluctuations would be less prone to burnout. Furthermore, participants appeared attuned to the emotional experience of both colleagues and service-users, and their accounts highlighted the psychological impact of providing emotional support, particularly to the latter. Again, one might postulate that those with greater capacity to manage emotions in others, would be less vulnerable to the stress associated with offering emotional support. EI has been found to predict burnout in forensic mental health nurses (de Looff, Didden, Embregts, & Nijman, 2019), and to moderate the influence of negative emotions on burnout in general nursing staff (Szczygiel & Mikolajczak, 2018). Future research could investigate whether these relationships exist for the staff population on which the research paper focused and explore the potential mediating role of the emotional regulation aspects of EI. Evidence to support these hypotheses would have important clinical implications, as interventions aimed at enhancing emotional regulation skills could be used to promote staff wellbeing, as has been indicated for other populations of caring professionals (Buruck, Dörfel, Kugler, & Brom, 2016; Jackson-Koku & Grime, 2019; Jiménez-Picón et al., 2021). There is a small amount of evidence for the effectiveness of mindfulness-based interventions to reduce distress of staff in services for people with intellectual disabilities (Ó Donnchadha, 2018) but is unclear that this outcome was a result of changes in the tolerance of difficult emotions, which is the focus of this intervention type. Thus, future research, on interventions which target staff wellbeing, should attend to investigating mediating variables, as well as end-point outcomes, before substantive claims can be made about their effectiveness.

The findings of the research paper also highlighted the important role that team and managerial support play in helping staff to manage the emotional demands of the job, suggesting that individual emotional regulation capabilities are unlikely to be the whole story. Support to manage the emotional impact of the work, in order to practice effectively, is proposed as a key function of clinical supervision across different supervisory models in the helping professions (Hawkins & Shohet, 2012, Chapter 6; Scaife & Walsh, 2003, Chapter 3). However, surveying 20 research reviews on clinical supervision, covering various care professions, Watkins Jr (2020) found results, on supervision impact and effectiveness, to be somewhat equivocal, highlighting a lack of research on evidence-based models and practice. Whilst two of the participants of this research project did make a reference to formal "supervision", it seemed that it was more often the sense of having a generally supportive relationship with supervising staff which was experienced as a resource for coping with emotional demands. In the research on direct care staff in intellectual disability services, there are findings to suggest that managerial support can influence staff wellbeing (Alexander & Hegarty, 2000; Deveau & McGill, 2014, 2016, 2019; Ito, Kurita, & Shiiya, 1999; Leyin & Wakerly, 2007) but there has been little investigation into specific processes underlying these relationships, with studies tending not to differentiate between practical and emotional support. Thus it would be useful for future research to probe the mechanisms by which different aspects of formal and informal support might help staff to manage the emotional demands of their work. Research by Deveau and McGill (2014, 2016, 2019) into "Practice Leadership" – a particular management style which aims to enhance staff practice through modelling and regular supervision (Beadle-Brown et al., 2014) – suggests that it is associated with improved staff wellbeing. Interestingly, managers using this approach were rated as demonstrating a more "developmental" than emotionally "supportive" style of leadership (Deveau & McGill, 2014). Alongside the findings of the current project, it appears that supervisory relationships which facilitate skill development, as well as providing emotional support, contribute to staff wellbeing. Again, further research which examines the effect of specific techniques would be useful in order to translate these findings into practice. It would also be interesting to investigate if these processes can influence direct care staff EI, and indeed whether manager EI plays any role in their wellbeing. As highlighted by the literature review however, future research on staff EI needs to rectify the lack of attention to service-user outcomes before it can meaningfully inform service development.

The research paper findings indicated the role that the organisational context may play in facilitating the quality of working relationships within supported living services, in order to provide effective care. This builds on the critical perspective which I offered in the discussion section of the literature review: that research on individual staff EI can only go so far in contributing to an understanding of the caring relationship, and the associated quality of care provision. Despite enthusiasm about EI's potential for enhancing health and social care delivery (Hurley & Linsley, 2012), and a proliferation of research into EI as a target for professional development and improving care outcomes (Arora et al., 2010; Dugué, Sirost, & Dosseville, 2021; Mintz & Stoller, 2014; Nightingale, Spiby, Sheen, & Slade, 2018; Powell, Mabry, & Mixer, 2015; Toriello et al., 2021), conclusive evidence to justify this focus appears to have been somewhat elusive. A number of commentators have offered a critique of the increasing drives towards individualism and neo-liberalism which have emerged in UK health and social care culture in the last two decades (Campling, 2015; Crawford, Brown, Kvangarsnes, & Gilbert, 2014; Kerasidou, Bærøe, Berger, & Caruso Brown, 2021; Mercer & Flynn, 2017), suggesting that associated attempts to improve care quality and address historic failings (e.g. Francis, 2013) are paradoxically hindering the delivery of truly compassionate care. One might view the ongoing quest for evidence to support the utility of EI as a tool for service improvement, as yet another manifestation of these trends. Crawford et al. (2014) point out that policy makers have tended to emphasise individual responsibility for compassionate practice, at the expense of considering the systemic factors which influence staff's capacity to show compassion. They suggest that focus should turn to promoting organisational design and culture which demonstrate compassion towards both staff and service-users. For some participants of the research project, feeling undervalued by the organisation, and a lack of recognition of their commitment to promoting service-users' quality of life, could in itself be a source of stress. This indicates that interventions aiming to enhance staff wellbeing through targeting individual coping strategies will be of limited use without addressing contextual influences on wellbeing, such as ensuring direct care staff feel supported and listened to by senior managers. Participants also identified that they could only provide the best possible support to service-users through working effectively within their team, recognising the value of opportunities to bond and develop mutually supportive relationships with team members. Again, this highlights the need for organisations to attend to systemic factors which enable effective teamwork, in order to deliver high quality care for service-users.

Reflections on the Research Process

Selecting a Topic and Methodology

My interest in the research project topic initially arose from my previous experience of being a support worker in residential services for adults with intellectual disabilities, prior to Clinical Psychology training. During this time, I experienced first-hand how the issues with staff retention in the care sector, outlined in the research paper introduction, impacted on the wellbeing of both service-users and staff, as well as on implementation of the Transforming Care programme (Department of Health, 2012). The foreword to the report which instigated this policy agenda, set out the underlying ethos of "promoting […] compassionate care across the system" and recognising that people with intellectual disabilities "have exactly the same rights as anyone else to the best possible care and support". However, the minimal training and qualifications required to take on employment as a support worker seemed to implicitly position this role as a 'low-skilled' job, which I felt was in conflict with the aforementioned ethos. Furthermore, the report stated "we should remember that not everything will be solved through action driven from the centre. Stories of poor care are a betrayal of the thousands of care workers doing extraordinary things to support and improve people's lives"; yet these proclamations appeared to have become lost in the myriad of subsequent policy and legislation which sought to deliver the original aims. Thus, it felt essential to give a voice to the experiences of these "workers", to better understand how the "best possible care" could be facilitated. On exploring the literature, I found that there was in fact already much research on the direct care worker population, particularly regarding their wellbeing (as reviewed by Ryan, Bergin, & Wells, 2021), but relatively little probing the nature of staff's working relationships. To 'support', by definition, is done in relation to another, and so investigation of this topic appeared crucial to furthering the research that informs policy on care provision for people with intellectual disabilities. Beach and Inui (2006) argue for the centrality of interpersonal relationships to the purposes and tasks involved in [health]care, highlighting that relationships with service-users occur alongside those with other staff. Taking the perspective that these principles could reasonably be applied to a social care setting, alongside the rationale outlined in the research paper, I thus arrived at my research topic. Evidently my relationship with the topic was value-laden and so I was aware of the need for attentiveness to how this might influence my decisions throughout the research process. However, I believe that my personal connection with it was a strength of the project, enabling "sensitivity to context", and "commitment and rigour"; two of the four principles which Yardley (2000) proposes for demonstrating quality and validity in qualitative research.

Wyer, Alves Silva, Post, and Quinlan (2014) suggest that moving away from the traditional positivist approach and recognising the complex experiential domain of interpersonal relationships is needed for research to effectively inform healthcare policy, which indicated the relevance of using a phenomenological methodology. Whilst descriptive phenomenology is concerned with illuminating the essence of an experience in general terms, interpretive phenomenology is underpinned by the epistemological position that experience is intrinsically contextualised in meaningful interaction with the world (Larkin, Watts, & Clifton, 2006), which appeared more fitting for the intersubjective nature of my topic. Inherent to an interpretive approach, is recognition of the researcher's own situated position as a meaning-maker (Davidsen, 2013), which was important for maintaining credibility, given my strong personal involvement with the topic; therefore IPA presented as an appropriate methodology. An alternative phenomenological approach which I could have taken is critical narrative analysis, which moves beyond a hermeneutics of empathy, to one of suspicion, in which the interpretation is critically informed by social theory (Langdridge, 2008). I chose not to use this method as I preferred to keep the participants' voices central, but future research in this field might use it to explore how care provision is influenced by socio-political narratives. As a novice to conducting qualitative research, I opted for the traditional data collection method of one-to-one semi-structured interviews but, as noted in the research paper, this approach limited insight into the intersubjective nature of relationships. With more experience, I would be keen to explore using visual and multi-perspectival data collection techniques, which have been proposed to facilitate capturing the complexity and depth of relational experiences (Boden, Larkin, & Iyer, 2019; Larkin, Shaw, & Flowers, 2019).

Reflexivity

Whilst its epistemological and analytical flexibility is considered by some to be a strength of IPA (e.g. Dennison, 2019; Larkin et al., 2006), these features have also attracted criticism of the method's rigour and credibility (e.g. Giorgi, 2010; Sousa, 2008). Reflexivity – the examination of the researcher's role in shaping the research process – is a well-established practice for maintaining validity in qualitative research (Berger, 2015; Finlay, 2002b), and proposed as a tool for increasing transparency of the interpretative process in

IPA (Shaw, 2010). Therefore, I aimed to incorporate reflexivity throughout, using a journal systematically at each stage to “bracket” presuppositions (Tufford & Newman, 2010), as well as recording reactions evoked during data collection and analysis on a more spontaneous basis (see excerpts from my journal in Appendix 3-A). Finlay (2002a) outlines several “modes” of reflexivity, suggesting that researchers choose how they employ these to differing degrees, depending on research aims and theoretical orientation. Engaging in these considerations in more depth from the outset, might have facilitated better insight into how my responses to the data were influencing its interpretation. On the other hand, as a trainee clinical psychologist, I was able to transfer skills developed in clinical practice, to aid reflexivity in other ways. For instance, Finlay (n.d.) describes characteristics of phenomenological attitude and enquiry, such as non-judgemental and genuine curiosity, which can be commonly applied to the therapeutic and research processes. I was able to draw on my experience of taking this stance in clinical work, to facilitate interview participants to reflect in depth on the meaning attached to their experiences, which IPA is particularly concerned with (Smith, 2019). As Declan attested during the interview: “I’ve never thought about it like this before to be honest, it’s quite good!” (line 213-214).

Berger (2015) discusses how familiarity with participants’ experiences can promote engagement and sensitivity towards them, but also increases the risk of overlooking important experiential details. I similarly found that my previous experience of support work gave me a perspective on the research which had both strengths and limitations. Aware of the pressures and unpredictability typically faced by direct care staff in their work shifts, I was able to facilitate engagement with those who expressed interest, through my understanding of their situation, and the need to be flexible around this. I was also mindful of the power dynamic which my position as a clinician might engender, and therefore chose to explain to participants that my interest in conducting the research had arisen from having previously been a support worker, which I think facilitated rapport and allowed them to be more open about their experiences. Noting Berger’s caution, that assumed similarities in shared experience may prevent them being made explicit, I was careful to explore personal understandings of the language and concepts participants used, such as asking what being “person-centred” meant for them. Feeling that some of my enquiries had been a little clumsy in the first interview, I reviewed the transcript with my supervisors, to consider how I might conduct subsequent interviews ensuring that participants did not feel interrogated, which might have hindered in-depth exploration of their experiences.

There were frequent occasions where participants’ experiences resonated with my own, such as the internal conflicts encountered, in trying to maintain an appropriate “boundary” with service-users or facilitate their independence whilst also exercising duty of care. I tried to note down when these memories arose, after each interview and throughout data analysis, using supervision to discuss where I might inadvertently be privileging my own experiences, and to check that my interpretations were grounded in the data. However, a potential limitation of the current project’s findings, is that I was not able to integrate reflexive appraisal into the data analysis as effectively as a more experienced researcher might have done. Goldspink and Engward (2019) offer a framework for incorporating reflexive journaling into the stages of analysis outlined by Smith, Flowers, and Larkin (2009, Chapter 5), to gain insight into “echoes” of personal experience, and use these to guide the transition from describing, to interpreting, the data. This is an approach that I would aim to take in future, to achieve greater “transparency and coherence”; another of the quality assurance principles proposed by Yardley (2000). I also found that “echoes” from other transcripts occurred throughout the stage of developing emergent themes for each new transcript independently. Again, journaling was a helpful way of bracketing these in order to focus on understanding each individual account, but at the stage of developing a set of themes across the transcripts, I found it trickier to negotiate overlaps in language used by different participants. This was particularly apparent when deciding how to interpret variations on the phrases “fine line” or “fine balance”, which all participants used in some form when speaking about relationships with service-users, but sometimes in quite different contexts. My perception was, that there was a common theme, of experiencing significant mental demand in trying to manage conflicting interests, but I was unsure that I would have drawn the same meaning had I had been analysing a single account in isolation. Considering this issue with supervisors, we agreed that there was indeed a shared experience of the psychological impact of navigating “tight margins” (supervisor’s words) in order to fulfil the job role. Reflecting on this further, I realised that the nature of disclosing one’s experience to another, is that it will always be interpreted in the context of all that has gone before; thus there is always the potential for new meanings to be uncovered, which were not originally accessible to the discloser. As Larkin et al. (2006) suggest, when conducting IPA one may “draw from a wide range of analytic strategies […] informed by prior experience and knowledge, psychological theory, or previous research”, providing the interpretation can be related back to the original account.

The Context of the Covid-19 Pandemic

As might be expected, the pandemic had a significant impact on the overall research process. Practically, I was not able to carry out the recruitment strategy originally planned, to maximise engagement with potential participants by advertising the project at services in person. I think this contributed to considerable difficulties with recruitment, in addition to high staff absence levels limiting the capacity of organisations to respond to my communications, and of staff to offer their time. As a result, the participants came from two organisations which my field supervisor already had links with and could distribute information through multiple channels. Whilst IPA does not seek to generate results which are widely generalisable, I think that had I obtained a slightly more diverse sample, it would have added weight to the proposal that the findings are worth consideration by supported living services generally, and not just these two organisations. Time constraints prevented me from arranging to advertise via social media but with hindsight, planning this from the start would have increased the potential range of organisations involved, perhaps enabling better exploration of how convergence versus divergence of experience functioned according to individual context, which Nizza, Farr, and Smith (2021) propose as an element of good quality IPA. Slow recruitment also meant that the data collection occurred over a 6-month period, coinciding with the transition from full national lockdown to the ending of all legal restrictions; thus the topic of the pandemic featured far less in later interviews. In one respect, this might be considered a strength of the findings, in that the restrictions brought attention to more general elements of the organisational and social context which influenced relationships (such as how staff training days provided opportunities to bond with colleagues without the pressures of the usual working environment), but did not define the context of the dataset, which might have limited its applicability to future timepoints. However, it would have been useful to consider adapting my interview topic guide over time, to facilitate participants' reflection in equal depth on their experience of relationships throughout the pandemic. This could have enabled the findings to contribute to research seeking to understand longer-term impacts of the pandemic on both service-users and staff (e.g. Doody & Keenan, 2021; Fisher, Sung, Kammes, Okyere, & Park, 2022; Sheerin et al., 2022), of which initial results suggest this is a vital area for future research and policy to address.

Conclusion

On reflection, I think my research has provided important new insights into how support workers' experience of their working relationships may relate to their wellbeing, and their capacity to deliver compassionate care, thus fulfilling the original aims. The findings also offer an alternative perspective on dominant lines of enquiry into interpersonal factors involved in care provision, such as EI, and open up further avenues for research which can contribute to a more holistic understanding of the wellbeing of people with intellectual disabilities, and the staff supporting them. As both the literature review and research paper highlighted, giving greater voice to the lived experiences of people with intellectual disabilities will be a key endeavour for developing future research which can meaningfully inform policy and practice in care provision.

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Appendix 3-A

Extracts From Reflexive Journal

Pre-data collection reflections on my own support work experiences:

… I found it was physically and emotionally demanding work, with little headspace for reflective practice or opportunity to get to know other staff on a personal level. I worked in one service where there were a lot of tensions between support staff and managers, and very much an 'us and them' atmosphere which felt very discouraging, whereas in another service, relations were much better because managers were far more actively involved in shifts…

Reflections following an interview:

... I noticed that my reaction to her talking about paperwork changed as the interview went on, as initially I was aware of my desire to explain to her why recording detailed information about service-users can be really useful, to understand their behaviour, but then as she gave more examples I really started to feel and understand her frustration about the excessive 'tick-box' nature of paperwork and how it can get in the way of spending time with service-users…

Reflections during analysis:

... it's very interesting how she initially responded to the question about challenges in relationships with service-users by telling me that there were none, but later went on to talk about a few situations where she had found it difficult to cope with service-users' display of emotions. I wonder what this might suggest about the acceptability of acknowledging it can be a tough job…

... I can really feel the extent of her anger and helplessness in this passage. There's almost a sense of moral injury in how she's being "forced" to support service-users in a way she doesn't want to because it's not in line with her values. It seems telling of the love she wants to show to service-users but I'm a little hesitant about including this quote in the final paper because of how service providers might perceive it to reflect negatively on them…

SECTION FOUR: ETHICS PROPOSAL

Rachel D’Sa

Lancaster University

Doctorate in Clinical Psychology

2018 Intake

All correspondence should be sent to:

Rachel D’Sa

Doctorate in Clinical Psychology

B31 Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

r.dsa@lancaster.ac.uk

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: Exploring how staff experience their working relationships in services for adults with a learning disability.

Name of applicant/researcher: Rachel D'Sa

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:

E-mail: r.dsa@lancaster.ac.uk **Telephone**: [redacted]

Address: Doctorate in Clinical Psychology, Health Innovation One, Sir John Fisher Drive, Lancaster University, LA1 4AT

Names and appointments of all members of the research team (including degree where applicable):
n/a

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website)

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant:

Dr Ian Fletcher (academic supervisor)

Dr Stephen Field (field supervisor)

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Ian Fletcher – Senior Lecturer, Division of Health Research, Lancaster University

Dr Stephen Field – Locality Consultant Clinical Psychologist [redacted]

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

n/a

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

A recommendation has been made, by the National Institute for Health and Care Excellence, for research into enabling staff resilience in Learning Disability (LD) services. Although there is much existing research on stress in direct-care staff, there is little account of the lived experience of such work. This project aims to further awareness of the relational aspects of support work, and to begin providing insights into how relationships might influence staff wellbeing.

12-15 support workers will be recruited from supported living services for adults with an LD, to participate in interviews about experiences of their working relationships. Participants will be asked open-ended questions, to elicit a detailed perspective on their relationships with service-users and colleagues. Their responses will be analysed and interpreted by the researcher, to explore how staff make sense of their experiences. The findings of this project will contribute to the body of research on staff wellbeing in LD services, which may promote understanding of staff's capacity to deliver compassionate care.

2. **Anticipated project dates (month and year only**)

Start date: October 2020 End date: June 2021

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The researcher is interested in investigating the population of Care Workers, in roles which do not require specific qualifications, for which a high turnover rate has been identified (Skills for Care, 2018, 2019). The participants will be a purposive sample of 12-15 staff, working in services which offer supported accommodation to adults with an LD. The sample size is chosen to balance the need for exploration of similarities and differences between individuals, with the practicalities of data analysis (Smith & Shinebourne, 2012). Participants will be asked to confirm that they meet the eligibility criteria below.

Inclusion:

a) Staff with job title of ‘Support Worker’ or ‘Care Worker’

Note: the researcher is aware that organisations occasionally use different job titles for an equivalent role, such as ‘Transforming Care Practitioner’ as was identified during consultation with a potential recruitment site. As it is not practical to identify all possible job titles prior to recruitment, the researcher will clarify this when making initial contact with service managers.

b) Have been employed in their current post for a minimum of three months (regardless of any prior experience in a similar role).

Exclusion:

a) Job title which includes the word ‘Senior’

b) Staff in lone working roles.

c) Staff who are employed by an external agency or work for multiple providers.

d) Staff who work only for the organisation in a ‘bank’ capacity i.e. providing temporary cover for vacancies and staff absences.

The criteria are set to ensure that participants have had sufficient opportunity to develop meaningful relationships with co-workers and service-users in a single setting. Staff who work for multiple organisations, or in temporary roles, may have a very different experience from that of permanent staff, which could disrupt sample homogeneity. National records from 2017/18 suggest that 88% of care workers in the LD social care sector were employed on a permanent contract (Skills for Care, 2018); thus, the exclusion criteria should not hinder recruitment. The report gives data on ‘Senior Care Workers’ as a separate category from ‘Care Workers’, suggesting that characteristics of these populations may be different and thus staff in senior roles will not be included in the study.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited via the organisations which employ them, to ensure that the study protocol is in line with any policies the service has, which aim to safeguard the rights of vulnerable service-users. Most supported living providers are now independent because of the national policy, described above. The researcher has chosen to recruit only from private organisations, as there may be considerable differences in organisational characteristics between the public and private sector, which could influence staff experiences.

The field supervisor has obtained a list of the providers in [redacted] which are registered with the Local Authority to offer supported living services to adults with an LD. A recruitment email will be sent to each organisation, including a project summary, along with the participant information sheet, and a recruitment flyer to advertise the study (see supporting documents). The field supervisor already has links with some services and has facilitated direct contact with the service manager. For other providers, the researcher will look up the contact details for general enquiries on the organisation’s website, and request to speak with a manager. The researcher will attempt to make direct contact with service managers in the first instance, to give a full explanation of the project, and provide the opportunity to address any concerns which the organisation may have about the study, such as potential impact on staff and service-users.

Due to national guidance on social distancing during the Covid-19 pandemic, the researcher will arrange to attend a staff team meeting at each service, via a virtual platform, to introduce themselves and explain the project. They will ask service managers to distribute information sheets to staff before-hand, and in the meeting draw particular attention to the procedures around consent, confidentiality and data management. The researcher will explain that interviews responses will be anonymised but that if anything is said which suggests significant risk of harm to anybody, then they will have to break confidentiality and share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies the participant's employing organisation has about safeguarding and reporting risk issues. The researcher is mindful that in advertising the project via employers, there may be a sense of pressure or expectation for individuals to sign up; it will therefore be made explicit that that the purpose of the initial meeting is solely to introduce potential participants to the research. Should staff express interest in becoming involved, there will be opportunity at the end of the meeting for individuals to discuss this further with the researcher but it will be emphasised that they may also contact the researcher later, via the contact details provided, to maintain their privacy. It will also be explicitly stated that the decision to participate, or not, will have no impact upon staff's existing employment conditions or expectations.

If it is not possible to attend a virtual team meeting for recruitment, then the researcher will request that service managers display the recruitment flyer in staff-only areas and distribute the information sheet to their eligible staff, who can then contact the researcher directly if they are interested.

If there is a limited response to contact made with services in [redacted], then the researcher and field supervisor will aim to identify services across England (through networking with colleagues) to which the study could be advertised. The researcher will also identify key forums and people within Learning Disability services, who could provide links to the staff population being investigated. They will be contacted to request if they could distribute the participant information within their networks, via email, and to display a recruitment advert on their social media accounts (see supporting documents).

When somebody approaches the researcher to express interest in participating, they will firstly be asked to verbally confirm that they meet the eligibility criteria; if not, then the offer of participation will be politely declined. The researcher will aim to arrange interviews with participants as soon as they are available, so that data collection can be carried out alongside ongoing recruitment. This process will continue up to a minimum of 12 interviews and a maximum of 15; offers of participation received after this will be declined.

Participants are likely to be in roles involving shift work, so flexibility will be needed in the planning of interviews and allowing for last minute changes. Due to the risks involved in face-to-face contact during the Covid-19 pandemic, interviews will predominantly need to take place remotely. Participants will initially be offered a virtual interview using the university-approved software (currently Microsoft Teams). There will be an option for a telephone interview, but preference will be given to offers of participation via video conferencing, as this is likely to better facilitate rapport and communication between the researcher and participant.

If difficulties are encountered in recruiting for remote interviews, and if it is possible with the precautions under current government, local and university Covid-19 guidelines, face-to-face interviews will be considered; however, this will be a last resort option. Interview locations which are accessible to participants, and where appropriate risk management procedures can be implemented, will be offered e.g. university campus, community centre. Suitability and safety of locations will be discussed with the field supervisor, and a risk assessment completed by the researcher for each individual site to be used.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Scoping of the literature suggests that most research on interpersonal facets of staff wellbeing in LD services is quantitative (e.g. Ryan et al., 2019; Thompson & Rose, 2011) and does not appear to probe experiential aspects of relationships. Hence, the researcher has chosen to use a qualitative approach for this study, to facilitate understanding of the complexities involved in participants' relationships at work. Interpretative Phenomenological Analysis (IPA) has theoretical foundations in phenomenology, hermeneutics, and idiography (Smith, Flowers & Larkin, 2009). This method is appropriate for the present study, which aims to capture the nuance of individual support workers' lived experience of their working relationships. The double hermeneutic involved in IPA will enable the researcher to acknowledge how their experience of previous employment in such a role might shape their interpretation of how participants frame their experience. Given the range of individual differences which are suggested to play a role in staff wellbeing, in previous research (Ryan et al., 2019), the idiographic focus of IPA is well-suited to exploring how these differences might function in an interpersonal context. In addition, the consultation with stakeholders carried out by the researcher (see attached document) highlighted the importance of a "good fit" in the relationship between a service-user and the person supporting them, which is dependent on individual characteristics. IPA is concerned with individual meaning-making, which will enable exploration of how aspects of different relationships might function as demands or resources from a staff perspective.

Face-to-face semi-structured interviews are widely held to be a fitting method of data collection for IPA, as they facilitate engagement and flexibility to cover issues which are important to participants (Smith et al., 2009; Smith & Shinebourne, 2012). The researcher will use an interview topic guide to prompt participant's exploration of their working relationships. Topic arising in this discussion which are not on the schedule, but appear pertinent to the research aim, will be followed up spontaneously, and may inform development of the topic guide for later interviews. The researcher will audio-record and transcribe interviews verbatim. Following the first interview, the researcher will review the transcript with the academic supervisor to further develop the interview schedule and refine technique.

Each transcript will be analysed using the main stages described by Smith et al. (2009):

1. Engagement with the data through repeated reading of transcripts
2. Making initial notes and reflections on the data
3. Developing emergent themes
4. Exploring connections across themes.

This is an iterative process, in line with the hermeneutic underpinnings of IPA. The final stage will involve exploring patterns and recurrent themes across the whole dataset.

The researcher will use a reflexive diary and discussion with supervisors, throughout the process, to maintain quality and credibility. This will facilitate awareness of how the researcher's personal experiences may influence interpretation and analysis of the findings, which will be made explicit in the final report.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Interviews will be audio-recorded, using a digital voice recorder, and the electronic files will be transferred immediately to a secure space and deleted from the device. This will apply to all interviews, including any which take place via telephone or video conference (the recording function on MS Teams will not be used). The recordings will be stored as encrypted electronic files on the researcher's password-protected file-space (H drive) on the university server. If it is not possible to access the university network from the interview location, the files will be transported on an encrypted USB device and transferred to the H drive within 24 hours. Although the written transcripts will be used for data analysis, the encrypted audio files will be kept on the H drive until the project has been examined, in case they need to be checked for any reason. The researcher will be responsible for destroying the audio files, once the project has been examined. The researcher will transcribe the recordings, and the transcripts will be stored as electronic files on the H drive, labelled by participant number only. The files can only be accessed off campus by using a virtual private network connection to the university server; no data will be stored locally on a personal device. Any personal data which participants choose to provide will also be stored in encrypted electronic format on the H drive, in a separate folder to interview transcripts, and will be destroyed as soon as possible (e.g. if a participant requests to receive a summary of the research then I will need to keep their contact details until the study has been completed). Consent forms, and any handwritten notes made during analysis, will be scanned and stored as encrypted files on the H drive, and the hard copies destroyed immediately. Once the project has been examined, all files will be password protected and transferred, using the university-approved secure method (currently OneDrive), to the DClinPsy programme's research co-ordinator. The data will be stored in a secure area of university network, according to DClinPsy programme policy, and the research co-ordinator will be responsible for guardianship of the data and for its deletion after 10 years.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

The only time that data may be stored on a portable device is if the university server cannot be accessed from the location where an interview takes place. The audio recording will then be stored temporarily on an encrypted USB drive and transferred within 24 hours to the H drive.

b. What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Interviews will be audio-recorded using a digital voice recorder and the electronic files will be transferred immediately to the H drive if possible, or to the encrypted USB device, and deleted from the recording device. The recordings will be stored as encrypted electronic files on the H drive. Although only the written transcripts will be used for data analysis, the audio files will be kept until the project has been examined in case they need to be checked for any reason. The researcher will be responsible for destroying the audio files once the project has been examined.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder.

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Once the project has been examined, all files will be password protected and transferred, using the university-approved secure method (currently OneDrive), to the DClinPsy programme's research co-ordinator. The data will be stored in a secure area of university network, according to DClinPsy programme policy, and the research co-ordinator will be responsible for guardianship of the data and for its deletion after 10 years. The data will not be shared with anyone else.

8b. Are there any restrictions on sharing your data ?

Due to the relatively small sample size and the location of recruitment sites, there is a small risk that participants may still be identifiable after the data is fully anonymised. Therefore, only the researcher and supervisors will have access to the data, and it will not be shared with anyone else

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

During the recruitment process, staff will be made aware that they are not required to provide any further details at the point of contacting the researcher to express interest in the study, other than to check they meet the eligibility criteria. Their agreement to arrange, a time and method ~~place~~, to meet for an interview is implied consent to this part of the process. An information sheet and consent form will be sent to all participants by email, or by post if necessary, prior to the interview. When participants attend the arranged meeting, they will be asked to read through both documents fully, and to clarify any queries they have about them, before giving verbal consent (see supporting documents).

Before commencing all interviews, the researcher will remind the participant, that they are not expected to talk about anything they do not wish to, and can choose to stop the interview at any time. They will also remind the participant about the limits to confidentiality: if anything is said which suggests significant risk of harm to anybody, then the researcher will have to share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies the participant's employing organisation has about safeguarding and reporting risk issues.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

There are no significant risks anticipated with participating in this study. However, it is possible that the process of reflecting on their experiences as a support worker, may generate distressing emotions for participants during the interview. If it appears at any point that a participant is becoming distressed, the researcher will check whether they feel able to continue, would like a break, or prefer to discontinue the interview. A verbal debrief opportunity will be provided for all participants afterwards and they will be signposted to relevant agencies which can provide additional support if needed. Possible sources of support are detailed on the participant information sheet. Participants will be informed that they may withdraw from the study at any point before or during the interview, and up until two weeks after its completion. The reason for this timeframe is to allow for simultaneous data collection and analysis, so that each interview can inform the development of subsequent ones; this is an aspect of the iterative approach which IPA involves.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

To protect the researcher's privacy during the recruitment process, a mobile phone provided by the DClinPsy programme will be used for contacting participants. This phone number, and a university email address, will be provided on the participant information sheet for any correspondence.
If it is necessary for an interview to be conducted face-to-face (a last resort option, due to Covid-19 guidelines, as explained in the section on recruitment), then it will be arranged with participants to take place at a suitable safe location, during office hours (9am-5pm), and the university lone working guidance will be followed. In accordance with Division of Health Research Lone Researching Policy, the researcher will carry a SkyGuard device with a GPS location tracker. Details of planned meetings with participants for interviews, will be recorded on the SkyGuard system. This information will only be accessed should the device be used to make an emergency call. It will be the responsibility of the researcher to contact the field supervisor after an interview, should any risk issues arise which do not require emergency action. It is not anticipated that any distress will be associated with conducting interviews but, should this occur, the researcher would seek support from the field supervisor in the first instance.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Although participants may find it interesting or useful to reflect on their experiences of support work, there are unlikely to be direct benefits of taking part in the study. The results are intended to contribute to the body of research which informs awareness of staff wellbeing, and developing good practice, in LD services in the UK; thus there may be small, indirect benefits to the participants, to the wider staff population, and to individuals who use these services.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentives offered to participants, but they can be reimbursed for travel expenses incurred in attending the interview (should a face-to-face meeting be necessary), up to a maximum of £20. Full details of the claim process can be found in the DClinPsy course handbook:

https://wp.lancs.ac.uk/dclinpsy/research-expenses/

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Participants can contact the researcher directly to express interest in the study and their decision to be involved will be kept confidential. The researcher will be working from their own home when conducting remote interviews and will ensure this is done in a confidential space. If it is necessary to arrange a face-to-face meeting for an interview, then maintaining the participant's anonymity will be taken into consideration when choosing a suitable location. The participant will have the choice to revoke their offer of participation if it is not possible to find somewhere where both anonymity can be ensured and Covid safety precautions can be implemented (for example if the location requires that people provide personal details for the purposes of contact tracing

Interview transcripts will be made anonymous, by removing any identifying information, and will be assigned a participant number. Only the researcher and supervisors will have access to the data. Any direct quotations which are used in the report, or in publications resulting from the study, will be anonymous. Any other personal data will be stored separately and will be confidential. At the start of the interview, the researcher will remind participants about the limits to confidentiality: if anything is said which suggests significant risk of harm to anybody, then the researcher will have to share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies their employing organisation has about safeguarding and reporting risk issues. The researcher will inform the participant if they need to do this, unless it would increase the risk.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Please see the attached document on stakeholder consultation.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The project will be reported in the form of an academic research paper, which will form part of the researcher's DClinPsy thesis submission. The researcher will aim to submit this for publication in a relevant academic journal, to be discussed with the supervisors, although publication is not guaranteed. A summary of the study findings will be provided to participants, and to managers of services involved, along with the researcher's contact details, should they wish to discuss these in more detail. The service managers who have already been informally approached, have suggested that staff would be keen for the researcher to attend a team meeting and present the findings in person.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Services which are recruited from may have concerns about safeguarding the privacy of service-users, whom staff may refer to when being interviewed about their experiences of working relationships. When making initial contact with services, the researcher will explain that participants will be reminded at the start of the interview not to refer to other individuals by name but if this does occur, then the interview transcripts will be fully anonymised. The possibility that individuals may still be identifiable, from participant's descriptions of events or interactions, is very small but cannot be fully excluded; it will be at the service managers' discretion to permit recruitment from their service, if this remains a concern. There is a possibility that, whilst undertaking the project, the researcher may encounter quality issues or poor practice, either from hearing participant accounts of their work, or when attending virtual team meetings for the services which are being recruited from. Examples of this might be unmet needs of service-users, abuse, staff harassment, or health and safety hazards. Any concerns will be discussed with the field supervisor, who will advise on the appropriate course of action, in line with the relevant policies of the organisation.

Applicant electronic signature: Rachel D'Sa Date 14/12/20

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Ian Fletcher Date application discussed 14/12/20

Note. Please see Research Protocol in Supporting Documents (Appendix 4-A) for reference list.

Appendix 4-A

Supporting Documents for Ethics Application

Contents:

Research Protocol p.4-13

Stakeholder Consultation p.4-31

Example Recruitment Email p.4-34

Recruitment Flyer p.4-35

Social Media Advert p.4-36

Participant Information Sheet p.4-37

Consent Form p.4-42

Interview Topic Guide p.4-44

Research Protocol

Title: Exploring how staff experience their working relationships in services for adults with a learning disability.

Background

The UK government's *Transforming Care* programme aims for all adults with a learning disability (LD)[1] to reside in appropriate, community-based housing rather than institutional environments, which impinge on their human rights (Department of Health, 2012, p.75). Further developments in this policy recommend that people be offered a choice of housing, including small-scale, supported living (NHS England, 2015). Recently, a staff turnover rate of around 30% was highlighted for the adult social care sector in England (Skills for Care, 2019). An earlier report, specifically on the workforce supporting adults with a learning disability and/or autism, estimates an even higher turnover of 36.1% for unqualified care worker roles (Skills for Care, 2018), which might be expected to impact negatively upon policy implementation.

There is a large body of research on staff in direct-care roles, in LD services, which identifies organisational and environmental issues, inequality in workplace relationships, the demands of the job role, and individual staff or service-user characteristics, as contributors to worker stress (Rose, 2009; Ryan, Bergin, & Wells, 2019). Stress and burnout have been linked to outcomes of poor retention, quality, and continuity of care (Buntinx, 2008; Skirrow & Hatton, 2007). However, the meta-analysis by Skirrow and Hatton (2007) indicated that burnout levels are somewhat lower in LD services than in normative samples, having decreased steadily over the last 20 years. Hastings (2010) queries why staff retain jobs that are evidently stressful and poorly paid, arguing that better understanding of staff relationships

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[1] The term 'learning disability' is still commonly found in UK legislation and is equivalent to the internationally agreed term 'intellectual disability'. See guidance from the Division of Clinical Psychology (2015) for further definition and explanation.

with service-users, and of positive contributions that staff perceive to arise from their work, are future research priorities. Ryan et al. (2019) review findings which suggest that positive aspects of the work can contribute to staff wellbeing. They also highlight the impact that a lack of reciprocity between staff and service-users, colleagues, or the organisation, has on worker stress.

There are examples in the literature of staff relationships with service-users (e.g. Lunsky, Hastings, Hensel, Arenovich, & Dewa, 2014; Whittington & Burns, 2005), and with colleagues (e.g. Judd, Dorozenko, & Breen, 2017; Thomas & Rose, 2010), being a source of both stress and support. Devereux, Hastings, and Noone (2009) suggest application of the job demands-resources model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) to advance applicability of research in the field. In this framework, aspects of relationships could function as job demands, or as resources which buffer against psychological costs of the work. Further investigation of the nature of workplace relationships, specifically in supported living services, may contribute to development of interventions which can improve staff wellbeing and thus the quality of care that they provide in this setting.

Researching links between staff relationships and their wellbeing holds relevance for national guidelines: a recommendation has been made by the National Institute for Health and Care Excellence (NICE), for research into approaches that enable staff to be resilient in supporting people with an LD and behaviour that challenges (NICE, 2018). On workplace health, NICE has called for employee wellbeing to be an organisational priority, recommending management practices that promote mental wellbeing at work, by creating supportive environments (NICE, 2016). This guidance refers to the Health and Safety Executive (HSE) management standards on work-related stress, which include relationships as a key area of consideration for work design (HSE, n.d.).

This study will investigate the working relationships of direct-care staff who are employed in services which provide supported accommodation for adults with an LD. This is pertinent to the profession of Clinical Psychology as applied psychologists are expected to provide consultancy to various health and social care organisations, to develop effective teamwork (Onyett, 2007). In the LD field, clinical psychologists aim to promote psychological understanding at all levels of service, to enable good practice, and wellbeing (Division of Clinical Psychology, n.d.). The proposed study will contribute to the body of literature which aims to facilitate understanding of the wellbeing of staff who support adults with an LD, and thus their capacity to deliver compassionate care.

Research Aim

To explore support workers' experiences of their working relationships with service-users and colleagues.

Participants

The researcher is interested in investigating the population of care workers, in roles which do not require specific qualifications, for which a high turnover rate has been identified (Skills for Care, 2018, 2019). The participants will be a purposive sample of 12-15 staff, working in services which offer supported accommodation to adults with an LD. The sample size is chosen to balance the need for exploration of similarities and differences between individuals, with the practicalities of data analysis (Smith & Shinebourne, 2012). Participants will be asked to confirm that they meet the eligibility criteria below.

Inclusion:

- Staff with job title of 'Support Worker' or 'Care Worker'

  Note: the researcher is aware that organisations occasionally use different job titles for an equivalent role, such as 'transforming care practitioner', as was identified during consultation with a potential recruitment site. As it is not practical to identify all possible job titles prior to recruitment, the researcher will clarify this when making initial contact with service managers.

- Have been employed in their current post for a minimum of three months (regardless of any prior experience in a similar role).

Exclusion:

- Job title which includes the word ‘Senior’
- Staff in lone working roles.
- Staff who are employed by an external agency or work for multiple providers.
- Staff who work only for the organisation in a ‘bank’ capacity i.e. providing temporary cover for vacancies and staff absences.

The criteria are set to ensure that participants have had sufficient opportunity to develop meaningful relationships with co-workers and service-users in a single setting. Staff who work for multiple organisations, or in temporary roles, may have a very different experience from that of permanent staff, which could disrupt sample homogeneity. National records from 2017/18 suggest that 88% of unqualified care workers in the LD social care sector were employed on a permanent contract (Skills for Care, 2018); thus the exclusion criteria should not hinder recruitment. The report gives data on ‘Senior Care Workers’ as a separate category from ‘Care Workers’, suggesting that characteristics of these populations may be different, and thus staff in senior roles will not be included in the study.

Recruitment

Participants will be recruited via the organisations which employ them, to ensure that the study protocol is in line with any policies the service has, which aim to safeguard the rights of vulnerable service-users. Most supported living providers are now independent because of the national policy, described above. The researcher has chosen to recruit only from private organisations, as there may be considerable differences in organisational characteristics between the public and private sector, which could influence staff experiences.

The field supervisor has obtained a list of the providers in [redacted] which are registered with the Local Authority to offer supported living services to adults with an LD. A recruitment email will be sent to each organisation, including a project summary, along with the participant information sheet, and a recruitment flyer to advertise the study. The field supervisor already has links with some services and has facilitated direct contact with the service manager. For other providers, the researcher will look up the contact details for general enquiries on the organisation's website, and request to speak with a manager. The researcher will attempt to make direct contact with service managers in the first instance, to give a full explanation of the project, and provide the opportunity to address any concerns which the organisation may have about the study, such as potential impact on staff and service-users.

Due to national guidance on social distancing during the Covid-19 pandemic, the researcher will arrange to attend a staff team meeting at each service via a virtual platform, to introduce themselves and explain the project. They will ask service managers to distribute information sheets to staff before-hand, and in the meeting draw particular attention to the procedures around consent, confidentiality, and data management. The researcher will explain that interview responses will be anonymised but that if anything is said which suggests significant risk of harm to anybody, then they will have to break confidentiality and share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment, or poor practice, which will be in line with any policies the participant's employing organisation has about safeguarding and reporting risk issues. The researcher is mindful that in advertising the project via employers, there may be a sense of pressure or expectation for individuals to sign up; it will therefore be made explicit that that the purpose of the initial meeting is solely to introduce potential participants to the research. Should staff express interest in becoming involved, there will be opportunity at the end of the meeting for individuals to discuss this further with the researcher but it will be emphasised that they may also contact the researcher later, via the contact details provided, to maintain their privacy. It will also be explicitly stated that the decision to participate, or not, will have no impact upon staff's existing employment conditions or expectations.

If it is not possible to attend a virtual team meeting for recruitment, then the researcher will request that service managers display the recruitment flyer in staff-only areas and distribute the information sheet to their eligible staff, who can then contact the researcher directly if they are interested.

If there is a limited response to contact made with services in [redacted], then the researcher and field supervisor will aim to identify services across England (through networking with colleagues) to which the study could be advertised. The researcher will also identify key forums and people within Learning Disability services, who could provide links to the staff population being investigated. They will be contacted to request if they could distribute the participant information within their networks, via email, and to display a recruitment advert on their social media accounts.

When somebody approaches the researcher to express interest in participating, they will firstly be asked to verbally confirm that they meet the eligibility criteria; if not, then the offer of participation will be politely declined. The researcher will aim to arrange interviews with participants as soon as they are available, so that data collection can be carried out alongside ongoing recruitment. This process will continue up to a minimum of 12 interviews and a maximum of 15; offers of participation received after this will be declined.

Methodology

Scoping of the literature suggests that most research on interpersonal facets of staff wellbeing in LD services is quantitative (e.g. Ryan et al., 2019; Thompson & Rose, 2011) and does not appear to probe experiential aspects of relationships. Hence, the researcher has chosen to use a qualitative approach for this study, to facilitate understanding of the complexities involved in participants' relationships at work. Interpretative phenomenological analysis (IPA) has theoretical foundations in phenomenology, hermeneutics, and idiography (Smith, Flowers, & Larkin, 2009). This method is appropriate for the present study, which aims to capture the nuance of individual support workers' lived experience of their working relationships. The double hermeneutic involved in IPA will enable the researcher to acknowledge how their experience of previous employment in such a role might shape their interpretation of how participants frame their experience. Given the range of individual differences which are suggested to play a role in staff wellbeing, in previous research (Ryan et al., 2019), the idiographic focus of IPA is well-suited to exploring how these differences might function in an interpersonal context. In addition, the consultation with stakeholders carried out by the researcher (see attached document) highlighted the importance of a "good fit" in the relationship between a service-user and the person supporting them, which is dependent on individual characteristics. IPA is concerned with individual meaning-making, which will enable exploration of how aspects of different relationships might function as demands or resources from a staff perspective.

Face-to-face semi-structured interviews are widely held to be a fitting method of data collection for IPA, as they facilitate engagement and flexibility to cover issues which are important to participants (Smith et al., 2009; Smith & Shinebourne, 2012). The researcher will use an interview topic guide to prompt participant's exploration of their working relationships. Topic arising in this discussion which are not on the schedule, but appear pertinent to the research aim, will be followed up spontaneously, and may inform development of the topic guide for later interviews. The researcher will audio-record and transcribe interviews verbatim. Following the first interview, the researcher will review the transcript with the academic supervisor to further develop the interview schedule and refine technique.

Each transcript will be analysed using the main stages described by Smith et al. (2009):

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This is an iterative process, in line with the hermeneutic underpinnings of IPA. The final stage will involve exploring patterns and recurrent themes across the whole dataset.

The researcher will use a reflexive diary and discussion with supervisors, throughout the process, to maintain quality and credibility. This will facilitate awareness of how the researcher’s personal experiences may influence interpretation and analysis of the findings, which will be made explicit in the final report.

Practical Considerations

Mode and timing of interviews.

Participants are likely to be in roles involving shift work, so flexibility will be needed in the planning of interviews and allowing for last minute changes. Due to the risks involved in face-to-face contact during the Covid-19 pandemic, interviews will predominantly need to take place remotely. Participants will initially be offered a virtual interview using the university-approved software (currently Microsoft Teams). There will be an option for a telephone interview, but preference will be given to offers of participation via video conferencing, as this is likely to better facilitate rapport and communication between the researcher and participant.

If difficulties are encountered in recruiting for remote interviews, and if it is possible with the precautions under current government, local and university Covid-19 guidelines, face-to-face interviews will be considered. Interview locations which are accessible to participants, and where appropriate risk management procedures can be implemented, will be offered e.g. university campus, community centre. Suitability and safety of locations will be discussed with the field supervisor, and a risk assessment completed by the researcher for each individual site to be used.

Equipment.

The Doctorate in Clinical Psychology (DClinPsy) programme has a stock of equipment for the purpose of trainee research. The researcher will arrange to borrow a digital recording device, to audio-record interviews, and a mobile phone (to receive communication from participants) over a provisional 6-month period. Ideally this will fit in with the proposed timescale below but may need to be adjusted if the equipment is not readily available. For video-conference interviews, the researcher will use their university Microsoft Teams account to set up a virtual meeting with the participant. For telephone interviews, the researcher will use their personal mobile phone to make the call, ensuring the number is withheld, in line with the programme guidance.

Expenses.

The DClinPsy programme provides a research budget of £300, with costs to be approved by the research director. Any travel expenses incurred by the researcher are covered by the NHS trust which employs the researcher and are not charged to this budget. The researcher has a mobile phone contract with unlimited minutes and a broadband connection contract, so remote interviews will not incur any additional costs. The main cost will be participant travel expenses, should it be necessary to arrange a face-to-face meeting for an interview. Participants will be reimbursed up to a maximum of £20 and the researcher will explain the claim process, when making arrangements for the interview with each participant. Full details can be found in the DClinPsy course handbook:

https://wp.lancs.ac.uk/dclinpsy/research-expenses/

The only other anticipated cost will be for stationary and postage of the information sheet and consent form if participants are unable to receive these by email; however, this is expected to be minimal, as interviews are most likely to take place via video-conference, which the participant will need an email address for.

Ethical Concerns

Data management.

Interviews will be audio-recorded, using a digital voice recorder, and the electronic files will be transferred immediately to a secure space and deleted from the device. This will apply to all interviews, including any which take place via telephone or video conference (the recording function on MS Teams will not be used). The recordings will be stored as encrypted electronic files on the researcher's password-protected file-space (H drive) on the university server. If it is not possible to access the university network from the interview location, the files will be transported on an encrypted USB device and transferred to the H drive within 24 hours. Although the written transcripts will be used for data analysis, the encrypted audio files will be kept on the H drive until the project has been examined, in case they need to be checked for any reason. The researcher will be responsible for destroying the audio files, once the project has been examined. The researcher will transcribe the recordings, and the transcripts will be stored as electronic files on the H drive, labelled by participant number only. The files can only be accessed off campus by using a virtual private network connection to the university server; no data will be stored locally on a personal device. Any personal data which participants choose to provide will also be stored in encrypted electronic format on the H drive, in a separate folder to interview transcripts, and will be destroyed as soon as possible (e.g. if a participant requests to receive a summary of the research then the researcher will need to keep their contact details until the study has been completed). Consent forms, and any handwritten notes made during analysis, will be scanned, and stored as encrypted files on the H drive, and the hard copies destroyed immediately. Once the project has been examined, all files will be password protected and transferred, using the university-approved secure method (currently OneDrive), to the DClinPsy programme's research co-ordinator. The data will be stored in a secure area of university network, according to DClinPsy programme policy, and the research co-ordinator will be responsible for guardianship of the data and for its deletion after 10 years.

Informed consent.

During the recruitment process, staff will be made aware that they are not required to provide any further details at the point of contacting the researcher to express interest in the study, other than to check they meet the eligibility criteria. Their agreement to arrange a time and method, to meet for an interview, is implied consent to this part of the process. An information sheet and consent form will be sent to all participants by email, or by post if necessary, prior to the interview. When participants attend the arranged meeting, they will be asked to read through both documents fully, and to clarify any queries they have about them, before giving verbal consent

Before commencing all interviews, the researcher will remind the participant that they are not expected to talk about anything they do not wish to, and can choose to stop the interview at any time. They will also remind the participant about the limits to confidentiality: if anything is said which suggests significant risk of harm to anybody, then the researcher will have to share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies the participant's employing organisation has about safeguarding and reporting risk issues.

Confidentiality and anonymity.

Participants can contact the researcher directly to express interest in the study and their decision to be involved will be kept confidential. The researcher will be working from their own home when conducting remote interviews and will ensure this is done in a confidential space. If it is necessary to arrange a face-to-face meeting for an interview, then maintaining the participant's anonymity will be taken into consideration when choosing a suitable location. The participant will have the choice to revoke their offer of participation if it is not possible to find somewhere where both anonymity can be ensured and Covid safety precautions can be implemented (for example if the location requires that people provide personal details for the purposes of contact tracing).

Interview transcripts will be made anonymous, by removing any identifying information, and will be assigned a participant number. Only the researcher and supervisors will have access to the data. Any direct quotations which are used in the report, or in publications resulting from the study, will be anonymous. Any other personal data will be stored separately and will be confidential. At the start of the interview, the researcher will remind participants about the limits to confidentiality: if anything is said which suggests significant risk of harm to anybody, then the researcher will have to share this information with a supervisor, who will then decide if the issue needs to be taken further. Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies their employing organisation has about safeguarding and reporting risk issues. The researcher will inform the participant if they need to do this, unless it would increase the risk.

Researcher safety.

To protect the researcher’s privacy during the recruitment process, a mobile phone provided by the DClinPsy programme will be used for contacting participants. This phone number, and a university email address, will be provided on the participant information sheet for any correspondence.

If it is necessary for an interview to be conducted face-to-face, then it will be arranged with participants to take place at a suitable safe location (e.g. university, community centre), during office hours (9am-5pm), and the university lone working guidance will be followed. In accordance with Division of Health Research Lone Researching Policy, the researcher will carry a SkyGuard device with a GPS location tracker. Details of planned meetings with participants for interviews, will be recorded on the SkyGuard system. This information will only be accessed should the device be used to make an emergency call.

It will be the responsibility of the researcher to contact the field supervisor after an interview, should any risk issues arise which do not require emergency action. It is not anticipated that any distress will be associated with conducting interviews but, should this occur, the researcher would seek support from the field supervisor in the first instance.

Risks and benefits.

There are no significant risks anticipated with participating in this study. However, it is possible that the process of reflecting on their experiences as a support worker, may generate distressing emotions for participants during the interview. If it appears at any point that a participant is becoming distressed, the researcher will check whether they feel able to continue, would like a break, or prefer to discontinue the interview. A verbal debrief opportunity will be provided for all participants afterwards and they will be signposted to relevant agencies which can provide additional support if needed. Possible sources of support are detailed on the participant information sheet. Participants will be informed that they may withdraw from the study at any point before or during the interview, and up until two weeks after its completion. The reason for this timeframe is to allow for simultaneous data collection and analysis, so that each interview can inform the development of subsequent ones; this is an aspect of the iterative approach which IPA involves.

Services which are recruited from may have concerns about safeguarding the privacy of service-users, whom staff may refer to when being interviewed about their experiences of working relationships. When making initial contact with services, the researcher will explain that participants will be reminded at the start of the interview not to refer to other individuals by name but if this does occur, then the interview transcripts will be fully anonymised. The possibility that individuals may still be identifiable, from participant's descriptions of events or interactions, is very small but cannot be fully excluded; it will be at the service managers' discretion to permit recruitment from their service, if this remains a concern. There is a possibility that, whilst undertaking the project, the researcher may encounter quality issues or poor practice, either from hearing participant accounts of their work, or when attending virtual team meetings for the services which are being recruited from. Examples of this might be unmet needs of service-users, abuse, staff harassment, or health and safety hazards. Any concerns will be discussed with the field supervisor, who will advise on the appropriate course of action, in line with the relevant policies of the organisation.

Although participants may find it interesting or useful to reflect on their experiences of support work, there are unlikely to be direct benefits of taking part in the study. The results are intended to contribute to the body of research which informs awareness of staff wellbeing, and developing good practice, in LD services in the UK; thus there may be small, indirect benefits to the participants, to the wider staff population, and to individuals who use these services.

Proposed Timescale

October – December 2020: Make contact with services, send out recruitment packs and arrange to attend virtual team meetings for the researcher to introduce themselves.

January – April 2021: Ongoing recruitment and data collection.

February – May 2021: Ongoing data collection and analysis.

June 2021: Complete data analysis.

July 2021: Submit draft report to supervisor.

August 2021: Submit second draft to supervisor.

September 2021: Thesis submission.

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Stakeholder Consultation

I met with representatives from two stakeholder organisations, to ask for informal feedback on my initial research ideas:

- I will contact supported living services in [redacted] and arrange a time to come and explain more about the project to staff
- If someone volunteers to participate then they can contact me directly to arrange a convenient time and place for an interview – nobody else needs to know that they are taking part in this
- The interview will last up to one hour
- The questions will be about relationships (with service-users and colleagues) but they will be open-ended, to allow people to talk in depth about their experiences and the things which are important to them
- Things that might be covered are
  - how relationships develop at work
  - similarities/differences between relationships with service-users and with colleagues
  - the roles people take in these relationships
  - the quality of these relationships and things which affect that
  - the pros and cons of different relationships
- It is completely up to the person taking part how much they share about their experience
- I will not be able to give any opinions or advice on what participants share, but I will direct them to sources of support if the interview brings up anything difficult for them
- The interviews will be made anonymous, and I will look for themes in the overall set of responses and produce a report on my findings
- Once the report has been examined by the university, I will be able to share the findings with people who participated.

Learning Together North West Ltd. is a social enterprise which provides training and consultancy on inclusivity issues. I approached this organisation to hear the views of people who might use the type of service from which I plan to recruit staff. I also approached a provider of supported living services which my field supervisor already has links with, and spoke to two managers and two support workers about my proposal.

Summary of feedback from Learning Together group meeting:

- The group thought that potential participants would want to know the following before they could agree to take part:
  - what questions they might be asked in the interview
  - the reasons behind the doing the research
  - who would see their responses afterwards
  - what would happen to the information
  - that managers of the service they worked for had approved the project
  - whether it was confidential
- It was pointed out that the model of supported living varies between services and individuals; for example, some people had 24hr live-in carers, others had a support worker who visited them once a week for a few hours, and one person lived as part of a "family unit" according to that particular service's ethos
- Several aspects of the relationship between a service-user and support worker were highlighted as important:
  - the power imbalance between service-user and the person supporting them
  - communication and the opportunities both parties had to express their views
  - differences of opinion about lifestyle and domestic issues
  - the effect of differing personalities and needing a "good fit" to form a bond
  - the conditions needed for honesty and trust to form between parties
  - how much choice either party were given over who they worked with and the effect this had on how authentic they felt they could be
  - the need for shared interests and activities that they could participate in collaboratively
  - whether it is possible for paid support to be reciprocated in any way
- The group co-ordinator identified "supporting people to know what good support looks like" as a gap that exists in research and training i.e. people with learning disabilities should be able to expect a certain standard of support but they might not know what this looks like in practice
- A support worker present at the meeting had a job title of 'Transforming Care Practitioner' which reflects the service aim to put legislation into practice through the supported living model; this person said that they would appreciate the opportunity to talk about their experiences of working relationships and did not anticipate

difficulties in discussing this topic openly, provided they were not expected to divulge personal details of service-users

- The group were keen to have a summary of the research findings when the project is completed and wondered if they might be able to use them in developing their training packages.

Summary of feedback from staff at potential recruitment site:

- The senior manager of the service said that the main concerns of the organisation would be:
    - What are the overall aims and objectives of the research
    - The benefits to our client group
    - Time required per employee
    - Confidentiality
    - Getting feedback
- It was suggested that approaching the Lancashire Learning Disability Consortium would be a good way of recruiting staff from key providers of supported living services
- The managers agreed that it would be most appropriate for me to try and recruit in person by attending a staff meeting at the service but due to time pressures, I would probably be given a maximum of 15 minutes during the meeting
- Frequent changes in staffing and the high rate of turnover in supported living services were highlighted as issues which have a significant impact on all relationships in this setting
- The support workers welcomed any opportunity to share their experiences of the job role and thought that they would not have any difficulties with being interviewed specifically about their working relationships
- They thought that if participants were assured of confidentiality and anonymity of their responses at the start then they would be more likely to answer questions honestly and in depth
- Staff wanted to know how they might find out about the results of the project and how it might help them in their day-to-day work.

Example Recruitment Email

Hello,

My name is Rachel D'Sa and I am training to be a Clinical Psychologist at Lancaster University. Part of my training involves carrying out research in a health or social care setting and for this purpose, I have designed the following project:

Exploring how staff experience their working relationships in services for adults with a learning disability.

A summary of the project is included below, and I can share the full research protocol with you if it would be helpful. The project has been given ethical approval by Lancaster University's Faculty of Health and Medicine (please see attached letter).

I am contacting you to request if I can approach staff at your service who might be interested in participating. I understand that many services are currently holding staff team meetings via a virtual platform, due to Covid restrictions. If possible, I would like to attend one of these, to explain more about the project in person, and to recruit volunteers. If this is not possible, then I would be grateful if you could distribute the attached participant information sheet to the support workers that you employ, and display the attached flyer in an appropriate staff-only area of the service.

Thank you for taking the time to read this message. Please do get in touch by replying directly to this email, so that we can discuss any questions you might have.

Kind Regards,
Rachel

Project Summary

A recommendation has been made, by the National Institute for Health and Care Excellence, for research into enabling staff resilience in Learning Disability (LD) services. Although there is much existing research on stress in direct-care staff, there is little account of the lived experience of such work. This project aims to further awareness of the relational aspects of support work, and to begin providing insights into how relationships might influence staff wellbeing.

12-15 unqualified support workers will be recruited from supported living services for adults with an LD, to participate in virtual interviews about experiences of their working relationships. Participants will be asked open-ended questions, to elicit a detailed perspective on their relationships with service-users and colleagues. Their responses will be analysed and interpreted by the researcher, to explore how staff make sense of their experiences. The findings of this project will contribute to the body of research on staff wellbeing in LD services, which may promote understanding of staff's capacity to deliver compassionate care.

Doctorate in Clinical Psychology | Lancaster University

We want to hear from you.

My name is Rachel D’Sa and I am a Trainee Clinical Psychologist at Lancaster University.

I am carrying out a research project to find out about the experiences of staff in supported living services for adults with a learning disability.

I am looking to interview **support workers** about the working relationships they have with service-users and colleagues.

If you are interested in taking part, or would like to find out more, then please contact me by email or phone:

r.dsa@lancaster.ac.uk

[redacted]

Social Media Advert

Hello,

My name is Rachel D'Sa and I am a Trainee Clinical Psychologist from Lancaster University. As part of my training, I am conducting a research project to find out about the experiences of **Support Workers in supported living services for adults with learning disabilities**. The project has been given ethical approval by Lancaster University's Faculty of Health and Medicine.

I am looking for support workers to participate in an interview with me via video-link or phone. I am particularly interested in hearing about how they experience their working relationships with service-users and with colleagues. I hope that this research will increase awareness of the relational aspects of support work, and how this may impact on staff wellbeing.

If this sounds like something you would be interested in, or you want to find out more about what it involves, please don't hesitate to get in touch with me at:

r.dsa@lancaster.ac.uk

[redacted]

Thank you for taking the time to read this message.

Doctorate in Clinical Psychology | Lancaster University

Participant Information Sheet

Exploring how staff experience their working relationships in services for adults with a learning disability.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Rachel D'Sa and I am conducting this research study as a trainee on the Clinical Psychology Doctorate course at Lancaster University.

What is the study about?

The purpose of this study is to investigate the experiences of staff, who directly support adults with a learning disability in their daily activities. Specifically, it aims to explore how staff perceive their working relationships, with both service-users and colleagues, and how they make sense of these experiences.

Why have I been approached?

You have been approached because the study requires information from up to 15 people employed in a support or care worker role, in services which provide supported accommodation for adults with a learning disability.

If you are interested in taking part, I will ask you what your job title is, to ensure that your role is in the category of work which I am interested in finding out more about. You will need to have worked in your current role for a minimum of three months and be employed with a single organisation. If your role mainly involves lone working, if you only work for the organisation as 'bank' staff, or if you are in a senior support/care work role, then unfortunately you will not be eligible to participate.

Do I have to take part?

It is completely up to you to decide whether you participate in this study. Before you make a decision, it is important that you have taken time to read through this information sheet so that you understand the purpose of the study and what it involves.

If you do agree to take part, you will be asked to give your consent, but this does not mean that you have to complete the study. You will be free to withdraw at any stage before or during participation. You may also request that your data be withdrawn, up until two weeks after the interview. After this time, it is likely that the data will have been anonymised and the analysis will be ongoing, so it will not be possible to extract your individual data.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to undertake an interview with myself, which would last up to one hour. Although you have been approached via your employer, it is anticipated that the interview will take place in your own free time.

I will firstly take offers of participation from people who can attend a video conference using Microsoft Teams (an internet browser and email address is the only thing required to access the invitation I send for this; you would not need to download the software). Telephone interviews will be offered as a second option. If neither of these methods are possible for you then we may consider a face-to-face meeting, depending on current government guidance in relation to Covid-19. We would arrange a place to meet which will ensure your privacy and where appropriate safety procedures can be implemented. You will be able to claim reimbursement for travel expenses to this location, up to a maximum of £20.

Before the interview, I will briefly explain the process, what to expect, and answer any questions you may have about it. During the interview I will ask you some open-ended questions which allow you to explore your experiences in depth. The interviews will be audio-recorded so that I can later type out your exact responses for analysis. Afterwards, I will answer any further questions you may have and signpost you to sources of support, if required.

Will my data be identifiable?

Your decision to participate in the study will be kept confidential and only the researcher will be present during the interview, to maintain your privacy. The data collected for this study will be stored using university-approved secure cloud storage. Only the researcher and supervisors will have access to this data:

- Audio recordings will be stored as electronic files and deleted once the project has been examined
- The typed version of your interview will be stored as an electronic file and kept by Lancaster University in secure storage for 10 years after the study has finished, in accordance with university regulations
- Electronic data will be stored as encrypted files on the university computer system, which is password protected
- Files may need to be stored temporarily on an encrypted portable device (e.g. if the university system cannot be directly accessed from the location where the interview takes place) but will be transferred within 24 hours to the university system
- The typed version of your interview will be made anonymous by removing any identifying information, including any names. **Anonymised direct quotations from your interview may be used in the report, or publications which result from the study, but your name will not be attached to them.**
- Any personal data which you provide will be confidential, will be kept separately from your interview responses, and will be destroyed as soon as possible (e.g. if you request to receive a summary of the research then I will need to keep your contact details until the study has been completed)
- Any hard copies of written data (e.g. consent forms) will be converted into an electronic format and stored securely, as above.

Are there any limits to confidentiality?

Your responses during the interview will be made anonymous and I will not discuss the data with reference to you personally, with anybody else. However, if you say something during the interview which suggests that you, or someone else, is at significant risk of harm, I will have to break confidentiality and share this information with one of my supervisors, who will then decide if the issue needs to be taken further (e.g. CQC, local safeguarding board). Examples of this might be unmet needs of service-users, abuse, staff harassment or poor practice, which will be in line with any policies your place of work has about safeguarding and reporting risk issues. If appropriate, then I will let you know before-hand if I need to share something that you tell me.

What will happen to the data?

The responses you give in the interview will be anonymised, pooled with the responses of other participants, and then analysed for themes. The results of this process will be summarised and reported in my doctoral thesis. The report may also be submitted for publication in an academic journal, or for presentation at a professional conference.

Are there any risks?

There are no significant risks anticipated with participating in this study. However, it is possible that the process of reflecting on your experiences as a support worker may generate distressing emotions. If it appears that you are becoming distressed, I will check whether you feel able to continue, would like a break or prefer to discontinue the interview. You will not be expected to talk about anything that you do not wish to, and you can choose to stop the interview at any time. After the interview, I will signpost you to relevant agencies which can provide additional support should you require it.

Are there any benefits to taking part?

Although you may find it interesting or useful to reflect on your experiences of support work, there are unlikely to be direct benefits of taking part in the study. The results of the study are intended to contribute to the body of research which informs awareness of staff wellbeing, and developing good practice, in learning disability services in the UK. It is possible that your participation may therefore have some indirect benefit for yourself, other staff, or service-users.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please do not hesitate to contact me:

Rachel D’Sa
Doctorate in Clinical Psychology
Health Innovation One
Sir John Fisher Drive

Lancaster University
Lancaster
LA1 4AT

Tel: [redacted]
Email: r.dsa@lancaster.ac.uk

The project is being supervised by the following people:
Dr Ian Fletcher
Senior Lecturer
Division of Health Research, Lancaster University
Email: i.fletcher@lancaster.ac.uk

Dr Steve Field
[redacted]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

[redacted]

If you wish to speak to someone outside of the Doctorate in Clinical Psychology Programme, you may also contact:

[redacted]

Thank you for taking the time to read this information sheet.

Resources

Should you feel distressed either as a result of taking part, or in the future, you can contact your GP surgery and arrange to speak to somebody for support.

If stress as a result of your work has become an issue for you, you are advised to raise this with your line manager. The following resources may also be of assistance:

- Fit For Work – provides free and impartial occupational health advice
  www.fitforwork.org
  helpline: 0800 032 6235

- Skills for Care has provided a resource on personal wellbeing for employees in the adult social care sector
  https://www.skillsforcare.org.uk/Documents/Leadership-and-management/Resilience/Building-your-own-health-resilience-and-wellbeing-WEB.pdf

Doctorate in Clinical Psychology | Lancaster University

Consent Form

Study Title: Exploring how staff experience their working relationships in services for adults with a learning disability.

You are being asked if you would like to take part in a research project which aims to explore the experiences of support workers in supported living services for adults with a learning disability. Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form, please speak to the main researcher, Rachel D’Sa.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw from participating at any time before, during and up until two weeks after the interview. ☐
6. I understand that once my data have been anonymised and incorporated into themes it will not be possible for it to be withdrawn. ☐
7. I understand that the information from my interview will be pooled with other participants’ responses, anonymised and may be published. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
9. I understand that the researcher will discuss data with their supervisor as needed. ☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor. ☐

11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
12. I consent to take part in the above study. ☐

Name of Participant: ____

Signature: ____

Date: ________________________________

Name of Researcher: Rachel D’Sa

Signature: ____

Date: ________________________________

Interview Topic Guide

Verbal reminders to participant:

1. They are not expected to talk about anything they do not wish to
2. They can ask to stop the interview at any time
3. Limits of confidentiality
4. Try to avoid naming other individuals (although the data will still be anonymised)

Opening questions:

Can you tell me a bit about the type of things you do in your job?

Have you always worked in this sort of role? What attracted you to this area of work?

Questions about relationships with service-users:

What’s it like for you, working with the people you support? How do you get on with them?

What’s good about working with them? Are there any challenges?

Can you describe the kind of relationship you have with the people you support? Is this the same for everyone you support or are there any differences?

What do you like about these relationships? What do you dislike?

What do you think helps to build these relationships? What is less helpful?

Have these relationships changed in any way since you first started this work? Why do you think that is?

Do these relationships affect your wellbeing in any way?

Questions about relationships with other staff:

What’s it like working with your colleagues? How do you get on with them?

What’s good about working with them? Are there any challenges?

Can you describe the kind of relationship you have with your colleagues? Is this the same for everyone you work with or are there any differences?

What do you like about these relationships? What do you dislike?

What do you think helps to build these relationships? What is less helpful?

Have these relationships changed in any way since you first started this work? Why do you think that is?

Do these relationships affect your wellbeing in any way?

Final questions:

Is there anything you would like to be different about any of the relationships you have told me about? Why/ why not?

Is there anything else that you think is important for me to know about what it’s like working with the people you support or with your colleagues?

Additional prompt questions:

Could you give me an example of that? Could you describe that in a little more detail?

What is/was that like for you?

How do/did you feel about that? What do/did you think about that?

How do/did you deal with, cope or respond to that?

What does that mean for you?

Appendix 4-B

FHMREC Ethical Approval Letters

Applicant: Rachel D'Sa
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC19036

14 February 2020

Dear Rachel

Re: Exploring how staff experience their working relationships in services for adults with a learning disability.

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:
- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.
Tel:- [redacted]
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]
Research Ethics Officer, Secretary to FHMREC.

Applicant: Rachel D'Sa
Supervisor: Dr Ian Fletcher
Department: Division of Health Research
FHMREC Reference: FHMREC20074 (amendment to FHMREC19036)

16 December 2020

Re: FHMREC20074 (amendment to FHMREC19036)

Dear Rachel,

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.
Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted],
Research Ethics Officer, Secretary to FHMREC.