

Research Article

“Who’s Caring for Us?”: Understanding and Addressing the Effects of Emotional Labor on Home Health Aides’ Well-being

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Abstract

Background and Objectives: Interventions to strengthen the home care workforce focus on workers’ economic and physical well-being, without acknowledging the caring labor affecting emotional well-being. Our study examined workers’ perceptions of the emotional effects of caring work, coping mechanisms, and desired support.

Research Design and Methods: We conducted 4 worker focus groups ($n = 27$). Moderators cross-checked codes and themes, and aides provided input through report-backs.

Results: Building close, trusting relationships with clients was central to aides’ emotional well-being. Well-being was also influenced by relationships with client families and agency supervisors, work–life balance, and the level to which aides felt their work was valued. Aides were largely alone in managing job stressors and desired more communication, connection, and support from supervisors and peers.

Discussion and Implications: Recognizing and supporting the emotional demands of caring work is crucial to strengthening the workforce. Policy makers and agencies must realign reimbursement systems, job descriptions, and care plans to include measures of emotional labor, improve communication between workers and supervisors, and provide training, mental health benefits, and peer support.

Keywords: Occupational health, Workforce development, Emotional labor, Well-being, Home health aides

All health care involves some level of emotional labor, or the relational work required to build trust with patients and ensure their comfort (Hochschild, 1983). Emotional labor is critical to high-quality care, but can also cause workers stress by requiring them to “perform” or regulate emotions while masking their true feelings (Hochschild, 1983; Stacey, 2011). These demands are of particular concern in home care. Personal care assistants and home health aides deliver the majority of direct home care services and shoulder the bulk of emotional labor that patients require (Butler, Wardamasky, & Brennan-Ing, 2012; Rodat 2014).

This can include “surface” acting, or “performing” caring expressions or gestures, as well as deeper emotion work where aides make an effort to build genuine emotional bonds with clients (Hochschild, 1983).

Emotional labor is often considered a stressor in occupational research, and home care workers report a high level of on-the-job stress caring for ill, dying, aggressive, or disoriented clients, and prioritizing patients’ emotional needs and happiness above their own (Arts, Kerkstra, Van der Zee, & Huyer Abu-Saad, 1999; Hakanen, Schaufeli, & Ahola, 2008; National Institute for Occupational Safety

and Health, 2010). However, aides' emotion work can also have positive effects, leading to caring, family-like relationships. Many aides report these relationships are the most rewarding part of their job and allow them to find value and meaning in their work, factors which psychological research has found to be critical to job satisfaction and workers' emotional health (Banijamali, Hagopian, & Jacoby, 2012; Blustein, Schultheiss, & Flum, 2004; Blustein, 2008; Butler et al., 2010; Russell, Rosati, Peng, Barrón, & Andreopoulos, 2013). These relationships can also be mutually beneficial; nursing home research suggests a culture of "companionate love" can improve both nurses' job satisfaction and residents' outcomes (Barsade & O'Neill, 2014).

Despite this, efforts to recruit and retain aides fail to address the specific impacts of emotional labor. Because home care payment models, job descriptions and care plans prioritize physical tasks like helping clients bathe, dress and eat, emotional labor is effectively an "invisible" job requirement for which workers receive no training, support or compensation (Stacey, 2011). As a result, most workforce development efforts are limited to structural interventions to improve workers' economic and physical well-being, such as increasing wages, offering health coverage, or providing safety training (Butler, Simpson, Brennan, & Turner, 2010; Folbre, 2006; Stone et al., 2016). Although these improvements are much needed, they do not address the considerable emotional demands workers face on the job. Understanding and supporting workers' emotional labor is critical to building and maintaining a skilled, qualified workforce, and ultimately improving patient care.

Conceptual Framework: Emotional Labor in the Context of Worker Well-Being

To better understand the effects of emotional labor on workers and patient care, we must put them in the context of workers' overall well-being. Across industries, poor worker well-being is connected to depression, burnout, stress, and exhaustion, and can cause workers to withdraw and become less engaged in their jobs, known as "stress-related presenteeism" (Karimi, Cheng, Bartram, Leggat, & Sarkeshik, 2015). On the other hand, supporting workers' well-being allows them to "flourish" and function more productively both on and off the job (Huppert & So, 2013).

In examining workforce functionality and productivity, Schulte and colleagues (2015) propose a "unified" concept of worker well-being that addresses all factors affecting "the health of workers and the quality of their working lives," with the goal of a "flourishing" worker "who benefits from a safe, supportive workplace, engages in satisfying work, and enjoys a fulfilling work life." This includes not just objective, structural factors like wages and benefits, but subjective factors like performing meaningful, valued work (Schulte et al., 2015). The conception of total worker well-being both on and off the job is particularly important in home care, where personal and professional lines are often blurred.

Our model identifies three primary domains that contribute to overall home care worker well-being: the *economic*, *physical*, and *emotional* work environments (Figure 1). Traditionally, workforce development efforts focus on economic domains like wages, benefits, and scheduling, as well as control over the physical workplace. These factors are often driven at the policy and organizational

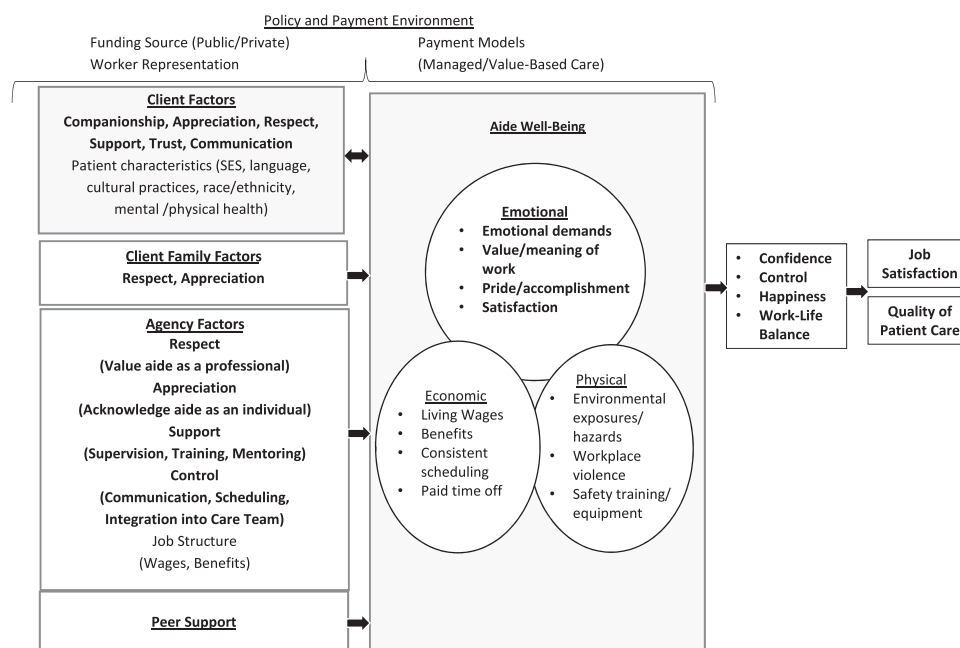


Figure 1. Factors affecting home care workers' well-being (factors explored in this study in bold). Informed by: Delp, Wallace, Geiger-Brown, and Muntaner (2010); Feldman, Ryvicker, Evans, and Barrón (2017); and Schulte and colleagues (2015).

level by a complex industry framework that includes public and private funding, agency and independent work, and union representation.

Our study sought to build and refine the model to more thoroughly incorporate the often unaddressed *emotional* domain (indicated in bold in Figure 1). Central to this domain is the core aide–patient relationship. Aides and clients spend most of their time alone together, building an intimacy which can offer emotional and professional rewards, but also create emotional demands (Delp et al., 2010; Hoppe, Heaney, Fujishiro, Gong, & Baron, 2015). These relationships, and aides' emotional well-being, are influenced by clients' family members at the individual level, and agency and care team staff at the organizational level (Franzosa, Tsui, & Baron, 2017). Emotional well-being may also be influenced by the level to which aides feel they and their work are respected, valued, and supported (Delp et al., 2010; Donoso, Demerouti, Garrosa Hernández, Moreno-Jiménez, & Carmona Cobo, 2015; Naring and van Drofferlaar, 2007).

As a step toward developing effective workforce supports, our study specifically asked how the emotional demands of home care labor and the conditions under which it is performed affect workers' well-being, how workers are currently managing these demands, and what support they need on and off the job.

Design and Methods

Our data are drawn from four focus group discussions ($n = 27$) and report-backs held in April 2016 with unionized, New York City area home health aides (HHAs) primarily serving Medicaid-qualified clients. The union, 1199SEIU United Healthcare Workers East, represents approximately 65,000 of New York City's 158,000 HHAs, home attendants, and housekeepers.

Recruitment

Focus groups were integrated into two college preparatory writing courses offered through aides' labor-management Home Care Industry Education Fund, which provides academic and occupational certification programs to 20,000 home care workers employed in 65 agencies. Participants had to be over 18; proficient in English; and have cared for two or more long-term nonfamily clients. All enrolled students were HHAs, eligible for the study, and chose to participate. Likely due to their union status, this was a highly experienced group. Fifty-six percent had been aides for 3+ years; 77% had worked with 5 or more clients; and 92% were working with 1–3 long-term clients. We held only English language focus groups due to time and resource constraints. Participants were primarily Caribbean/West Indian (63%), and 78% were foreign-born. (Although specific demographics for 1199SEIU HHAs were not available, 57% of New York State's direct care workers are foreign-born; Rodat, 2014.) All but two were women.

Data Collection

Each class (of 11 and 16 students, respectively) was divided into two randomly assigned, balanced focus groups of 5–8 participants. Three research team members (one facilitated two sessions) led the groups in 60–90 minutes of guided inquiry around our central constructs of *effects of emotional labor*, *coping mechanisms*, and *desired support* (e.g., What does a good day/hard day with a client look like? How do you feel after a good/hard day? What do you do to manage after a hard day?). Participants also completed a demographic survey, a written reflection in the following week's class (with the open prompt "what are your thoughts about the research project you participated in?"), and participated in report-backs 1 month later.

Analysis

Focus groups and reflection papers were coded in Dedoose qualitative software (SocioCultural Research Consultants, LLC, 2015) and analyzed together. Our analysis was informed by grounded theory (Corbin & Strauss, 2008; Glaser, Strauss, & Strutzel, 1968), although rather than a fully emic approach, our constructs of interest were the starting point. We intentionally designed our analysis to allow emic themes to emerge around these constructs, using strategies like questioning and constant comparison. We also borrowed from the tools of grounded theory as appropriate for our research setting and questions; for instance, using open, axial, and selective coding as a starting point to develop hierarchical categories (e.g., respect, appreciation, control), major themes (e.g., aides' work being valued) and broader concepts (e.g., emotional well-being) that became the basis of our codebook. Because our goal was to engage the same participants throughout the analytic process, we used report-backs (described later) rather than theoretical sampling to probe and clarify emerging themes (Charmaz, 2014). We were also attentive to the way participants used and understood the language of care, consistent with the practice of discourse analysis (Tonkiss, 2004).

To ensure validity, after research team members independently coded the transcripts, focus group moderators checked their groups' coded transcripts against the codebook. We discussed discrepancies until reaching consensus. Because aides' voices were central to this project and often left out of policy discussions, we were committed to ensuring our findings reflected their priorities. To that end, our project lead (E. Franzosa) visited each class 1 month after the focus groups to share and explain initial results, solicit feedback, and provide a brief written summary of the findings. Overall, aides agreed the findings captured their concerns, particularly around issues of respect and communication (or lack thereof) from supervisors. We used this input to further refine themes (e.g., agency support and peer connection), and build on aides' suggestions. All activities were approved by the Lehman College IRB, and participants provided written consent.

Results

Factors Affecting Aides' Well-being

Aides identified three primary relationships affecting their emotional well-being: *clients*, *clients' family members*, and *agency supervisors*. In each relationship, aides' well-being was influenced by the level to which they felt they and their work were valued, meaning personal contributions were appreciated, and professional expertise respected. These relationships, and accompanying responsibilities, also affected aides' ability to balance work and home life.

Client Relationships

Consistent with previous research, aides reported building close, trusting relationships with clients was central to both their own emotional well-being and to performing quality patient care (Butler et al., 2012; D. Stone, 2000; R. Stone, 2004). Personally, aides found these close relationships emotionally satisfying, frequently describing time with clients as "[having] fun together" (Aide 1202, Group 1). Professionally, leaving clients "with a smile on their face" gave aides a sense of pride and accomplishment, making them feel they had "done a good deed for the day" (Aide 1100, Group 1).

The genuine emotional connection aides experienced on these "good" days reduced emotional demand, allowing workers to be themselves; participants described feeling "light" or "free," or as one aide put it, "you don't feel overwhelmed. You don't feel bombarded. You feel confident enough to where you feel like you're home. You can be yourself" (Aide 1732, Group 1). Aides also appreciated when clients acknowledged their expertise, sharing these stories with pride. "Hearing [clients] say thank you and they appreciate what you do" (Aide 1854, Group 2) made aides feel valued and "wonderful. I go home smiling. Happy" (Aide 1507, Group 4). One aide was particularly proud when a former patient contacted her supervisor after his case was closed. "He told her, 'Thank you very much to [aide]. She was the best.' It was so happy for me" (Aide 1485, Group 4).

When aides had difficulty forming relationships, either because clients were demanding, disrespectful, or experiencing declining mental health, emotional labor was more stressful. Most aides had stories of feeling personally and professionally hurt when patients "looked down" on them and made them feel unwelcome or untrusted, telling aides not to use their phones, keep food in the refrigerator, or even "touch the paper towels." One participant was reprimanded about electricity use and told "don't waste my energy. You don't pay my light bill here." That was very challenging to me that I used to cry in bed and everything a couple of times" (Aide 1202, Group 1).

These challenges were particularly evident with dementia patients. As one aide shared, her patient was "good at times. She can be very nice ... then, the next time she just

blows up and goes crazy" (Aide 1049, Group 4). Another described the strain of keeping her client both emotionally calm and physically safe, telling the group that:

I have to be running every minute. If she tried to open the door – have to be behind, almost 12 hours a day ... from 8:00 to 8:00...she'd get up—I'd have to walk behind her because I don't know what she was going to do. You understand? Sometimes she want to go to the bathroom ... I say, Grams, let me help you—before she reaches the bathroom—I tried to put her on the toilet—she done messed the whole place ... I was so depressed and tired that I tell my agency—I said I don't want this job. (Aide 1620, Group 4)

In these "hard" cases, aides consciously employed emotional regulation to remain supportive and caring, although many acknowledged this was not easy. In some cases, aides were able to adopt a professional distance and attribute the behavior to physical discomfort or dementia, but others disagreed over whether difficult behavior could, or should, be explained away. As one aide noted ruefully, "well some of them, they don't have dementia" (Aide 1700, Group 2).

Client Family Relationships

Relationships with clients' families could also both positively and negatively affect aides' emotional health. Similar to client relationships, aides noted that positive feedback from family members gave them a sense of accomplishment. In some cases, appreciation and respect could mediate the strain of working with a difficult patient and build aides' confidence. One aide who worked with a volatile patient for several years noted the family's recognition kept her on the case, and that "I feel good because I know that I'm doing a good job and they've seen that things have been changed as I'm doing them" (Aide 1049, Group 4).

However, aides' sense of their personal and professional value could be undermined by family members who they felt disrespected the care plan and their professional role. Aides were often asked to take on extra tasks (which is not permitted by agencies), and felt family members perceived them as "housekeepers" or "maids." Some aides suspected family members understood the boundaries but exerted power by trying to "test" or "intimidate" them. As one aide explained, "family members ... they look down on you. They look down on you and tell their self that, you know what, you have to do what they say" (Aide 1100, Group 1).

These power dynamics were further complicated by the ambiguity in aides' and families' roles. In practice, aides often did perform off-plan work when they felt it was important to their client's care, or when a family member was "nice." Aides also did not think of family members as supervisors, since they were employed by agencies and paid through Medicaid, but acknowledged family still wielded considerable power over hiring and firing, scheduling, the household environment and clients' moods. One

participant likened navigating these relationships to walking a tightrope, saying “it takes a lot of work. You got to make that family member happy and you got to make that client happy ... sometimes I get like, wow, I don’t know how long I’m going to be on this job. It takes a lot of toll” (Aide 1378, Group 2).

Agency Relationships

Workers noticed and valued agency supervisors who treated them with empathy and respect. A few aides said coordinators supported them in scheduling time off for school or family obligations, or negotiating boundaries with clients’ families, and this support was appreciated. One aide working with multiple agencies described how the personal touch and acknowledgment from a smaller employer improved his confidence, noting that “[The agency] always call and say, ‘Oh [name], thank you very much’ before I leave... sometimes [it’s important to hear], you know what, thank you. You’re doing a good job” (Aide 1237, Group 3).

However, much more frequently, relationships with agency supervisors were described as aides’ least supportive interactions. One of the strongest and most consistent themes was a perceived lack of respect and appreciation from supervisors, around both patient care and administrative issues. Aides’ general consensus was that agencies “don’t care about us” (Aide 1202, Group 1) and “don’t appreciate what you do” (Aides 1065 and 1378, Groups 2 and 3). Many aides felt the agency viewed them as interchangeable, and that “it’s all about the money. Make sure you have a body there to take care of that client” (Aide 1378, Group 2). When aides did experience challenges with a client or family member, or a scheduling or payroll error, they could rarely reach a supervisor, noting that the phone just “rings and rings” and calling was generally “a waste of time.”

This was particularly evident and hurtful in aides’ stories of patient death, a frequent experience considering the elderly and disabled client population. Participants felt agencies rarely acknowledged client loss, viewing the death simply as a scheduling issue to be resolved. As one aide shared, “my patient who I had actually for seven years passed away and she’s like family. But no one—don’t nobody come to ask me how I’m doing ... the supervisors don’t ask you how you’re doing, all they tell you, go to another case. You get a new patient” (Aide 1029, Group 1). For some aides, moving to a new patient quickly could be traumatic. As one said, “I was so depressed it’s like a part of me just left ... I had to stay away from work for at least two, three weeks. Before I could start it again” (Aide 1202, Group 1). But for others, the immediate loss of income and financial security was even more stressful. In both circumstances, aides rarely felt they could turn to a supervisor for help.

Work–Life Balance

As has been found among nursing home aides, the emotional demands workers faced on the job also affected their

home lives (DePasquale et al., 2017). Many aides were caregivers both at work and at home, and their own needs often came last. As one aide noted, after work “I go home and I do mostly the same thing [caretaking].... Because I have children” (Aide 1537, Group 3).

The clearest conflicts were around *physical* scheduling, where aides often felt they had little control. Participants were acutely aware that “most of your time is not with your family” but when the agency calls, “you got to take it” (Aide 1878, Group 3). One aide, speaking to the financial precarity of her job, explained, “I could be sitting right here, and the phone ring, and they call you. You on call. You can refuse it, but you don’t know when they’re going to call you again” (Aide 1324, Group 3).

Aides also experienced the stress of competing *emotional* scheduling, often feeling they were disappointing their client, their own family, or their employer by prioritizing one over another. One participant illustrated this tension in a story about requesting Thanksgiving off, after several years of volunteering to make her client a holiday dinner. “[The client] doesn’t like it,” she told the group. “She wants you to stay there with her.... I said this year I have to spend [the holiday] with my family because I have a sick mother who needs me too ... but some of the people in the agency, they don’t like it ... they say, ‘Well you can have that day off. You’re fired’. That hurts me” (Aide 1304, Group 1). This lack of respect for aides’ personal lives frustrated workers, and even made them question whether the job was worth it. As one aide said, “You have so much regret, especially when you know that you put so much effort into what you’re doing, then someone is not appreciating what you do. Leaving your family to come and care for them. I mean, that’s a lot” (Aide 1202, Group 1). Even when aides could be with their families, they worried about bringing the stress of a difficult day home. As one aide explained:

You find yourself ... expressing those emotions to people who really don’t deserve them. It’s like you don’t catch yourself until they point it out to you—listen, something’s going on, you don’t look right, you don’t sound right, do you want to talk about it, do you want to vent. Sometimes it’s like you want to but you don’t because you don’t want to bring—you don’t want your problems to be their concerns. (Aide 1732, Group 1)

Coping Mechanisms: “We’re on Our Own”

When asked how they coped with job challenges, aides said they largely managed on their own. Participants identified three primary coping strategies: *self-reliance*, *faith and prayer*, and *social support and education*.

Self-reliance

Aides’ most frequent response to work stress was to try to “let it go” or “just cope.” As one worker explained, “you got to discipline yourself. Just like a soldier. You got to

suck it up" (Aide 1378, Group 2). Many took a fatalistic approach, noting that bad days were simply part of the job: "That's what you take the job for, right? To be a home health aide. Some days good, some days bad" (Aide 1854, Group 2). But aides also said "letting it go" wasn't easy and took deliberate work. One participant described the conscious choice to put work stress behind her, while acknowledging that in practice, this could be difficult. "I'm not going to get mad and get stressed with nobody ... I let it go. I'm not going to stay for the whole day with this" she said, going on to admit, "it's not easy" (Aide 1065, Group 2).

Faith and Prayer

Many participants drew on religious faith to manage stress. One aide told the group, "I do pray to God so that he may give me strength, I get patience" (Aide 1807, Group 1), while another asked God "to give me knowledge and understanding" (Aide 1100, Group 1) on hard days. Faith was also frequently described as a substitute for formal support when managing difficult emotional situations. One aide described how after a client died, "I wish I had a support group to vent all my stress and anxiety to. The only thing ... was to pray to God that the pain I felt inside would go away" (Aide 1202, Group 1).

Social Support and Education

Many aides sought emotional support through friends, family, church, and school. Despite not wanting to burden their families, several participants said their partners helped to "calm [their] nerves" and "take [their] mind off it" (Aide 1537 and 1324, Group 3). Education Fund classes were also an important support, both to "[do] something for yourself" and to connect with other workers facing similar challenges. As one aide said, "coming to school has helped me a lot to cope. Because when you come, you associate with people and then the teacher, if she's a good teacher ... it gives you hope" (Aide 1202, Group 1). In addition to connection with others, classes gave aides an opportunity to envision a better life, saying that school "strengthens you

in a way where it's like, I'm bettering myself, and I'm going to keep on going" (Aide 1732, Group 1), while another agreed that "when I have a bad time, I just think about school and [moving] forward" (Aide 1807, Group 1).

What Support Do Aides Want and Need?

Aides had clear, specific suggestions for job supports. Overwhelmingly, these suggestions reflected the need to be recognized for the central role they played in patient care, and the desire for more communication and connection with supervisors and each other (Table 1).

Agency Support

At the agency level, aides wanted easier access to coordinators, and to know their concerns were heard and addressed, with one group suggesting a nurse or supervisor "hotline." Although practical on the surface, this request revealed a deeper desire for coordinators to better appreciate aides' job challenges. As one aide explained, to general agreement, "coordinators need to leave the office, come to the patient's home, see what's going on there" (Aide 1065, Group 1). Aides also requested "worker-focused" training that went beyond patient care skills and addressed the demands of caring work, from caring for dementia patients to negotiating boundaries. However, there was disagreement over employers' roles, and some felt it was unrealistic to expect agencies to be more active. "You're there to do a job, and I say don't look for that," noted one participant. "If you're looking for support, then that's the wrong job" (Aide 1378, Group 2). Aides also asked for specific structural supports, from paid time off to more control over scheduling.

Peer Support

At the peer level, aides expressed a strong need for more connection with each other in person or virtually, including opportunities to share expertise or "just vent." Education Fund classes were seen as a valuable opportunity to interact with other aides, but workers also asked for support groups

Table 1. Support Requested by Aides

Employer/union/institutional support	Peer support
<ul style="list-style-type: none"> ◦ A "hotline" with someone who will "listen to you," (designated agency coordinator, or outside advocate to "represent us in the agency") ◦ Open, responsive communication across the care team (nurse, coordinator, family, and aide) ◦ In-service trainings focusing on aides' needs (dementia care; death and dying; managing "difficult" patients) ◦ Boundary-setting with patients' families ◦ Supervisor check-ins and home visits ◦ Grief counseling and mental health services ◦ Paid time off ◦ Control over scheduling 	<ul style="list-style-type: none"> ◦ Support groups and/or one-on-one peer support ◦ Classes and educational and social opportunities to interact with peers ◦ A magazine with advice from peers and experts on coping strategies and skills

and other gatherings to specifically talk about job challenges. Many participants found the focus groups themselves to be a helpful and supportive experience. As one aide wrote in her reflection paper, the group “was the first time I really had a chance to speak about what I was feeling” (Aide 1202, Group 1), while another wrote that “it was ... a relief to be able to communicate to each other openly” (Aide 1304, Group 1). However, aides also acknowledged the challenges of scheduling these activities around their complex work schedules and family responsibilities.

Discussion and Implications

Policy discussions of home care workforce development, when they occur at all, are often limited to structural job improvements. Although these issues are important, this reductive approach fails to acknowledge what home care workers’ emotional labor adds to the system, and what is lost when the demands of this work harms aides’ well-being and ability to perform caring work effectively or stay in the industry at all.

Our study suggests that aides’ emotional well-being is an important, yet often overlooked, factor in supporting “flourishing” workers. It also shows that the emotional demands of this work are multifaceted. As Figure 1 illustrates, in addition to client relationships, we found that clients’ families and agency supervisors have a strong effect on aides’ emotional well-being, and these factors interact with other structural domains (such as scheduling, or training needs) to affect aides’ sense of confidence, control, happiness, and ability to balance work and home life.

Navigating Emotional Labor

As our study showed, HHAs are navigating a host of emotional demands on the job and off, largely on their own. Aides’ emotional labor operates on several levels; first, in working to develop genuine caring bonds with patients; second, in employing emotion work in situations where relationship building is difficult (as with “mean” clients or dementia patients); and third, in employing surface acting to maintain professional relationships with clients’ families and supervisors. These efforts are further complicated by the conflicting organizational and individual “feeling rules” aides must navigate on the job (Hochschild, 1983). For instance, although agency policies dictate that aides manage emotions and maintain professional distance, aides’ own perception of quality care aligns more with the nurturing, caring, and loving “feeling rules” of family relationships (Franzosa et al., 2017). These rules were often difficult to reconcile, leading to role ambiguity and emotionally challenging situations (such as family members “testing” boundaries, or the client who had come to expect a Thanksgiving dinner). Conflicting feeling rules also left aides feeling frustrated and disrespected when supervisors

only acknowledged their professional roles and dismissed or actively discouraged aide–client relationships.

Aides’ caring labor was further complicated by a work environment that fails to provide adequate recognition and support. Consistent with previous research, we found that emotional labor can be both stressful and rewarding (Stacey, 2011). Aides valued the emotional rewards of caring labor, with most participants emphasizing how much they loved their jobs and their clients. These relationships were central to aides’ emotional well-being, and their understanding of themselves both as caring individuals and skilled, confident professionals. When aides felt seen and respected by clients, supervisors, and clients’ families, they were better able to manage day-to-day challenges. But when they were not, the work “took a toll,” leaving them exhausted, stressed, and even considering leaving the job. This was complicated by the fact that aides often voluntarily took on uncompensated emotional and physical labor outside their assigned tasks to fill perceived gaps in care, a gesture that was often either misunderstood or unacknowledged by clients’ families and agency supervisors. This type of chronically stressful work environment, which Siegrist (1996) terms the “effort-reward imbalance” or ERI, can have significant negative consequences for workers. The ERI suggests high-demand jobs, particularly those requiring emotional “over-commitment,” have socioemotional and physical impacts when they are not reciprocated with sufficient economic or emotional rewards, from pay and job security to support, respect, and esteem. This imbalance, and the resultant stress, was particularly evident among our participants, and is an important consideration for worker retention and productivity because ERI has been tied to adverse stress-related health outcomes (Siegrist & Li, 2017).

Research and Policy Implications

Building supportive work environments that allow home care workers to “flourish” will require recognizing, acknowledging and valuing aides’ full scope of work. Our study found that workers’ stress was often related to the role ambiguity that arose from the invisibility of their emotional labor, a cornerstone of care that must be incorporated into training, job descriptions, care plans, and payment systems. Our study also pointed toward priorities for future research, primarily the need for more robust and complete data on the workforce as a whole, particularly measures that go beyond wages and benefits to reflect workers’ emotional well-being, and how this ultimately affects patient care. Other important areas to explore include effort–reward imbalance and physical and mental health outcomes in aides; the complex interaction between physical, emotional, and economic domains of well-being (for instance, the ways that public funding cuts may result in lower pay, more stress and added physical strain from performing more tasks in less time); how workers and families can better negotiate roles and boundaries; the emotional

and financial impacts of client death; emotional scheduling; and the use and demographic implications of faith as a coping strategy.

Opportunities for Agency Support

One of our most striking findings was aides' need for more connection and communication with supervisors, and each other. Supervisor support has shown important benefits; for instance, nursing research suggests that when coupled with institutional support, high emotional job demands may actually improve workers' psychological well-being, be perceived as professional development opportunities, and generate satisfaction and a sense of control over work (Karimi, Leggat, Donohue, Farrell, & Couper, 2014; Karimi et al., 2015). Similarly, the few studies examining home care workers' experience of patient death have found aides who felt they could seek supervisor support, and did, were better able to process their grief and more likely to stay in their jobs (Boerner, Burack, Jopp, & Mock, 2015; Boerner, Gleason, & Barooah, 2016; Gleason, Boerner, & Barooah, 2016). With technological innovations, there are many opportunities for agencies to better connect with workers, whether during traumatic events like a death, or day-to-day patient care issues.

There are also opportunities and calls for agencies to invest in supportive training, either on their own or in partnership with unions and worker groups (Gilster, Boltz, & Dalessandro, 2018). For instance, aides in our study cited their Education Fund classes as an important social and educational resource, while the research and advocacy group PHI has shown promising results with worker-focused training including peer mentoring, supportive services, case management, and perhaps most importantly, supervisor coaching (PHI State Data Center, n.d.; VNSNY Center for Home Care Policy and Research, 2015). Yet, few aides around the country have access to these opportunities, and even the comparatively privileged HHAs in our study wanted more. In combination with supportive structural benefits like paid sick days, bereavement leave, low-cost or free counseling services, and robust mental health benefits to allow aides respite from caring work without jeopardizing their economic stability, these programs could not only improve aides' skills but also make them feel valued and heard in the workplace.

Opportunities for Peer Support

Agencies, unions, and worker groups can also offer opportunities for peer support. However, these efforts must take into account aides' many competing priorities and complex, 24/7 schedules. As our study showed, aides' input is critical to making these programs successful. For example, many participants were eligible for mental health benefits through their labor-management health benefit fund, but few mentioned they had utilized them. At the time of our

study, the Benefit Fund was polling members to determine why these benefits were underutilized, and using the findings to develop tailored programs and outreach, including support groups and bereavement counseling. Other options to accommodate aides' needs and schedules could include virtual or telephonic support.

Of course, in making these recommendations, we acknowledge the ever more austere policy and payment environment, where efforts to manage costs and improve care through new payment models may be putting additional pressure on agencies, front-line supervisors, and aides to do more with less. Researchers and advocates must continue to emphasize that retaining skilled, engaged, and empathetic workers is not just a smart investment, but a necessary one.

Limitations

There were several limitations to this analysis. Our study reflects the experiences and concerns of aides working for one type of agency, in one type of program, which may differ from aides working for private-pay clients or private, for-profit agencies. Participants were unionized aides, who represent only one-quarter of the total home care workforce and have more job support and benefits than most, although our findings demonstrate the need to improve job quality even for these more advantaged workers (Schriever, 2015). Finally, this analysis does not capture the experience of other members of the care team or aides who leave the industry—a particularly important factor to explore when considering the emotional effects of this work. However, even with these limitations, the themes were consistent with the home care literature, particularly around aides' need for more respect, support, and communication.

Conclusion

Supporting a high-quality home care workforce will require us to build supportive work environments that acknowledge the emotional, as well as the physical, demands of care. Researchers, policy makers, and employers must consider total worker well-being in designing jobs, worker supports, and payment systems that better meet workers' needs. By seeing and valuing the full scope of home care workers' labor, we can both improve aides' well-being and retain and build the engaged, committed, and skilled workforce that our aging population will need.

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Conflict of Interest

None reported.

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